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AIDS Discrimination by Medical Care Providers: Is Washington Law an Adequate Remedy?

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AIDS DISCRIMINATION BY MEDICAL CARE PROVIDERS: IS WASHINGTON LAW AN ADEQUATE REMEDY?

The acquired immune deficiency syndrome ("AIDS") epidemic has burdened the medical community in a number of ways. One disturbing result is discrimination against AIDS patients. Irrational fear of contagion, prejudicial reactions to AIDS patients' personal characteristics, and business concerns, all play a role in this discrimination.

The fear of contagion is not justified by the facts. Clinical evidence shows that health care workers are at little risk of contracting AIDS occupationally. Health care workers are just as likely to contract other serious diseases through their work. In the midst of an epidemic, health care workers must not give way to irrational fears, nor fail to provide all patients with quality care, regardless of sexual preference, drug use, or other personal characteristics.

Discrimination against AIDS patients[1] by medical care providers violates antidiscrimination law. In evaluating legal tools to enforce fair AIDS care, this Comment focuses primarily on the federal Rehabilitation Act of 1973,[2] and Washington's recently amended antidiscrimination[3] and public health law.[4] Discriminatory acts are difficult to defend under these laws. Nonetheless, existing law is inadequate for combating AIDS discrimination because the law is underused by

1. This Comment also discusses discrimination against persons having no symptoms but who nonetheless test positive for exposure to human immunodeficiency virus ("HIV"). HIV is the retrovirus causing AIDS. R. BERKOW, THE MERCK MANUAL OF DIAGNOSIS AND THERAPY 288, 290 (15th ed. 1987). A San Francisco study estimated that between 65% and 100% of HIV positive persons develop AIDS or AIDS-Related Complex ("ARC") within 16 years. *100 Percent of Infections Seen Progressing to AIDS,* AIDS POLICY & L., Jan. 2, 1988, at 8.

AIDS symptoms commonly include Kaposi's sarcoma (tumors in skin or lymph nodes), primary lymphoma of the brain (diseases of the lymph system), and secondary diseases including *Pneumocystis carinii* pneumonia (*P. carinii* is a parasite), toxoplasmosis (a parasitic infection capable of organ damage), and cryptococcosis (a fungal disease, either pulmonary or systemic) among many others. R. BERKOW, *supra*, at 291. ARC refers to a different constellation of symptoms including generalized lymphadenopathy (any lymph disorder), weight loss, malaise, chronic diarrhea, leukopenia (leukocyte deficiency), and others. *Id.* at 290–91.

2. The Rehabilitation Act of 1973, § 504, 29 U.S.C. § 794 (1987). This law prohibits discrimination against the handicapped by programs or facilities receiving federal funds. AIDS is a protected handicap. *See infra* text accompanying notes 86–91.

3. WASH. REV. CODE § 49.60 (1987), *amended by* The 1988 Omnibus AIDS Act, 1988 Wash. Legis. Serv. 662 (West). AIDS is a protected handicap under this law. *See infra* text accompanying notes 102–04.

4. WASH. REV. CODE § 70.24 (1987), *amended by* The 1988 Omnibus AIDS Act, 1988 Wash. Legis. Serv. 662 (West). Tort and constitutional law may also offer the AIDS patient an avenue of action. *See infra* note 77.

AIDS patients and vague. This Comment recommends expressly banning the common forms of medical care discrimination, and requiring heightened human immunodeficiency virus ("HIV") testing standards, as important steps towards creating effective AIDS antidiscrimination law.

I. PROGNOSIS FOR THE AIDS EPIDEMIC

AIDS was first recognized as a disease in the United States in 1981. Since that time more than 29,000 people have died from AIDS in the United States.[5] Statistically, this number is only some sixty percent of the highway death toll in a single year,[6] but AIDS is a much more frightening killer than accidental death. AIDS projections for the future also add to the alarm. The Centers for Disease Control ("CDC")[7] note that an additional 23,000 persons suffer from AIDS. The prognosis for most of these people is death within two years of diagnosis.[8] The CDC also estimates that another 100,000 to 200,000 people have AIDS-Related Complex ("ARC") and up to an estimated one and a half million persons are infected with HIV.[9] Discussion of AIDS must be mediated by awareness of what lies ahead. Health care providers will face increasing numbers of AIDS patients, making discrimination against these patients of even greater concern.

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5. Telephone interview with Deenie M.T. Dudley, Program Specialist, AIDS Program, Washington Dept. of Social and Health Services (Feb. 12, 1988) (notes on file with the *Washington Law Review).*

In Washington there were 119 AIDS cases in 1985, 216 in 1986, and 210 as of late November 1987. INTERIM REPORT, GOVERNOR'S TASK FORCE ON AIDS 11 (Dec. 1987) [hereinafter GOVERNOR'S TASK FORCE REPORT]. Extrapolation from the November total suggests a complete flattening of the growth curve with only a few more cases likely in 1987 than in 1986. (A bar graph on the following page incorrectly indicates a low 1986 total and an exaggerated prediction for 1987.)

AIDS deaths may be underreported. At least a few physicians are not listing AIDS as the cause of death on death certificates at the request of families. Zamichow, *Officials Say AIDS Deaths Underreported in Dallas,* Dallas Times, June 2, 1987 (NEWSBANK, Health file 77:G8) (copy on file with the *Washington Law Review*).

6. Approximately 45,700 persons died on the highways in 1985. U.S. DEPT. OF COMMERCE, STATISTICAL ABSTRACT OF THE UNITED STATES 588, Table 1026 (107th ed. 1987) [hereinafter STATISTICAL ABSTRACT].

7. The CDC, created in 1973, is an agency within the United States Public Health Service, and is charged with prevention and control of health problems. 38 Fed. Reg. 18,261 (1973) (order of Sec. of Health, Education, and Welfare, never codified).

8. Faulstich, *Psychiatric Aspects of AIDS,* 144 AM. J. PSYCHIATRY 552 (1987).

9. Telephone interview with Deenie M.T. Dudley, *supra* note 5. For definitions of ARC and HIV, see *supra* note 1.

II. FEAR OF AIDS CONTAGION VERSUS CLINICAL REALITY

AIDS poses a very low threat of infection to health care workers. Out of 6.8 million United States health care workers, 1875 are reported as having AIDS.[10] The CDC believes that only eight health workers contracted AIDS from workplace exposure.[11] By comparison, ten to twelve thousand health care workers each year are occupationally infected with hepatitis.[12] Perhaps a hundred of these health care workers die of hepatitis.[13] In fact, the Occupational Safety and Health Agency noted that hepatitis rates heightened the urgency of adopting HIV infection control procedures.[14]

AIDS is not transmissible via the casual contact generally found in schools and the workplace. The CDC has determined that only contact with HIV infected blood, semen, vaginal secretions, and possibly breast milk poses risk of transmission.[15] Thus, CDC guidelines rec-

10. CDC, *Recommendations for Prevention of HIV Transmission in Health-Care Settings*, MORBIDITY & MORTALITY WEEKLY REP., Supp. Aug. 21, 1987, at 4. The CDC reports on health issues and lists significant disease statistics in this weekly report.

11. N.Y. Times, Nov. 13, 1987, at 10, col. 1, 2. Eight may be a low number for several reasons. It includes only those health care workers reported to the CDC. Further, it assumes that any health care worker with AIDS who was at risk for AIDS due to intravenous drug use or homosexuality did not contract AIDS occupationally. Finally, five percent of health care workers with AIDS have "undetermined risk" for AIDS, compared to only three percent for the population at large. CDC, *supra* note 10, at 4S. The CDC does not offer a hypothesis for this differential.

In January 1987 an AIDS researcher contracted a strain of AIDS virus from his lab despite the researcher's belief that he had no unprotected contact with the virus. Seattle Times, Jan. 1, 1988, at A2, col 1. This infection might be explained by micro-leakages in a glove, or might fall into the "risk undetermined" group.

12. *OSHA Publishes Rulemaking on AIDS, Hepatitis B Hazards*, AIDS POLICY & L., Dec. 2, 1987, at 1. Viral hepatitis attacks the liver and may lead directly to death (fulminant hepatitis) or cause fatal liver cancer or cirrhosis. Iserson, *Hepatitis B and Vaccination in Emergency Physicians*, 5 AM. J. EMERGENCY MED. 227, 229 (1987).

There are three strains of hepatitis: A, B, and hepatitis non-A non-B. A vaccine exists only for hepatitis B. While AIDS has a higher rate of fatality per case, once developed, hepatitis, like AIDS, is generally not susceptible to medical cure. Telephone interview with Anne Collier, M.D., Medical Director, AIDS Clinic, Harborview Medical Center, Seattle, Washington (Dec. 31, 1987) (notes on file with the *Washington Law Review*).

13. Telephone interview with James McGough, Ph.D., AIDS Counselor, AIDS Prevention Program, Tacoma/Pierce County Public Health Dept. (Dec. 30, 1987) (notes on file with the *Washington Law Review*). In 1985, hepatitis B and non-A non-B caused death in one percent of those hepatitis patients under 40. For patients over 40, between three and five percent died. CDC, HEPATITIS SURVEILLANCE, May 1987, at 19, 21 (a study based on 26,595 of the 59,100 hepatitis cases in 1985). Hepatitis B alone is estimated to lead to the death of one in 540 emergency physicians over a 30 year career. Iserson, *supra* note 12, at 230.

14. AIDS POLICY & L., Dec. 2, 1987, at 1.

15. CDC, *supra* note 10, at 3S.

ommend that *all* health workers wear rubber gloves[16] and gown if contact with bodily fluids is anticipated; masks and goggles should be worn if needed to avoid exposure to mucous membranes.[17] These guidelines should be observed with all patients, not merely HIV positives, because any patient may have hepatitis or produce a false HIV negative test result due to latent infection or error.[18] Gloves, however, will not protect health care workers from fluid exposure due to needlesticks or blade cuts. Needlesticks are not uncommon. There are an average of between four and sixteen needlesticks each year per hundred health care workers.[19] Following CDC procedure should eliminate up to forty percent of needlestick exposure,[20] although some needlestick and blade contact remains inevitable due to human error.

Thus, AIDS patients pose "a small but real risk"[21] to health care workers. Hepatitis patients, however, also pose a real risk to these workers.[22] As no health care workers suggest it is legitimate to discriminate against hepatitis patients, it appears health care workers

16. *Id.* at 6S. Some health care workers argue that gloves decrease needed freedom of movement leading to increased likelihood of needlesticks. Improved gloves are being developed. *Spills Cause of Most Health Care Worker Blood Exposures,* Boston Herald, June 1, 1987 (NEWSBANK, Health file, 81:E5) (copy on file with the *Washington Law Review*). A member of President Reagan's AIDS commission declared that gloves are not HIV impermeable and that the Food and Drug Administration would soon announce this. Christian Science Monitor, Sept. 14, 1987, at 8, col. 2. No such announcement was made. Unwarranted ideas as to transmissibility may lead to increased discrimination. For an extreme example of unwarranted prejudicial views, see *Aids Coverup Can Kill You: Angry Doctors Blow Lid Off Conspiracy—No American Is Safe!,* Weekly World News, Mar. 25, 1986, at 1 (cited in a list of AIDS scare story headlines compiled in a Seyfarth, Shaw, Fairweather & Geraldson memorandum (on file at Harvard Law Library)).

17. Dentists have widely adopted these precautions. An Oregon dentist who charged AIDS patients extra for these infection control measures was told by the Oregon Labor Commissioner that the extra charge might violate civil rights law. *DC, 21 States Bar AIDS Discrimination; Disease Victims Considered 'Handicapped' By Law,* AM. DENTAL A. NEWS, Feb. 2, 1987, at 1 [hereinafter AM. DENTAL A. NEWS].

18. *Id.*

19. Lifson, *AIDS in Health Care Workers,* 256 J. AM. MED. A. 3231, 3233 (1986).

20. Friedland, *Transmission of Human Immunodeficiency Virus,* 317 NEW ENG. J. MED. 1125, 1127 (1987). The unnecessary practice of recapping needles before disposal is a major culprit.

21. N.Y. Times, Nov. 13, 1987, at 10, col. 1 (quoting a letter of Oct. 30, 1987 sent by federal officials to United States employers).

Firefighters and police face more significant risks. In 1985, 148 police officers fell victim to duty-related homicide. *See* STATISTICAL ABSTRACT, *supra* note 6, at 161, Table 275. Society does not guarantee that the risk a profession faces is fixed at entry—for example, the recent use of automatic weapons against police officers. Police, like health care workers, may always change their occupation if they find a risk unacceptable.

22. *See supra* notes 12–13 and accompanying text.

refusing to treat AIDS patients do so for reasons other than a rational fear of contagion.[23]

III. SOURCES OF THE ETHICAL DUTY TO TREAT AIDS PATIENTS

The American Medical Association ("AMA") amended its Principles of Medical Ethics in November 1987 to state that AMA member doctors[24] have an ethical duty to treat AIDS patients without regard to risk of contagion.[25] Although violation of ethical principles can lead to expulsion from the AMA, the organization does not plan to enforce the principle.[26] Further, many physicians are uncomfortable with the new principle or reject it outright.[27]

A health care provider's implied social contract is a sounder base than the AMA's views for premising an ethical duty to treat AIDS patients. Society spends a great deal of money training health care workers and recovers only a portion of it through tuition.[28] Further, society confers upon doctors status and privilege of the highest order. Thus, society may reasonably dictate responsibilities in return. Society demands that police and firefighters risk their lives for a smaller incentive than many health care providers receive.[29] Society needs all

23. One physician has noted the possibility that HIV could mutate in the future and develop increased contagiousness. The physician was attempting to justify his refusal to treat AIDS patients. Staver, *Fear of AIDS,* AM. MED. NEWS, Oct. 2, 1987, at 28. It is difficult to see how a future possibility can justify present discriminatory acts.

24. The AMA represents only about one-half of the nation's doctors. N.Y. Times, Nov. 13, 1987, at 10, col. 1.

25. *Id.* col. 2. The Surgeon General of the United States rebuked health care providers who refuse to treat AIDS patients, declaring such refusal cowardly and unwarranted by the CDC evidence. *Id.* col. 2.

26. *Id.* (statement of Kirk B. Johnson, General Counsel, AMA).

The AMA's third ethical principle begins "A physician shall respect the law." *Principles of Medical Ethics and Current Opinions of the Judicial Council,* in R. GORLIN, CODES OF PROFESSIONAL RESPONSIBILITY 101 (1986); *see also id.* at 102, annotation 1.02. Thus, any practice considered discriminatory under state law is unethical.

27. Prior to the AMA announcement, a survey revealed that nearly one-fourth of the surveyed doctors felt that refusing to treat AIDS patients was not unethical. Price, *Interns, Residents Believe They Can Become Infected,* Washington Times, June 5, 1987 (NEWSBANK, health file, 93:A8) (copy on file with *The Washington Law Review*). Doctors expressing this view include those very sympathetic towards AIDS patients and personally willing to treat them. Interview with Robert Wood, M.D., Medical Dir., AIDS Prevention Project, Seattle, Washington (Dec. 12, 1987) (notes on file with the *Washington Law Review*). Whether doctors are willing to extend this freedom of choice to residents and nursing staff is an open question.

28. In 1985, the federal government spent $227 million on health professionals' training and $1.4 million on facilities. *See* STATISTICAL ABSTRACT, *supra* note 6, at 116, Table 188.

29. For example, the average physician's yearly net income in 1984 was $102,000, compared to $22,000 for police and other state and local protective service personnel. *See* STATISTICAL ABSTRACT, *supra* note 6, at 93, Table 146 (physicians), 281, Table 470 (protective services).

its health care workers in times of public health emergency. Consider the devastating consequences should obstetricians refuse AIDS duty in New York City, where one baby in sixty-one is born with HIV antibodies.[30] Finally, health care providers should recognize a duty to fellow workers who, though willing to treat AIDS patients, are unfairly burdened by providers ducking their share of a professional duty.[31]

IV. AIDS DISCRIMINATION

Persons with AIDS have lost their jobs,[32] their insurance,[33] their access to education,[34] and various public accommodations.[35] In short, they suffer a full panoply of discrimination.[36] This Comment discusses three types of medical care discrimination: First, open refusal to treat AIDS patients; second, making unnecessary referrals of AIDS patients to other hospitals ("dumping"); third, performing HIV tests, or releasing HIV test results, without proper consent.

A. The Extent of "Refusal-To-Treat" AIDS Discrimination

AIDS patients often trouble medical staff emotionally. The patients, typically the age of the attending staff, face a death the staff is powerless to prevent. The death can be unpleasant: lesions may cover the patient's body and the patient may lose control of bodily functions due

30. N.Y. Times, Jan. 13, 1988, at 1, cols. 2–3.

31. Increased costs, decreased care quality, and provider burnout are associated with concentrating AIDS patients among a few providers. *See* GOVERNOR'S TASK FORCE REPORT, *supra* note 5, at 57–59. The AMA Principles of Medical Ethics state that a doctor's freedom to refuse any patient is suspended during emergencies. R. GORLIN, *supra* note 26, at 101 (principle four).

32. *See, e.g.*, Chalk v. United States Dist. Court, 832 F.2d 1158 (9th Cir. 1987).

A 1986 government memorandum stated that discrimination may not be illegal if an employer acts out of fear of AIDS transmission. The memo did not limit this to a legitimate fear. *Memorandum for Ronald Robertson, Dept. Health and Human Services, Oversight Hearings, Office of Civil Rights*, 99th Cong., 2d Sess. 191 (1986). This memo reflects the watery federal response to AIDS discrimination that existed at least until 1985. *Id.* at 72–73, 188–89, 248, 267, 350.

33. Life and health insurers have added clauses to existing policies excluding AIDS, or have failed to extend insurance to those fired or leaving work due to AIDS. Schatz, *The AIDS Insurance Crisis: Underwriting or Overreaching?*, 100 HARV. L. REV. 1782, 1786 (1987).

34. *See, e.g.*, Ray v. School Dist., 666 F. Supp. 1524 (M.D. Fla. 1987) (school district denied children with AIDS entry to the classroom).

35. For example, in 1987, Northwest Airlines denied an AIDS patient access to a flight until the patient could provide a doctor's certificate of noncontagiousness. After a lawsuit was filed, the airline changed its policy. Seattle Times, Aug. 15, 1987, at A2, col. 5.

36. One family's house was burned down apparently because the children had AIDS. Los Angeles Times, Sept. 21, 1987, pt. 1, at 2, col 6.

to dementia.[37] Further, dislike of homosexuals and intravenous drug abusers is not uncommon among medical personnel.[38] Unpleasantness, homosexuality, and drug addiction are even more unacceptable bases for discrimination than contagion fears.

Physicians, dentists, medical staff, substance abuse clinics, and nursing homes are among those refusing to treat AIDS patients.[39] At least two surgeons have publicly announced their refusal to treat AIDS patients.[40] Newspapers have reported paramedics, particularly volunteers, who refuse to respond to calls from AIDS patients or ignore calls from areas considered largely homosexual.[41] Recently, the head of the American Foundation for AIDS Research found the situation grave enough to recommend that AIDS patients injured in accidents not inform emergency personnel of their condition if they want to assure full care.[42] Nursing homes commonly refuse AIDS patients. Johns Hopkins Hospital, in recent attempts to place forty-one AIDS patients needing nursing home care, could place only seven and all in only one home.[43] Dental care is also routinely difficult for AIDS patients to obtain.[44]

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37. Informal discussions with Seattle area physicians (Nov. 25, 1987, Feb. 8, 9, 1988) (notes, without identifying information, on file with the *Washington Law Review*).

38. Zuger, *Professional Responsibilities in the AIDS Generation, AIDS on the Wards: A Residency in Medical Ethics,* HASTINGS CENTER REP., June 1987, at 16, 18.

39. For instances of medical discrimination in Washington, see text accompanying notes 62–72.

40. Bruce Wilbur, M.D., a midwest cardiovascular surgeon, does not accept AIDS patients. *See* Staver, *supra* note 23, at 1. Ronald Abel, M.D., also a cardiovascular surgeon, stated on nationwide television that he had already turned down four patients owing to their AIDS illness. *Nightline: AIDS Patients and Doctors* (ABC television broadcast, Nov. 24, 1987) (transcript on file with the *Washington Law Review*). Cardiovascular surgery involves a great deal of blood exposure; generally, this can be avoided by gloving and gowning. However, such surgery involves occasional work with one's hands out of sight in the body cavity increasing the likelihood of nicking hands. Telephone interview with Anne Collier, M.D., *supra* note 12.

Several studies presented at the Third International Conference on AIDS showed a "significant minority" of doctors preferred not to treat AIDS patients and felt it ethical not to. *See* Staver, *supra* note 23, at 1.

41. For example, in a Long Island, New York case six successive public ambulance units ignored an AIDS patient's calls. After an hour, the family called a private ambulance. Horvath, *Rescue Volunteers Battle Fear of AIDS,* Newsday (NY), Feb. 23, 1987 (NEWSBANK Health file, 11:C12) (copy on file with *The Washington Law Review*).

42. AIDS POLICY & L., Nov. 4, 1987, at 4.

43. Shane, *Nursing Homes Rejecting AIDS Patients,* Baltimore Sun, May 26, 1987 (NEWSBANK, Health file, 91:G6) (copy on file with *The Washington Law Review*). Nursing home discrimination is also a significant problem in Washington. *See infra* note 72 and accompanying text.

44. In some cities no dentist will serve AIDS patients. *See, e.g.,* Foltz, *Tulsa Dentists Turning Away AIDS Victims, Official Says,* Tulsa World, Sept. 25, 1987 (NEWSBANK, Health file 135:F12) (copy on file with *The Washington Law Review*). Finding dental care is problematic in Washington, as well. Telephone interview with James McGough, Ph.D., *supra* note 13.

AIDS discrimination is more common outside AIDS-experienced major cities,[45] but it is not limited to outlying areas. For example, at California's El Camino Hospital, which deals with many AIDS patients, up to one-third of the nurses reportedly avoid AIDS patient duty.[46] Avoidance discrimination is hard to detect. Hospitals can switch staff around so that the patient is unaware of any problem. Discrimination may also take the form of reduced care. A New York City commission report noted one case in which hospital staff ignored an AIDS patient's medication, meal service, and room cleaning.[47]

B. The Extent of "Referral" Discrimination Against AIDS Patients

Doctors may refer AIDS patients to other hospitals for several reasons. The doctor may believe better AIDS care is available elsewhere. Or the doctor may find AIDS patients undesirable personally or for business reasons. These latter medically unnecessary referrals ("dumping") are simply disguised refusals to treat.[48] Discriminatory referrals probably far outnumber the open refusals to treat.[49] Economically motivated referrals to public health hospitals occur because the AIDS patient cannot afford care or when the provider fears the AIDS patient will discourage other patient business.[50] This avoidance may begin at the start of a medical career. Anecdotal accounts indicate that some medical students avoid residencies in areas with heavy AIDS caseloads.[51]

C. The Extent of Discriminatory HIV Testing Practices

Positive HIV test results may expose an individual to the full range of discrimination.[52] Medical record access is not well controlled in

45. *See* telephone interview with Anne Collier, M.D., *supra* note 12.

46. *See* Staver, *supra* note 23, at 29.

47. Hermann & Gorman, *Hospital Liability and AIDS Treatment: The Need for a National Standard of Care,* 20 U.C. DAVIS L. REV. 441, 443–44 n.10 (1987).

48. In the early stages of the AIDS epidemic came reports that some states shipped their AIDS patients to San Francisco. Mathews, *The Initial Impact of AIDS on Public Health Law in the United States—1986,* 257 J. AM. MED. A. 349 (1987).

One doctor reports telling a family that the best care was available elsewhere to cover his staff's unwillingness to treat, rather than his own. *See* Staver, *supra* note 23, at 27.

49. *See* Zuger, *supra* note 38, at 19.

50. Banks, *The Right to Medical Treatment,* in AIDS AND THE LAW 180 (1987). Some clinics that are willing to treat AIDS patients place informational literature outside the waiting room. Telephone interview with James McGough, Ph.D., *supra* note 13.

51. Zuger, *supra* note 38, at 19.

52. For example, one Seattle psychotherapist terminated therapy upon learning her client had AIDS. Telephone interview with William Etnyre, Clinical Social Worker (Dec. 17, 1987) (notes

most hospitals,[53] making unnecessary testing potentially dangerous. Hospital labs report increasing requests for HIV tests from staff attending patients not being treated for AIDS or ARC.[54] Medical staff may intend to take heightened precautions if their patient tests HIV positive.[55] While this intention seems reasonable, the CDC recommends observance of full infection control for all patients owing to possible latent infection, erroneous test results, and hepatitis.[56] Thus, the rationale for testing is weakened.

Health care workers accidentally exposed to a patient's blood may also want the patient tested. The health worker may feel that knowing the patient's HIV status will help the worker make personal decisions,[57] despite the caveats concerning HIV tests noted above. Hospitals may perform tests even if consent is refused ("covert testing"). More commonly, consent is not sought. The HIV test is performed along with the routine battery of blood tests in the belief that the general consent signed upon admission covers such practice.[58] Again, the medical staff's concern is understandable. Nonetheless, medical procedures performed without consent violate tort law.[59] Covert testing may also violate constitutional and antidiscrimination law.[60] As HIV positive test results may lead to discrimination, workers should assume HIV exposure if a patient refuses consent[61] rather than perform covert tests.

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on file with the *Washington Law Review*). School children have been denied the classroom due to positive tests alone. *See infra* note 91.

As the amount of testing increases, the number of people testing false positive (i.e., a test indicating HIV when there is none) will probably increase. *See generally* Barnes, *New Questions About AIDS Test Accuracy,* 238 SCIENCE 884 (1987).

53. *See, e.g.,* UNIF. HEALTH-CARE INFORMATION ACT, prefatory note (1985) (noting privacy and confidentiality commission reports of hundreds of complaints of harm caused by misuse of medical records).

54. Informal discussions with Seattle area physicians, *supra* note 37.

55. Hospitals may permit testing to show support for their employees. Pankau, *AIDS: Responding to the Issues,* HEALTH CARE L., Fall 1987, at 12. Of course, hospitals and doctors also profit from testing.

56. CDC, *supra* note 10, at 5S.

57. Chiefly, workers must decide whether to practice "safe sex" with their partners. Unfortunately, the HIV latency period may be quite long, making HIV tests unreliable grounds for basing such decisions.

58. Informal discussions with Seattle area physicians, *supra* note 37. (Upon the author's request to one doctor for permission to attribute this information, the doctor denied having said such testing occurred.) Some hospital admission consent forms mention HIV tests.

Counsel for at least one major Seattle hospital has informed hospital staff of his opinion that covert testing is illegal. Telephone interview with Anne Collier, M.D., *supra* note 12.

59. RESTATEMENT (SECOND) OF TORTS § 15 comment a (1965); *see infra* note 133.

60. *See infra* note 77.

61. This view is taken by the Medical Director of the AIDS Clinic at Harborview Medical Center, as well as other doctors. Telephone interview with Anne Collier, M.D., *supra* note 12;

D. *Health Care Discrimination Against AIDS Patients in Washington*

In 1986 the shortage of Washington primary care physicians willing to treat AIDS patients was so acute that the King County Medical Society ran an item in its bulletin seeking doctors.[62] The situation has improved in Seattle since that time.[63] As recently as 1987, however, a Seattle surgeon covertly tested a patient under anesthetic,[64] and a psychotherapist terminated therapy upon learning of her client's HIV positive test results.[65] At least one major Seattle hospital has tested patients covertly.[66] Outside Seattle, obtaining medical care, especially dental care, remains difficult.[67]

Some Washington discrimination has led to litigation. In 1986, a Seattle AIDS patient who was denied access to a substance abuse clinic brought suit in superior court.[68] Another substance abuse clinic that refused to treat an AIDS patient settled after an attorney filed a complaint with the State Human Rights Commission.[69] In 1987, a hospital dental clinic performed some emergency work on an AIDS patient, then referred the patient to a public hospital for the remaining routine dentistry because he had no money.[70] In the past, however,

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telephone interview with Robert Wood, M.D., Medical Director, AIDS Prevention Project, Seattle, Washington (Dec. 15, 1987) (notes on file with the *Washington Law Review*).

62. Smith, *Growing Need for Primary Care Providers in AIDS Care,* KING COUNTY MED. SOC'Y BULL., Mar. 1986, at 9.

63. Telephone interview with Warren King, Medical Reporter, Seattle Times (Dec. 18, 1987) (notes on file with the *Washington Law Review*).

64. Telephone interview with Julya Hampton, Legal Program Dir., Washington ACLU, Seattle, Washington (Dec. 15, 1987); telephone interview with Maurice Skeith, M.D., Board of Trustees, King County Medical Society (Dec. 18, 1987) (notes from both interviews on file with the *Washington Law Review*).

65. Telephone interview with William Etnyre, Clinical Social Worker, Seattle, Washington (Dec. 17, 1987) (notes on file with the *Washington Law Review*).

66. Informal discussions with Seattle area physicians, *supra* note 37.

67. Telephone interview with James McGough, Ph.D., *supra* note 13.

68. The action was filed in King County, but was settled for pain and suffering damages and costs. Telephone interview with Jack Jones, Seattle attorney in private practice (Dec. 7, 1987) (notes on file with the *Washington Law Review*) (Mr. Jones would not reveal the name of the case).

69. The complaint was filed with the Kitsap County office. Terms included an undisclosed amount of damages, fees, and an agreement to change clinic policy to permit enrollment of AIDS patients. Telephone interview with Samuel Jacobs, Washington ACLU cooperating attorney (Dec. 18, 1987) (notes on file with the *Washington Law Review*).

70. Telephone interview with Mark Busto, Seattle attorney with Schweppe, Krug & Tausend (Feb. 12, 1988) (notes on file with the *Washington Law Review*) (response to a demand letter written by Mark Busto). Abandoning a patient after beginning treatment is tortious if the abandonment causes a patient harm. RESTATEMENT (SECOND) OF TORTS § 323 (1965). It is doubtful that this patient could show harm from a referral after emergency work was done.

the patient's indigence had not barred care.[71] The Region X Federal Office of Civil Rights is currently investigating some forty Washington nursing homes which apparently do not accept AIDS patients.[72]

V. STATUTORY TOOLS FOR COMBATING AIDS DISCRIMINATION

Although no common-law right to health care exists in the United States,[73] many legal tools for combating AIDS discrimination in health care are available. The federal Rehabilitation Act of 1973 protects handicapped persons from discrimination by federally funded programs or activities.[74] At least twenty-one states, including Washington, have statutes prohibiting discrimination against handicapped persons and have administratively classified AIDS as a handicap.[75] A few municipal codes prohibit AIDS discrimination.[76] Additionally, tort law may afford some protection.[77] Finally, state and federal con-

71. Telephone interview with Mark Busto, *supra* note 70. For a discussion of economically motivated referral, see *infra* notes 126–31 and accompanying text.

72. Region X of the Federal Civil Rights Office reports many cases of AIDS discrimination involving refusals of service by nursing homes, substance abuse clinics, dentists, and physicians. Region X includes Washington, Oregon, Alaska, and Idaho. However, Washington is responsible for most of the cases. Telephone interview with Carmen Rockwell, Region X Manager, Federal Office of Civil Rights (Nov. 13, 1987) (notes on file with the *Washington Law Review*).

An informal survey of Washington agencies in 1987 revealed twenty instances of AIDS discrimination. Telephone interview with Deenie M.T. Dudley, *supra* note 5.

73. RESTATEMENT (SECOND) OF TORTS § 314 (1965) (no duty to aid others); *see also, e.g.*, Childs v. Weis, 440 S.W.2d 104 (Tex. App. 1969). In *Childs*, a physician who refused to treat a pregnant woman, which led to the loss of her baby, was not liable since no doctor-patient contractual relationship existed. In Marcus Brown Holding Co. v. Feldman, 256 U.S. 170 (1921), however, the Supreme Court held that states can abridge an individual's freedom to contract during public emergencies. At issue in *Marcus* were landlords' duties during a housing emergency; by analogy, doctors' contractual rights may be vulnerable in an emergency.

74. The Rehabilitation Act of 1973, § 504, 29 U.S.C. § 704 (1987).

75. *See* AM. DENTAL A. NEWS, *supra* note 17, at 1; *infra* notes 102–04 (under Washington law AIDS is a handicap).

76. LOS ANGELES, CAL., MUNICIPAL CODE § 1, ch. III, *amended by* art. 5.8; SAN FRANCISCO, CAL., ORDINANCES art. 38 (order signed Nov. 20, 1985); AUSTIN, TEX., ORDINANCE 861211-V (amending ch. 7-4 (Dec. 1986)); Mayor Flynn of Boston, Exec. Order (Mar. 6, 1987). Some cities have ordinances prohibiting discrimination on the basis of sexual preference. These may offer grounds for action if the AIDS patient can show that the source of discriminatory action was linked to homosexuality. *See, e.g.*, SEATTLE MUN. CODE §§ 14.04.040(C), .08.040(A) (1985) (housing and unemployment).

77. *See, e.g.*, Doe v. Centinela Hospital, No. CV 87 02514 (C.D. Cal. filed May 1987), *reprinted in* ACLU LESBIAN AND GAY RIGHTS PROJECT, ACLU LEGAL DOCKET, AIDS AND THE LAW, SEXUALITY AND THE LAW 34 (July 1987) [hereinafter ACLU DOCKET]. Plaintiff sued a substance abuse clinic which required an HIV test of patients. After the plaintiff was refused admission and the results of his tests apparently made known to other patients, the plaintiff sued in tort for fraud, negligence, and intentional infliction of emotional distress. The

stitutions' due process and equal protection clauses may offer protection against AIDS discrimination.[78] Further, covert testing may violate the right to privacy.[79]

This Comment focuses on the statutory antidiscrimination scheme which in most states, including Washington, consists of overlapping federal and state law. No case law on AIDS under Washington's antidiscrimination law[80] has yet developed. Washington courts have authorized seeking guidance in interpretation of federal antidiscrimination law where relevant state law decisions are lacking.[81] Thus, discussion begins with federal law.

A. The Federal Rehabilitation Act of 1973

Section 504 of the Rehabilitation Act prohibits provision-of-service discrimination against handicapped persons by those receiving federal funds such as Medicare.[82] The United States Supreme Court held that the term "handicap" encompassed contagious disease in *School Board v. Arline*.[83] In *Arline,* a school board fired a teacher after she contracted tuberculosis. The Court noted that physical conditions that impair "major life activities" are handicaps under section 504.[84] Tuberculosis, the Court reasoned, impaired major life activities such as movement and work.[85] Permitting discrimination based on uninformed opinions as to the contagiousness of a handicap would circumvent section 504's goal of eliminating unfair denial of jobs or other benefits due to prejudice.[86] The Court also recognized the analogy

plaintiff also sued under section 504, the California constitution's right of privacy, California's antidiscrimination statute, and other sections of the state code.

78. *Id.* Other avenues of action include medical administrative bodies—hospital grievance committees or state medical boards. However, in a case arising in Whatcom County, Washington, concerning a substance abuse clinic that covertly tested a patient, the medical board refused to take action. Telephone interview with Julya Hampton, *supra* note 64.

79. *See* ACLU DOCKET, *supra* note 77, at 34.

80. WASH. REV. CODE § 49.60 (1987).

81. *See, e.g.,* Hollingsworth v. Washington Mut. Sav. Bank, 37 Wash. App. 386, 390, 681 P.2d 845, 848 (1984). In *Hollingsworth,* a Washington court sought such guidance in federal interpretation of the Civil Rights Act of 1964, 42 U.S.C. § 2000e-h. The federal Rehabilitation Act was amended in 1978 to incorporate the remedies, procedures, and rights of the Civil Rights Act. Consolidated Rail Corp. v. Darrone, 465 U.S. 624, 626 (1984). Both federal laws are closely linked; the Washington Supreme Court, in Holland v. Boeing Co., 90 Wash. 2d 384, 390, 583 P.2d 621, 624 (1978), noted that federal understanding of handicap discrimination paralleled Washington State's. Therefore, federal interpretation of handicap law under the Rehabilitation Act should guide Washington courts.

82. The Rehabilitation Act of 1973, § 504, 29 U.S.C. § 794 (1987).

83. 107 S. Ct. 1123 (1987) (Rehnquist, J., dissenting).

84. *Id.* at 1126.

85. *Id.* at 1127.

86. *Id.* at 1129.

between AIDS and tuberculosis. The Court implied that AIDS was a protected handicap by noting that discrimination against HIV positive persons, who have no debilitating AIDS symptoms, presented a separate issue the Court declined to address.[87]

The Supreme Court's intimation that AIDS might be a protected handicap under the 1973 Act was confirmed by a federal appellate court in *Chalk v. United States District Court*.[88] Chalk, a public school teacher, was fired after his employer learned he had AIDS. Chalk sued in federal court seeking an order under section 504 returning him to the classroom.[89] The trial court judge refused to issue the order, declaring he could not be sure that Chalk posed no threat of contagion to children.[90] On review, however, the appellate court found the evidence "overwhelming" that the risk of AIDS transmission in a classroom's casual contact was insignificant, and directed the trial judge to issue the order.[91]

No reported federal decision has required a doctor to treat an AIDS patient; various authorities believe, however, that the medical risk is too small to justify such discrimination.[92] Refusal-to-treat cases are pending. In *Doe v. Centinela Hospital,*[93] a hospital's drug and alcohol rehabilitation program denied entry to an AIDS patient.[94] As treatment programs involve only casual contact, the *Chalk* court's reason-

87. *Id.* at 1128 n.7. Although the majority thus sidestepped whether contagiousness alone is a handicap, the dissent in *Arline* focused on contagiousness, noting, if somewhat off point to the holding, that evidence of legislative intent to broaden section 504's applicability to mere contagiousness was meager. *Id.* at 1132–34 (Rehnquist, J., dissenting).

88. 832 F.2d 1158 (9th Cir. 1987).

89. Los Angeles Times, Nov. 19, 1987, pt. 1, at 1, col. 2.

90. *Id.*

91. *Chalk,* 832 F.2d at 1158–59.

A Florida AIDS case, Ray v. School Dist., 666 F. Supp. 1524 (M.D. Fla. 1987), also involved a classroom injunction. In *Ray,* a school district refused to enroll three children who had contracted AIDS from pre-1986 blood transfusions. The court cited *Arline* as authority for applicability of section 504 and the appropriateness of an injunction. *Id.* at 1536. The court found that reports from the CDC, American Academy of Pediatrics, American Red Cross, and Surgeon General indicated insufficient infection risk to justify discrimination. *Id.* at 1531. The court did note that for children too young to control bodily fluids, or who were prone to biting and similar behavior, segregation might be justified. The court therefore required monitoring of the childrens' behavior in school. *Id.* at 1536–37.

92. Telephone interviews with William Hamilton, Epidemiologist, King County Dept. of Public Health, and Judith Mentzer, Research Analyst, Washington State AIDS Surveillance Project (Feb. 19, 1988) (notes for both interviews on file with the *Washington Law Review*). At least one doctor feels that no amount of AIDS risk justifies refusal to treat. Telephone interview with Anne Collier, M.D., *supra* note 12.

93. Doe v. Centinela Hospital, No. CV 87 02514 (C.D. Cal. filed May 1987), *reprinted in* ACLU DOCKET, *supra* note 77, at 34.

94. The case is pending.

ing should apply, causing the plaintiff to prevail.[95] The plaintiff also complained that the drug program required an HIV test as a prerequisite for admission.[96] For medical treatment in which HIV status is irrelevant, entry tests should be stricken as discriminatory, even if care is not conditioned on a negative test result. Individuals have good reasons for keeping their status private.

B. Washington's Antidiscrimination Law

Washington's "law against discrimination"[97] prohibits discrimination by employers,[98] insurers, and by providers of public resort, accommodation, or amusement.[99] Chapter 49.60 of the Revised Code of Washington defines discrimination as any denial to protected persons of "full enjoyment" by directly or indirectly treating such persons as not welcome, accepted, or desired.[100] Discrimination is forbidden on the basis of race, creed, color, and any sensory, mental, or physical handicap.[101] In 1988, the legislature amended chapter 49.60 to include HIV positive persons, or those perceived to be HIV positive, as handicapped.[102] Facilities offering medical care are places of accommodation and full enjoyment of services includes the right to purchase services.[103] Thus, medical care discrimination against AIDS patients and HIV positives is prohibited in Washington.[104] Complaints may be

95. In McEnany v. Four Seasons Nursing Center, No. 409241 (D.C. Travis Cty, Tex. filed Dec. 2, 1986), an AIDS patient, denied entry into an Austin, Texas nursing home, sought relief under section 504 and Texas antidiscrimination law. *Chalk's* reasoning would favor this plaintiff; however, the plaintiff died before a hearing was set. Following his death, Austin passed an ordinance prohibiting discrimination against persons with AIDS. *McEnany, reprinted in* ACLU DOCKET, *supra* note 77, at 84.

96. *Doe, reprinted in* ACLU DOCKET, *supra* note 77, at 34.

97. WASH. REV. CODE § 49.60.010 (1987).

98. The law applies to employers of eight or more employees. *Id.* § 49.60.040.

99. Also, the law applies to real property and credit transactions. *Id.* § 49.60.010.

100. *Id.* § 49.60.040.

101. Discrimination is forbidden as well on the basis of age, national origin, sex, or marital status. *Id.* § 49.60.010; *see also* WASH. ADMIN. CODE tit. 162 (1986) (various sections addressing these catagories of discrimination).

102. The 1988 Omnibus AIDS Act § 902(1), 1988 Wash. Legis. Serv. 671 (West). Under section 902(2) insurance entities may discriminate against HIV positive persons on the basis of statistical differences in risk.

Prior to the 1988 amendment, the Human Rights Commission considered AIDS a handicap. Washington State Human Rights Commission, Staff Policy Guidelines, AIDS and Public Accommodation (single page) (copy on file with the *Washington Law Review*). However, the Commission had not clarified the status of HIV positives.

103. WASH. REV. CODE § 49.60.040 (1987).

104. For a list of other states classifying AIDS as a handicap, see AM. DENTAL A. NEWS, *supra* note 17, at 1 (summarizing a National Gay Rights Advocates survey which also found that another five states give informal opinions that AIDS is a handicap). The remaining states did not

filed with the Washington Human Rights Commission under section 49.60.120(4). A private right of action also exists.[105] Remedies under section 49.60.030(2) include damages and reasonable attorney fees. Under section 49.60.250(5), an administrative law judge may order equitable relief in addition to damages for humiliation and suffering.[106]

Washington law does, however, permit refusal of service to persons whose behavior or actions are a risk to property or other persons.[107] This allows a state fact finder latitude to decide that a certain discriminatory act is reasonable.[108] State courts, like federal courts, have not determined what level of risk might justify discrimination in health care provision.

The 1988 Omnibus AIDS Act[109] ("the Act") also extensively amended the public health law governing sexually transmitted diseases.[110] Under section 702 of the 1988 Act no person may undergo HIV testing without consent, except that local health departments must now test all those convicted of sexual, prostitution, and intravenous drug offenses for HIV.[111] Further, police, fire fighters, health care, and other workers at risk of "substantial" occupational exposure to a person's bodily fluids can require testing of that person if the worker is in fact substantially exposed.[112] How well this will work in

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respond, or had not yet determined the issue. Kentucky, however, does not class communicable disease as a handicap. *Id.* at 3.

105. WASH. REV. CODE § 49.60.030(2) (1987).

106. Orders may include injunctions and orders to hire or reinstate, among others. Up to $1000 may be awarded for mental suffering. *Id.* § 49.60.250(5). Supplemental rules and Commission procedure are found in WASH. ADMIN. CODE tit. 162 (1986).

107. WASH. REV. CODE § 49.60.215 (1987). Further, employers can discriminate against AIDS patients who cannot perform the work. *Id.* § 49.60.180(1); *see* Clarke v. Shoreline School Dist., 106 Wash. 2d 102, 720 P.2d 793 (1986) (teacher's blindness was a permissible basis for dismissal because this handicap prevented monitoring students).

108. A power federal judges reserved, for example, in Ray v. School Dist., 666 F. Supp 1524, 1536–37 (M.D. Fla. 1987), by noting that should monitoring of the HIV positive school children reveal biting or other risky behavior, segregation would be warranted.

109. 1988 Wash. Legis. Serv. 662 (West).

110. WASH. REV. CODE § 70.24 (1987). The Washington legislature incorporated in the 1988 Act many recommendations made by the GOVERNOR'S TASK FORCE REPORT, *supra* note 5. The Task Force recognized that ignorance concerning AIDS discouraged health care providers from treating AIDS patients and the adoption of provider training programs were recommended. GOVERNOR'S TASK FORCE REPORT, *supra* note 5, at 57. Such training was provided for in part VI of the 1988 Act. Plans to improve the status of physicians, dentists, and nurses who work with AIDS patients, and increasing financial incentives for treating AIDS patients, are under study.

111. The 1988 Omnibus AIDS Act § 703(1)(a)–(c), 1988 Wash. Legis. Serv. 667–68 (West). Sections 706–707 allow testing of prisoners whose behavior is a possible risk to others. The Task Force recommended mandatory testing only for convicted sex offenders. GOVERNOR'S TASK FORCE REPORT, *supra* note 5, at 214.

112. The 1988 Omnibus AIDS Act § 703(4), 1988 Wash. Legis Serv. 668 (West).

practice is questionable.[113] The 1988 Act forbids disclosure of HIV test results, while allowing several exceptions.[114] There is a private right of action to enforce the Act's provisions.[115]

VI. THE HARM CAUSED BY AIDS DISCRIMINATION IN MEDICAL CARE

A. Referral and Refusal-To-Treat: Reasons for Concern

Discriminatory referrals are undesirable because these referrals "snowball." Physicians who have neither irrational infection fears nor economic motivation may refer AIDS patients to a public hospital simply because everyone else is. Of course, some facilities do develop specialties that justify referral. Nonetheless, AIDS is incurable, and most AIDS care is within the abilities of primary, nonspecialist physicians.[116] Indeed, various authorities recommend keeping AIDS patients in their home community because this lessens patient stress and facilitates friends' and family's offering of emotional support.[117]

Needless referral of AIDS patients also dangerously burdens public hospitals. The Washington Governor's AIDS Task Force noted with concern the health care worker "burnout" prevalent at AIDS centers.[118] A few workers should not have to bear this burden alone,[119] nor will such a system succeed as the AIDS epidemic grows.

113. If permission for the test is refused, an officer of the health department may petition in superior court for a hearing. Emergency room patients, however, whose care may involve blood exposure and who are often from groups at risk for AIDS, may leave the hospital before any hearing could occur. The only way an HIV test could be performed then is if a blood sample were saved. The legality of saving a blood draw for this purpose is unclear.

114. 1988 Omnibus AIDS Act § 904(1)–(4), 1988 Wash. Legis. Serv. 672–73 (West). This section prohibits disclosure of test results except to the subject and to health officers and workers. Under § 904(2)(g) past or present sexual partners of persons testing positve may also be informed.

115. *Id.* § 914. For negligent violation a plaintiff may recover the greater of $1000 or actual damages, and for intentional or reckless violation the minimum amount is $2000. *Id.* § 914(1). Relief also includes recovery of attorney fees, costs, and injunction. *Id.*

116. GOVERNOR'S TASK FORCE REPORT, *supra* note 5, at 57. However, the report also noted that the therapy of AIDS patients is complicated owing to 730 opportunistic infections, some requiring special equipment at the hospital. *Id.* at 60.

117. *Id.* at 39; *see also* Staver, *supra* note 23, at 27.

118. GOVERNOR'S TASK FORCE REPORT, *supra* note 5, at 37. Seventy percent of King County, Washington, AIDS patients are cared for in three hospitals. *Id.* Staff burnout which results in turnover costs an institution money. Further, if AIDS is undercompensated by Medicare, patient concentration is an additional burden.

119. Zuger, *supra* note 38, at 19 (describing the burden on others when staff evade AIDS patients).

B. Referral and Refusal-To-Treat: Possible Justifications

Doctors and nurses have noted the possibility that contagion fears, or dislike of the AIDS patient due to homosexuality or drug addiction, may be strong enough to affect the quality of care afforded the patient.[120] Malpractice may result when doctors treat patients they dislike.[121] Thus, if providers know that they will place an AIDS patient at risk, referral is necessary. Nonetheless, courts or agencies reviewing an AIDS complaint labeled as a necessary referral should scrutinize the claim carefully. Unchecked, providers could use a "necessary referral" defense to justify all discrimination and thus vitiate important law. The best solution when faced with invocation of this defense would be ordering the provider to undergo educative counseling to avoid repeat occurrences.[122] Placing all discrimination within reach of the law discourages it and indicates society's unwillingness to accept a discriminatory status quo.

Another common motivation for referral is economic. For example, some nursing homes fear that accepting AIDS patients will drive out other patients or staff.[123] Courts should not excuse discrimination to save someone money. Further, if all nursing homes obey the law none will be at a competitive disadvantage. Some nursing homes also fear patient lawsuits if they accept AIDS patients.[124] This fear is unwarranted. As nursing home residents have only casual contact with each other, considering both the CDC evidence and the *Chalk*[125] case, patient suits should be dismissed summarily.

Hospitals which take only paying patients exclude many AIDS patients because they cannot pay.[126] Whether this should be consid-

120. Interview with Jan Hillson, M.D., Senior Fellow, University of Washington Hospital, Seattle, Washington (Feb. 10, 1988) (notes on file with the *Washington Law Review*).

121. A Washington physician treating a member of a minority group apparently ignored signs of severe illness due to a prejudiced attitude, which may have led to the patient's death. *Id.*

122. Such an order is theoretically available under WASH. REV. CODE § 49.60.250(5) (1987), which provides that "administrative law judges may order . . . affirmative action" including any action "as . . . will effectuate the purposes of this chapter." Counseling has proved effective with recalcitrant health care staff. Telephone interview with Jean Nahan, Infection Control Practitioner, Group Health Cooperative, Seattle, Washington (Dec. 17, 1987) (notes on file with the *Washington Law Review*).

123. GOVERNOR'S TASK FORCE REPORT, *supra* note 5, at 59. Some clinics treating AIDS patients place informational materials where they will not be seen by people in the waiting room. Telephone interview with James McGough, Ph.D., *supra* note 13.

124. Telephone interview with Virginia Raymond, Esq., plaintiff's attorney in McEnany v.. Four Seasons, No. 409241 (D.C. Travis County, Tex. filed Dec. 2, 1986), *supra* note 95 (Feb. 17, 1988) (notes on file with the *Washington Law Review*).

125. Chalk v. United States Dist. Court, 832 F.2d 1158 (9th Cir. 1987).

126. For example, the University of Washington Hospital refers AIDS dental patients who are unable to pay. Telephone interview with Stephen Milam, Washington Attorney General's

ered illegal discrimination is unclear. Hospital care for AIDS patients is costly.[127] AIDS patients are often uninsured due to unemployment, or have inadequate insurance.[128] Thus, many patients' finances are exhausted.[129] It is the role of public hospitals to take indigent patients, but the dangers of AIDS patient concentration[130] warrant a different approach.[131]

C. *Discriminatory Testing: Reasons for Concern*

Covertly tested patients may eventually learn of HIV test results, often without counseling. In one case, a patient did not learn of his test until he saw his hospital bill.[132] In another case, a blood buying business tested an individual covertly and announced the positive test result without warning in a room full of people.[133] Both CDC guidelines and common decency clearly require that counseling should accompany testing.[134] Increased risks of depression or suicide are associated with AIDS.[135] Without supportive counseling of a person testing positive, these risks may increase. Further, a person learning of a test result without counseling is not encouraged to engage in responsible sexual practices.[136] Finally, the poor access control to

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Office, Seattle, Washington (Dec. 31, 1987) (notes on file with the *Washington Law Review*); telephone interview with Mark Busto, *supra* note 70.

127. Health measures for preventing AIDS may be evaluated in terms of potential dollars saved. In 1987, $45,000 was the average cost of care for an adult with AIDS each year. GOVERNOR'S TASK FORCE REPORT, *supra* note 5, at 125. It is predicted that Washington AIDS cases will cost between $143 and $238 million by 1991. *Id.* at 1.

128. *See supra* note 33 and accompanying text.

129. While Medicaid helps some of these people, the Task Force reported "[o]f the cases studied from diagnosis to death, thirty-five percent were Medicaid recipients and twenty-four percent had no payment mechanism at all." GOVERNOR'S TASK FORCE REPORT, *supra* note 5, at 42. Further, hospitals believe the current system for Medicaid reimbursement does not pay the real costs of AIDS care and thus perceive an economic disincentive for accepting AIDS patients. *Id.* at 43.

130. *See supra* text accompanying notes 118–19.

131. For example, the state could fund health care for AIDS patients with a voucher system. The Task Force suggested increasing the incentives for AIDS care in various ways. Governor's Task Force Report, *supra* note 5, at 43–44.

132. Telephone interview with James McGough, Ph.D., *supra* note 13.

133. As blood buying is not medical care, the King County Medical Society had no jurisdiction. Telephone interview with Maurice Skeith, M.D., *supra* note 64.

Medical procedures exceeding consent are battery. *See, e.g.*, In re Colyer, 99 Wash. 2d 114, 660 P.2d 738 (1983), *rev'd on different grounds*, 102 Wash. 2d 810, 689 P.2d 1372 (1984). Presumably, this would include an HIV test.

134. CDC, *supra* note 10, at 15S; GOVERNOR'S TASK FORCE REPORT, *supra* note 5, at 77 (counseling beneficial for educational, emotional, behavioral, medical, and public health reasons).

135. Pankau, *supra* note 55, at 12; *see also* Faulstich, supra note 8, at 553.

136. GOVERNOR'S TASK FORCE REPORT, *supra* note 5, at 77.

medical records or intentional, unauthorized release of test results[137] increases the potential harm of covert testing and discourages participation in AIDS testing and prevention generally.[138]

D. Discriminatory Testing: Possible Justifications

Some have argued that the broad consent for "necessary tests" signed by patients at admission encompasses an HIV test.[139] This claim of consent is artificial. Express HIV test consent is not obtained either because the patient refused to give it or the patient was not asked.[140] A parallel consent problem exists with medical records release. Records have been released under authority of broad waivers required by some insurers and employers. The validity of these waivers has not been litigated with clear result.[141]

Some states permit mandatory HIV testing under warrant.[142] Washington law now permits health and emergency personnel substantially exposed to a person's bodily fluids to require that the person be tested.[143] The number of instances in which these patients refuse to be tested is generally limited.[144] The worker has the option of assum-

137. *See supra* note 53. One Washington doctor released test results to a welfare agency, incorrectly assuming that this would help his patient's claim to benefits. Telephone interview with Maurice Skeith, M.D., *supra* note 64.

138. GOVERNOR'S TASK FORCE REPORT, *supra* note 5, at 93. Awareness of HIV infection does not necessarily lead to changed behavior (such as practicing safe sex) among members of groups at risk. This is not true of non-at risk patients contracting AIDS, for example, through blood transfusions. CDC, *Recommended Additional Guidelines for HIV Antibody Counseling and Testing in the Prevention of HIV Infection and AIDS,* MORBIDITY & MORTALITY WEEKLY REP., April 30, 1987, Appendix III, at 1. Possibly, individuals practicing behaviors disapproved of by society feel less responsibility to that society. Covert testing and failure to counsel seems likely to contribute to alienation and unconcern for spread of infection.

139. *See* informal discussions with Seattle area physicians, *supra* note 37 and accompanying text.

140. *Id.*

141. Gellman, *Divided Loyalties: A Physician's Responsibilities in an Information Age,* 23 SOC. SCI. MED. 817, 819 (1986).

142. Florida courts issue such warrants. *See* Pankau, *supra* note 55, at 13. In California, a state court held that a test performed without consent on a gay rights demonstrator who bit a police officer was an illegal search and seizure. The court held the test was unjustified because by the time it was performed the officer involved would likely have seroconverted and a test on the officer would have been sufficient. Barlow v. Superior Court, 190 Cal. App. 3d 1652, 236 Cal. Rptr. 134 (1987) (opinion withdrawn from official reporter May, 26 1987).

143. The 1988 Omnibus AIDS Act § 703(4), 1988 Wash. Legis. Serv. 668 (West); *see supra* notes 111–12 and accompanying text.

144. Informal discussion with Seattle area doctors, *supra* note 37; *see also,* GOVERNOR'S TASK FORCE REPORT, *supra* note 5, at 86. The Task Force recognized a possible constitutional problem with forced testing and voted fourteen to six to recommend tests as opposed to making tests mandatory. *Id.* at 215. At Group Health, a large Washington health maintenance organization, no patient has refused consent. Group Health policy requires written consent for

ing the patient is HIV positive.[145] This alternative arguably leaves a court with no overriding concern justifying the invasion of an unwanted test, especially as a negative test result does not mean the worker is necessarily safe.[146]

Those performing covert tests may argue that the tests do not support a battery cause of action because the tests are done in self-defense. Self-defense is defined as reasonable force used against an intentionally aggressive or negligent actor to prevent impending injury to oneself or other persons.[147] Because AIDS is incurable, a covert test cannot prevent injury to the health care worker,[148] although the results might be used to protect the sexual partners of the health care worker. A claim of self-defense nonetheless fails for two reasons. First, the patient being tested is not an intentional aggressor nor negligent: the exposure to the patient's bodily fluids is accidental, if not caused by the carelessness of the health care worker. Second, the risk of contagion is so slight that imminent injury is not threatened. Hospitals or health care workers performing covert tests thus cannot argue self-defense successfully.

VII. THE EFFECTIVENESS OF CURRENT ANTIDISCRIMINATION LAW

AIDS patients suffering discrimination generally do not avail themselves of the law. In eighteen of twenty reported instances of discrimination in a Washington survey of social agencies, neither legal nor regulatory investigation took place.[149] AIDS patients may not seek redress out of a desire to avoid spending their remaining time in legal

testing. Telephone interview with Jean Nahan, *supra* note 122. However, the Group Health admission consent permits testing if a health worker is exposed to a patient's blood.

145. This view is espoused by some Washington doctors. Telephone interview with Anne Collier, M.D., *supra* note 12; telephone interview with James McGough, Ph.D., *supra* note 13.

However, if health workers become less aggressive in providing emergency procedures such as mouth to mouth resuscitation, or avoid emergency duty for fear of uncertainty regarding HIV status of patients, this view should be reevaluated.

146. *See supra* text accompanying note 18.

147. RESTATEMENT (SECOND) OF TORTS §§ 63, 64, 76 (1965) (the *Restatement* expresses no opinion on self-defense against actors whose threat is posed innocently).

148. Emergency room personnel, who deal repeatedly with certain patients, may argue that learning the patient's HIV status allows medical staff to take heightened precautions in the future. However, as the CDC recommends full precautions with all patients, this argument is unavailing. *See supra* text accompanying notes 16–18.

149. Washington Dept. of Social and Health Services, Washington State AIDS-Related Discrimination (an informal survey taken in Aug. 1987 for the Assoc. of State and Territorial Health Officials) (on file with the *Washington Law Review*); telephone interview with Deenie M.T. Dudley, *supra* note 5.

battle.[150] The relative dearth of AIDS discrimination cases is also due to the slowness of judicial remedy. Defendants may stall in various ways. For example, they may argue that the plaintiff must exhaust administrative remedies under the Rehabilitation Act of 1973.[151] Further, AIDS patients need to avoid stress.[152] Litigation might worsen a patient's condition. Finally, seeking judicial redress for discrimination can be self-defeating because the public exposure may lead to added discrimination.[153] HIV positives will also be leery of publicly announcing their status in court, perhaps more so than AIDS patients whose illness may have already compromised their privacy.

Filing complaints with the state and federal antidiscrimination offices is more private than court actions and correspondingly more popular.[154] The Washington Commission takes informal unpublicized actions on complaints.[155] Some AIDS patients feel guilt over their condition and may not pursue persons discriminating against them.[156] Further, informal Commission actions have significant limitations. Damages may be small or nonexistent. The process may drag on with no adverse publicity accruing to the malefactors.[157] Thus, the effect on other providers pursuing similar discriminatory practices is diminished.

Because victims of AIDS discrimination are reluctant to pursue violations, the law's role of making clear what practices are unaccept-

150. Some attorneys report initiating litigation but then being forced to drop it when the client dies. Telephone interview with Julya Hampton, *supra* note 64.

151. 29 U.S.C. § 794 (1987). In at least one AIDS case, Shuttleworth v. Broward County, 639 F. Supp 654, 657–58 (S.D. Fla. 1986), the exhaustion tactic failed. *Shuttleworth* concerned a county office worker who, fired due to AIDS, brought suit under section 504. The county argued that the plaintiff had not exhausted state administrative remedies. However, exhaustion, the court held, even if required by section 504, was excused in this case due to the plaintiff's physical condition. *Id.* at 658. Washington courts should adopt this approach as well.

152. *See supra* text accompanying note 117.

153. The Washington ACLU has received telephone inquiries about discrimination in which the caller will not even reveal his or her name. Telephone interview with Julya Hampton, *supra* note 64.

154. Only a few Washington AIDS discrimination cases have been filed with the Human Rights Commission. However, the Commission has received many complaints. Telephone interview with Deenie M.T. Dudley, *supra* note 5.

155. The office will not discuss details of settlements or names of parties. *Id.*

156. Guilt over the lifestyle which led to the disease has been noted generally. *See* Faulstich, *supra* note 8, at 553.

157. Pursuant to settlement agreements or ongoing investigation, the office will not reveal names of parties. Telephone interview with Deenie M.T. Dudley, *supra* note 5. However, private litigation has also been settled in a similarly silent way. Telephone interview with Jack Jones, *supra* note 68.

able[158] may be as important as specifying penalties and procedure. Antidiscrimination law should therefore clearly condemn and prohibit referral and refusal-to-treat discrimination.

VIII. RECOMMENDATIONS FOR STATUTORY CHANGES

By banning AIDS discrimination in employment, housing, public accommodations, and provision of public services, the 1988 Act[159] begins the process of demonstrating social, humanitarian support for AIDS patients and discouraging discriminatory behavior. In showing this support, the law encourages individuals to modify their behavior upon learning of their infected status. Unfortunately, the Act expands HIV testing past the realm of consent and does so without offering sufficient strengthening of confidentiality protections. The following recommendations address these and other weaknesses remaining in Washington AIDS law.

Recommendation 1. *Health care providers shall not discriminate against AIDS or HIV positive patients, either by refusal to treat or by unnecessary referral.* Washington should expressly prohibit medical care discrimination against AIDS and HIV positive patients. The current language concerning public accommodation is vague and insufficient.[160] Further, the discriminatory practice of unnecessary referral requires express prohibition. This would help prevent provider burnout,[161] spread the costs of AIDS care more equitably,[162] and keep AIDS patients in their communities where a supportive and less stressful environment exists.[163]

Recommendation 2. *Procedures shall be implemented to assure HIV test results do not become part of a patient's routine medical record.* The 1988 Act allows exposed health care workers to force HIV tests on patients.[164] Simply assuming the patient is infected is a generally sounder practice than state ordered intrusive testing.[165] Further, the Act fails to implement sufficient safeguards for this extraordinary step. The Act prohibits release of HIV test data except to proper authori-

158. Hospital and medical staff are kept abreast of law affecting their practice by their counsel. Telephone interview with Anne Collier, M.D., *supra* note 12.

159. 1988 Wash. Legis. Serv. 662 (West).

160. For example, a surgeon associated with a hospital, or a solo practitioner, might not consider him or herself as offering public accommodation.

161. *See supra* text accompanying notes 118–19.

162. *Id.; supra* text accompanying notes 127–31.

163. *See supra* text accompanying note 117.

164. The 1988 Omnibus AIDS Act § 703(4), 1988 Wash. Legis. Serv. 668 (West).

165. *See supra* text accompanying note 145.

ties. Access control to medical records is nonetheless problematic.[166] Leaks will occur. Although the Act prohibits discrimination based on HIV test results, a judicial remedy for AIDS patients is often ineffective.[167] Proper controls might include, for example, keeping results in separate controlled-access files and destroying them once the necessary parties are informed.[168] To maintain accountability, a specific individual at the hospital could oversee safeguard procedures.

Recommendation 3. *Remedies: a) AIDS plaintiffs bringing actions under chapter 49.60 or chapter 70.24 of the Revised Code of Washington need not exhaust administrative remedies. b) A court may order educational counseling of persons or institutions found guilty of violations of either chapter, in addition to any damages assessed.* Express exception to the doctrine of administrative exhaustion protects AIDS patients from the harmful stress of protracted litigation and recognizes an AIDS patient's need for a speedy verdict.[169] While injunctive relief is available under chapter 49.60, expressly indicating that health care workers refusing or referring AIDS patients may be ordered to undergo educational counseling[170] increases the likelihood of judicial use.

IX. CONCLUSION

The AIDS epidemic will be with us into the indefinite future. Medical professionals must learn to face this disease. With the privileges of the medical profession come responsibilities. In times of a public health emergency, society has no choice but to turn to its health care providers. The CDC has determined that the risk of occupational HIV infection in the health care setting is very small. Medical ethics require that this small risk be faced. Society needs and has the right to expect a high standard of duty from this profession.

Federal and Washington antidiscrimination law already requires health care providers to treat AIDS patients fully and equally. Unfortunately, providers may not view disguised refusals to treat or poor testing procedures as discrimination. By expressly prohibiting these

166. *See supra* note 53.

167. *See supra* text accompanying notes 149–57.

168. In the case of emergency personnel who have been exposed to several peoples' blood, it is unnecessary to inform the worker which blood was HIV positive.

169. *See supra* text accompanying note 117.

170. *See also supra* note 122 and accompanying text.

practices, offending health care providers are clearly told that their acts are unacceptable.

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