AIDS and the Health Care Provider: The Argument for Voluntary HIV Testing

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AIDS AND THE HEALTH CARE PROVIDER: THE ARGUMENT FOR VOLUNTARY HIV TESTING

BARRY R. FURROW†

TABLE OF CONTENTS

I. INTRODUCTION ........................................ 824

II. RISKS AND HIV TESTING ..................................... 828
   A. Risks to Patients: The Costs of Leaked Secrets—Discrimination, Prejudice and Violence .......... 828
   B. Risks to Medical Staffs .................................... 831
      1. The Risk of Needle Sticks and Other Exposures .......... 832
      2. Risks Arising From the Proportion of Patients Treated Who Are HIV-Seropositive .......... 833
      3. The Risk of Becoming HIV-Positive from a Single Needle Stick ..................................... 834
      4. The Cumulative Risk of HIV Infection to Health Care Workers ........................................ 835
   C. Risks of Not Testing Patients ................................ 837
      1. The Alleged Purpose of Testing .............................. 837
      2. Accuracy of Testing ........................................ 838
         a. Laboratory Shortcomings .................................. 839
         b. Staff Errors .............................................. 840
      3. Results of Testing: Alleviating Workers’ Risk Versus Adverse Patient Consequences ................. 841

III. LEGAL PRINCIPLES AND FUNDAMENTAL RIGHTS ........ 842
   A. The Principle of Autonomy: Informed Consent .............. 843
   B. The Principle of Preserving Secrets: The Right to Privacy ....................................................... 846
   C. The Principle of Reasonableness: Balancing on a Weighted Scale .............................................. 855
      1. Constitutional Balancing: Mandatory Testing as a Fourth Amendment Violation ................. 855
      2. Private Law: The Threat of Tort Actions .................. 859
         a. Existing Tort Theories ..................................... 860
         b. The Emergence of a Standard of Care ..................... 863

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(823)
The Acquired Immune Deficiency Syndrome (AIDS), and fear of exposure to the Human Immunodeficiency Virus (HIV), which causes AIDS, has induced a tremendous fear in modern society. This fear is understandable: AIDS has no cure, it is inevitably fatal and it suggests membership in a group that presently includes mostly unpopular minorities. By the middle of 1988, over 70,000 cases of AIDS had been reported in the United States. By the end of 1992, 365,000 cases are projected; and by 1993, 450,000. Those infected with HIV are estimated at between 940,000 and 1,500,000, with a substantial increase in that level of infection expected in the next few years. The time from

1. Since 1981, when epidemiologic reporting on the incidence of AIDS first began, 63% of the victims have been homosexual or bisexual men with no history of IV drug abuse; 7% homosexual or bisexual men with a history of drug abuse; 19%, heterosexual men and women who used IV drugs; 3% of the cases have been due to transfusions with contaminated blood; and 3% of the cases have been of undetermined origin. Heyward & Curran, The Epidemiology of AIDS in the U.S., 259 Sci. Am. 72, 78 (1988). As of July 4, 1988, homosexual or bisexual men and IV drug abusers made up 89% of the adult cases. Id.


3. Id.


a person's initial infection with HIV to diagnosis with AIDS appears now to be over eight years. Once diagnosed, however, a person with AIDS generally has less than eighteen months to live, although this survival time depends on how one views the stages of progression of the disease. Studies of the treatment benefits of Zidovudine (AZT) show that its use can extend that period somewhat, but there is currently no cure. The only medical intervention is to treat the infections associated with the HIV virus.

Unlike powerful disease vectors in past plagues, the AIDS virus isn't easily transmitted; rather, it is only mildly contagious, requiring the exchange of a volume of bodily fluids, such as blood or sperm, to convey the virus. However, health care profession-

6. Ginzburg, supra note 4, at 567.
7. Redfield & Burke, HIV Infection: The Clinical Picture, 259 Sci. Am. 90, 94-95 (1988). The Walter Reed Classification System groups patients by stage of infection, judged by indicators of immune impairment underlying HIV disease: stage 1 is acute infection; stage 2 is chronic lymphadenopathy; stages 3 and 4 are marked by progressive subclinical immune dysfunction; stage 5, by skin and mucous membrane immune defects; and stage 6, by systemic immune deficiency. Stage 6 is what we think of as the final stage—AIDS—with most patients dying within two years of entering stage 6.
10. Redfield & Burke, supra note 7, at 90. HIV induces the progressive destruction of the T4 lymphocyte, a cell essential to the immune system. Infections and malignancies against which cellular immune mechanisms normally defend therefore increase. Glatt, supra note 9, at 1439. Such conditions include parasitic infections, such as Pneumocystis carinii pneumonia; viruses such as cytomegalovirus; and bacteria, fungi and malignancies such as Kaposi's sarcoma. See also Rosencranz and Lavey, Treating Patients with Communicable Diseases: Limiting Liability for Physicians and Safeguarding the Public Health, 32 St. Louis U.L.J. 75, 95-101 (1987).
11. Unfortunately, its primary current modes of transmission—sexual relations and infected needles—implicate sensitive private activities that do not lend themselves easily to behavioral change. The effectiveness of education in changing risky behavior is still unclear. See Sisk, Hewitt & Metcalf, The Effectiveness of AIDS Education, Health Aff., Winter 1988, at 37. Most people can remain in a low-risk category for exposure to the human immunodeficiency virus (HIV) by practicing "safer sex," (i.e., limiting sexual contacts and using prophylactics, avoiding intravenous drug use and taking other precautions such as donating their own blood in anticipation of elective surgery). For a discussion of the con-
als—surgeons, emergency room nurses and others—are in a category of individuals frequently exposed to blood and blood products of patients who may be HIV-positive or have AIDS. Over 170,000 patients will be treated for AIDS in 1992.12 

"[M]ore than 500 thousand emergency allied health care workers . . . [treat] 80 million emergency room patients per year in 5,382 hospital-based emergency departments."13 Outside the emergency setting, almost 5,000,000 health care personnel in 500 thousand health care facilities have patient contact or are involved in handling blood products in a variety of settings from elective surgery to drawing patient blood for testing.14

Health care workers lacking prior risk factors have tested HIV-seropositive after treating patients and handling blood. Four of eleven such occupationally-related transmissions occurred in emergency room or outpatient settings.15 Thus, health care workers are becoming anxious.16 Their anxiety leads them to demand that patients be tested for HIV without consent, either as a standard test in the battery of those customarily performed upon a patient's admission to a hospital, or when a worker suspects that a patient might be HIV-positive or have AIDS or AIDS Related Complex (ARC).

Mandatory testing—blood-testing done without the patients' consent or even their knowledge—has been proposed in the health care setting as a way to protect health professionals against the disease.17 As one such proponent argues: "AIDS testing


14. Mayer, Union Wants OSHA to Extend Inspections, HEALTH WEEK, Dec. 27, 1988, at 8 (health care workers' union wants federal inspectors to inspect more facilities to ensure proper protection from AIDS for workers).

15. Kelen, supra note 13, at 1645 (citations omitted).


17. Lewin, Judge Refuses to Declare AIDS a Sexual Disease, N.Y. Times, Nov. 16, 1988, at A15, col. 4. A state supreme court judge refused to issue an injunction to force the New York Health Commissioner to declare AIDS and HIV infection to be communicable and sexually transmitted diseases. Such a listing would have meant that a doctor in New York who reasonably suspects that a patient has the disease has the right to test the patient without consent. Id.
should be routinely performed on all patients admitted to hospitals. It makes little sense to treat all surgical patients as if they pose the risk of AIDS to hospital personnel when it is possible to identify those who are potential sources of infection.\textsuperscript{18} Surreptitious HIV testing of all patients has been implemented in many hospitals. One study concluded that almost ninety percent of the HIV tests at one major medical center were done without justification or patient consent.\textsuperscript{19}

It is not surprising that health care institutions engage in surreptitious testing of patients without their consent, given the quiet approval by the American Medical Association (AMA) of such an approach. In an AMA Board of Trustees' report, several recommendations were proffered.\textsuperscript{20} The AMA wanted ready availability of voluntary testing, stressing the importance of counseling before tests for AIDS and after a seropositive result. Recommendation 11 stated that "[p]atients should knowingly and willingly give consent before a voluntary test is conducted."\textsuperscript{21} But Recommendation 6 then compromised much of the patient protections of the other recommendations:

Voluntary testing should be regularly provided for the following types of individuals who give informed consent: (1) patients at STD clinics, (2) patients at drug abuse clinics, (3) pregnant women in high-risk areas in the first trimester of pregnancy, (4) individuals seeking family planning services who are from areas with a high incidence of AIDS or who engage in high-risk behavior, and (5) patients requiring surgical or other invasive procedures who are from areas with a high incidence of AIDS or who engage in high-risk behavior. If the voluntary policy is not sufficiently accepted, the hospital and medical staff should consider a mandatory program for the institution.\textsuperscript{22}

Since mandatory testing presumably means that patient consent is

\begin{itemize}
\item \textsuperscript{18} Tanay, \textit{Psychiatric Reflections on AIDS Education}, 18 \textit{Psychiatric Annals} 594, 597 (1988); see also Crenshaw, \textit{HIV Testing: Voluntary, Mandatory, or Routine?}, 48 \textit{The Humanist} 29 (1988) (there would be widespread voluntary compliance once testing is recognized as a matter of common sense for health and not as coercion).
\item \textsuperscript{19} Henry, Maki & Crossley, \textit{Analysis of the Use of HIV Antibody Testing in a Minnesota Hospital}, 259 J. A.M.A. 229 (1988) [hereinafter Henry].
\item \textsuperscript{21} \textit{Id.}
\item \textsuperscript{22} \textit{Id.} (emphasis added).
\end{itemize}
no longer sought, this provision defeats the purpose and idea of informed consent. The implication of the AMA position—"[i]f the voluntary policy is not sufficiently accepted"—means in effect that if too many patients exercise their right to refuse testing, a voluntary position is a failure and the imposition of a mandatory system is justifiable. This sends a strong message to health care institutions that they need not encourage voluntary testing.

Government officials have also proposed routine testing, whether voluntary or not to protect health care workers, to better track the disease and to identify those infected so that individuals with HIV can act responsibly.\textsuperscript{23} Former Secretary of Education William Bennett wrote: "There is a strong case to be made for proposals to make testing routine for hospital admissions; to make routine testing a part of the treatment at clinics, perhaps particularly at those serving 'high risk' populations . . . ."\textsuperscript{24} Routine testing under this proposal becomes the norm, with states and localities allowing exceptions to routine testing under limited circumstances.\textsuperscript{25}

This article argues that routine testing of patients entering a health care institution is of little benefit in protecting health care workers. Furthermore, testing of blood without the consent of the patient greatly compromises the patient's rights and is neither legally nor morally defensible.

\section*{II. Risks and HIV Testing}

\subsection*{A. Risks to Patients: The Costs of Leaked Secrets—Discrimination, Prejudice and Violence}

We live in an imperfect world in which confidences are violated, employees retaliate, acquaintances shun, landlords evict and strangers stigmatize. Because of these societal reactions, the act of testing for AIDS imposes significant costs of prejudice and discrimination on the person tested.\textsuperscript{26} Tests can have adverse

\textsuperscript{24} Id. at 6.
\textsuperscript{25} Id.
\textsuperscript{26} See J. Goffman, Stigma 5 (1963). Goffman writes:
By definition, of course, we believe the person with a stigma is not quite human. On this assumption we exercise varieties of discrimination, through which we effectively, or often unthinkingly, reduce his life chances. We construct a stigma-theory, an ideology to explain his inferiority and account for the danger he represents, sometimes rationalizing an animosity based on other differences, such as those of social class.
consequences even if the result is correct. If the result is incorrect, the consequences can be truly destructive. Societal prejudice means that careless, inaccurate or overzealous HIV testing can result in the loss of one’s job, uninsurability, shunning, adverse psychological consequences, including suicide attempts and major depressive illnesses, and, with a negative result, a false sense of security.\textsuperscript{27}

Further, nonconsensual testing increases the risk of disclosure of an HIV test result, and such disclosure can have substantial detrimental effects.\textsuperscript{28} This report by a physician details such effects:

In 1985, I was the primary physician for a young man whose life was ruined by the inappropriate disclosure of a positive human immunodeficiency virus (HIV) antibody test. A physician ordered the test without consent and notified the local health department of the positive result. The health department notified the individual’s employer and he was promptly fired. These events became common knowledge at his workplace and in his rural Midwestern town and he was shunned. His landlord asked him to move. Ten days after testing, the life he had known for the past ten years was permanently ruined and he left town. With the loss of his job came loss of health insurance and uninsurability; he has been un-

\textsuperscript{Id.}

\textsuperscript{27} For a discussion of the need for counseling before and after testing, see \textit{Morris, Correspondence, AIDS Counselling and Informed Consent}, 294 Brit. Med. J. 839 (1987). See also the damages alleged by plaintiffs in Doe v. Conly, Civ. No. CV-88-0486 (M.D. Pa. Mar. 31, 1988); Doe v. Wills Eye Hosp., No. Civ. 5248 (C.P. Philadelphia County Mar. 30, 1988). The plaintiffs, tested without their knowledge or consent and notified later as to positive HIV results, alleged that they suffered extreme mental anguish, distress and depression.

Admiral James D. Watkins, Chair of the Presidential Commission on the Human Immunodeficiency Virus epidemic, expressed concern about discrimination against AIDS victims:

If the nation does not address this issue squarely, it will be very difficult to solve most other HIV-related problems. People simply will not come forward to be tested, or will not supply names of sexual contacts for notification, if they feel they will lose their jobs and homes based on an HIV-positive test. So, once those with HIV are treated like anyone else with a disability, then we will find that what is best for the individual is also best for the public health.

\textsuperscript{Gianelli, Panel’s Chairman Urges Radical Change in U.S. War on AIDS, Am. Med. News, June 17, 1988, at 1, col. 1; at 32, col. 1.}

able to obtain health or life insurance since then. 29

Such testimony is becoming commonplace. Courts also have noted the stigmatization and discrimination that may result from disclosure of AIDS test results. 30

Physical violence is yet another cost of the leaked secret of HIV seropositivity. Violence against homosexuals has escalated from 4,946 reported cases in 1986 to 7,008 in 1987, suggesting that the AIDS epidemic has intensified anti-homosexual sentiment. 31 The public is merging fears of the AIDS epidemic with negative attitudes toward high-risk groups.

The risk of stigma and its attendant damages from various forms of discrimination is apparent. While voluntary testing is often proposed as a desirable public health policy, such a policy will only work if those who consent to testing can be assured both full pre- and post-test counseling, and protection from discrimination and violence. However, it appears that such reassurances cannot be offered. One survey revealed that “between one in four and one in five people (one in three in the South) believe that those with AIDS should be excluded from working with them, attending school with their children, [sic] and living in their neighborhoods.” 32 A person who tests HIV-positive faces a discriminatory mindset and hostility from many Americans. To sub-

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30. One of the important objectives of an AIDS clinic is to encourage people suffering from AIDS, or who suspect that they may be infected by the HIV virus, to come in for testing and treatment without the fear of public disgrace or shame. The stigma which comes from the disclosure that a person is a patient at an AIDS clinic will deter a person from seeking treatment or testing, particularly at the early stages of the disease before symptoms develop.


As another court wrote: "AIDS is the modern day equivalent of leprosy. AIDS, or a suspicion of AIDS, can lead to discrimination in employment, education, housing and even medical treatment." South Fla. Blood Serv., Inc. v. Rasmussen, 467 So. 2d 798, 802 (Fla. Dist. Ct. App. 1985).

31. Blendon & Donelan, Discrimination Against People with AIDS: The Public's Perspective, 319 NEW ENG. J. MED. 1022, 1023 (1988). See Law, Homosexuality and the Social Meaning of Gender, 1988 Wis. L. Rev. 187 (discussion of reasons for social disapprobation of homosexual behavior, including social reaction to violation of gender norms). Law argues that "the persistence of negative social and legal attitudes toward homosexuality can best be understood as preserving traditional concepts of masculinity and femininity as well as upholding the political, market and family structures premised upon gender differentiation." Id. at 188.

32. Blendon & Donelan, supra note 31, at 1026.
mit to testing is to risk the costs and consequences of that mindset.

B. Risks to Medical Staffs

The fear of exposure to HIV, like fear generally, is built on layers of uncertainty: uncertainty as to who might be infected; uncertainty as to channels of transmission; and uncertainty as to the volume of inoculum or blood sufficient to transmit the infection. Individuals' perceptions and reactions to risks are often exaggerated, given the actual risks. People overestimate the probabilities of falling victim to dramatic and sensational diseases or injury. Risky events are often judged as more likely to occur if they are easy to imagine. Because health care workers are exposed to the reality of AIDS symptoms and death, they are among those likely to overestimate the risks of their exposure to HIV and to search for technological cures to ease their anxieties. This irrational fear, compounded with homophobia, underlies many demands for routine testing. Routine testing is the technological fix to appease fear of contagion.

Risks to health care workers can be separated into four categories. First, it is necessary to consider the frequency of needle stick injuries and other exposures by health care workers. Second, the degree of risk must include the proportion of people treated who are HIV seropositive. These two factors together determine the third risk category—the risk of becoming HIV seropositive through a needle stick or exposure. Fourth, the health care worker must consider the impact of these risks together in determining the cumulative risk of HIV infection among health care workers.


36. See Kelly, St. Lawrence, Smith et al., Stigmatization of AIDS Patients by Physicians, 77 AM. J. PUB. HEALTH 789 (1987) (important for health care professionals to develop programs to counter unreasonable stigma and prejudicial attitudes).

37. Emanuel, Do Physicians Have an Obligation to Treat Patients with AIDS?, 318 NEW ENG. J. MED. 1686, 1688 (1988) (obligation depends on viewing medicine as profession which requires some personal risk).
1. The Risk of Needle Sticks and Other Exposures

The frequency of needle sticks and other exposures varies by medical specialty and job. Internists have an overall risk of becoming HIV positive at a rate of about 0.5%.\textsuperscript{38} Firefighters in Boston on the front line face a risk of death of about 0.5% during each of the worst years and 0.2% in average years.\textsuperscript{39}

Surgeons who operate frequently on AIDS patients may face higher risks. Assuming forty needle sticks per year, emergency room doctors in the Kelen study had a 2% annual risk of contracting HIV infection (forty sticks per year, with 4.6% infected with HIV and 1% risk of HIV infection from each stick). This may present excess risk.\textsuperscript{40}

Physicians have a compelling ethical duty to treat patients with AIDS and a failure to treat breaches this obligation.\textsuperscript{41} Professional obligations require that physicians treat patients in need, even at some reasonable risk to personal safety.\textsuperscript{42} Health care workers are at some risk of contagion. For example, surgeons and pathologists may face a risk of contracting hepatitis B that is five times that of the general population.\textsuperscript{43} The risk may be even higher for dentists.\textsuperscript{44} Even if the risks facing health care workers are somewhat higher than the general population, those risks do not justify wholesale testing. Emanuel writes:

In this respect, medicine is no different from other occupations in which one is expected to accept some personal risk in pursuit of one's aim. Thus, it is expected that firefighters will risk burns, even death, to fight blazes, and that lifeguards will risk injury to rescue

\begin{itemize}
\item \textsuperscript{38} Dr. Lorraine Day, Chief of Orthopedics at San Francisco General Hospital, has estimated, without hard data, that even with proper infection control precautions surgeons will contaminate themselves. She has said that she "may get stuck 20 times in the next six months." Emanuel, supra note 37, at 1688 (citation omitted).
\item \textsuperscript{39} Id.
\item \textsuperscript{40} Id. (citation omitted).
\item \textsuperscript{41} Id. at 1687. This view is endorsed by the AMA. \textit{See American Medical Ass'n, Ethical Issues Involved in the Growing AIDS Crisis: Revised Report of the Council on Ethical and Judicial Affairs} 4 (1988) (physician "may not ethically refuse to treat a patient whose condition is within the physician's current realm of competence" simply because patient is seropositive or has AIDS).
\item \textsuperscript{42} Emanuel, supra note 37, at 1687.
\item \textsuperscript{43} Id.
\item \textsuperscript{44} Klein, Phelan, Freeman \textit{et al.}, \textit{Law Occupational Risk of Human Immunodeficiency Virus Infection Among Dental Professionals}, 318 New Eng. J. Med. 86 (1988).
\end{itemize}
drowning people. Taking such risks is part of joining the profession and affirming its objective to help the needy.45

The risk of exposure of some health care professionals—certain surgeons for example—may be viewed as excessive. In those cases, it may be necessary to design policies that limit levels of risk. Surgeons who are subject to excessive risk could lower the risk by spreading operations among groups of surgeons or curtailling elective procedures.46 Nevertheless, in all cases, health care professionals are expected to take appropriate precautions given the reality that they will also labor under some uncertainty about the HIV status of some of their patients with or without HIV testing.

2. Risks Arising from the Proportion of Patients Treated Who are HIV-Seropositive

The proportion of patients who may be HIV-positive upon admission to the health care setting will depend upon the location of the institution. At the operating suite at Johns Hopkins, Kelen found that 4% of patients requiring emergency surgery had unrecognized HIV infection.47 The Kelen group found that 119 of 2,302 consecutive adult patients, or 5.2%, were seropositive for HIV; furthermore, among 2,275 patients with unknown HIV status, only 659 (29%) were determined by the clinical team as being in a high-risk group.48 Kelen concluded that

[o]f the patients who presented with active bleeding, 6.0 percent were seropositive, and 3.8 percent of the patients who were transported to the hospital by ambulance and in whom access to peripheral veins was necessary before they arrived at the hospital were seropositive. More than 4 percent of the patients who were admitted, including 4.6 percent of the patients who required emergency major surgery in the operating suite,

45. Emanuel, supra note 37, at 1687.
46. Id.
47. Kelen, supra note 13, at 1645. See also Baker, Kelen, Sivertson & Quinn, Unsuspected Human Immunodeficiency Virus in Critically Ill Emergency Patients, 257 J. A.M.A. 2609, 2610 (1987) (three percent of critically ill or severely injured patients with no history of HIV infection were seropositive in indigent, urban areas).
48. Kelen, supra note 13, at 1645-47.
were found to have unrecognized HIV infection.\textsuperscript{49}

The authors noted that Centers for Disease Control (CDC) recommendations for universal precautions were not followed. Only the twenty-seven patients known to be seropositive for HIV were treated with special precautions. The 2,275 patients with unknown HIV status were treated with no special measures except for the use of gloves when blood was drawn. The authors noted that the risk of exposure to unrecognized HIV infection and to bodily fluids is not trivial since many of the patients admitted (4.1\%) were seropositive. Of those admitted directly to the operating suite, 4.6\% were unrecognized as HIV-seropositive. “Because there are an estimated 1 to 1.7 million asymptomatic HIV-infected persons in the United States, the potential risk of exposure for emergency department personnel and other health care workers can only increase.”\textsuperscript{50} Attempts to apply risk-factor assessment would miss many patients, such as those entering the emergency room with altered mental status, active bleeding and negative test results (since two of five tested positive on admission). The authors concluded that only “universal blood and body fluid precautions” would adequately protect health care workers: “[I]nfection-control precautions should be consistently applied, particularly in emergency settings, by all health care workers coming in contact with blood or other body fluids, whether HIV infection is known or suspected, and regardless of patients’ condition at presentation or knowledge of their risk-factor status.”\textsuperscript{51}

3. The Risk of Becoming HIV-Positive from a Single Needle Stick

Needle stick injuries are the most important risk event for most health care workers. The risk of becoming HIV-positive after one needle stick has been estimated at less than 1\% for lab workers and health care workers, with one study calculating the risk of HIV transmission from a single needle stick accident at 0.35\%.\textsuperscript{52} At least fifteen cases have been reported of health care workers with HIV infection caused by needle sticks.\textsuperscript{53} The risk of

\textsuperscript{49} Id. at 1648.
\textsuperscript{50} Id. at 1649.
\textsuperscript{51} Id.
\textsuperscript{53} \textit{Centers for Disease Control, U.S. \textit{Dept of Health \\& Human Serv.}, Update: Acquired Immunodeficiency Syndrome and Human Immunodeficiency Virus Infec-
séroconversion after a needle stick depends on the size of the inoculum. Some of the health care workers who tested positive after a needle stick suffered not just a stick but the injection of blood. One study of health care workers at San Francisco General Hospital with a year of exposure to AIDS patients, 35% having sustained accidental exposure to patient fluids, found no seroconversion.

The level of exposure to needle stick injuries can be reduced by attention to proper procedures for handling needles. Equipment can be modified to reduce the risks, including replacing antiquated containers with safer designs. Both manufacturers and health care institutions can create a safer working environment by taking advantage of new technology to reduce worker exposure. While seroconversion has been reported after exposure to HIV through skin and mucous membranes, that risk is much lower. Needle sticks remain a serious risk factor that must be addressed in the health care setting.

4. The Cumulative Risk of HIV Infection to Health Care Workers

The cumulative risk of HIV infection among health care workers is roughly equivalent to the risk level in the general population. Among Health Care Workers, 37 MORBIDITY & MORTALITY WEEKLY REP. 229, 232 (1988) (risk of seroconversion following needle stick exposure to blood of HIV-infected patient is less than one percent); CENTERS FOR DISEASE CONTROL, U.S. DEP'T OF HEALTH & HUMAN SERV., Recommendations for Prevention of HIV Transmissions in Health-Care Settings, 36 MORBIDITY & MORTALITY WEEKLY REP. 5S (1987 Supp.) (hereinafter Recommendations) (as of April 30, 1987, of 332 exposed health care workers, 103 were exposed by needle sticks). See also Weiss, Goedert, Gartner et al., Risk of Human Immunodeficiency Virus (HIV-1) Infection Among Laboratory Workers, 299 SCIENCE 68 (1988) (study of 265 laboratory and affiliated workers concluded incidence rate of 0.48 per 100 person-years exposure to concentrated virus, which is comparable to risk of needle stick exposure by health care workers). For a summary of the report, see Allen, Health Care Workers and the Risk of HIV Transmission, HASTINGS CENTER REPORT, Apr.-May 1988, at 2 (Special Supplement).


55. Gerberding, Bryant, LeBlanc et al., 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 DISEASES 1-8 (July 1987) (study results indicate that health care workers are at minimal risk for HIV transmission from occupational exposure to AIDS patients).

56. Kempen, Equipment Modifications to Reduce Needle Sticks, 319 NEW ENG. J. MED. 308 (1988) (use of European intravenous cannulae eliminates need for needles and is cost-effective way of reducing needle stick injuries).


58. See Recommendations, supra note 53.
ulation. The distribution by age, race and sex of those with AIDS employed in health care is similar to all AIDS cases.\textsuperscript{59} A review of studies done to date, combining 1,400 health care workers and 1,300 dental personnel, concluded that the risk of HIV infection in health care workers was generally quite low.\textsuperscript{60}

Studies of health care workers exposed to contaminated blood through the skin or mucous membranes have shown that such contact rarely results in the transmission of HIV. In one study, none of the 103 workers with skin exposures and none of the 229 workers with mucous membrane exposures to the blood or body fluids of patients with AIDS were seropositive.\textsuperscript{61} Of the three reported cases of transmission, two occurred in the outpatient clinic setting and one resulted from a resuscitation effort in an emergency room shortly after the arrival of the patient.\textsuperscript{62}

While some health care workers are at increased occupational risk compared to other professions because of the risk of exposure to patient blood products, the risk appears to have been overstated. Dental professionals are often exposed repeatedly to persons who are HIV-positive for months or years before the patients know they are positive, and accidental parenteral inoculations and splashes and aerosolizations of blood and saliva are common; therefore, dental professionals are considered to be a sentinel population for potential HIV exposure. However, one study has found dental professionals to be at less risk than might be expected.\textsuperscript{63} It has been suggested, therefore, that the risk to dental professionals “is likely to indicate the maximal anticipated rate of occupational risk for health care workers in general.”\textsuperscript{64} The authors of the dental study concluded that “despite infre-

\textsuperscript{59} Allen, supra note 53, at 2. Allen states that 95.1% of health care workers have a risk factor for HIV infection unrelated to employment. \textit{Id.} Moreover, the “maximum estimate” even where the worker was exposed to mucous membrane or inoculation of blood, was one risk of infection in 200 incidents. \textit{Id.} at 4.

\textsuperscript{60} \textit{Id.}

\textsuperscript{61} \textit{Recommendations, supra} note 53, at 55. \textit{See also} \textit{An Unexplained AIDS Infection, Newsweek, Sept. 14, 1987, at 63 (discussion of AIDS transmitted through skin and mucous membrane exposure).} A later study noted that the observed rate of HIV infection among dentists was one in 3396, a rate that pales in comparison to other causes of death for dentists in any given year. Klein, Phelan, Freeman \textit{et al., Dentists and the Risk of HIV,} 319 \textit{New Eng. J. Med.} 112, 114 (1988).


\textsuperscript{64} \textit{Id.} at 89.
quent compliance with recommended infection-control precautions, frequent occupational exposure to persons at increased risk for HIV infection, and frequent accidental parenteral inoculations with sharp instruments, dental professionals currently are at low occupational risk for HIV infection."}

C. Risks of Not Testing Patients

Technology often drives policy in our culture, and health care is no exception. The tests for HIV are powerful tools, and they are getting better. The very existence of these tests creates a desire in health care providers to use them without sufficient introspection about the purposes and consequences of their use. This technological imperative leads to an often unstated presumption in favor of the use of a technology such as a diagnostic test, even when its usefulness is not clearly established. Once a patient enters the hospital or clinic, the imperative begins to operate in the minds of the staff: test and get information on the patient's HIV status. Ordinarily, the justification for such intervention has been to promote the welfare of the patient. In the case of HIV testing, the justification is to protect the staff.

Any proposal to test groups of people might be evaluated by answering three groups of questions: First, why test? Second, how good is the test? How does its performance measure up, based on its sensitivity, specificity and predictive value in populations with different prevalences of the disease? Third, what are the consequences of testing? Each of these issues will be addressed in turn.

1. The Alleged Purpose of Testing

In the health care setting, the argument is that health care workers could use the HIV test results of patients to better pro-

65. Id. The authors noted that risky patients cannot be detected reliably, and that infected persons may not feel or appear ill. They may not want to inform the dentist or may not consider themselves at high risk. Testing takes time, requires confirmatory testing, and may yield false negatives. Id.

66. See generally J. ELLUL, THE TECHNOLOGICAL SOCIETY (1964). "Ours is a progressively technical civilization. ... It is a civilization committed to the quest for continually improved means to carelessly examined ends." Id. at vi.

67. Thomas, The Perils of AIDS Testing, I.A. LAW 39, 46 (Sept. 1988) ("[T]oo many health care professionals are acting from fear and not scientific knowledge in requesting (and in some cases demanding) that their patients undergo HIV testing.").

68. Weiss & Thier, HIV Testing is the Answer—What's the Question?, 319 NEW ENG. J. MED. 1010 (1988).
tect themselves from infection. "[I]f all patients entering the hospital were tested for HIV, hospital workers could take extra precautions against occupational exposure." 69

2. Accuracy of Testing

A person is identified as HIV-positive when a sequence of tests, starting with repeated enzyme immunoassays (ELISA) and including a Western Blot (WB), are repeatedly reactive. Persons infected with HIV, which acts as an antigen, usually develop antibodies against the virus within six to twelve weeks after infection. These tests do not test for HIV itself, but rather are an indirect test for HIV in that they react to the antibodies developed by the body in reaction to the HIV infection. Some false positives are expected with these tests, depending on the prevalence of infection in the populations tested. 70 The lower the level of infection generally in the population, the higher the false positive rate. 71 Increased prevalence of the disease in the population affects the predictive value by reducing the relative level of false positives. 72 False negatives will also occur because of the latency period of weeks between the onset of HIV infection and appearance of detectable antibodies. False negatives also occur because some individuals contain the HIV virus in macrophages and therefore do not develop detectable antibodies for months or years. 73 Some infected individuals will therefore be missed by the ELISA test. 74

A confirming test, usually a repeat ELISA test followed by a WB test, is required to improve the accuracy of the initial test. While this reduces the number of false positives, the WB is also an indirect test that may give false positives. 75

69. Id. at 1101.
71. Meyer & Pauker, Screening for HIV: Can We Afford the False Positive Rate?, 317 NEW ENG. J. MED. 238 (1987).
72. For a discussion of sensitivity, specificity and prevalence as parameters of the predictive value of a test, see Banks & McFadden, Rush to Judgment: HIV Test Reliability and Screening, 23 TULSA L.J. 1, 7 (1987).
75. See Roy, Portney, Wainberg & Davis, Need for Caution in Interpretation of Western Blot Tests for HIV, 257 J. A.M.A. 1047 (1987) (suggesting that blood banks
The sensitivity of the currently licensed tests is at least 99% when they are performed under optimal laboratory conditions on serum specimens from persons infected for more than twelve weeks. A newer test, an antibody detection procedure called the autologous red cell agglutination test, "is potentially suitable for simple, rapid, qualitative screening for antibodies to a variety of antigens." The test takes less than two minutes to complete. It is hoped that such a test "will contribute to the protection of health care workers and aid in the control of the spread of AIDS." The promise of the instant AIDS test is less encouraging than it may appear. The accuracy of such tests and the quality of the laboratories using them remain problematic.

a. Laboratory Shortcomings

The predictive value of a positive test for HIV has been low among populations with low prevalence rates of HIV. That is, the ratio of false positive to true positive diagnoses would be unacceptable. The military HIV screening program has claimed a low rate of one false positive in 135,187 tests in its mandatory screening of recruits. But the American military screening program is a "carefully designed, high-volume, closely monitored program" with several special features to ensure accuracy, including meticulous screening of the laboratories used. As the authors of the military screening study themselves note: "HIV testing in the civilian sector may not be done in laboratories that have such large volumes and extensive experience in the performance and use both HIV-infected and noninfected cell lines when confirming seropositivity by Western Blot test)."
interpretation of tests for HIV, especially Western blotting." 81

The quality of laboratory testing in private commercial laboratories varies substantially since accepted national standards are not yet in place. Many of the commercial labs testing for the AIDS virus offer a substandard service. The Army's screening of labs for its use found ten of nineteen labs evaluated to be substandard in that they could not analyze samples to a level of 95% accuracy. 82 Analysis of laboratory proficiency data by one expert revealed that the false positive rate for HIV tests in low-risk populations would be even greater if the rate were adjusted for the probable accuracy rates of participating laboratories. 83 One study found a false positive rate as high as one in fifteen specimens tested. 84 While laboratory experience has improved and quality controls make a substantial difference, the risk of both excessive false positives and errors remains substantial.

b. Staff Errors

The results of studies on the quality of HIV testing in hospital settings have not been encouraging. One study evaluated clinical use of HIV antibody serology in a large Minnesota medical center. 85 The authors of the study found:

In 44% of the tests performed, the patient had no recognized risk factor for acquiring HIV infection. . . . In an additional 44% of tests performed, the test was medically indicated but patient consent and counselling were not documented . . . . Only 10% of tests performed fulfilled the criteria for an appropriate test (where the test was indicated and consent and counseling were provided with documentation in the medical record). 86

Errors were common. Eleven patients were tested with no record

81. Id. at 963-64.
82. Thomas, supra note 67, at 43.
83. Quality AIDS Testing: Hearing Before the Subcommittee on Regulation and Business Opportunities, 100th Cong., 1st Sess. 2-12 (1987) (testimony of Dr. Lawrence Miike, AIDS Laboratory Testing Analyst, Office of Technology Assessment). Miike conjectured that the laboratory performance was probably worse than the tests suggested, since the labs knew they were being tested and could take extra care with the proficiency test specimens. Id. at 3.
85. Henry, supra note 19, at 229.
86. Id. at 232.
of who ordered the test or why. With six patients, a positive ELISA result was interpreted by physicians as a positive test without regard to a negative WB. In five patients, asymptomatic seropositive HIV patients were diagnosed as having AIDS. In one case, a patient specimen was mislabeled.

Other studies have confirmed the extent to which physicians and health care professionals generally remain poorly informed about the meaning of a positive HIV serotest. While patient education about AIDS is vital, physicians and staff also need to be better educated about the accuracy of HIV testing and proper procedures for achieving accurate results.

3. Results of Testing: Alleviating Workers' Risk Versus Adverse Patient Consequences

Even if instantaneous antigen tests are developed, and false positive and negative rates caused by laboratory error are dramatically reduced, routine mandatory testing without patient consent still cannot be justified. An example of a poorly justified screening program was the sickle cell trait screening which occurred during the 1970s. Such screening was ultimately abandoned since positive sickle cell carrier status "led to harm to personal and social relations and to discrimination in insurance, in employment, and even in the schoolyard." This result can be compared to AIDS testing where "the results of mandatory testing are unlikely to offer much benefit to the individual screened, while exposing that person to many economic, social, psychological, and even physical harms." The information gained by HIV testing is not of particular benefit in most health care settings, especially if universal precautions and other safeguards are followed. The CDC has maintained that "[t]he utility of routine HIV serologic testing of patients as an adjunct to universal pre-

87. Id. at 231.
88. Id.
89. Id.
90. Id.
93. Id.
94. See Weiss & Thier, supra note 68, at 1011 ("[I]f recommendations to take universal precautions are followed, it is unclear what further action the additional information suggests.").
cautions is unknown. Results of such testing may not be available
in emergency or outpatient settings." The CDC also warns that
routine testing will provide little comfort to health care workers
because recently-infected patients will not demonstrate detecta-
ble antibodies to HIV.

III. LEGAL PRINCIPLES AND FUNDAMENTAL RIGHTS

Social norms are an important source of law. "Law repre-
sents in a stylized way the concerns, the social organization, the
aspirations, the political life of a particular society in a particular
place and time . . . . Looking at legal doctrine when judges pretty
it up for public display tells us something important about ideals
of justice." Tort law and constitutional law subject individual
conduct and governmental behavior to judicial scrutiny in the
light of legal values.

The legal principles that should guide policy in the area of
AIDS testing are beacons to guide the conduct of health care
providers. These principles illuminate the proper constraints on
defensive, fearful behavior by health care institutions. These
principles include: (1) the principle of autonomy and informed
consent; (2) the principle of preserving secrets and the right to
privacy; and (3) the principle of reasonableness. It is worth-
while to elaborate on and re-establish these legal principles as a
counterpoint to the powerful medical imperative to use testing as
a tool for safeguarding staff. The legal constraints tip the

96. Id. (adherence to precautions recommended for care of all patients will
minimize risk of transmission of HIV; utility of routine HIV serologic testing as
adjunct to precautions unknown).
97. K. SHEPPELE, LEGAL SECRETS: EQUALITY AND EFFICIENCY IN THE COM-
MON LAW 316 (1988).
98. For a discussion of this principle, see infra notes 102-15 and accompa-
nying text. See generally Goff, AIDS: The Legal Issues, THE WASHINGTON LAWYER,
99. For a discussion of this principle, see infra notes 116-60 and accompa-
nying text. See generally Closen, Connor, Kaufman & Wojcik, AIDS: Testing Dem-
ocracy—Irrational Responses to the Public Health Crisis and the Need for Privacy in
Serologic Testing, 19 J. MARSHALL L. REV. 835 (1986); Comment, Doctor-Patient Con-
fidentiality Versus Duty to Warn in the Context of AIDS Patients and Their Partners, 47
100. For a discussion of this principle, see infra notes 161-202 and accompa-
nying text. See generally Banks & McFadden, supra note 72; Hermann, AIDS:
101. Rosencranz & Lavey, supra note 10; see also W.J. Lewis, M.D., The AIDS
Epidemic: Providing Competent Compassionate Medical Care and Preserving
scale, requiring that testing first pass threshold tests of patient consent and assurances of protection of private information from disclosure before it can be employed.

A. The Principle of Autonomy: Informed Consent

The informed consent doctrine is based upon the premise that a patient has the right to make an informed choice about medical options for diagnosis and treatment. The doctrine is rooted in a model of the physician-patient relationship in which decision making is a collaborative process rather than a one-way path. When doctors treat competent patients, the informed consent doctrine has provided some impetus for the sharing of decision-making power between doctor and patient. The doctrine represents a wavering judicial attempt to establish boundaries for the doctor-patient relationship.

The doctrine of informed consent serves several functions. First, it promotes patient self-determination. The historic origins of the doctrine address the right of an individual to be free from unconsented interference with his person. Such concerns reflect the moral principle that it is prima facie wrong to force individuals to act against their will. Such a principle is a value in itself, independent of any instrumental goals that may be achieved. It is a value because, in the words of H.L.A. Hart, "it enables individuals to experiment—even with living—and to discover things valuable both to themselves and to others." The requirement that a doctor inform a patient of the risks of and alternatives to a particular therapy, or the nature of the tests to be done, reconfirms the status of the patient as a thinking person, capable of sharing in the decision making. Neither person can command the participation of the other, but must obtain it freely. To fail to disclose to patient the risks and consequences is to reduce him to a

the Rights and Dignity of the Patient (Widener University School of Law, unpublished manuscript in possession of author).


104. The functions of informed-consent include: (1) protection of patient self-determination; (2) minimizing coercion of the patient; (3) avoidance of unrealistic patient expectations; (4) enhancement of therapeutic self-scrutiny; and (5) fostering rational decision making. I have developed these justifications in more detail in B. Furrow, Malpractice in Psychotherapy 65-68 (1980).


level of dependency in which he has been judged incapable of making his own decisions.

Second, the doctrine may also minimize patient coercion. The inequality of information and power between health care professionals and patients in the typical medical relationship means that any notion of a contract is a fiction. The exchange of information between doctor and patient reduces the disparity and enables the patient to make his own informed decision.

Finally, informed consent encourages a joint venture between doctor and patient in which disclosure of information will promote patient decision making. This joint venture promotes patient autonomy in his own decision regarding treatment, where the patient understands the consequences of his decision.

It may be argued that, in general, the informed consent doctrine has done little to insure that patients are an integral part of the treatment process. Nevertheless, the values that the doctrine represents are important in that they are based on social norms that we value as a society, so called “autonomy” norms. Society values individual control over decisions concerning one’s body and self (even though others may find those decisions irrational), as well as the right to full information before making difficult medical choices and the right to control information about oneself that can prove destructive if generally known (i.e., secrets). These autonomy norms focus on information, access to it and control of it.

However, the autonomy-based rights often conflict with other social norms, such as the right of third parties to obtain information about risks or to be protected from the risk-creating

107. See J. Katz, supra note 102, at 130-64.

108. Under the informed consent doctrine, the existence of a duty to disclose is determined on the basis of whether the reasonable practitioner similarly situated would disclose the information. See B. Furrow, S. Johnson, T. Jost & R. Schwartz, Health Law: Cases, Materials and Problems 246 n.1 (1987) [hereinafter B. Furrow]. If the duty to disclose exists, the doctrine requires that a doctor disclose the diagnosis, the nature and purpose of the treatment, the risks of the treatment, the probability of success, the treatment alternatives and the prognosis if the treatment is not given. Id. at 247-48 (and cases cited). Failure to disclose the risks of a treatment and possible alternatives to a treatment have been held to be tortious in that it fails to respect the patient’s right to self-determination. Keogan v. Holy Family Hosp., 95 Wash. 2d 306, 622 P.2d 1246 (1980) (doctrine of informed consent is based on patient’s right to self-determination; physician’s duty to disclose arises whenever physician becomes aware of abnormalities indicating possible risk or danger).

behavior of others. But autonomy deserves serious weight in calibrating the scales before there is any social or political balancing of public and private interests.\textsuperscript{110} The conflict between the patient and the health care professional may be inevitable, and the law can provide a valuable counterbalance to professional dominance.\textsuperscript{111}

Consider the argument that HIV testing is really just another "routine" test for which informed consent is neither needed nor desirable. The consent of the patient to routine testing is viewed as implied by the patient's act in presenting himself for treatment. Treatment requires diagnosis; diagnosis requires testing as part of the search for causes; and such routine diagnostic testing is, therefore, impliedly consented to by the patient.\textsuperscript{112}

Calling HIV testing "routine" is not supportable. First, while testing patient blood for conditions to which the patient has not consented may be standard practice, it is not justifiable on principles of informed consent generally. Second, even if much testing of patient blood without consent may be a trivial ethical violation, HIV testing certainly cannot be considered to be such. A positive reading can be devastating to the individual and extremely destructive if disclosed, while a false negative can breed a false sense of security. Any judicial look at such testing would find such levels of risks to be significant to the patient.\textsuperscript{113} Third, such test-


\textsuperscript{111} See Wolf, Conflict Between Doctor and Patient, 16 L. MED. & HEALTH CARE 197 (1988).

\textsuperscript{112} In Plowman v. United States Dep’t of the Army, 698 F. Supp. 627 (E.D. Va. 1988), the district court dismissed a suit brought by a civilian employee of the Department of the Army, who had tested HIV positive in a non-consensual testing by Army doctors, was forced to resign, and who then sued his supervisor. The court cited to two other recent decisions upholding use of a person’s blood sample for an HIV test as long as the sample “was already required for a series of other diagnostic tests.” \textit{Id.} at 636. The court seemed to treat HIV testing as just another harmless diagnostic procedure with no psychological or other repercussions to the patient or to third parties, and yet, in a footnote, observed that HIV testing was not a routine feature of diagnostic blood tests, contrary to the allegations of the defendants that the plaintiff had consented to the HIV test by consenting to the withdrawal of blood generally. \textit{Id.} at 629 n.6.

\textsuperscript{113} For further discussion of a variety of risks to patients, see supra notes 26-32 and accompanying text.
ing violates the principle of beneficence—that medical interventions should be done for the good of the patient. Testing under these conditions is primarily for the putative protection of staff.\textsuperscript{114} Further, failure to implement routine pre-test counseling could lead to tremendous patient distress if the results are disclosed to them, both because they were deceived and acted upon without permission and because a positive result is distressing to a patient not properly given pre-test counseling.\textsuperscript{115} Finally, nonconsensual routine patient testing may risk harm to third parties. If positive test results are kept secret, then the patient will lack crucial information about his AIDS status. He may therefore expose third parties through sexual contacts. The failure of medical personnel to act on the test information may violate tort requirements that third parties be warned of risks created by a party with whom the medical staff has a relationship.

B. The Principle of Preserving Secrets: The Right to Privacy

Secrecy is the desire to intentionally withhold information from others, usually on a rational basis.\textsuperscript{116} The creation and protection of secrets is an intentional and social act.\textsuperscript{117} Secrets are valuable means of defining the social world by censoring social spaces from others. Secrets are also "tools of power."\textsuperscript{118} As Scheppele writes: "[W]hile secrets enable the social world to be


\textsuperscript{115} See, e.g., Doe v. Wills Eye Hospital, No. Civ. 5248 (C.P. Philadelphia County Mar. 30, 1988), in which the plaintiff alleged as damages:

20. As the direct result of the shock of being informed without warning that he tested positive for AIDS, plaintiff suffered, and continues to suffer, severe mental anguish, distress, and related psychological conditions. Plaintiff's mental stress and depression has resulted in a general deterioration of his physical health, including stress-related fatigue and insomnia.

21. As the direct result of the mental distress and physical symptoms resulting therefrom, plaintiff has experienced, and continues to experience, severe limitation on his ability to concentrate at work, with the result that his productivity, and his income, has and will continue to be reduced.

22. Additionally, plaintiff has been unable to engage or participate in his normal life activities, as a result of his physical symptoms and the depression and other psychological ill-effects he has suffered.

\textsuperscript{116} See K. Scheppele, supra note 97, at 12-13.

\textsuperscript{117} Id. at 14.

\textsuperscript{118} Id. at 5.
partitioned and individualized, making the expression of individual autonomy in the construction of the social world possible, they also serve as staging grounds for the deployment of power, assaults on the very autonomy that they constitute. 119 The assessment of privacy as a fundamental right, therefore, requires a look at the nature of the secrets that are being withheld and the purposes for keeping them.

An individual's secret information about his health status may be valuable to him, a secret to be shared only selectively and carefully. As Fried states:

Privacy is not simply an absence of information about us in the minds of others; rather it is the control we have over information about ourselves... But it is not simply control over the quantity of information abroad; there are modulations in the quality of the knowledge as well... For instance, a casual acquaintance may comfortably know that I am sick, but it would violate my privacy if he knew the nature of the illness...

Privacy in its dimension of control over information is an aspect of personal liberty. 120

HIV test results, as we have seen, may result in grave harm if disclosed to others without the permission of the patient. Yet health care institutions are not respectors of secrets. Patient information contained in medical records is frequently disclosed. It has been estimated that up to seventy-five people (including nurses, administrators and insurers) have access to the typical patient's chart. 121 The power to devastate an individual lies with the holder of that person's medical record. That power can be limited both by allowing patients to control what the record contains, in the case of test results, and by imposing a duty to maintain confidentiality, backed by sanctions for its breach. 122

A patient may want to share his secret—an HIV-positive test result—with a health care provider for a valid treatment objective

119. Id.
121. B. Furrow, supra note 108, at 220. See also Wilkes & Shuchman, "Holy Secrets," N.Y. Times, Oct. 2, 1988 (Magazine) at 57, 58 ("In general, a hospital is one of the most difficult settings in which to protect confidentiality. Information a patient and doctor consider private may get out.").
or for sound medical advice if he can minimize the risk that the secret will be revealed to others. He may want to share it with others in his life as long as he can decide when and how. Given the risk of disclosure of patient secrets, however, and the fact that repercussions continue to follow from such revelations, the law must protect such secrets unless the patient has made an informed decision to risk the consequences of their disclosure.

A right to privacy is not firmly anchored in our constitutional jurisprudence.\textsuperscript{123} The Supreme Court has carefully avoided recognizing the right of privacy in sharp, clearly delineated terms. In \textit{Whalen v. Roe},\textsuperscript{124} the Court recognized that a privacy claim might include two classes of interests: "the interest in independence in making certain kinds of important decisions" pertaining to family, procreation, and medical treatment,\textsuperscript{125} and the "interest in avoiding disclosure of personal matters."\textsuperscript{126} The Court, however, declined to expressly grant such interests constitutional protection, finding that the applicable New York law gave adequate protection.\textsuperscript{127}

The Supreme Court, in cases following \textit{Whalen}, has looked at the sensitive nature of the information. In \textit{Nixon v. Administrator of General Services},\textsuperscript{128} the Court applied the interest in "avoiding disclosure of personal matters"\textsuperscript{129} set out in \textit{Whalen} in recognizing ex-President Nixon's legitimate expectation of privacy in communications between himself and his family and minister. In \textit{Detroit Edison v. NLRB},\textsuperscript{130} the Court further built on \textit{Whalen} and overturned an NLRB order requiring that employees' psychological test results be distributed without their consent.\textsuperscript{131} The Court considered this information sensitive and the risk of unauthorized

\textsuperscript{123} In Griswold v. Connecticut, 381 U.S. 479 (1965), the Supreme Court first developed a right of marital privacy in the penumbra of the Bill of Rights. \textit{Id.} at 484. This right was expanded in Eisenstadt v. Baird, 405 U.S. 438 (1972), to include the right of unmarried people to make contraceptive decisions, clarifying what Tribe has labeled the right of "reproductive autonomy." L. Tribe, \textit{American Constitutional Law} \S 15-10, at 1339 (2d ed. 1988). \textit{Roe v. Wade}, 410 U.S. 113 (1973), extended this right to cover a woman's abortion decision. Tribe characterizes this decision as one that "affirmed the value of individual autonomy over the virtue of collective choice and the prerogative of majoritarian coercion." L. Tribe, \textit{supra}, at 1352.

\textsuperscript{124} 429 U.S. 589 (1977).

\textsuperscript{125} \textit{Id.} at 499-600.

\textsuperscript{126} \textit{Id.} at 599.

\textsuperscript{127} \textit{Id.} at 598.

\textsuperscript{128} 433 U.S. 425 (1977).

\textsuperscript{129} \textit{Whalen}, 429 U.S. at 599.

\textsuperscript{130} 440 U.S. 301 (1979).

\textsuperscript{131} \textit{Id.} at 317-20.
disclosure substantial and, therefore, sufficiently personal to fall under the Whalen doctrine.\textsuperscript{132} The Court noted that federal and state legislation recognized "a person's interest in preserving the confidentiality of sensitive information."\textsuperscript{133} Most federal courts have read Whalen as acknowledging the status of privacy as a constitutional right.\textsuperscript{134} One federal court noted that "a majority of courts considering the question had concluded that a constitutional right of confidentiality is implicated by disclosure of a broad range of personal information."\textsuperscript{135}

The federal courts have become conversant with the psychological dimensions of HIV testing and the disclosure of a positive test result. Recognizing the attendant harms, they have consistently refused to grant routine status to such testing.\textsuperscript{136} Federal courts in recent prisoner privacy cases and in cases involving fourth amendment issues have shown a sophisticated appreciation of the risks of carelessness with HIV testing.\textsuperscript{137}

The prison cases exemplify judicial recognition of the primacy of a right of privacy in the judicial balancing of a privacy right against countervailing state interests. By virtue of their incarceration, prisoners admitted have forfeited a variety of rights. However, prisoners do retain significant rights, and federal courts have been respectful of inmates' privacy interests in HIV results. The courts have balanced prison interests against

\begin{footnotes}
\footnotetext{132} Id. at 318-20.
\footnotetext{133} Id. at 318 n.16.
\footnotetext{134} See, e.g., Kimberlin v. United States Dep't of Justice, 788 F.2d 434, 438 (7th Cir.) (constitutional interest in avoiding disclosure of personal matters not applicable to prison inmate within routine use of Privacy Act), cert. denied, 478 U.S. 1009 (1986); Fadjo v. Coon, 633 F.2d 1172, 1175 (5th Cir. 1981) (right to privacy found to exist where state attorney releases information told to him in confidence); United States v. Westinghouse Elec. Corp., 638 F.2d 570, 577 (3d Cir. 1980) (court identified right to privacy and need for notice in employee medical records); Plante v. Gonzalez, 575 F.2d 1119, 1127-28 (5th Cir. 1978) (upheld financial disclosure for elected officials because right of privacy does not include financial privacy), cert. denied, 439 U.S. 1129 (1979); Borucki v. Ryan, 658 F. Supp. 325, 327-30 (D. Mass. 1986) (constitutional right to privacy protects information in court-ordered psychological report), rev'd, 827 F.2d 836 (1st Cir. 1987).
\footnotetext{135} Borucki v. Ryan, 827 F.2d 836, 846 (1st Cir. 1987).
\footnotetext{137} See, e.g., Doe v. Coughlin, 697 F. Supp. 1234 (N.D.N.Y. 1988) (involuntary transfer of HIV-positive inmates to separate cell blocks violates inmates' right of privacy); Woods v. White, 689 F. Supp. 874 (W.D. Wis. 1988) (right to privacy is retained despite incarceration and extends to inmate's test results).\end{footnotes}
privacy interests in a way that grants substantial deference to prisoner privacy regarding medical information. In *Woods v. White*, for example, the District Court for the Western District of Wisconsin considered a case where prison medical service personnel had disclosed to nonmedical staff and other inmates the fact that an inmate had tested positive for AIDS. The court found that the right of privacy extended to the inmate's test results because a prisoner "retains his right to privacy, although he is incarcerated. The right to privacy is not terminated by conviction for a crime." The court noted that such a privacy right is usually balanced on a case-by-case basis against the government's interest in limited disclosure, stating:

> Given the most publicized aspect of the AIDS disease, namely that it is related more closely than most diseases to sexual activity and intravenous drug use, it is difficult to argue that information about this disease is not information of the most personal kind, or that an individual would not have an interest in protecting against the dissemination of such information. I find that plaintiff has a constitutional right to privacy in his medical records.

In *Woods*, the government could assert no adequate governmental interest in disclosure.

In *Doe v. Coughlin*, inmates who had tested positive for HIV challenged a program requiring their compulsory assignment to an AIDS dormitory, asking only that placement be voluntary. The class plaintiff asserted a "right to privacy in preventing the non-consensual disclosure of his medical diagnosis and that of the other class members." The court granted an injunction prohibiting further implementation of the involuntary transfer program. The district court balanced the desire of inmates to control their secrets of HIV seropositivity against the penologic objectives of the government.

The court's analysis of the privacy right, based on *Whalen*,

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139. *Id.*
140. *Id.* at 876.
141. *Id.* (citation omitted).
142. *Id.*
144. *Id.* at 1237.
145. *Id.* at 1236.
stressed the linkage between AIDS stigma and an individual's need to control information about it. The court stated:

Each is fully aware that he is infected with a disease which at the present time has inevitably proven fatal. In the court's view there are few matters of a more personal nature, and there are few decisions over which a person could have a greater desire to exercise control, than the manner in which he reveals that diagnosis to others. An individual's decision to tell family members as well as the general community that he is suffering from an incurable disease, particularly one such as AIDS, is clearly an emotional and sensitive one fraught with serious implications for that individual.146

Furthermore, the court sought to protect the inmates from potential harms not only while in prison, but also after their release. Again the court in Coughlin noted:

[O]nce the prisoner leaves the prison, he should be burdened with only those residual scars imprisonment must inflict. The threat to family life and the "emotional enrichment [gained] from close ties with others," is quite real when an AIDS victim's diagnosis is revealed. Ignorance and prejudice concerning the disease are widespread; the decision of whether, or how, or when to risk familial and communal opprobrium and even ostracism is one of fundamental importance.147

The court, therefore, concluded that prisoners are entitled to some protection against non-consensual disclosure of their diagnoses.

In civil cases, where plaintiffs have acquired HIV-positive status through blood transfusions and have sought the identity of the blood donor or release of information about HIV status, the courts have been solicitous of HIV status and the need to protect secrets. In the case of Belle Bonfils Memorial Blood Center v. District Court of Denver,148 a patient who had become infected with the

146. Id. at 1237. The court quoted Justice Stevens' observation that "the concept of privacy embodies the 'moral fact that a person belongs to himself and not others nor to society as a whole.' " Thornburgh v. American College of Obstetricians & Gynecologists, 476 U.S. 747, 777 n.5 (1986) (Stevens, J., concurring) (quoting Fried, 6 PHIL. & PUB. AFFAIRS 288-89 (1977)).
147. Coughlin, 697 F. Supp. at 1238 (citation omitted).
AIDS virus after receiving a transfusion of blood supplied by a blood center sued the center for negligence. The plaintiff sought discovery of the identity of each of the blood donors. The court held that while the donors had a right of privacy, the patient’s interest in obtaining the information outweighed the donors’ privacy interests, stating:

[The donor has a privacy interest in remaining anonymous and avoiding the embarrassment and potential humiliation of being identified as an AIDS carrier. Belle Bonfils, and society as a whole, have an interest in maintaining the availability of an abundant supply of volunteer blood for distribution to numerous hospitals. These interests must be weighed against K.W.’s and C.W.’s rights to the disclosure of all information necessary to pursue their claims.]

The court thus seemed to exalt the rights of plaintiffs to full discovery over a strong privacy interest of the donors. It should be noted, however, that the court did impose an elaborate system of judicial safeguards to avoid unnecessary disclosure of donor identity.

Other courts have drawn the line in civil cases much more sharply to preclude disclosure. In Doe v. Prime Health/Kansas City, Inc., a health maintenance organization was enjoined from disclosing the results of a man’s AIDS test to his ex-wife. The relevant facts that justified blocking disclosure were that “John Doe has declared that he will not have sexual relations with Jane Doe in the future” and that “the risk of [HIV] exposure from nonsexual, daily contact with persons infected with the . . . virus is so insignificant that separating HIV carriers from others is not justified.”

In another case, Doe v. University of Cincinnati, the court reviewed a discovery order of the identity of a blood donor at the request of a plaintiff who had contracted AIDS through a transfusion. The court followed the reasoning of Rasmussen v. South Florida Blood Service, Inc., in which the Florida Supreme Court held,
based on a right of privacy, that a plaintiff’s interests in discovery were less important than those of blood donors in remaining anonymous.

A wide range of secrets carrying varying weight in terms of their informational privacy value may be implicated in HIV testing. One type of secret a patient may wish to keep is the fact of his HIV status. The patient may know that he has tested positive, but may not want this information to be disclosed to the world at large. The individual might fear employment retaliation, loss of housing or insurance. However, the patient may be exposing sexual partners to contagion by concealing his condition. Secrets are double-edged: to treat them as inviolate is to allow the holder to protect himself while at the same time to risk deceiving those around him. How can a health care provider protect against the risk that a patient might have such a secret? The solution is for the health care institution to impose a policy that assumes that any patient might have good reasons for secrecy and to act accordingly. The alternative is to force disclosure and thereby invade the patient’s privacy. Because privacy is not absolute, we justify limited invasions of privacy in many contexts when compelling interests are at stake. However, the right of privacy requires a substantial justification before it can be breached. A bald assertion of the public good alone should not be sufficient.

A second category of secrets is created if the medical staff is allowed to test patients without their consent. The medical staff now has a secret—the results of an HIV test—not known by the patient. The consequences of having such a staff secret are double-edged. If the test result is disclosed to the patient, it will cause the patient distress for two reasons. First, the patient will know her HIV status, which, if positive, can lead to substantial personal grief, depression and even suicide. Second, the patient’s autonomy as well as her trust in the health care institution has been violated by the surreptitious testing for HIV.

However, if the test result is not disclosed to the patient, then the medical staff may owe an obligation to third parties who may come into contact with this HIV-positive patient. To what extent is a health care provider obligated to disclose this secret? To whom must it be disclosed? A spouse? Sexual partners, whomever they might be? What are the risks of doing nothing except using the information to protect those working within the health
care institution? Having chosen to unveil the secret, the responsibility for dealing with its consequences now shifts to the health care provider, making him answerable to third parties.

A third secret may be generated not, or not solely, for staff protection but to satisfy epidemiologists. Epidemiologists favor broad-based prevalence studies which provide as much information as possible to enable them to accurately track the incidence and spread of AIDS. Thus, mandatory testing with reporting of positive HIV results to a central registry would greatly advance epidemiological research. Curran and other public health lawyers have objected to such reporting and data collection in that it has limited epidemiological value and raises confidentiality issues. An additional objection may be raised that such testing for the purpose of collecting data violates strong national norms against research on human subjects without their consent. Such data collection, after all, is to further the goals of a national experiment in disease tracking. Each person from whom blood is drawn would thus be a human subject entitled to the consideration we grant to any research subject.

A fourth category of secret involves individuals who suspect that they have been exposed to the HIV virus. Suppose an individual is anxious about what a positive result might mean, but is inclined to be tested and needs some advice about what comes next. He has a profound distrust of institutions, having had unfavorable experiences in the past. Can he trust the health care institutions with which he might have contact? Will they keep results to themselves? The self-protective and thoughtless institutional attitude evidenced by willingness to test anyone’s blood without consent demonstrates a lack of respect for the person. Realistic

156. This is often advocated, since the importance of tracking the disease is clear. For a discussion of the need for epidemiological research, see Doll, A Proposal for Doing Prevalence Studies of AIDS, 294 Brit. Med. J. 244 (1987).
158. Id.
159. The regulations on federal research involving human subjects are found at 45 C.F.R. § 46.101 (1981) and cover “(5) Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens.” Id. Section 46.116, General Requirements for Informed Consent, provides that “no investigator may involve a human being as a subject in research covered by these regulations unless the investigator has obtained the legally effective informed consent of the subject.” Id. § 46.116.
concerns about the mishandling of test results may deter significant numbers of individuals from seeking medical attention. Those deterred may be precisely those who most desperately need to know and to be counseled.\textsuperscript{160}

C. The Principle of Reasonableness: Balancing on a Weighted Scale

A test of reasonableness is the foundation for further analysis once a duty or a constitutional right of privacy has been found. What is gained and what is lost by nonconsensual testing? The burden lies with the proponent of an invasive and potentially harmful approach to provide justifications adequate to override powerful individual rights. The justification of preserving the public health usually satisfies the minimum threshold of a compelling state interest. Once this threshold requirement is met, the court will closely scrutinize the objectives considering whether the institutional ends justify the means.\textsuperscript{161} Testing blood samples of a suspected HIV-positive individual must therefore be justified by significant reasons before a defendant in a tort case can avoid liability, and before governmental action can mandate such testing. The privacy interests of the individual are important and powerful interests that deserve substantial protection in the face of miscalculated risks, medical biases and risks of stigma.\textsuperscript{162}

1. Constitutional Balancing: Mandatory Testing as a Fourth Amendment Violation

Blood testing is not a trivial intrusion. In fact, federal courts have found the taking and testing of body fluids to constitute a\textsuperscript{160} See Hermann & DeWolfe, \textit{HIV Antibody Testing Without Patient's Informed Consent: Illinois Abandons Patients' Rights}, 21 J. Health & Hosp. L. 263 (1988). HIV antibody testing can lead to a medical record notation which reports the positive HIV antibody test. Since those who are HIV positive report discrimination in housing, employment, insurance and access to health care, anonymous testing has been sought by anxious people. Most commentators have concluded that testing should only occur with counseling, informed consent and assurances of confidentiality of the results. For a discussion of voluntary testing, confidentiality and informed decisionmaking, see Institute of Medicine, Nat'l Academy of Sciences, \textit{Confronting AIDS} 15, 122-26 (1986); AIDS Task Group of the Am. Academy of Hosp. Attorneys of the Am. Hosp. Assoc., \textit{AIDS and the Law: Responding to the Special Concerns of Hospitals} 14-15 (1988).

\textsuperscript{161} See Kramer v. Union Free School Dist., 395 U.S. 621, 633 (1969) (classification of individuals allowed to vote for school board must be tailored so that exclusion of class denied right is necessary to achieve state goal).

search and seizure under the fourth amendment.163 Government
testing of body fluids, therefore, requires a second level of judi-
cial scrutiny in which the government justifies its actions with ref-
ence to a compelling interest. "Particularized suspicion" tradi-
tionally has been held to be essential before testing is al-
lowed. However, in two recent cases, the U.S. Supreme Court has
allowed employee privacy interests in the workplace setting to be
outweighed by "special needs" of the state. In Skinner v. Railway
Labor Executives' Association164 and in National Treasury Employees
Union v. Von Raab,165 the Court held various modes of invasive
testing, including breath, urine and blood tests, to be a "search"
within the meaning of the fourth amendment. In Skinner, the
Court concluded that the compelling governmental interest in
railroad safety outweighed the tests' limited intrusion upon the
privacy interests of employees in the "pervasively" regulated rail-
road industry. The testing of railway workers was to be limited to
post-accident testing of workers in safety-sensitive jobs. Testing
without either a warrant or an individualized suspicion was there-
fore held to be reasonable under the fourth amendment. This
"special needs" balancing analysis creates an exception to prob-
able cause searches of the human body unsupported by any evi-
dence of wrongdoing.166 As Justice Marshall, joined by Justice
Brennan, wrote in dissent: "[T]he majority substitutes a manipu-
lable balancing inquiry, under which, upon the mere assertion of
a 'special need,' even the deepest dignitary and privacy interests
become vulnerable to governmental incursion."167 The privacy
rights of employees in Skinner are narrowed in the face of con-
cerns about railroad accidents and employee drug abuse. How-
ever, the Court did emphasize the pervasively-regulated industry
aspect of the railroad business, so that this encroachment into the
core of fourth amendment protections may, for the present, be
restrained.

The lower courts, in the specific context of HIV testing of
government employees, have been reluctant to narrow fourth

163. See Railway Labor Executives Assoc. v. Burnley, 839 F.2d 575 (9th Cir.
1988) (search and seizure of urine for testing is similar to blood testing, thus
need warrant absent reasonableness), cert. granted, 108 S. Ct. 2033 (1988); Mc-
Donell v. Hunter, 809 F.2d 1302 (8th Cir. 1987) (urinalysis is search and seizure
within meaning of fourth amendment); Tucker v. Dickey, 613 F. Supp. 1124
(W.D. Wis. 1985) (urinalyses and body cavity searches equally degrading).
166. Skinner, 109 S. Ct. at 1423.
167. Id. at 1425.
amp;ment requirements. In *Glover v. Eastern Nebraska Community Office of Retardation*, the policy of the Eastern Nebraska Human Services Agency (ENCOR) requiring certain employees to submit to mandatory testing and reporting for tuberculosis, hepatitis B and HIV was attacked on fourth amendment grounds. ENCOR clients, many of whom were retarded, were sometimes violent, and staff members occasionally had been bitten or scratched. Testing was targeted at staff with extensive client contact. One staff member had died of AIDS.

The federal district court noted the level of false positives from the HIV test, particularly in low prevalence areas such as Nebraska, examined the medical reasons for HIV testing, and concluded that testing in isolation as provided in ENCOR’s policy did not serve these purposes. The court noted: “The reaction of patients to [HIV test results] is devastation. If not handled properly, it can lead to disastrous results, including suicide. Because of the foreboding message that accompanies a positive HIV test result, some people simply do not want to know if they are infected.” The court further noted that “the risk of transmission of the AIDS virus . . . in the ENCOR environment is extremely low, approaching zero” and concluded that “the risk of transmission of the HIV virus at ENCOR is minuscule at best and will have little, if any, effect in preventing the spread of HIV or in protecting the clients.”

The court held that the fourth amendment applied, and that mandatory blood testing constituted an unreasonable search and seizure given a low risk of infection to the clients. The court, in the balancing process, then considered the virtues of testing:

Although the pursuit of a safe work environment for employees and a safe training and living environment for all clients is a worthy one, the policy does not reasonably serve that purpose. There is simply no real basis to be

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169. Id. at 247.
170. “Thus the percentage of false positives in a low prevalence community will be much higher than in a high prevalence community.” Id. at 248.
171. The court noted the following reasons: “(a) as an adjunct to the medical workup of a patient who may be infected, (b) for epidemiological purposes to establish the level of infection in a community, and (c) as a device used in conjunction with counseling those in high risk groups to stimulate them to change their high-risk behaviors.” Id.
172. Id.
173. Id. at 249.
concerned that clients are at risk of contracting the AIDS virus at the work place. These clients are not in danger of contracting the AIDS virus from staff members and such an unreasonable fear cannot justify a policy which intrudes on staff members' constitutionally protected rights.174

Other courts have taken a more restrictive view of the rights of an employee vis-a-vis institutional interests in testing. In Plowman v. United States Department of the Army,175 the district court dismissed a suit brought against a supervisor of a civilian employee of the Department of the Army, who had tested HIV-positive in a nonconsensual test conducted by Army doctors and had then been forced to resign. The case involved issues of qualified immunity of a government employee in the face of unclear constitutional law in the areas of both privacy and the fourth amendment.176 The court noted the split among the courts of appeals and the lack of a definitive statement by the Supreme Court articulating the limits of a constitutional right to privacy.177 Despite this uncertainty, the Plowman court concluded that in the very special context of the military, and of command decisions at foreign bases, the balance favored the government.178

The court also considered the fourth amendment issues arising in the case. The court used the remoteness of causation to avoid deciding whether the fourth amendment protects against nonconsensual HIV testing, since the supervisor had not ratified the testing.179 The court argued that the extension of the fourth amendment to an AIDS test “is far from clear.”180 The invasion by HIV testing was not intrusive since the blood sample “had already been extracted for the purposes of other, arguably consensual diagnostic tests; no further extractions or intrusions were necessary.”181 Further, Army surgeons had a “medical need to know” the patient’s HIV status if surgery ever became neces-

174. Id. at 251.
176. Id. at 633.
177. Id.
178. Id. at 636.
179. Id. at 635-36.
180. Id. at 636.
181. Id. (court found intrusion significantly less than required to evoke fourth amendment protection and questioned whether there was any intrusion at all since blood tested had been extracted for other purposes).
The court cited no testimony to suggest what the surgeons would have done differently if they had this information or whether they would follow CDC universal precautions as a matter of practice in all cases. In support, the court cited two recent decisions which upheld the use of a person's blood sample for an HIV test provided "that the sample was already required for a series of other diagnostic tests."

The Plowman court treated HIV testing as merely another harmless diagnostic procedure with no psychological or other repercussions to the patient or to third parties. This approach reflects unthinking judicial deference to very modest government justifications. The court noted that "AIDS is a fatal, infectious disease; it is not a political or constitutional status. AIDS does not... confer on its victims any greater constitutional rights than are possessed by victims of other infectious or fatal maladies, such as herpes, tuberculosis, or cancer." Yet the court also noted that "AIDS may provoke heightened reactions among people, especially in foreign countries. This reaction could be a factor pertinent to the constitutional calculus where, as here, a right is not absolute and balancing is required."

Plowman is a case plagued with inconsistency in which the military context has loaded the scales against the individual. Even here the court struggled to sort out the weight to be given to the stigma of AIDS in balancing the respective rights and interests of the parties.

2. Private Law: The Threat of Tort Actions

In the private arena, where constitutional constraints do not apply to the actions of private actors and institutions, the reasonableness principle of tort law is combined with a judicial inclina-

182. Id. (court suggested that even if fourth amendment analyses were applied, purpose of testing was compelling).
183. Interestingly, the court commented in a footnote that there was no evidence that justified the army doctors' failure to inform the plaintiff of the reasons for the HIV test. "Given the circumstances, the physicians should have given plaintiff notice of the test. Their failure to do so, however, is irrelevant to the issues at bar." Id. at 636 n.27.
184. Id. at 636-37 (citing United States v. City & County of San Francisco, No. 84-7089, slip op. (N.D. Cal. Aug. 28, 1987); Local 1812, Am. Fed'n of Gov't Employees v. United States Dep't of State, 662 F. Supp. 50 (D.D.C. 1987)).
185. The court noted, but declined to resolve, the issue of whether HIV testing was a routine feature of diagnostic blood tests and whether the plaintiff had therefore consented to the HIV test by consenting to the withdrawal of blood generally. Id. at 629 n.6.
186. Id. at 632 n.20.
187. Id.
tion to protect individual autonomy in medical decision making. Given the possible pernicious consequences of blood testing of suspected HIV-positive individuals, courts seem likely to impose a stringent burden on defendants where plaintiffs are in fact injured.

Suppose that a hospital has a policy of routine testing. As we have seen, many health care providers would like the right to test without the patient’s permission. If the Minnesota study previously cited is representative of hospital practice around the country, then some of these tests will be improperly read, errors in record keeping for the blood samples will occur and staff confusion about the meaning of positives may result. Thus, the potential for tort liability is great.

a. Existing Tort Theories

Errors in testing can result in a large damage claim. If a patient who tests positive is mistakenly interpreted as HIV-positive even though a follow-up test is negative, or an HIV-seropositive patient is misdiagnosed as having AIDS, the resulting mental distress of that patient may be compensable in a tort suit. Given the nature of AIDS, such distress is presently foreseeable to a physician. A false or erroneous test result may trigger “AIDS anxiety” with debilitating effects on a patient rendering a health care worker liable. Overly broad testing by health care workers to alleviate their own anxieties about exposure to AIDS will do little to calm them, while exposing them to tremendously increased potential for tort suits. Patients are put at risk unnecessarily as are medical staffs.

Failure to Counsel. Even if an unconsented test result accurately identifies the patient as HIV-positive and the patient is notified, a cause of action may still exist for the distress caused by the news. Given the policy statements of a variety of professional and governmental organizations, the failure to provide pre-test counseling, rendering the patient poorly prepared for the news of HIV positivity, is itself a negligent act. If counseling is not done at all, or is performed poorly, given a vulnerable patient, then the possi-

188. Henry, supra note 19.
189. See, e.g., Holland & Tross, The Psychosocial and Neuropsychiatric Sequelae of the Acquired Immunodeficiency Syndrome and Related Disorders, 103 ANNALS INTERNAL MED. 760 (1985).
190. See the damages alleged in Doe v. Wills Eye Hospital, No. Civ. 5248 (C.P. Philadelphia County Mar. 30, 1989) discussed at supra note 115.
bility of liability for the patient's mental distress is arguable.191

Failure to Diagnose. If the testing is clandestine, with the pa-
tient not notified, and the results are true positive, then a diagno-
sis is missed that could have led to positive medical action at the
early stages of seropositivity. The courts' reactions to such a situ-
ation have been quite consistent: compensation has been
awarded for any mental distress and psychic injury suffered by the
patient and also for the "loss of a chance" of treatment because of
the missed diagnosis.192 As evidence accumulates as to the effec-
tiveness of treatments such as AZT in extending the lives of AIDS
patients, or in delaying the onset of symptoms of AIDS once a
person is HIV-positive, or in preventing seropositivity after expo-
sure to the virus, failure to inform patients will increase health
care provider liability risks.

It is precisely in the case where the test is done surrepti-
tiously and the results not disclosed to the patient that the great-
est harm can be done to both the patient and to third parties. A
chance is lost both to warn and to treat.

Negligent Testing. A surreptitious test for staff protection, for
example, doing a single ELISA test on a patient's blood, poses a
significant risk of being erroneous. Standard procedure is a sec-
ond ELISA, followed by a Western Blot test. If the single test
reveals a false positive and the results are somehow revealed to
others, as they are likely to be, the patient might suffer economic
injury and personal psychological and other harms. The health
care provider is ultimately liable for revealing such information
and causing these results.

Duties to Warn Third Parties. There is an interesting twist to
overzealous testing and the increase in the risk of suit. If a patient
is offered a test after proper pre-test counseling, and declines,
then the health care worker does not have information about the
presence of the HIV virus in that patient. The obligation of the

191. See, e.g., Rowe v. Bennett, 514 A.2d 802 (Me. 1986) (vulnerable psychi-
atric patient); Newton v. Kaiser Hosp., 184 Cal. App. 3d 386, 228 Cal. Rptr. 890
(1986) (contractual relationship may form basis of recovery for negligent inflic-
tion of mental distress).

192. See Chappell v. Master, 255 So. 2d 546 (Fla. Dist. Ct. App. 1971) (fail-
ure to communicate to prospective adopting parents that child was affected with
fatal hydrocephalus held actionable), cert. denied, 260 So. 2d 517 (Fla. 1972);
Hofmann v. Blackmon, 241 So. 2d 752 (Fla. Dist. Ct. App. 1970) (duty to cor-
rectly diagnose and also to inform members of family of patient with contagious
disease and steps to reduce contagion), cert. denied, 245 So. 2d 257 (Fla. 1971);
to reduce spread of infection).
health care provider stops there. Any obligation to third parties shifts to the individual to take precautions and to test later. At a minimum, pre-test counseling will have sensitized the patient to the risks of the HIV virus. If, however, the provider tests a patient's blood and the test is positive, then must that provider warn the patient? The provider now has information that can lead to injury to others if they are not informed. If the provider does not inform the patient and does not explain how to minimize harm to third parties through safe sex and sterile needles, then an infected third party has a suit against the provider. This obligation to warn third parties, derived from the California Supreme Court's decision in *Tarasoff v. Regents of the University of California*, may extend even further the risks of nonconsensual testing.

The common law duty to warn, articulated in *Tarasoff* and other cases, intersects with state statutory requirements to report HIV infection to state authorities. Statements by various professional organizations often are in disagreement over the duty of health care professionals. Such statements sometimes assume that all obligations to warn are satisfied by reporting to state agencies rather than undertaking the responsibility directly. However, this will be the case only where the state has a special statute addressing the duty to report. Some organizations such as the Infectious Disease Society of America recommend that if the HIV-positive patient refuses to tell others of his status, the physician should then consider his duty to the patient's contacts: "It is clear that, under some circumstances, the duty to inform will take precedence over the duty to protect confidentiality." Under certain circumstances, where the physician has counseled the patient and is still convinced that the HIV-positive individual is likely to deliberately have risky contacts with others who are unaware of the risk, he may have a duty to warn.

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197. "Whether a physician has a duty to warn is not clear, but such a duty
b. The Emergence of a Standard of Care

As early as in *Darling v. Charleston Community Memorial Hospital* and as recently as in *Jackson v. Power*, state courts have measured the conduct of health care institutions by reference to existing private and governmental guidelines and standards, at times imposing liability directly on an institution that fails to comply with external standards.

Routine screening for HIV, if considered at all, should follow guidelines of the CDC. Since the CDC has established a standard, failure of a health care worker or institution to follow that standard risks tort liability. The CDC does not recommend such routine screening and questions its value in most cases. If screening of patient blood is to be done on a routine basis, however, the CDC proposes that the patient’s consent be obtained and that patients be informed of test results and counseled by properly trained counselors. CDC guidelines further stress the need for confidentiality safeguards to limit knowledge of test results to those directly involved in the care of infected patients, or as required by law; and require assurances that identification of infected patients will not lead to denial or limitation of needed care. The CDC noted that routine testing, even with the above

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199. 743 P.2d 1376 (Alaska 1987) (under doctrine of corporate negligence, hospital owes duty to its patients to use reasonable care to ensure physicians are competent).

200. The corporate negligence cases include: Fridena v. Evans, 127 Ariz. 516, 622 P.2d 463 (1980) (hospital as corporation may be held liable for negligent supervision); Purcell v. Zimbelman, 18 Ariz. App. 75, 500 P.2d 335 (1972) (failure of hospital to take action against surgeon who lacked adequate skills constitutes negligence on part of hospital); Felice v. St. Agnes Hosp., 65 A.D.2d 388, 411 N.Y.S.2d 901 (1978) (hospital can be held liable for treatment of patients assigned by doctors who are not hospital employees because every doctor using hospital’s facilities must comply with its standards); Bost v. Riley, 44 N.C. App. 638, 262 S.E.2d 391 (1980) (hospital may be held liable if breach of duty to monitor treatment was contributory factor to injury), *cert. denied*, 300 N.C. 194, 269 S.E.2d 621 (1980); Pedroza v. Bryant, 101 Wash. 2d 226, 677 P.2d 166 (1984) (doctrine of corporate negligence imposes on hospital a nondelegable duty owed directly to patients).


safeguards, should be constantly evaluated for its effectiveness in protecting health care workers and its effect on patients.

IV. THE INSTITUTION AS TRUSTEE: THE PROPER LOCUS FOR SAFER ALTERNATIVES

The central actor is often ignored in the policy debates over AIDS testing, with sides drawn between medical staff and patients. Yet, the lesson from both the informed consent doctrine and judicial balancing tests in constitutional privacy cases is that the institutional interest in routine HIV testing or another potentially harmful policy must consider alternatives to that policy. Thus, if the purpose of widespread routine testing of patients is to protect staff, one must first evaluate alternatives that create a lesser risk to patients while adequately protecting staff.

The health care institution, whether a hospital or clinic, is the central actor in protecting both patients and staff. It establishes policies, buys medical equipment, admonishes staff, faces liability hazards for improper acts and insures staff against health and disability consequences. An institution has the capacity to develop safeguards to ensure the safety of its staff which provide alternatives to routine testing and which better protect both staff and patients.

A. Protecting Staff

1. Limiting Individual Exposure

Institutions can track employee exposure to patient fluids and limit the staff’s occupational exposure to the HIV virus. Limiting exposure occurs at several levels. For example, it may be that the surgical staff in some hospitals faces a risk of exposure that might be deemed “excessive.” A surgeon in an emergency room, performing invasive procedures that result in needle stick injuries might be protected by spreading the risk so that no one person faces an unduly high level of exposure. The institution could further develop a policy reducing certain elective procedures, and “reducing the number of patients with AIDS treated by a single physician by requiring other competent physicians to treat them.”

Where it is reasonably certain that a subset of health care personnel is facing high levels of exposure, it is the duty of the institution to search for ways to reduce this risk and to dissipate it.

203. Emanuel, supra note 37, at 1688.
2. Ensuring Implementation of Proper Precautions

The Occupational Safety and Health Act requires that each employer furnish each employee a work place “free from recognized hazards . . . likely to cause death or serious physical harm.” The Occupational Safety and Health Administration (OSHA) is preparing new detailed regulations to govern AIDS in the workplace. Late in 1988, OSHA issued enforcement procedures for occupational exposure to HIV and hepatitis B (HBV). These guidelines are to provide “uniform inspection procedures and guidelines to be followed in conducting inspections and issuing citations under pertinent standards for health care workers potentially exposed to HBV and HIV.” The procedures focus on universal blood and bodily fluid precautions to be used for all patients whenever there is a risk of exposure to blood or other bodily fluids or tissues. The OSHA guidelines note that “OSHA is relying on these guidelines as reflecting an appropriate and widely recognized and accepted standard of protection to be followed by health care employers.” The focus of OSHA surveys of health care institutions will be “emergency rooms, operating rooms, direct patient care areas, laboratories, and X-ray. Secondary areas of concern are laundry and housekeeping.” In citing hazards, inspectors will apply OSHA requirements wherever employees are expected to have direct contact with body fluids, whether or not a patient is known or even suspected to have been infected with hepatitis B or HIV.

OSHA has begun to conduct surveys under these new enforcement guidelines, focusing on health care facilities in states with the largest numbers of hepatitis B and HIV infection.

205. Id. § 654(a)(1).
208. Id.
209. Id.
210. Id.
cases. OSHA inspectors have cited over eighty health care facilities during the past year for failure to protect workers from AIDS and other diseases. Facilities cited had failed to require that laboratory or health care workers wear protective gloves or had permitted reuse of disposable gloves; had failed to dispose of used needles properly; or had failed to educate workers. It is clear that health care institutions can improve their procedures for protecting workers in line with OSHA requirements.

3. Educating Staff

A medical staff should be knowledgeable about the various modes of transmission and actual risks of contagion; however, this knowledge is often lacking. The Report of the President's Commission on the HIV Epidemic urged: "Employers should develop an HIV education program for all employees [that]... should emphasize two goals: information about transmission to prevent the further spread of HIV infection and education about legal issues—such as how to ensure confidentiality and prevent discrimination."214

4. Guaranteeing Benefits

Health care workers will still have serious fears even if OSHA requirements are satisfied and staff education improved. These fears relate to practical concerns about job security for an employee who seroconverts, or disability and health insurance coverage or payment for prophylactic AZT if the worker is stuck by a needle. The financial risks for the health care worker are serious if the institution does not provide generous benefits. As one writer has argued:

Not to provide such financial protection sends a message that society expects health care workers to care for patients with HIV but is unwilling to back that expectation with direct support for the health care workers themselves. Such a program would somewhat ameliorate the

stress arising from concern about HIV infection in the workplace and would help to maintain a professional approach to the care of patients with HIV by health care workers.215

B. Protecting Patients

The institution has an obligation to both the patients and to the employees. Institutions must consider removing HIV-infected employees from any contact with patients suffering from easily transmitted diseases. Reasonable accommodations are often possible that allow an employee to perform her job without endangering patients or herself.216

Patient consent and adequate pre-test counseling and post-test discussions are critical to achieving the goal of protecting both patients and third parties. The problem of a patient secret—an HIV-positive result—known to the health care provider poses a difficult legal and ethical problem of a duty to warn. If we keep in mind, however, the goals of the informed consent doctrine, treating the patient as part of a collaborative effort to cope with a medical problem, then a health care provider can be encouraged to talk with the patient prior to jumping into the legal quagmire of a duty to warn third parties. As Eth writes: “[S]tandard psychiatric interventions may prove effective. Clarification, interpretation, and suggestion may assist the patient in working through conflicts over the shame and guilt associated with HIV infections. With relief of anxiety and depression, patients may become less resistant to discharging their responsibility to inform partners of their seropositivity.”217 Only after serious efforts have been made to counsel the HIV-positive patient about his status and the risks to his partners should an institution consider the obligation to contact third parties.218


217. Eth, supra note 194, at 575.

218. See Closen & Isaacman, supra note 195.
Routine screening in the health care institution performed simply to relieve staff anxiety must be rejected as standard practice. Such testing without patient consent offends legal and ethical norms. HIV screening can be justified to manage patients, but not to protect staff. Staff protection is best achieved by a general practice of using precautions in any situation where medical personnel might come into contact with patient body fluids and by demanding that the institution, as a trustee of staff safety, invest time and money in routines, equipment and procedures that will ensure a higher level of protection for staff. The burden should be on the institution to protect both staff and patients.

Health care providers should test only with the consent of the patient. This policy avoids most of the liability hazards and is consistent with the advice of thoughtful medical commentators, the recommendations of state hospital and professional associations, and the law of several states.219 Such a policy minimizes

219. See, for example, the Michigan Hospital Association’s Model AIDS Policy, which states:

Given the potential for serious discrimination, all testing should be voluntary, anonymous, and conducted with informed consent.

Testing for HIV is appropriately performed for the purposes of making a diagnosis; answering a patient’s question about whether he or she is infected; conducting a follow-up after a potential exposure has occurred, (e.g. after needlesticks or other inadvertent violation of universal precautions, whether such exposure involves employee exposure to a patient’s blood or body substances or patient exposure to an employee’s blood or body substances) or screening blood, organs or other body substances prior to donation. Routine testing of either patients or staff should not be used as a means of reducing the risk of exposure to HIV.

If there are acceptable modifications in invasive procedures that can further minimize the risk of exposure, ideally they should be incorporated into established practices for all patients in order to afford protection for all patients and staff. However, if there are certain procedures where specific modifications can be identified which could not be applied universally but would materially reduce the risk of transmission for the patient or staff (without creating an unacceptable risk for the patient), then in these cases, limited testing might appropriately be used to identify which patients would be candidates for the modified procedures.

When an HIV test is performed for any reason the informed consent of the patient should be obtained. Obviously emergency situations may prevent obtaining informed consent. The physician should obtain the informed consent from the patient.

All patients should be notified of the results of their HIV test by the patient’s physician. The physician and hospital may arrange for appropriate counseling and follow-up either in the hospital itself or in a community-based agency for patients whose tests indicate that they have been infected by the HIV.
the destructive side effects that inadvertent or intentional breaches of confidentiality might have on a patient's life.

Hospitals should adhere to FDA approved test procedures and follow CDC approved criteria for determining the presence of HIV infection, both of which establish protocols for repeat and confirmatory testing.

HIV test results are appropriately used by physicians or hospital staff in the direction or conduct of the patient's medical care. The delivery of care should not be conditioned on the willingness of a patient to undergo testing or on the results of a test. Appropriate care should be delivered to HIV positive patients. Employees or medical staff members who refuse to treat patients based on the patient's HIV status may be subject to disciplinary action in accordance with the applicable hospital's policy and/or collective bargaining agreements, up to and including suspension or termination.


The Pennsylvania Hospital Association AIDS Guidelines state:

**Testing**

I. Routine testing of patients and/or health care workers is not necessary to reduce the risk of exposure to HIV and should not be substituted for rigorous adherence to universal precautions.

**Informed Consent**

I. When an HIV antibody test is performed for any reasons other than blind epidemiologic studies to determine HIV prevalence, the specific written informed consent of the patient should be obtained. . . .

II. Hospitals should designate trained personnel, including physicians, to seek consent and to provide pre- and post-test counseling. The patient should be presented with the option of discussing the test further with his/her physician prior to granting consent.

III. The explanation (pretest counseling) should include the reasons for conducting the test, a description of the way(s) in which the test results could affect the patient's medical regimen, and the personal significance for the patient of the possible results of the test. . . .

IV. Existing law governing informed consent does not require a patient to sign anything, but merely that certain information on risks, nature of procedure, consequences, etc., which a reasonable person in similar circumstances would want to know in order to make an informed choice be conveyed to the patient. However, if there is subsequently any dispute over whether the information was actually conveyed to the patient before the test, the hospital will be better able to defend its liability if the patient has signed a document acknowledging receipt of the information. Documentation in the patient's chart by the physician would be less likely to resolve a subsequent difference of opinion as to whether the informed consent explanation was actually given. Thus, since proving that informed consent was obtained prior to the procedure could ultimately be as important as obtaining it in the first place, the most prudent course from a liability defense perspective would be to have the patient sign a written consent form dealing specifically with the HIV antibody test. (Sample Form A)

V. Release of information pertaining to test results should follow general guidelines for release of information from the medical record.

VI. The patient should be notified of the results of his/her blood test.


Both of the guidelines are contained in **National Ass'n of Social Work-**
The recommendations of Searle and others are relevant here: "[T]hose professionals who do not believe that informed consent is essential before HIV serotesting are risking many difficulties for their patients, and perhaps also medicolegal hazards for themselves." 220

The following principle should guide action whether judicial or legislative: No HIV test should be ordered until physicians understand the appropriate use of and potential adverse consequences of the HIV-antibody tests, have provided complete counseling to their patients and have obtained the patient's written informed consent to the test.

This principle strikes a balance between valuable uses of such test results and the downside risks. A non-mandatory system, based on the physician-patient relationship, would offer a less restrictive alternative to compulsory screening in any form. 221 Voluntary screening may better serve the interest in protecting healthy people from becoming infected. Such testing of a counseled, consenting subject provides a way to "protect uninfected persons who want to know their HIV status, to improve their own health, and to avoid harming others." 222 People are entitled to discover and control the boundaries of their own secrets, subject only to persuasion as to careful discovery and disclosure of those secrets, and should not be deceived by health care workers in whom they have placed their trust.

ERS, ACQUIRED IMMUNE DEFICIENCY: A SOCIAL WORK RESPONSE, Nov. 1987 (in AIDS REFERENCE GUIDE, § 902, p. 1, 2), which states: "Therefore, routine practices to prevent occupational infections should be formulated with the idea that all patients have the potential to transmit infection. . . . Strict adherence to recommended infection-control guidelines for dental professionals should help to minimize the risk of occupationally acquired HIV infection."

220. Searle, supra note 91, at 28. In Searle's words:
In view of the fragile nature of the virus outside the body, the large volume of evidence indicating an extremely low risk of transmission in the hospital, the certainty of not being able to identify which patients are in high-risk groups, and the danger of forcing homosexuals to seek help elsewhere, it seems most appropriate to adopt hepatitis-B-level precautions in all situations involving possible contact with body fluids that may contain virus.

Id.

221. Even in the prison setting, where constitutional rights of prisoners are limited, courts have searched for alternatives to accommodate prisoner rights at de minimis cost to state interests. Privacy rights are entitled to weight even in that circumscribed setting. See Turner v. Safley, 482 U.S. 78 (1987). See also Capron, supra note 92, at 182.

222. Capron, supra note 92, at 183.