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The HIV/AIDS epidemic raises many issues for the health care industry. From a legal perspective, the most important are those that deal with liability. This annotated bibliography attempts to comprehensively gather citations to periodical articles, as well as to some books and monographs, that discuss liability issues in the following areas: the duties of health care workers (HCWs) to be serologically tested, to disclose test results to patients, and to restrict the scope of their professional practices if serologically positive; the rights of seropositive patients to receive medical treatment and to have access to not-yet-approved experimental therapies; the rights of patients in the areas of serologic testing and confidentiality of test results; the rights of third parties who are sexual or needle-sharing partners of seropositive patients to be warned of their risk of acquired HIV; and the duties of blood banks, hospitals and physicians regarding transfusion-associated HIV-transmission. Some background materials in the following areas are also cited: attitudes of health care professionals (HCPs) and patients toward HIV/AIDS; medical aspects of HIV/AIDS and the risks of health care occupational exposure; HIV-antibody testing, reporting and confidentiality; and HIV/AIDS and the law.

Annotations are organized under subject headings as follows:

I. Health Care Professionals, Patients and HIV/AIDS: General Materials

II. Health Care Professional/Patient Attitudes Toward HIV/AIDS

III. Medical Aspects of HIV/AIDS and Health Care Occupational Exposure

IV. The Seropositive Health Care Professional: General Materials

V. The Seropositive Health Care Professional: The Duties to be Tested and to Disclose

VI. The Seropositive Health Care Professional: The Duty to Restrict the Scope of Practice (also includes material on

* J.D., DePaul University; M.L.S., Indiana University. Associate Professor, Northern Illinois University, College of Law Library.
discrimination and on mandatory HIV-testing in the con-
text of imposing practice restrictions or making hiring
decisions)

VII. Third Parties at Risk: The Right to be Warned
VIII. Transfusion-Transmitted HIV: Liability Issues
IX. Transfusion-Transmitted HIV: Discovery Issues
X. The Seropositive Patient: Rights of Access to Treatment
XI. The Seropositive Patient: Rights of Access to Experimental Therapies
XII. Patient Screening, Testing and Confidentiality Issues
XIII. General Materials on HIV Testing, Reporting and Confidentiality
XIV. General Materials on HIV/AIDS and the Law

There is a vast amount of literature in these areas and this
bibliography is not a complete guide to it. Some of the omissions
were deliberate (e.g., newspaper articles, popular materials, and
most non-footnoted pieces); others were due to human fallibility.

To keep up with this rapidly changing area of law and medicine, a researcher should consult looseleaf services, “current awareness” periodicals, specialized newspapers, and on-line HIV/AIDS, medical, legal, and news databases.¹ For additional legal periodical material, general HIV/AIDS legal bibliographies should be utilized.²

I. HEALTH CARE PROFESSIONALS, PATIENTS AND HIV/AIDS: GENERAL


The author examines the implications of the Occupational Safety and Health Act, the common law duty to provide a safe


HIV/AIDS
Annotated Bibliography

workplace, and the right to privacy for hospitals and other employers of health care workers.


Includes policy statements on discrimination against seropositive patients, informed consent, and other related issues. Available from the American Chiropractic Association's Legal Department, 1701 Clarendon Blvd., Arlington, VA 22209; ph. 703-276-8800.


Includes HIV/AIDS policies. Available for $5.00 from the American Dental Association's Office of the Executive Director, 211 E. Chicago Ave., Chicago, IL 60611; ph. 312-440-2500.


Catalog no. 094691. Available for $10.00 (members) or $18.00 (non-members) from the Association's Order Processing Department, 840 N. Lake Shore Dr., Chicago, IL 60611; ph. 800-242-2626.


Available from the Association's Department of HIV, 515 N. State St., Chicago, IL 60610; ph. 312-464-5460.

American Nurses Association, Position Statement (dates vary).

The American Nurses Association has adopted sixteen separately published position statements on HIV/AIDS. They are available from the American Nurses Association, 600 Maryland Ave., S.W., Suite 100W, Washington, D.C. 20024; ph. 202-554-4444, ext. 256.


The article examines the following potential bases for hospital liability: negligence in treating the seropositive patient through misdiagnosis and lack of informed consent or inadequate counsel-
ing; HIV-transmission by transfusion (including blood bank liability); handicap discrimination; duty to treat AIDS patients; confidentiality; the duty to warn third parties at risk; the federal Occupational Safety and Health Act of 1970; and the restriction of work activities of seropositive health care workers. The authors also discuss the financial implications of AIDS for hospitals.


The authors provide an overview of the following areas: testing and screening; reporting and confidentiality; the duty to treat; occupational exposure, discrimination and labor relations implications of AIDS in the health care workplace; and transfusion-associated liability.


This short article examines hospital liability arising from blood transfusions, the transmission of HIV from patient to health care worker, discrimination against AIDS patients in access to treatment, bad medical advice based on misdiagnosis, and the violation of patient privacy rights.


In this introduction to a symposium issue, the author offers a brief discussion of the implications of mandatory HIV testing, the physician's duty to warn those at risk of being infected by a patient, confidentiality, and discrimination.


The author, a member of the Board of Trustees of the American Medical Association, provides a brief overview of the following areas: the obligation of the physician to treat AIDS patients; the duties of the physician toward the patient when the physician is HIV-positive; the responsibility of organized medicine to educate the public and to help prevent discrimination against AIDS victims; and the appropriate role of HIV testing and reporting of results.


The author speculates about when a jury would be likely to use a "reasonable person" rather than a "reasonable physician" stan-


The authors offer a brief overview of the right to confidentiality, the right to medical information, and the right to treatment. They derived this information from a “synthesis” of 524 articles obtained from searches in four bibliographical databases: Medline, CNRS (Pascal), Bioethicsline, and AIDSLine.


This short article addresses the following issues in layman’s terms: an occupational therapist’s right to know a patient’s HIV status prior to treatment, and the legality of demanding the patient submit to an HIV test. In addition, the article discusses the duty to treat and the duty to warn third parties at risk.


The author provides a brief overview of an HIV-infected person’s right to treatment, confidentiality, and the right to be free from discrimination. The author also discusses the civil and criminal liability for spreading infection and the rights and duties of health care professionals.


The authors offer a comprehensive overview, exploring such issues as regulatory restrictions on the admission of AIDS patients and the legal implications of refusing to admit them. The article also addresses patient concerns such as confidentiality of medical information, treatment decisions, possible liability to other residents, reimbursement, and issues relating to the HIV-positive employee.


The authors provide examples of the legislative treatment of AIDS issues directly concerning health care workers from the more than twenty-two countries which had enacted such legislation as of September 1988.

A general survey of the following areas is offered: discrimination against HIV-infected health care workers; duty to disclose the HIV status of either patient or physician; and the rights of access to health care of HIV-infected individuals.


The author examines the implications of the following for hospital HIV testing and infection-control programs: handicap discrimination laws; the Employee Retirement Income Security Act of 1974; confidentiality duties; negligence liability; occupational safety and health laws; the National Labor Relations Act; and workers' compensation statutes.


The author provides a general survey of tort liability for the transmission of HIV. The discussion regarding liability for misdiagnosis or failure to inform of diagnosis or counsel, and liability related to provision of blood or blood products is of direct interest to the health care worker.


During the course of a general discussion on the evolution of hospital liability law, the authors note that a growing trend is to replace local standards of care with national standards. The authors argue that guidelines from the Centers for Disease Control should serve as the national standard for treating AIDS patients.


The author examines the following potential causes of action of direct interest to health care professionals: medical malpractice based on failure to diagnose or to inform the patient; failure to provide adequate counseling or treatment; failure to report AIDS diagnoses to health authorities and to third parties at risk; and liability for transmission of HIV via transfusion. In addition, the author discusses other causes of action that do not arise in a health care context (e.g., drug abuser needle-sharing; perinatal or sexual transmission).

The author presents a brief summary of the areas explored in this symposium issue, namely; public health aspects, including health policy considerations, demography and transmission; clinical manifestations; the role of legislation; testing, reporting, and other confidentiality issues such as the physician's duty to warn those at risk of being infected by a patient; discrimination; employment and occupational risk; criminal law; insurance; immigration; housing; education; the duty of physicians to treat; the right of AIDS patients to refuse treatment; and the implications of HIV for the surgeon, for the clinical laboratory, and for the long-term care facility.


Part six presents an overview of the following areas: breach of confidentiality, refusal to treat, defamation, negligence and other traditional bases for tort liability. Part nine offers a discussion of discrimination against those who are seropositive, focusing on the rights of patients and health care workers in the context of workplace safety.


The authors offer advice to those developing AIDS policy for health care facilities. Specific areas covered include Centers for Disease Control and Occupational and Health Administration guidelines; patient testing, counseling and confidentiality; seropositive health care professionals; and professionals who refuse to treat AIDS patients.


This short, practice-oriented article discusses the following liability scenarios for health care providers: failure to warn third parties at risk because of a seropositive patient's behavior; failure to diagnose a patient's HIV infection; and failure to inform a surgery patient of the surgeon's seropositive status.


In the context of HIV/AIDS, the author provides a general overview of hospital and physician liability to patients in the following areas: duty to treat or to refer; decision-making regarding life-sus-
The John Marshall Law Review


This brief article examines the obligation to provide treatment, screening patients for HIV-infection, and the duty to notify third parties at risk.


The authors offer a brief overview of physician responsibilities, including the physician's duty: to report AIDS cases to public health authorities; to counsel HIV-positive patients; and to warn those at risk because of a patient's behavior. The authors also discuss the patient's right to confidentiality and liability for transmitting HIV and the powers of public health authorities to take steps to promote infection control.


The author presents a very brief discussion of the legal and ethical issues raised for the treating physician by an AIDS patient's progression from normal mental functioning to dementia, namely, the author discusses confidentiality, risk assessment, involuntary restraint or quarantine, and informed consent. Background on the medical aspects of the condition are also provided.


An overview of the following areas is provided: testing and confidentiality; malpractice liability for failure to diagnose, inform or treat; and financing AIDS care. A reprint of the AIDS-related guidelines promulgated by the Arizona Medical Association is included.

The authors survey physician liability based on the following: negligently creating the need for a transfusion; invasion of patient privacy through the use of HIV-screening; breach of duty to treat HIV-infected patients; and breach of duty to warn third parties at risk. In addition, the authors examine the liability of blood banks and sexual partners. An appendix surveys HIV/AIDS legislation in Ohio, Kentucky, Maryland, Missouri, and West Virginia.


The author provides a brief overview of the following areas: employment discrimination against HIV-infected health care workers; employer’s duty to provide a safe workplace; informed consent for testing; confidentiality of HIV test results; and routine screening of patients.


The authors provide extensive analysis of the following areas: the rights of HIV-infected health care workers; HIV testing in the health care institution; confidentiality issues including the duty to warn third parties at risk; and the duty to treat.

II. HEALTH CARE PROFESSIONAL/PATIENT ATTITUDES TOWARD HIV/AIDS


Although the American Medical Association (AMA) recommends that HIV-infected physicians continue to practice as long as there is no risk to their patients, 45% of all respondents in a nationwide survey believed that HIV-infected physicians should not be allowed to continue to practice. In fact, more than half of those who had seen a physician in the past five years would change physicians if their physicians were HIV positive, and one-fourth would change physicians if their physician were treating people with AIDS. The authors conclude that the public needs to be educated about the appropriateness of the AMA policy.


This is a report of a random national survey sampling 300 dentists about the likelihood of dentist-to-patient transmission of HIV. Respondents tended not to believe the case report of HIV transmis-
sion during an invasive dental procedure. However, respondents did believe that infected dentists should refrain from clinical work.


The authors report results of a national random sample survey mailed to 2004 family physicians in the United States in 1990, with a 59% response rate. They found, *inter alia*, that 68% of the respondents believed that it was their professional duty to treat patients with HIV/AIDS, but that 50% would not do so if given a choice.


The authors discuss the following reasons why health care professionals fear occupational exposure to HIV: the perception that health care officials have unduly minimized the risks; concerns about the effectiveness of infection control procedures; and lack of meaningful communication between health care officials and health care professionals.

R. Nathan Link et al., *Concerns of Medical and Pediatric House Officers about Acquiring AIDS from their Patients*, 78 AM. J. PUB. HEALTH 455 (1988).

The authors report the results of a survey of 263 medical and pediatric interns (98% return rate) which revealed that 48% of medical and 30% of pediatric respondents had a moderate to major concern about acquiring HIV from patients and that 25% of all respondents would not treat AIDS patients if given a choice.


The authors report results of a survey of 353 patients at a university-based outpatient clinic in a midwestern city. The authors reported, *inter alia*, that 42% of the respondents thought that patients could “sometimes” be infected by HIV during a “medical interaction” with an infected physician, 48% would not allow the physician to continue treatment, and 88% would wish to be told of their physician’s seropositive status.


The author describes results of a 1991 survey conducted by the Medical Expertise Retention Program of the American Association of Physicians for Human Rights, a national program providing services and advocacy for seropositive health care professionals. The
survey revealed, inter alia, that 73% of HIV-positive health care workers feared losing their positions and 55% feared that restricting their practices would lead others to suspect that they were HIV-positive.

III. MEDICAL ASPECTS OF HIV/AIDS AND HEALTH CARE OCCUPATIONAL EXPOSURE


This article provides a brief overview of the medical literature on the risks of HIV transmission from patient to health care worker.


The authors conducted an epidemiological study of infection of patients by an HIV-positive surgeon. They found that the infection rate was zero and attributed this to the use of surgical aseptic technique.


The authors report the results of a study which indicated, inter alia, that a dentist's risk of acquiring HIV from patients of unknown serostatus is 0.006% (cumulative annual risk) and the risk of a dentist's becoming infected by HIV-positive patients is 3.82% after 5,000 visits.


This publication updates earlier recommendations and includes the much debated list of seriously invasive procedures which the Centers for Disease Control recommended seropositive health care workers abstain from performing.


This review of surveillance data reported in the United States through June 30, 1990, suggests that most health care workers
with AIDS acquired their HIV-infection through a non-occupational route.


This editorial considers the extent of risk of HIV transmission during dental treatment and concludes that it is very small. A well-chosen bibliography on the topic is included.

Editor's Desk, *HIV-Infected Emergency Room Patients Pose Risk for Hospital Staff*, Trauma, June 1991, at 1.

This short article describes a study done at an unnamed hospital emergency department. The researchers concluded that there is great potential for exposure to HIV by health care workers unless universal precautions are utilized.


The authors summarize the results of a six-year study which found an HIV transmission risk to health care workers of 0.3% per percutaneous exposure to blood from an infected patient.


The author offers practical advice regarding medical procedure in the emergency room.


This study found that universal barrier precautions were used during approximately 44% of interventions, but that this rate dropped to 19.5% when patients were bleeding profusely. Six percent of the patients presenting to the department were seropositive.


The authors report results of a study which found that "despite infrequent compliance with recommended infection-control precautions, frequent occupational exposure to persons at increased risk for HIV infection, and frequent accidental puncturing of the skin with sharp instruments, dental professionals are at low occupational risk for HIV infection." *Id.* at 86.

This short piece offers a statistical model for calculating the probability that an HIV-positive surgeon will infect a patient upon whom he/she operates. The authors offer some examples to demonstrate that the risk of transmission is low.


The authors report results of a study indicating that risk of virus transmission from seropositive patient to health care worker exposed to the patient's blood is low.


The authors provided evidence that the risks to patients operated on by HIV-positive surgeons are low by contacting the patients of one such physician. Only one out of 616 of these patients was HIV-positive. After reviewing the patient's medical history, the authors concluded that the patient may have already had the virus at the time of his surgery.


The authors describe the development of the Centers for Disease Control (CDC) AIDS guidelines, beginning with a brief history of the promulgation of public health guidelines by the agency as early as 1962.


The authors report results of a study which found, *inter alia*, that surgeons have an average of 18.6 blood contacts per one hundred operations. They conclude that in many instances surgical techniques should be re-evaluated, the use of universal precautions should be increased, and the development of puncture-resistant gloves should be a priority.


Various models for procedures hospitals can use with regard to future surgery by a seropositive surgeon and contacting former patients of the seropositive surgeon for the purpose of HIV testing are discussed.

The authors report results of a study which found that use of universal precautions significantly reduced the frequency of direct physician-patient blood—body fluid contact.

**IV. THE SEROPOSITIVE HEALTH CARE PROFESSIONAL: GENERAL**


The author presents an extensive analysis and critique of the role played by the Centers for Disease Control in determining public health policy toward HIV-infected health care workers (HCWs) and the legitimacy of restricting the scope of their professional practices. She also addresses HCWs HIV testing issues.


The author provides a brief analysis of the recommendations for preventing transmission of HIV and HBV during exposure-prone procedures issued by the Centers for Disease Control on July 12, 1991. He argues that the recommendations divert attention from significant HIV related social problems such as stigma, poverty, neglect, and discrimination.


The author examines the issues of mandatory screening of HCWs for HIV, disclosure of test results to patients, and the imposition of practice restrictions on those HCWs who are seropositive. He concludes that these actions are not warranted from a medical or public health viewpoint, but that due to public pressure, adoption of limited practice restrictions may be a political necessity.


The author examines the duty to disclose a treating physician's HIV status to a patient under the doctrine of informed consent. In addition, the author discusses the evolving standard of care regarding an HIV-infected physician's performing seriously invasive procedures and the efficacy and potential consequences of mandatory physician HIV screening.

Professor Hermann surveys bills that were pending in Connecticut, Delaware, Florida, Hawaii, Louisiana, Maryland, New York, Oregon, Texas, and Washington.


The author provides a brief survey of the law in Great Britain regarding liability of a seropositive HCW who transmits HIV to a patient, confidentiality of HCW's HIV-status, and testing of HCWs.


The author provides a brief summary of points of agreement among the participants in a conference entitled The HIV + Health Professional: Policy Options for Individuals, Institutions, and States, held on December 7-8, 1990, in New Brunswick, New Jersey.


This is the edited text of a panel discussion presented at the Eleventh Annual Whittier Health Law Symposium on April 24, 1992. Mr. Stanton discusses HIV testing of patients, Brenda S. Reid focuses on disclosure of a physician's HIV-status and imposition of practice restrictions, and Reed E. Schaper considers HIV testing of health care workers.


The authors discuss whether an HIV-infected health care worker may be subject to tort liability for either transmitting HIV to a patient or causing a fear of such an infection. Specific tort theories examined are battery, misrepresentation, strict liability, intentional and negligent infliction of emotional distress, and negligence. In addition, the authors discuss a physician's duty to disclose his/her serologic status to a patient.


The author examines three congressional proposals designed to prevent transmission of HIV from HCWs to patients: the Helms


The author concludes that in Virginia, “a seropositive health-care worker will have difficulties proving that his infection is a disabling injury because of the asymptomatic nature of the seropositive state. Additionally, as the wait for the possible development of AIDS begins, the statute of limitations on exposure starts to run.” Id. at 138.

V. THE SEROPOSITIVE HEALTH CARE PROFESSIONAL: THE DUTIES TO BE TESTED AND TO DISCLOSE


Professor Beresford argues against compulsory HIV testing of either patients or health care workers and condemns mandatory disclosure of physicians' HIV status to patients.


The author examines the circumstances under which a hospital may be found liable for the failure of a physician to inform patients of his/her HIV status and contrasts this with the hospital's potential liability to the physician for invasion of privacy and discrimination based on handicap.


The author examines Canadian law regarding mandatory testing of HCWs and patients and disclosure of results. He finds that the risk of HIV transmission is extremely small if proper infection control procedures are utilized and therefore “the objective of enhancing the equality of HIV-infected persons outweighs the nature and degree of this risk.” Id. at 128. He concludes that neither mandatory testing nor disclosure of results is warranted for either HCWs or patients.

The author, a Florida legislator, examines whether HCWs should be required to undergo mandatory HIV testing and required to disclose test results to patients. She concludes that most state legislatures will find that the costs of mandatory testing far outweigh the benefits and that most state legislatures will conclude that improved infection control, counseling, and education are to be preferred to potentially stigmatizing mandatory disclosure.

Darrell Fun, HIV-Infected Healers: Do Patients Have a Right To Know?, BRIEF, Summer 1992, at 6.

The author examines the law of negligence and informed consent to determine whether HIV-infected HCWs who perform invasive procedures have a duty to disclose their seropositive status to patients. After an analysis of the competing interests of the risk of transmission and the magnitude of harm versus the burden on the HCW, and the statements issued by several medical professional associations, the author concludes that HCWs do not have a duty to disclose so long as they utilize established safety precautions.

Larry Gostin, Hospitals, Health Care Professionals and AIDS: The “Right to Know” the Health Status of Professionals and Patients, 48 Md. L. Rev. 12 (1989).

The author discusses the risk of acquiring HIV in a health care setting for both patients and HCPs, ways in which the risk can be reduced, the parameters of the informed consent doctrine, and the implications of routine HIV patient screening for hospitals. He concludes that mandatory testing of patients or HCPs would “ultimately undermine trust in our health care institutions without any public health utility.” Id. at 54.

Gregory P. Gramelspacher et al., When the Doctor Has AIDS, 162 J. Infectious Diseases 534 (1990).

The authors discuss whether physicians must disclose their HIV status to their patients and whether or not seropositive physicians must limit their professional practices. They conclude that there is no duty to disclose seropositivity and that the decision to refrain from “risky practice” should be made by “the infected physician and personal doctor in consultation with infection control personnel.” Id. at 536.


The author provides a general overview of the law of informed consent in an HIV/AIDS context.

The authors examine the law of informed consent and physicians' fiduciary duty and conclude that the application of these concepts would probably indicate that health care workers have a duty to disclose seropositivity if they intend to engage in invasive procedures that engender a material risk of HIV transmission.


The author argues that "[m]andatory HIV testing of health care professionals is ineffective in halting the spread of AIDS, a costly waste of health care dollars, and violates important individual rights." *Id.* at 347.


The author examines the circumstances under which disclosure of a physician's seropositive status may be required by the doctrine of informed consent.


The authors examine with approval the decision in *Leckelt v. Board of Comm'rs of Hosp. Dist. No. 1*, 909 F.2d 820 (5th Cir. 1990), which permitted the discharge of a hospital employed nurse who was suspected of being HIV-infected after he refused to submit HIV test results to his employer. The authors conclude that, in the absence of statutes which prohibit such testing, hospitals may require employees whom they suspect have been exposed to HIV-infection to undergo serologic testing without violating either section 504 of the Rehabilitation Act; federal or state constitutional protections against unreasonable search and seizure or denial of privacy, due process or equal protection rights; or state HIV testing or handicap discrimination statutes.


This short paper, adopted as a statement of policy by the Academy on February 15, 1991, argues against mandatory testing of health care workers.

The author provides a critical history and analysis of the informed consent doctrine and concludes that the HIV-infected physician should disclose his/her condition to patients only if he/she will perform a procedure that a publicly accountable medical review panel has identified as posing a significant risk of transmitting HIV.


Professor Oddi argues that patients should have the duty to disclose serologic status to treating health care providers (HCPs). He presents a "two-step comparative analysis," as follows:

First, the doctrine of informed consent was shown to impose a duty on HCPs to disclose their infectious status to patients prior to treatment. Second, the Article compared this proposition with its converse: the imposition of a duty on patients to inform their HCPs of the patients' infectious status. On the basis of analogy, risk-utility, and economic analyses, the Article concludes that placing a duty upon patients to disclose is clearly justified when a comparable duty is imposed upon HCPs . . . .

Id. at 1482.


The authors present brief overviews of the following areas: (1) mandatory HIV testing of health care workers (HCWs) and patients; (2) voluntary testing of HCWs and patient notification; and (3) tort claims against HIV-positive HCWs who performed exposure-prone procedures but who did not first disclose HIV status. The possible bases of tort liability examined are: battery, intentional and negligent infliction of emotional distress, failure to obtain informed consent, and misrepresentation.


The author, a physician, provides brief overviews of Centers for Disease Control guidelines for health care workers regarding transmission of HIV and the response from the medical community to those guidelines. He also summarizes the writings of fellow physicians about the efficacy of mandatory testing for health care professionals.

The author argues that health care workers who perform invasive procedures are under a duty to undergo testing and to inform patients of seropositivity.


The author examines with approval the decision in *Estate of Behringer v. Medical Ctr. at Princeton*, 592 A.2d 1251 (N.J. Super Ct. Law Div. 1991), which held that the doctrine of informed consent requires disclosure of a physician's HIV status before he/she performs invasive procedures which pose a material risk of physician-to-patient HIV transmission.


The author proposes that a health care institution's duty to disclose a physician's seropositive status to former patients (a "look back") should be based on an economic analysis which compares the benefit in reducing expected accident costs against the costs of notification.


The author examines the circumstances under which disclosure of a health professional's HIV status to a patient should be required as a part of informed consent. She concludes that mandatory disclosure would not serve the public interest because it would offer an "illusion of safety" for patients whose doctors are infected but have not yet seroconverted.


The author provides an extensive analysis of Illinois P.A. 87-763, 1991 Ill. Laws 4029, which authorizes the Illinois Department of Public Health to engage in contact tracing and retrospective patient notification in instances where the Department has determined that an HIV-infected health care provider has treated patients using invasive procedures.


The author discusses physicians' obligations to disclose their HIV status to patients. The author concludes that physicians who perform invasive procedures without first notifying patients of their
seropositivity and the possible risks of HIV transmission may be liable for negligence.


The author characterizes the court's decision in Leckelt, 909 F.2d 820 (5th Cir. 1990), as "ignor[ing] the command of the Supreme Court's decision in School Bd. of Nassau County v. Arline, 480 U.S. 273 (1987) to defer to the reasonable judgments of public health officials when determining whether an employee truly poses a significant risk and instead permits 'society's accumulated myths and fears' about AIDS to justify blatant discrimination." Id. at 1141.


The student author negatively critiques the 1990 Fifth Circuit decision.

VI. THE SEROPOSITIVE HEALTH CARE PROFESSIONAL: THE DUTY TO RESTRICT THE SCOPE OF PRACTICE


The authors examine the epidemiologic evidence of HIV transmission from infected HCWs to patients; guidelines on infected HCWs promulgated by the Centers for Disease Control, the American Medical Association, the New York State Department of Health, and other professional and public health associations; relevant judicial decisions; the benefits and costs of practice restrictions or exclusion, and the justification for such measures when no similar measures are taken against HCWs with Hepatitis B; and the effects of mandatory screening of both patients and HCWs. The authors conclude that mandatory testing of HCWs and patients is not warranted and that practice restrictions should be instituted on a case-by-case basis after weighing and balancing the likelihood of transmission against the professional skill, judgment, infection control record, wound infection rate, and peri- and post-operative mortality rates of the individual physician.

Professor Closen proposes that state licensing agencies require HCPs who engage in invasive procedures to be tested for HIV exposure and that those who are seropositive be prohibited from performing such procedures. He also offers an outline of the chief features of such a regulatory scheme.


Focusing on the case of seropositive Florida dentist Dr. David Acer's transmission of HIV to five of his patients, the author, a nursing professor, argues against imposition of practice restrictions on seropositive professionals and for greater emphasis being placed on the use of effective infection control techniques.


This short article discusses the probability of HCW-to-patient transmission of HIV and employment restrictions placed upon, and discrimination suffered by, infected HCWs.


The author, Legislative Counsel for the American Civil Liberties Union, agrees with the conclusions reached by Larry Gostin (see infra Section VI for annotation) except as follows: she believes that neither Gostin's contention that HIV-infected HCPs should be monitored and perhaps restricted in the performance of seriously invasive procedures nor his rule to determine when there is a significant risk of HIV transmission from HCP to patient would be acceptable to a court applying the standards set forth by the Americans with Disabilities Act.


This very short article describes the position of the General Medical Council on the duty of a physician in the United Kingdom to treat HIV-infected patients, and the responsibilities of HIV-infected physicians regarding restrictions on the scope of their professional practices.


The author summarizes and explains the Centers for Disease control guidelines published in July 1991. He rebuts the criticisms
of the guidelines concerning seriously invasive procedures offered by Chai Feldblum, Legislative council of the A.C.L.U. (See supra Section VI for annotation of Feldblum's article.)


The author examines whether HCPs should be required to undergo HIV testing, whether they should be required to disclose seropositivity to patients or their employers, and whether seropositive HCPs should be subject to practice restrictions. He concludes that HCPs should not be subject to mandatory HIV screening or mandatory reporting of test results to patients; however, they should be required to report seropositivity to employers. He argues that employers should have the following obligations: to monitor the performance of HIV-infected HCPs; to formulate practice policy guidelines; to restrict the performance of invasive procedures on a case-by-case basis where patient safety would be compromised; and to develop programs to retrain, support, counsel, and compensate those HCPs whose professional activities are curtailed.

Gregory P. Gramelspacher et al., When the Doctor Has AIDS, 162 J. INFECTIOUS DISEASES 534 (1990).

See supra section V. The Seropositive Health Care Professional: The Duties to be Tested and to Disclose for annotation.


The author offers a brief overview, aimed at hospital policy makers, of the following areas: informed consent and counseling in patient testing; testing errors; privacy and confidentiality of both patient and employee test results; employee testing; and the protections offered seropositive employees by both the Americans with Disabilities Act and the Rehabilitation Act.


The author examines the efficacy of testing both patients and HCWs and the liability that hospitals may face for revealing test results or discriminating against employees or patients who are seropositive. He concludes that mandatory testing is not justified.


After a thorough review of the medical and public health literature regarding HCWs and HIV/AIDS, and the responses of institutions, governments and professional organizations to the perceived
The risks of HCW-to-patient transmission of HIV, the author concludes that only a very conservative approach is warranted.


The author discusses whether individual physicians or the institutions that employ them should take responsibility for instituting practice limitations when the physician is HIV-infected; he concludes that this responsibility must be shared. This paper was presented at a conference entitled “The HIV + Health Professional: Policy Options for Individuals, Institutions, and States,” held December 7-8, 1990, in New Brunswick, New Jersey.


The author examines the implications for medical and dental schools of HIV positive faculty and students. He concludes that both faculty and students should be restricted from performing invasive procedures because of the risk of infecting patients and that, while the Rehabilitation Act of 1973 requires that reasonable accommodation be made for infected faculty, it offers no such protection for infected students.


The author examines the implications for hospitals of the July 1992 report of the National Commission on AIDS; Centers for Disease Control and equivalent guidelines; Joint Commission of Accreditation of Health Care Organizations requirements; and mandates of the Americans with Disabilities Act and section 504 of the Rehabilitation Act.


The author, a clinical researcher and administrator at an inner-city medical center, offers “‘observations and vignettes’ from policy debates of the past” and opines that current policy should have as its basis an accurate perception of the risk of transmission of infection and should embrace the least restrictive appropriate alternative. This article contains the text of remarks made at a conference entitled “The HIV + Health Professional: Policy Options for Individuals, Institutions, and States,” held Dec. 7-8, 1990, in New Brunswick, New Jersey.

The authors conclude that the health professions should implement the Centers for Disease Control revised guidelines in order to prevent further erosion of the public trust. According to the revised guidelines, expert review panels would decide on a case-by-case basis whether seropositive HCWs may perform invasive procedures.


The author surveys and analyzes federal and state legislation, proposed state legislation, and the Occupational Safety and Health Administration and Centers for Disease Control guidelines aimed at preventing transmission of HIV between patients and health care workers. The author also addresses the role that disability insurance might play in minimizing hardship for seropositive physicians and dentists upon whom practice restrictions have been placed.


The author discusses the appropriate medical safety standards that should be established for HIV-infected HCWs, and how to balance the HCW’s rights of privacy and non-discrimination against the patient’s right of informed consent. He also recommends governmental emphasis on education of HCWs and the general public and promulgation of federal policy that outlines basic safety standards and encourages private sector regulation.


The author proposes that courts engage in a comparative risk analysis on a case-by-case basis to determine whether practice restrictions should be imposed on an HIV-positive physician. He reaches this conclusion after an analysis of the requirements of the Americans with Disabilities Act and section 504 of the Rehabilitation Act of 1973.


The author examines whether employers in health care or related industries are constitutionally prohibited from basing hiring,
dismissal, and assignment of responsibilities decisions on results obtained from mandatory HIV antibody tests. She concludes that the Constitution permits mandatory testing and reassignment or refusal to hire of those who would have worked in areas involving use of invasive procedures where there is a high risk of HIV transmission through accidental exchange of blood.


The author examines HCW-to-patient HIV transmission. She provides an overview of the Centers for Disease Control guidelines of 1991 regarding transmission during exposure-prone invasive procedures and the medical community and legislative responses to them. She concludes that: "HCWs who perform invasive procedures should be required by state law to undergo periodic testing for the virus and that those HCWs who test positively should be required to obtain their patients' informed consent before performing further invasive procedures." Id. at 668.


The author examines Estate of Behringer v. Medical Center at Princeton, 592 A.2d 1251 (N.J. 1991), in which the court upheld restrictions imposed by a hospital on a seropositive surgeon, "in terms of its conformance to federal and New Jersey law concerning the protection of handicapped individuals from discrimination, protection of hospital patients from undisclosed risks, and the protection of hospitals' rights to implement policies to ensure the safety of patients [and he concludes that that] the Behringer rule offers the best resolution to a very difficult situation." Id. at 469-70.


The authors examine mandatory HIV testing of HCWs in light of the constitutional prohibitions regarding unreasonable searches and seizures, privacy violations, and denial of equal protection. They also consider the role of the Rehabilitation Act of 1973 and the Americans with Disabilities Act in preventing discrimination against seropositive HCWs. They conclude that the relatively low risk of HCW-to-patient transmission of HIV does not warrant mandatory testing or severe curtailment of the scope of seropositive HCWs' practice activities.

The author examines the extent to which an equal protection analysis would protect HIV-positive health care workers from practice restrictions imposed upon them through legislation or hospital regulations. He concludes that while traditional equal protection analysis offers little protection, such persons would be protected if the courts employ a more rigorous rational basis test.


The author concludes that section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act protect HIV-infected hospital-employed HCWs against discrimination and that strict adherence to Centers for Disease Control guidelines regarding HIV transmission will protect hospitals from liability should HIV transmission from HCW-to-patient or HCW-to-HCW occur. She suggests that public policy considerations may persuade courts to extend section 504 protection to physicians having hospital staff privileges as well.


The author concludes that, while section 504 of the Rehabilitation Act of 1973 generally protects asymptomatic HIV carriers, health care settings are among a limited number of situations in which seropositive employees would not be otherwise qualified. In these situations, the author states that it would be appropriate for employers to institute testing programs and use the results to make employment decisions.


The author concludes that:

The common law, within the tort theory of the "special relationship" among HCWs, medical institutions, and patients, articulates the duties triggered..., delineates the proper actions, and effectively minimizes liabilities. The CDC guidelines, on the other hand, fail both to articulate specific duties and to delineate alternatives. Guidelines setting national standards are necessary and should be binding as regulations. The CDC guidelines, however, should be amended to reflect more accurately the state of the common law, which assumes a greater duty on the part of the hospital in confronting the HIV-infected HCW.

Id. at 541.

Joel Neugarten, Note, The Americans with Disabilities Act: Magic Bullet or Band-Aid for Patients and Health Care Workers Infected

The author contends that the Americans with Disabilities Act and other currently existing federal legislation will not alone be able to prevent discriminatory withholding of quality medical care from HIV-infected patients or prevent practice restrictions from being placed on seropositive health care workers. He recommends additional measures such as instituting educational programs to eliminate misconceptions about AIDS and fostering development of better institutional infection control policy.


The author examines “reasonable accommodation” and “undue hardship” under the Americans with Disabilities Act (ADA) as applied to HIV-infected health care workers (HCWs). He concludes that the ADA’s “direct threat” defense will only be applicable to HCWs who are engaged in exposure-prone invasive procedures, and that health care employers will be required to explore job restructuring and job reassignment as they seek to reasonably accommodate these HCWs before any attempt to discharge them is made.

VII. THIRD PARTIES AT RISK: THE RIGHT TO BE WARNED


The authors critique the decision-making model for physicians to use in deciding when to warn a third party at risk of being infected by a patient developed by Smith and Martin in their article Confidentiality in the Age of AIDS: A Case Study in Clinical Ethics. (See infra this section for annotation.)


The authors argue that psychotherapists should break confidentiality and warn third parties at risk of being infected by a patient if the following criteria are met: (1) the patient knows that he is seropositive and has been counselled about safety precautions; (2) the patient has a mental disorder; and (3) it is likely that the mental disorder may significantly impair the patient's ability to follow the recommended safety precautions.

The author provides a brief overview and concludes that state legislatures should balance the following areas of concern as they amend the confidentiality acts that deal with the physician's duty to warn: confidentiality and civil liberties; the role of public health authorities; physicians' immunity from suit for failure to warn; and education for physicians about the extent and scope of their duty to warn.


The author questions whether a Canadian physician is under a legal duty to warn third parties at risk of being infected with HIV by a patient. He concludes that "unless disclosure is authorized or required by statute, policy considerations require that the physician maintain the patient's confidence." Id. at 254.


After an examination of case law and statements issued by medical professional associations and public health agencies, the authors conclude that physicians have a duty to warn third parties at risk of being infected by a seropositive patient. They offer practical suggestions to physicians regarding documentation of patient testing, interviewing, and counseling in the medical record.


The authors offer practical advice to both health care providers and the lawyers who represent them regarding the circumstances under which a duty to warn is owed to third parties and how that duty can best be met. [(Adapted from the authors' earlier article published at 21 J. HEALTH & HOSP. L. 295 (1988))].


The author discusses AIDS confidentiality in the contexts of the physician's duty to warn third parties, criminal law proceedings that involve attempted HIV transmission, and breach of confidentiality in the exercise of state police powers.


The authors propose general criteria for compulsory HIV-screening programs and discuss their implications for pre-marital
testing, screening in drug treatment and STD clinics, and a physician's duty to maintain confidentiality versus a duty to warn third parties at risk.


The authors provide a general overview of the professional counseling and psychological literature on the therapist's duty to warn the sexual partners of HIV-infected clients. In addition, the authors summarize the positions of the American Association for Counseling and Development, the American Psychiatric Association, the American Psychological Association, the American Medical Association, and the National Association of Social Workers.


The authors explore the issue of whether a psychotherapist is under a legal duty to warn a seropositive patient's spouse or known sexual partner(s) if it appears likely that the patient will not do so. The authors conclude that in the absence of legislation addressing this issue, therapists “must depend on their ethical consciences to determine which course of action to follow.” Id. at 76.


Dr. Hirsh surveys the legal and ethical aspects of the physician's duty to warn third parties at risk, mandatory reporting, and other confidentiality issues.


The author discusses the following problems: difficulties associated with a patient's reluctance to discuss prior homosexual conduct with military physicians; the role that physicians should play in assisting military patients in appointing surrogate decision-makers; and the duty of military physicians to warn the patient's sexual partners.

The author concludes that military physicians have a definite duty to warn third parties who are at risk of being infected by their patients.


The author examines the physician's duty to warn third parties at risk of HIV infection from a patient, as determined by judicial decisions and by standards and guidelines promulgated by medical professional associations and the Centers for Disease Control. He concludes that this duty to warn is well established and that physicians who fail to meet it are liable for medical negligence.


The author discusses testing of, and access to, new and not-yet-approved therapies and the physician's or public health official's duty to warn sexual partners of seropositive patients.


The author presents an overview of the Australian law regarding a physician's duty to warn third parties at risk.


The author offers a very brief overview of a physician's duty to disclose a patient's HIV status to third parties at risk drawing upon American Medical Association guidelines, case law, and New Jersey statutes and regulations. He also discusses the federal Rehabilitation Act of 1973 and New Jersey statutes as they affect employer's disclosure liability.


The authors outline a risk/benefit analysis to determine whether a duty to warn is owed a third party that includes the following factors: (1) foreseeability of harm; (2) identifiability of potential victims; (3) degree of certainty of injury; (4) absence of other HIV risk factors for the third party; (5) costs of imposing a duty; (6) potential for violent harm to the patient; and (7) applicable professional ethical codes and confidentiality laws.

The author makes a policy argument that all attempts to resolve this dilemma should be at the local, rather than at the national, level, "because that is where the people affected are." Id. at 249.


Paterson examines the "limits of confidentiality in relation to HIV related information in New Zealand [and] potential liability of a doctor who fails to disclose HIV related information to a third party at risk of infection." Id. at 380.


The author takes a position contrary to that taken by Howard Zonana (see infra section VII for annotation) and argues that the American Psychiatric Association's policy, that psychiatrists may warn third parties who are at risk of HIV-infection because of the behavior of a patient, does not serve the public as well as would a policy of absolute confidentiality. He further argues that the duty to warn postulated by *Tarasoff* should not be applied in the HIV transmission context.


The authors explore whether a psychotherapist has an affirmative duty to warn a third person with whom a patient, with an incurable and potentially fatal communicable disease, intends to have sexual relations. The authors conclude that therapists probably do have a duty to warn if it seems probable that the patient will do so.


The author argues against a duty to warn or giving physicians or others a discretionary power to warn third parties at risk. The author's rationale is that strict confidentiality is necessary to ensure the cooperation of high risk groups in seeking testing and counseling services.


The authors discuss liability of physicians to foreseeable third persons infected by patients in the contexts of HIV/AIDS and tuberculosis. They conclude that tort liability should not extend to force
conduct such as quarantine, surveillance, or general warnings. However, in the case of HIV/AIDS, the authors conclude that the physician should make reasonable attempts to identify and counsel sexual contacts of patients.


The authors “present a case of an HIV seropositive, bipolar, intravenous drug abusing patient who participates in unsafe sexual practices to illustrate clinicolegal dilemmas involving dangerousness, involuntary hospitalization, confidentiality, and Tarasoff-like duty.” Id. at 33.


The authors present a decision-making framework for physicians to use when treating an HIV-positive mentally incompetent patient and where there is reason to believe a third party may be at risk of being infected.


Utilizing a negligence analysis, the author concludes that a doctor has a duty to warn third parties. He further concludes that the enactment of statutes which require reporting to a state agency is not an adequate substitute for a doctor personally warning a non-patient who is at risk of becoming infected by a patient.


The author provides a very brief exploration of the physician's obligation to warn third parties at risk of being infected by seropositive patients as well as reporting patients' infectious status to other medical personnel or to public health authorities.

Martha Swartz, Is There A Duty to Warn?, HUM. RTS., Spring 1990, at 40.

The author provides a brief overview of the American Medical Association's position on, and the common law and statutory bases for, a physician's duty to warn third parties at risk of being infected with HIV by a patient. She also contrasts mandatory notification versus discretionary notification and concludes that the latter is the better approach to take.

The author presents a strong defense of the American Psychiatric Association's policy authorizing psychiatrists to warn third parties at risk of being infected with HIV by a patient, a position in marked contrast to that presented by "debate" opponent Samuel Perry (see supra section VII for annotation).


The author discusses the tension between the duty of physicians to maintain confidentiality and the duty to warn third parties who may be at risk, emphasizing on the law of New York State. The author also proposes a statute which encourages patient consent to disclosure and, in an appendix, offers a negative critique of the confidentiality and disclosure provisions of a 1988 New York AIDS statute.


Through the use of a hypothetical, the author examines the conflicting duties of maintaining confidentiality and warning sexual partners and concludes that the duty to warn is unclear. She also discusses the provisions of the Report to the Governor of Maryland's Task Force on Acquired Immune Deficiency Syndrome, which would require disclosure by the physician but fails to deal with the possible legal consequences of such disclosure.


The author suggests that legislation must clarify the scope of a physician's duty to warn third parties at risk of being infected by a patient and must also provide immunity from suit for physicians who follow the statutory guidelines.


The author examines the implications of a 1989 amendment to the Texas Human Immunodeficiency Virus Services Act which excises language from the previously existing statute that indicated that a physician had no duty to warn the spouse of an infected patient and provided immunity from liability for a failure to warn. He
concludes that the Texas Legislature should enact a statute which would require physicians to notify state health authorities if a patient is HIV-positive and the physician has good reason to believe that the patient is acting in such a way as to endanger the patient's spouse.


The author suggests that a legislative solution is needed for the problem of defining the parameters of a physician's duty to warn third parties at risk of contracting HIV from a patient. The author offers a model statute.


The author, an osteopathic physician, concludes that physicians do have a duty to warn the spouse and known sexual partners of a seropositive patient if it appears likely that the patient will not do so.


The author finds that a physician has a duty to warn third parties at risk based on both a physician's common law duties to warn a patient's family of the risk of infection and to prevent the spread of a communicable disease and on the principles established by Tarasoff v. Regents of the Univ. of Cal., 551 P.2d 334 (Cal. 1976). The author also maintains that Tarasoff supports waiver of the doctor-patient privilege when there is a foreseeable risk of HIV-infection.

Jill S. Talbot, Note, The Conflict Between a Doctor's Duty to Warn a Patient's Sexual Partner that the Patient has AIDS and a Doctor's Duty to Maintain Patient Confidentiality, 45 WASH. & LEE L. REV. 355 (1988).

The author concludes that the conflict between the physician's duty to warn the spouse or other known sexual partner of a seropositive patient and the physician's duty to safeguard patient confidentiality can only be resolved through appropriate state and federal legislation.

The author concludes that state and local health department contact tracing programs are the best means of enabling the physician to fulfill the duty to warn third parties at risk of HIV infection while safeguarding the patient’s confidentiality rights.


Wiseman argues against physicians having the right to violate patient confidentiality to warn the seropositive patient’s sexual partners. His rationale is that the effectiveness of voluntary testing programs may be compromised.

VIII. TRANSFUSION-TRANSMITTED HIV: LIABILITY ISSUES


The author examines the American blood shield statutes and strict liability exemptions for blood and argues that Australia should follow the United States’ example in this instance.


The author argues that “the present system of direct governmental regulation and industry self-regulation is a poor substitute for liability. Strict liability is absent, and the weak negligence rule based on industry custom gives blood bankers fewer incentives to compare the benefits and costs to society of taking extra precautions.” *Id.* at 207. He further argues that since the American National Red Cross, the Council of Community Blood Centers and the American Association of Blood Banks jointly set industry-wide standards of care, they should be held jointly liable under strict liability in tort for transfusion-associated HIV transmission.


Approximately one quarter of this article explores liability on the part of blood banks, physicians and health care facilities for transmission of HIV via blood transfusion. Other parts of the article examine liability for sexual transmission, discrimination in employment, child custody, education and housing, and criminal liability issues.


The author argues that tort law provides little opportunity for recovery by victims of transfusion-transmitted HIV and that adop-
tion of an administrative no-fault recovery system is needed to remedy this injustice. He critiques the National Childhood Vaccine Injury Program as a model for such a system.


The author discusses public policy considerations of products liability law, the sale/service dichotomy, and the blood shield statutes. She concludes that those who have become HIV-infected via transfusion essentially have been left without a remedy.


The author offers a brief overview of the strict liability, warranty, and negligence bases for liability. The author suggests that an exception to the blood shield statutes should be made to permit recovery under a strict liability theory by that small group of plaintiffs who have been infected by HIV-positive blood.


The author offers a brief, practice-oriented discussion of physician liability for transfusion-associated HIV transmission, focusing on the following areas: (1) ordering an unnecessary transfusion; (2) negligently treating the patient in such a way that a usually unnecessary transfusion becomes necessary; (3) failing to use directed or autologous donations; (4) failing to warn a transfusion recipient of possible HIV infection; and (5) failing to inform the patient that surgery could be deferred until after the general availability of effective HIV blood screening.


The author provides a concise, practice-oriented discussion of how to deal with client fears and concerns, background investigation, and liability issues for both health care providers and blood banks.


The authors argue that directed donations are not less likely to transmit HIV than are donations from the pooled blood supply. They also offer a short discussion of suits for emotional distress by plaintiffs who do not receive their directed donations and the legal obligation of blood banks to provide designated donor programs.

The authors offer brief overviews of the following areas: transfusion-related AIDS; sexual transmission; and intravenous drug use.

Karen S. Lipton, Blood Donor Services and Liability Issues Relating to Acquired Immune Deficiency Syndrome, 7 J. Legal Med. 131 (1986).

The author examines blood bank liability for HIV-transmission based upon theories of negligence, strict liability, and breach of implied warranties; liability for disclosure or non-disclosure of blood donor HIV-test results to the donor or to third parties; and liability for failure to maintain confidentiality of donor records.


The author presents a practice-oriented discussion, drawing heavily on materials obtained from pleadings or discovery documents.


The author concludes that state blood shield statutes cannot be relied upon to provide a successful affirmative defense and that courts in many jurisdictions are prepared to find negligence. He also describes a proposal to create a federally-assisted no-fault compensation fund for plaintiffs who acquired HIV through transfusions prior to the availability of the ELISA test in 1985.


The author examines donor, hospital and blood bank liability based on negligence, breach of implied warranties and strict liability theories. He concludes that negligence may be the only theory available in suits against donors and that a compelling argument could be made for strict liability when the defendant is a hospital or blood bank.


The authors provide a comprehensive, practice-oriented discussion of the following areas: choice of defendant; theories of liability;
discovery issues; statute of limitations considerations; and affirmative defenses.


The author criticizes the "blood shield statutes," which permit recovery against blood banks for providing HIV-contaminated blood only on a negligence theory. She argues that the cost of coping with AIDS must be democratically apportioned among plaintiffs and the insurers of blood banks and hospitals for the public good. She also argues that a liability without fault approach in transfusion cases is essential to balance the relative positions of the parties and to provide "the most compensation with the least amount of impact." Id. at 113.


The author recommends that state legislatures follow the example set by Louisiana, which permits the imposition of strict liability on blood banks if a reliable detection test was available at the time the blood that infected the plaintiff was banked.


The author examines civil and criminal liability of HIV-infected blood donors. She also addresses the problems of donor identity discovery.


The author examines breach of warranty, strict liability, res ipsa loquitur, and negligence theories of liability. To ensure safer transfusions, he suggests that legislation be enacted which promotes the use of autologous, i.e. self-donated, blood, high standards for donor screening, and adequate warnings.


The author examines how hospitals, blood banks, and commercial producers of blood products are motivated to efficiently allocate risks and resources when they are either shielded from liability, liable under a negligence theory, or strictly liable.

The author argues that blood shield statutes should be amended to provide for strict liability for blood banks and manufacturers of blood products who distribute HIV-tainted blood when there are testing procedures that would provide nearly 100% effective screening.


The author concludes that negligence theory generally provides the only means of recovery.


The author discusses transfusion liability in South Carolina, focusing on *Samson v. Greenville Hosp. Sys.*, 368 S.E.2d 665 (S.C. 1988). He concludes that recovery is possible only under a negligence theory.


The author examines liability based on negligence and strict liability theories and concludes that only negligence is viable.


The author condemns the Joint Policy Statement prohibiting directed blood donations issued by the American Red Cross, the American Association of Blood Banks, and the Council of Community Blood Centers on June 22, 1983.


The author examines legal bases for liability of blood banks, health care facilities, and health care professionals for transfusion-transmitted HIV infection. He concludes that public policy considerations of cost spreading and protecting donor confidentiality suggest adoption of strict liability as a viable theory for recovery.

The author examines the Louisiana blood immunity statutes and liability based on theories of breach of implied warranties, strict liability, and negligence.


The author advocates adoption of a "positive tort theory" approach to blood bank liability, in which plaintiffs are allowed recovery under warranty and strict liability theories for detectible defects in blood, but are denied recovery under those theories for non-detectible defects.


The author examines plaintiffs' use of breach of warranty, strict liability, and negligence theories in suits against blood banks for transfusion-related transmission of HIV. The author concludes that negligence remains the only viable basis for recovery.


The author examines negligence-based liability of blood banks, hospitals, physicians, and donors for HIV-transmission via transfusion. The author speculates on the effects of the imposition of strict liability and concludes that it would lead to "destruction of the American blood service system." *Id.* at 167.


The author recommends the imposition of strict liability on blood products manufacturers.

IX. TRANSFUSION-TRANSMITTED HIV: DISCOVERY ISSUES


The authors examine the following bars to discovery: the physician-patient privilege, the donor's constitutional right to privacy, and state abuse-of-discovery rules.


Jenner examines the implications of *Fed. R. Civ. P. 26(c)* for discovering blood donor identity, the donor's right to privacy, public
policy considerations, the physician-patient privilege, and naming the donor as defendant.


The author analyzes South Fla. Blood Serv. v. Rasmussen, 467 So. 2d 798 (Fla. Dist. Ct. App. 1985), aff'd 500 So. 2d 533 (Fla. 1987), the first case involving discovery of the identity of blood donors.


The author analyzes the reasoning of the Rasmussen court's decision not to permit discovery of blood donor identity. He finds the reasoning to be somewhat persuasive but flawed in that a constitutionally mandated strict scrutiny analysis was not done.


The author discusses discovery under Rule 26 of the Federal Rules of Civil Procedure, the right to privacy, the physician-patient privilege, and policy regarding a safe and adequate blood supply. The author concludes that balancing all of these competing interests should lead courts to permit limited discovery of donor information.


The author analyzes South Fla. Blood Serv. v. Rasmussen, 467 So. 2d 798 (Fla. Dist. Ct. App. 1985), aff'd, 500 So. 2d 533 (Fla. 1987) (prohibiting the release of donor identity) and Tarrant County Hosp. Dist. v. Hughes, 734 S.W.2d 675 (Tex. Ct. App. 1987) (permitting the disclosure of donor names). After examining the good cause standard for issuing a protective order required by Fed. R. Civ. P. 26(c) and the constitutional and public policy implication of these decisions, the author concludes that blood donors' identities should remain absolutely confidential.


The author "argues that courts should deny discovery from a blood donor in multiple donor cases but should permit limited dis-
covery from a blood donor in single donor cases." *Id.* at 929. The author maintains the importance of protecting the donor’s identity from public disclosure.


The author analyzes *Doe v. Puget Sound Blood Center*, 819 P.2d 370 (Wash. 1991), in which the court permitted discovery of the identity of the donor of HIV-infected blood and did not make any provision for maintaining the confidentiality of this information. She argues that this decision compromises both the blood donor’s privacy rights and the public’s interest in an adequate blood supply while providing comparatively little benefit to the plaintiff.


The author examines confidentiality of volunteer blood donor records as that issue was decided in *South Florida Blood Serv. v. Rasmussen*, 467 So. 2d 798 (Fla. Dist. Ct. App. 1985), aff’d, 500 So. 2d 533 (Fla. 1987).


The author analyzes *Snyder v. Mekhjian*, 593 A.2d 318 (N.J. 1991), which permitted limited discovery of blood donor identity by a plaintiff suffering from transfusion-associated AIDS.


The author criticizes the court’s decision to permit limited discovery of donor identity in *Belle Bonfils Memorial Blood Center v. District Court*, 763 P.2d 1003 (Colo. 1988).
X. THE SEROPOSITIVE PATIENT: RIGHTS OF ACCESS TO TREATMENT


The author examines the right to treatment in the context of the requirement to treat imposed upon physicians by common law, by licensing statutes, by American Medical Association guidelines, and by the Rehabilitation Act of 1973. The author provides an extensive analysis of the Act's interpretation in School Board of Nassau County v. Arlene, 480 U.S. 273 (1987). He also addresses the implications of 42 U.S.C. § 1983 and of state human rights statutes such as the Pennsylvania Human Relations Act.


Dr. Annas provides a brief discussion of the rights of AIDS patients to medical care and to experimental drugs as he analyzes the opinion of a Texas trial court that prohibited hospital bed rationing and prescription of non-F.D.A.-approved drugs for those suffering from HIV/AIDS.


The author summarizes the law relating to the obligation of physicians to treat HIV-infected patients and attempts to identify ways in which the legal duty to treat could be strengthened and clarified.


The author discusses whether physicians have a duty to treat HIV-infected patients. To answer this question, he examines individual rights and professional obligations, conceptions of professional virtue, and the characteristics of "historically-based" versus "virtue-based" duties.


Professor Banks examines the legal and ethical duties of physicians to offer medical care and the right of those in need to receive it. She concludes that "[s]hifting the focus of the duty from individual physicians to public or private hospitals may result in greater access to health care for all." Id. at 173.

This brief practice-oriented article concludes that physicians have a duty to continue treatment once it is begun. If this duty is breached the physician may incur liability for abandonment, breach of contract, or negligence. In addition, the author states that a physicians' employing institution may face liability under handicap discrimination statutes.


The author examines the ethical bases for an AIDS patient's right to treatment as well as the following legal bases for the physician's or hospital's duty to treat: the development of an implied contract between physician and patient once treatment has begun, giving rise to a cause of action for abandonment; the common law and statutory duties of hospitals to provide emergency care to the public; a hospital's duty to provide care for the indigent if it receives federal construction grants pursuant to the Hospital Survey and Construction Act ("Hill-Burton Construction Act"); Title VI of the Civil Rights Act; and the Rehabilitation Act of 1973. The author also addresses the role of workers' compensation acts, private insurance, and tort remedies in providing compensation to health care workers who become HIV-infected in the workplace.


After considering evidence that significant numbers of physicians may be systematically avoiding caring for AIDS patients, the authors suggest that state medical licensing boards and hospitals be required to enforce the ethical standards requiring physicians to treat. The authors also suggest that greater attention be paid to making physicians aware of their ethical obligations.


The author concludes that physicians may be precluded from conditioning their acceptance of a patient because of one or more of the following: (1) the doctrine of abandonment; (2) federal statutory limitations such as Section 504 of the Rehabilitation Act of 1973 or (3) Title VI of the Civil Rights Act of 1964; (4) state-imposed limitations; (5) ethical conduct rules promulgated by medical professional groups; (6) the "common law duty" rule, i.e., a duty not to discriminate imposed by courts on businesses closely linked with the public welfare; or (7) possible contractual prohibitions against discrimination.

The author argues that physicians have a duty to treat those with HIV/AIDS when there is only a "standard level of nonsocomial risk of HIV infection" and that, under most circumstances, the risk level falls within this standard. The author acknowledges that there is no duty to treat when risk exceeds the "standard level."


The article offers a short discussion of the risks posed to physicians by seropositive patients and provides a brief summary of the positions of the American Medical Association, the American College of Physicians, the Infectious Disease Society of America, and several state medical professional groups.


The author concludes that physicians have an obligation to treat patients with AIDS, but that the obligation is limited by the need to avoid excessive personal risk.


The author discusses the legal and ethical duties of health care professionals to treat persons with AIDS. He emphasizes the ethical statements issued by the American Nurses Association.


The author offers a brief examination of the role of the physician in offering treatment to the afflicted during the great epidemics of history and examines the response of the medical community to AIDS in light of that history.


The author provides a brief overview and analysis of the statements issued by the American Medical Association and the American Nurses Association that apply to the treatment of AIDS patients. He concludes with a discussion of the merits of general codes of ethics as contrasted with single ethical statements or "ad hoc reactions."

The author analogizes AIDS to leprosy and looks at the response of physicians to treating that disease throughout history. He concludes that no firm historical basis for a duty to treat AIDS patients can be found.


The authors provide a brief overview of the duty to treat AIDS patients on the part of both hospitals and individual physicians, citing both federal and New Jersey statutes, case law, and American Medical Association and other professional association guidelines.


See supra section VI. *The Seropositive Health Care Professional: The Duty to Restrict the Scope of Practice* for annotation.


The author presents an overview of common law and statutory bases of physicians' duty to treat seropositive persons and concludes that there may be such an obligation. Particular areas examined include ethical duties imposed by medical professional associations and legal duties imposed by physicians' employment contracts, state anti-discrimination statutes, and Section 504 of the Rehabilitation Act of 1973.


The author examines the implications of Section 504 on the right to receive medical care of those who are HIV-infected, focusing on the following areas: who is an otherwise qualified handicapped person; which health care services fall within Section 504's scope; and what types of health care discrimination are prohibited.


The author discusses the duty of British physicians to treat HIV-positive patients and concludes that they do have such a duty.

After an examination of physicians' attitudes toward patients with HIV disease, public policy statements of major medical organizations, and the medical literature regarding occupational risk of exposure, the authors conclude that there is no justification for a refusal to treat.


The author provides a brief discussion of the limitations imposed on health care providers conditioning treatment on HIV test results. She focuses on the Rehabilitation Act of 1973, the statutory duty of hospitals to provide emergency care, and the common law.


This brief, practice-oriented article concludes, “[t]here is little medical or ethical support for a provider's refusal to treat a patient with AIDS or HIV; therefore, a refusal to treat is illegal and actionable.” *Id.* at 61.


The author examines the risk to health care workers posed by treating HIV-infected patients and whether there is a duty to treat based on either ethical or legal obligations. He concludes that professional ethical codes that mandate a duty to treat are no longer accepted as binding by many practitioners and that there is generally no legal duty on the part of individual physicians to accept seropositive patients.


The author discusses the risks of HIV-transmission posed by the dental care setting and concludes that “the dentist, by adhering to strict infection control guidelines, has an ethical obligation to treat AIDS patients in a safe and effective manner not only in a hospital setting, but also in the private office.” *Id.* at 118.


The author argues that there is a moral obligation to treat HIV-infected patients and that criteria for withholding treatment for such patients should be the same as used for any other probably fatal illness.

The author, a surgeon, discusses the medical and social responsibilities of surgeons regarding treatment of HIV-infected patients. The author concludes that "refusals by individual surgeons to operate on HIV infected patients threaten a fundamental right to treatment with equal concern and respect, as well as a dependable system of health care delivery essential for an epidemic." Id. at 144.


The author applies Section 504 of the Rehabilitation Act of 1973 and the State of Washington's Law Against Discrimination to cases where AIDS patients are denied admission to long-term care facilities and concludes that both statutes prohibit such discrimination.


The author discusses the dentist's duty to treat. He also addresses the duty to maintain confidentiality of patient HIV-related information.


The author examines approximately thirteen general due process and equal protection bases for suit that might be brought by HIV-infected persons seeking access to health care and the likely standard of review that courts would apply to each of them. The author also examines three specific rights that patients might claim: (1) the right not to be subjected to mandatory HIV testing or disclosure of results; (2) the right to choose treating physicians who are themselves HIV-infected; and (3) the right to determine the course of treatment.

Robert Steinbrook et al., *Ethical Dilemmas in Caring for Patients with the Acquired Immunodeficiency Syndrome*, 103 Annals Internal Med. 787 (1985).

The authors discuss the ethical questions concerning when to use life-sustaining treatments to prolong the lives of AIDS patients. In addition, they address the ethical issues involved in choosing substitute health care decision-makers for incompetent patients.

The authors review the ethical considerations involved in refusing to treat; federal, state and local responses; and common law prohibitions.


This article takes a historical view of physician responses to contagious epidemic diseases beginning with the Black Death in Europe in the 1300s. The authors note that no consistent professional tradition emerged, but there is evidence that physicians have avoided contagious patients for whom there was no proven treatment. The authors review the modern ethical models of medical care including the rights and contracts models, but suggest that these should be supplemented with a virtue-based component.


This article provides a brief overview of applicable ethical statements issued by the American Medical Association, the American Dental Association, the American College of Physicians, and the Infectious Disease Society of America; case law; federal legislation such as the Civil Rights Act of 1964, the Rehabilitation Act of 1973, and the Vocational Rehabilitation Act; and various state and local anti-discrimination statutes and ordinances. The author concludes by proposing a model HIV/AIDS anti-discrimination in health care statute.


The author maintains that section 504 of the Rehabilitation Act offers only limited protection from discrimination in health care for those suffering from HIV disease because the statute applies only to health care providers (HCPs) who receive federal funds and requires that the HIV infection itself must be the sole reason for the HCP's refusal to treat. The author argues that the Americans with Disabilities Act (ADA) provides a better remedy because similar limitations do not apply to the duty to treat which it imposes. The ADA guarantees access to health care for those who are "otherwise qualified" for treatment and who do not pose a "direct threat" which cannot be eliminated. The author concludes that courts will impose an ADA-based duty to treat on even those health care workers who perform invasive procedures because of the significant risk reduction afforded by following Centers for Disease Control guidelines.

The author examines the common law duty to treat, the implications of the Rehabilitation Act of 1973 and the guidelines issued by the Centers for Disease Control in 1991 and Massachusetts antidiscrimination law.


The implications of the Rehabilitation Act of 1973 and the doctrines of respondeat superior and ostensible agency are examined as bases for physician and hospital liability for refusal to treat seropositive persons.


The author examines the following issues raised by a physician's acceptance of a patient conditioned on the results of a mandatory HIV test: constitutionally protected privacy rights; confidentiality concerns; guidelines issued by the American Medical Association; religious concerns raised by the Christian doctrine to "love one's neighbor"; and section 504 of the Rehabilitation Act of 1973. The author concludes that physicians should be legally and ethically free to demand patient HIV testing but that they may not refuse to treat those who test seropositive.


See supra section VI. *The Seropositive Health Care Professional: The Duty to Restrict the Scope of Practice* for annotation.


The author applies the Rehabilitation Act of 1973 and State of Washington anti-discrimination and public health law to issues of AIDS discrimination such as refusing to treat AIDS patients, making unnecessary referrals of AIDS patients to other hospitals, and testing or releasing test results without obtaining prior consent. The author concludes that the statutes adequately protect AIDS patients from open refusals to treat but often fail to protect them from other forms of health care discrimination.
XI. THE SEROPOSITIVE PATIENT: RIGHTS OF ACCESS TO EXPERIMENTAL THERAPIES


See supra section X. The Seropositive Patient: Rights of Access to Treatment for annotation.


The author argues forcefully against making not-yet-approved drugs available to AIDS patients outside of clinical trials.


The author argues that FDA regulations requiring use of the double blind placebo method in evaluating new drugs does not violate constitutional procedural due process guarantees, contrary to the position of Bret Lansdale as outlined in his Student Essay (published at 18 Hastings Const. L.Q. 417 (1991)). However, the author challenges the regulations on public policy grounds.


The authors critique the proposals of Mathilde Krim and the Food and Drug Administration to make non-validated therapies accessible to those suffering from HIV/AIDS. In addition, the authors describe an alternative approach that would utilize “authorized investigational units” composed of physician-researchers who would have authority to offer their patients experimental therapies.


The author examines the history of AZT use and argues that experimental and not-as-yet proven therapies should be available for physicians' discretionary use with AIDS patients.

The author examines the ethical justification for randomized clinical trials of new AIDS drugs, and whether not-as-yet proven new drugs should be made available to AIDS patients on a "compassionate use" basis.


See supra section VII. Third Parties at Risk: The Right to be Warned for annotation.


Using as examples the demand for access to unapproved drugs for the treatment of HIV/AIDS and the demand for RU486 to induce abortion, the author suggests that the problem of access should be addressed as one of governmental responsibility for equal access to health care rather than as a question of individual rights.


The authors offer a brief discussion of scientific approaches to vaccine development, tort liability for AIDS vaccine-related injury, and the "barrier removal" potential of statutes like the federal Childhood Vaccine Injury Act of 1986 or California's 1986 legislation to encourage the development of an AIDS vaccine (Cal. Health & Safety Code, ch. 1.14 (1986)).


The author examines the Food and Drug Administration's (FDA's) "safety and efficacy" standards as applied to the terminally ill and outlines how the unique nature of the AIDS epidemic precipitated significant changes in the FDA's regulation of distribution of experimental drugs. The author further provides a detailed analysis of the "parallel track" program, which allows simultaneous distribution of drugs undergoing clinical investigation to AIDS patients who are not participating in clinical trials and who have no other treatment alternatives available.


The author offers a brief overview of the FDA drug licensing process, its treatment IND (investigational drug) program, and its
Florida counterpart, the Florida Investigational Drug Statute. He concludes that either of these mechanisms may enable attorneys to assist HIV-infected clients in obtaining not-yet-approved drugs.


The authors analyze the Food and Drug Administration's regulations issued on May 22, 1987 that provide desperately ill patients who have no alternative therapy with access to new, not-as-yet approved drugs.


The author concludes:

Once the fundamental right to obtain necessary treatment is recognized, the courts should find that while the Federal and State governments do have a compelling interest in protecting non-terminal individuals and terminal patients with treatment alternatives against unapproved drugs, the governments do not have a compelling interest in protecting terminal patients with no treatment alternatives from electing to use a drug, while under the supervision of a licensed physician, which has not met the rigid safety and effectiveness testing requirements of the FDCA.

*Id.* at 228.


The author analyzes federal, Connecticut and California statutes that deal with limiting tort liability of vaccine producers and suggests that future legislation address liability at the development, testing and post-FDA approval stages as well as provide for vaccine victim compensation.


The author argues that strict liability for vaccine-related injuries must be precluded to encourage vaccine development and that a suitable mechanism for fostering development would be a "hybrid" of the programs set up by the National Childhood Vaccine Injury Act and California Health and Safety Code sections 199.45 through 199.51.

The author argues that the FDA-mandated double blind placebo method [(in which neither the doctor nor the patient is told whether the patient is receiving the experimental drug or a placebo[)] violates constitutionally protected procedural due process requirements when subjected to the analysis outlined by the Supreme Court in *Mathews v. Eldridge*, 424 U.S. 319 (1976).


The author argues that no further refinements of products liability law are needed to encourage manufacturers to develop an AIDS vaccine “[b]ecause health workers will make individualized vaccination decisions in the HIV context [and therefore] the learned intermediary doctrine . . . will insulate manufacturers of HIV vaccine from the liability that has plagued manufacturers of vaccines used in mass immunization programs.” *Id.* at 953.


The author chronicles the behind-the-scenes involvement of the Office of Management and Budget during the mid-1980s in the promulgation of Food and Drug Administration regulations facilitating access to investigational drugs by AIDS patients and other terminally ill persons.


The author answers his question in the affirmative. He justifies this conclusion by demonstrating that a negative answer unnecessarily interferes with the exercise of a fundamental right derived from a terminally ill person's privacy rights and that the state does not have a compelling interest in protecting the health of “the terminally ill,” a categorization that the author attempts to demonstrate is possible to accurately assign to persons who have AIDS. He proposes amendments to the federal Food, Drug and Cosmetic Act which would facilitate an AIDS patient's exercise of the right to choose experimental drug therapies.

The author argues that different legislative solutions are needed to support vaccine research and to compensate those who have had adverse vaccine reactions for diseases with established vaccines and well understood adverse reaction epidemiology as opposed to newer diseases like HIV/AIDS. The author analyzes the swine flu and childhood vaccine acts, compares them with California AIDS vaccine legislation, and concludes that the California legislation should be modified to provide a flexible approach to victim compensation based on an insurance model.


The author examines drug approval under the 1962 amendments to the federal Food, Drug and Cosmetics Act, the role of the Food and Drug Administration and the impact of the regulations it issued in 1987 and 1988. She concludes that the new regulations "meet the demands of the seriously ill public without compromising safety." Id. at 1057.

XII. PATIENT SCREENING, TESTING, AND CONFIDENTIALITY ISSUES


The author examines the use of HIV testing for medical screening purposes, particularly as it impacts on African-American and Hispanic women.


See supra section V. The Seropositive Health Care Professional: The Duties to be Tested and to Disclose for annotation.


The author examines confidentiality of patient HIV-data in the context of the physician-patient relationship under Canadian law. He concludes that strict confidentiality must be maintained unless release can be justified under a statutorily-mandated reporting and contact tracing system, a common law duty to warn or the common law doctrine of necessity.

The author examines patient rights in medical records privacy, state HIV/AIDS confidentiality statutes, and the unique confidentiality problems that computerized recordkeeping poses. He suggests practical solutions to these problems.


This is a reprint of the Task Force's final recommendations.


The author suggests that hospitals developing or reevaluating their current policies on HIV testing should address the following issues: goals of the testing; informed consent; counseling and guidance; and confidentiality.


See supra section V. The Seropositive Health Care Professional: The Duties to be Tested and to Disclose for annotation.


The author discusses mandatory versus voluntary HIV testing in health care settings. After an examination of the risks that seropositive patients pose of transmitting the virus to health care workers and the constitutional and ethical dimensions of mandatory testing, the author concludes that routine screening without the informed consent of the patient is unjustifiable, that testing should only be carried out with prior fully informed consent, and that testing will not serve to protect staff members. He notes that only the consistent use of barrier protections to prevent fluid exchange will provide meaningful protection.


See supra section V. The Seropositive Health Care Professional: The Duties to be Tested and to Disclose for annotation.


See supra section VI. The Seropositive Health Care Professional: The Duty to Restrict the Scope of Practice for annotation.

The authors present arguments against routine preoperative HIV screening for low-risk patients since it would serve little purpose and some patients would test false-positive.


See supra section VI. *The Seropositive Health Care Professional: The Duty to Restrict the Scope of Practice* for annotation.


The authors examine the following question: “What is wrong with HIV testing of women or infants without their knowledge, without their consent, and without supplying the test results to the people tested?” Id. at 418.


Several positions are examined regarding whether or not patients in Great Britain who have consented to have blood drawn need to be told that the blood will be tested for exposure to HIV.


The author outlines the law of informed consent and confidentiality in the testing context and briefly discusses the implications for the pathologist and the laboratory.


The authors report the results of a stratified random sample of all nonfederal general acute care hospitals in the United States. The authors found, *inter alia*, that more than 83% had formal HIV testing policies, 78% required pre-test patient informed consent, 75% required that the patient be informed of test results, and 3% required transfer of seropositive patients to other hospitals.


See supra section V. *The Seropositive Health Care Professional: The Duties to be Tested and to Disclose* for annotation.

See supra section V. The Seropositive Health Care Professional: The Duties to be Tested and to Disclose for annotation.


The author offers a statistical analysis of risk of HIV-infection of patients or health care workers in a hospital setting and the factors that need to be considered in constructing a decision analysis model to determine the desirability of screening patients.


The authors advocate voluntary testing, accompanied by safeguards for confidentiality, of all adults under the age of sixty. The authors also recommend voluntary routine patient screening within the health care system. Their rationale is that early detection will generate medical and public health benefits.


Proposition 96, a 1988 California ballot initiative that permits nonconsensual HIV-antibody testing of persons who may have exposed police, fire, rescue or custodial personnel, or victims of sexual assault to the virus, does not apply to HCWs who may have been occupationally exposed through patient contact. After an exploration of California consent and confidentiality laws, Fourth Amendment search and seizure law, and the legal and ethical duties of HCWs to treat HIV-infected patients, the author concludes that the protections of Proposition 96 should be extended to HCWs who have been exposed to the body fluids of patients and who wish to have those patients tested for HIV.


The author, a nurse, argues in this one-page article that “mandatory screening, with provisions for maintaining confidentiality, would protect nurses from the grave risk of AIDS.”

The author examines mandatory patient HIV-antibody testing and reporting of results to "emergency responders" i.e., "pre-hospital" providers of emergency medical care such as emergency medical technicians. Included in an appendix are summaries of all relevant state and federal legislation enacted by the summer of 1990.


The author argues against patient HIV testing for the protection of hospital health care workers since use of universal barrier precautions offers far greater safety. She also argues that when an HIV test is indicated for diagnostic purposes, the patient's prior specific informed consent is needed.


The author provides a succinct overview of the conflict between the patient's interest in maintaining confidentiality of HIV-related data and the physician's duty to disclose that information under certain circumstances. The author also offers a concise overview of physician tort liability in the following areas: failure to inform patients of test results or to provide appropriate related counseling; communication of inaccurate test results; and failure to warn third parties at risk.


The author develops a model for decision-making regarding whether to preserve confidentiality of patient data regarding HIV-infection. The model "includes identifying the extent to which personal privacy and the trust essential for preserving the integrity of the professional-client relationship are implicated if confidentiality were to be breached, and weighing the extent to which access to HIV related information is necessary to further important interests." *Id.* at 908. The author applies this model to "easy cases" (viz. those involving disclosure to the patient or to persons authorized by the patient to receive this information, and disclosure in negligence suits brought against physicians or blood banks) and to "hard cases" (viz. those involving notification to sexual or needle-sharing partners of the patient).


The authors argue:
The general rule should be that mandatory testing for AIDS is permissible and REQUIRED for ANY INDIVIDUAL WITH a developmental disability who lives in a congregate living setting with other persons with developmental disabilities when the individual manifests medical conditions that give probable cause to believe that the person may have HIV infection and when the person emits behaviors that are likely to cause others to acquire AIDS.

Id. at 649.


The author examines two categories of Florida legislation providing for involuntary HIV testing: involuntary testing after judicial review, usually pursuant to a criminal prosecution; and involuntary testing of patients by health care providers after exposure to the patient's blood, both in and outside of the medical emergency context.


The author presents a concise overview of the medical aspects of HIV testing and the legal aspects of informed consent. He also offers recommendations and suggested policies for medical testing laboratories which perform such tests.


The authors provide an overview of the law of informed consent and medical records confidentiality in the HIV testing context. They also present practical advice to hospitals and physicians on securing valid informed consent and on safeguarding confidentiality of HIV test results. The authors appended a sample consent form and patient HIV information sheet.


The author examines a California appellate court's limitation of the state's HIV confidentiality statute to situations in which a patient's HIV status is disclosed by persons having direct access to the results of the patient's HIV test and not to situations in which the disclosure is brought about by persons to whom the patient has voluntarily disclosed such information. The author also discusses the court's finding that the California Constitution offers broad protection of privacy rights that would encompass a voluntary disclosure situation.

See supra section X. *The Seropositive Patient: Rights of Access to Treatment* for annotation.


The author concludes:

Given the concerns for individual privacy rights of patients, the potential legal complications inherent in any program of mandatory testing, as well as the questionable efficacy of mandatory AIDS testing, particularly in light of alternative methods of controlling the transmission of AIDS in the hospital workplace, mandatory testing does not appear to be the solution to the AIDS problem confronting health care providers. *Id.* at 671.

XIII. **General Materials on HIV Testing, Reporting, and Confidentiality**


The author provides an overview of the psychological and constitutional aspects of privacy as they relate to compulsory HIV testing and concludes that resources should be allocated to less intrusive means of halting the spread of AIDS, such as creating educational and voluntary testing programs, before mandatory testing is seriously considered.


The authors provide general background on testing, both medical and legal, and discuss the implications for various substantive areas such as informed consent, blood bank liability, premarital testing, and child custody, to name but a few.


The author provides an overview of statutes requiring mandatory disclosure to the tested individual. The author argues that such disclosure is not rationally related to legitimate state purposes nor does it serve a valid medical or public health purpose. He further argues that disclosure unnecessarily infringes upon the fundamental rights of personal choice and self-determination.

The authors survey the use of mandatory reporting of AIDS cases and seropositive test results, contact tracing, isolation, and quarantine as preventive measures. They conclude that reporting of AIDS cases is the only one of these that is justified on both legal and policy grounds.


The authors provide an overview of state legislation that deals with any aspect of HIV testing and the uses to which test results may be put.


The author examines mandatory HIV testing of two groups: status-defined (e.g., health care workers; patients) or individuals who have exposed others to their bodily fluids (e.g., rapists). The author concludes that neither testing scheme constitutes a rational public health policy, and that other, less intrusive but equally or more effective, measures are available.


The author addresses the issues of reporting seropositive test results and AIDS-related deaths to public health agencies; contact tracing and partner notification programs; and public health measures such as isolation and quarantine, regulation of gay meeting places, and civil commitment.


The author offers a general discussion of testing, paying particular attention to whether voluntary or mandatory testing programs would be more effective in helping to control the epidemic. She concludes that neither mandatory testing of the general population nor of specific subgroups is warranted.


The author advises public health policy makers to keep the following principles in mind when formulating testing programs: (1) to be clear about whether the test results are to be used for medical
purposes to benefit the individual tested, public health purposes to reduce the probability of infecting others, or surveillance purposes to track the spread of infection; (2) to be aware of the long window period between infection, seroconversion, and the development of any symptoms; and (3) to be clear about the ethical and scientific bases for the testing program.


Part 1 discusses the ELISA test, informed consent, confidentiality, and mandatory versus voluntary testing. Part 2 examines testing in the health care workplace and the Centers for Disease Control guidelines.


The author examines mandatory HIV testing and related confidentiality issues. She concludes that voluntary testing of high risk groups with stringent confidentiality safeguards, rather than mandatory testing of heterogeneous populations, is an effective way to control AIDS.


The authors offer a concise overview of all issues associated with testing in a health care context.


The author argues that partner notification programs must be voluntary, have strict confidentiality safeguards, be well defined by statute, and provide clear guidelines for physicians and public health workers.


The authors discuss the ethical considerations involved in voluntary screening programs, predictive value of tests, confidentiality and disclosure to third parties, and follow-up care and counseling.


A model policy, intended for use by health care facilities, residential programs and other types of agencies which provide services to persons who may be HIV-infected, is set forth, accompanied by a
thorough discussion of the underlying legal basis. This article is adapted from *AIDS/HIV and Confidentiality: Model Policy and Procedures* (1991), published by the American Bar Association.


The authors consider the rationale for mandatory testing or screening programs and conclude that mandatory testing is only justified for screening donated blood and tissue.


The author examines the efficacy of mandatory reporting and testing, contact tracing, quarantine, and education as methods of effectively dealing with the AIDS epidemic and concludes that a combination of mandatory and confidential reporting, contact tracing and education would prove to be effective.


The author provides an equal protection and public policy analysis of a Colorado regulation requiring doctors, hospitals and laboratories to report the names and addresses of those who test positive for HIV exposure to the Department of Health. She concludes that the regulation violates equal protection under a heightened scrutiny standard and that public policy considerations relating to respecting individual privacy and encouraging the testing of high risk groups dictate against the Colorado regulation.


The author analyzes Oklahoma statutory provisions regarding HIV testing, confidentiality of test results, and the duties and rights of health care workers, patients, and third parties in this area.


The author compares the Texas legislation to reporting statutes of other jurisdictions and analyzes its constitutionality. She concludes that the Texas Act effectively balances the interests of infected persons and the uninfected population.

The author discusses constitutional limitations on the disclosure of the names of HIV-infected persons and the need for legislation allowing dissemination of such information to groups like health care workers and funeral directors.


The author examines the constitutional constraints on the infringement of privacy rights that the government must overcome in order to institute mandatory testing programs.


The author examines confidentiality law and offers a model “Comprehensive AIDS Confidentiality Act” that would better protect the privacy rights of seropositive persons in the areas of HIV testing and participation in AIDS research programs.

**XIV. General Materials on HIV/AIDS and the Law**


This Yale University Press publication consists of separately authored chapters that are grouped under the following general headings: policies and priorities; prevention and treatment; patients' rights and public health; the threat to health care workers; professional responsibility; regulation of biomedical research; the financial impact on health care providers; and the international perspective.


This text consists of separately authored chapters that provide a comprehensive overview of AIDS law for the lay public (Published by John Wiley & Sons and kept up-to-date by supplements).


This practice-oriented comprehensive overview of AIDS law consisting of separately authored chapters includes appendices that provide state-by-state summaries of statutes dealing with HIV testing, reporting, confidentiality, duty to disclose, informed consent, quarantine, and transmission crimes. (Published by the National Lawyers Guild AIDS Network and kept up-to-date by supplements).

This second edition of AIDS AND THE LAW: A GUIDE FOR THE PUBLIC (Harlon L. Dalton et al. eds., 1987), also published by Yale University Press, consists of separately authored chapters that provide a comprehensive overview of AIDS law for a lay audience.


This first casebook on AIDS law offers a good general introduction, containing selections from the scholarly and popular periodical literature as well as case law. (Published by John Marshall Pub. Co.).


This is a compilation of summaries and citations to state AIDS laws that have been categorized by subject. Separately published non-cumulative annual supplements are available from 1988 to date.


This text, aimed at legal practitioners, provides separately authored chapters that together provide a comprehensive overview of AIDS and the law. Chapter fourteen offers an unannotated AIDS legal bibliography prepared by Arthur S. Leonard. (Published by Callaghan and kept up-to-date by supplements).


Part 1 focuses on the medical and public health implications of HIV/AIDS; part 2 provides an overview of the legal implications of the disease.

The author provides "[a]n overview of the AIDS problem [which] reveals particular areas of medical, societal, legal and ethical-moral concern that frequently overlap." Id. at 324.

Harrison L. Rogers, Jr., The Medical Profession and AIDS, 10 J. LEGAL MED. 1 (1989).

The author, a past president of the American Medical Association, provides a brief overview of the United States' commitment to quality health care, the public health aspects of the AIDS epidemic, and its ethical, social, and legal implications for organized medicine.