Mandatory AIDS Testing for Persons with a Developmental Disability in Residential Facilities

H. Rutherford Turnbull, III,* Alison Paul,** and Jan B. Sheldon***

I. Introduction

This Article argues for limited mandatory Acquired Immunodeficiency Syndrome (AIDS) testing of persons with developmental disabilities. Such testing is appropriate for those who reside in congregate living settings with other persons with developmental disabilities and who manifest medical conditions that give probable cause to believe that the person may have one or more of the AIDS conditions, and who emit behaviors that are likely to transmit AIDS to others in the setting. Medical conditions that manifest the possibility of AIDS infection include night sweats, loss of appetite, fever, weight loss, skin rashes, and lack of resistance to infection, or the development of a disease associated with HIV infection such as Kaposi's sarcoma or a persistent case of pneumonia.\(^1\) Behaviors likely to transmit the AIDS virus include sharing intravenous needles, biting, clawing, digging, scratching, and engaging in some forms of sexual behavior.\(^2\)

This Article advocates due process safeguards, so that any person who meets these criteria will not be tested compulsorily without a prior opportunity for a judicial or quasi-judicial hearing on the legal and factual proprieties of the mandatory testing.

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* Co-Director, Beach Center on Families and Disability, University of Kansas. B.A. 1959, Johns Hopkins; LL.B. 1964, University of Maryland; LL.M. 1969, Harvard University. Funding for the work on this Article was provided to the Beach Center on Families and Disability at the University of Kansas by the National Institute on Disability and Rehabilitation Research, U.S. Department of Education, Office of Special Education and Rehabilitative Services, Grant #H133B80046.


*** Associate Professor, Department of Human Development and Family Life and School of Law, University of Kansas. B.A. 1970, M.A. 1974, Ph.D. 1974, J.D. 1977, University of Kansas.


2. See infra notes 32-49 and accompanying text.
The goal is to offer a legally principled approach that serves the interests of people with developmental disabilities, their providers, and the public. By proposing limited mandatory testing, however, there is a risk of appearing to argue for differential treatment of people with developmental disabilities. To the contrary, by identifying the multiple interests served by the mandatory testing of carefully identified people, this approach advances the interests of people with developmental disabilities, their providers, and the public.

The important confidentiality concerns that accompany any AIDS testing policy are not addressed here. Similarly, the issues relating to fourteenth amendment equal protection guarantees and the possibility that special targeting of individuals with developmental disabilities for mandatory AIDS testing implicates equal protection issues are not addressed.

At the outset, a few words are warranted in light of the thrust of the argument and the politically charged atmosphere in which legal issues and AIDS have been discussed. First, one may assume that this approach to mandatory AIDS testing of only certain individuals singles out AIDS as a disease that warrants special treatment and that, by focusing only on AIDS, we subscribe to those connotations. These connotations are that AIDS and the individuals who are more affected by it than others—namely, the high-risk populations consisting of those individuals who engage in unprotected sexual activity, especially homosexual or bisexual activity; promiscuous sexual activity with prostitutes or other individuals who are more likely to catch the AIDS virus than others;

3. Confidentiality concerns are discussed in Rennert, AIDS/HIV and Confidentiality: Model Policy and Procedures, infra.


5. "Surely no physical problem has created greater public fear and misapprehension than AIDS. That fear includes a perception that a person with AIDS is substantially impaired in his ability to interact with others . . .." Doe v. Dolton Elementary School Dist. No. 148, 694 F. Supp. 440, 444 (N.D. Ill. 1988); see also West, Public Opinion, Public Policy, and HIV Infection, 27 MENTAL RETARDATION 245 (1989) (article develops a four-stage framework for analyzing the development of the interaction between public opinion, public policy, and HIV infection).
or needle sharing during injections of drugs—should be subjected to special rules of law restricting their rights to a greater degree than would be legally permissible if they were not members of high-risk populations.

We are indeed sensitive to and reject those connotations. This Article's purpose is not to create rights-restricting justifications. Instead, its purpose is to advance the established rights of treatment that the individuals with a developmental disability already have and that cannot be implemented without narrowly tailored mandatory AIDS testing. This targeted population is not typically regarded as high-risk and thus it generally has not been included in the legal and political arguments about mandatory AIDS testing. Persons with developmental disabilities deserve more thought than they have received in the AIDS-testing debate, in part because they have not been the focus of any extended discussion about mandatory AIDS testing and in part because they are by definition especially vulnerable.

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6. See infra notes 32-49 and accompanying text.


One might also assume, because the Article does not propose mandatory testing until medical manifestations appear even though a person may be contagious in the absence of such manifestations, that the proposal does not go far enough. That may well be so. Indeed, some readers of drafts of this Article noted that requiring AIDS testing before a person manifests medical symptoms may be justifiable. This Article is reluctant to extend its argument that far at this time because even this more limited argument will, for the reasons suggested above, be controversial and possibly rejected out of hand for political reasons. If, on the other hand, the argument has merit for those individuals with a developmental disability who have medical manifestations of AIDS, then it may also have merit for those with a developmental disability who do not have those manifestations. Indeed, it may have merit for those who are prone to diseases other than AIDS for which mandatory testing also may be efficacious and legally warranted.

II. AIDS: PREVALENCE, NATURE, TRANSMISSION, AND TESTING

A. AIDS and the Nondisabled Population

1. Prevalence

In 1988, the Centers for Disease Control (CDC) estimated that 1.0 to 1.5 million people were infected with the human immunodeficiency virus (HIV).\(^9\) As of December 31, 1988, 82,764 cases of AIDS had been reported to the CDC.\(^12\) In 1989 state and territorial health departments reported 35,238 additional AIDS

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9. "The incubation period for the disease—the time between the initial infection by the virus and the onset of AIDS... [can be] up to seven years, with the average being four and a half." Green, The Transmission of AIDS, in AIDS & THE LAW: A GUIDE FOR THE PUBLIC 28, 30 (Yale AIDS Law Project 1987) (footnote omitted); see also Public Health Service Guidelines for Counseling and Antibody Testing to Prevent HIV Infection and AIDS, 36 Morbidity & Mortality Weekly Rep. 509, 509 (1987).

10. Hepatitis B is such a disease. It is more prevalent than AIDS and equally devastating in its effects on the individual and equally transmittable within this population. See Kohl v. Woodhaven Learning Center, 865 F.2d 930, 933-34, 937 (8th Cir. 1989) ("A single exposure to hepatitis B contaminated blood on a mucous membrane or small break in the skin results in a 10-15 percent chance of infection, as compared with a less than 1 percent chance of infection of AIDS for the same exposure.").


cases to the CDC.\textsuperscript{13} Within the population of persons with a 
developmental disability served by state agencies, forty-five persons 
had evidenced a positive response to antibody testing as of 1987.\textsuperscript{14} 
This number is probably a minimal estimate because it comes from 
a voluntary survey of states, none of which had systematic screening 
procedures for their adult populations. Additionally, the reporting 
structure between state agencies and community service providers is unreliable, and additional adult carriers may have been known to the agencies and not reported.\textsuperscript{15}

2. Nature

The disease manifests itself in three basic ways.\textsuperscript{16} Some people 
are seropositive,\textsuperscript{17} remaining basically asymptomatic, but still able 
to transmit the disease.\textsuperscript{18} Others develop AIDS related complex (ARC),\textsuperscript{19} testing positive for AIDS and evidencing a specific set of clinical symptoms, but not yet meeting the epidemiologic definition of AIDS.\textsuperscript{20} Symptoms of ARC include night sweats, loss of appetite, fever, weight loss, skin rashes, and lack of resistance to infection.\textsuperscript{21} Finally, some have full-blown AIDS. These are people in whom the body's immune system has been destroyed, allowing otherwise controllable infections to invade the body and cause additional diseases.\textsuperscript{22} Pneumonia is the most commonly diagnosed

\textsuperscript{14} Marchetti, Nathanson, Kastner & Owens, AIDS and State Developmental Disability Agencies: A National Survey, 60 Am. J. Pub. Health 54, 55 (1990) [hereinafter National Survey]. The statistical data on the prevalence of HIV infection in the developmentally disabled population was compiled in a survey of state agencies serving persons with developmentally disabilities conducted in October of 1987. Forty-four states responded to the survey and 45 adult carriers were reported from 11 of these states. Kastner, Nathanson, Marchetti and Fincus, HIV Infection and Developmental Services for Adults, 27 Mental Retardation 229, 229 (1989) [hereinafter HIV and Developmental Services].
\textsuperscript{15} HIV and Developmental Services, supra note 14, at 229-30 (1989).
\textsuperscript{17} Green, supra note 9, at 29 nn.13 & 14; see also Surgeon General's Report, supra note 1, at 11.
\textsuperscript{18} Surgeon General's Report, supra note 1, at 11.
\textsuperscript{19} Id.
\textsuperscript{20} Id.
\textsuperscript{21} Id.
\textsuperscript{22} Id.
life-threatening disease in AIDS patients. At this level the tumors or infections are secondary to the immunodeficiency.

Not everyone who is seropositive or exhibits ARC will develop AIDS. Of the estimated 1.5 million people with HIV infection, between 100,000 and 200,000 will develop ARC. Twenty to thirty percent of those infected with the virus will develop an illness that fits the epidemiologic definition of AIDS within five years of infection.

There is currently no cure for AIDS and no vaccine for HIV infection. Absent therapy, persons who develop AIDS will die within a few years. Those who develop ARC or AIDS can be treated with zidovudine (AZT), which can extend their lives. The importance of early detection and treatment is only beginning to be recognized with the development of new experimental procedures for retarding the progression of the disease. Against this epidemiological backdrop, detecting the AIDS virus early is important so that appropriate treatment and education may be offered to slow its progression and reduce the risk of transmission by an unknowing carrier.

3. Transmission

The transmission of the AIDS virus occurs when an infected person’s bodily fluids, mainly blood or semen, enter the bloodstream of another person. The disease cannot be spread by casual contact. Although the AIDS virus has been found in tears and saliva, no known instance of transmission of the disease from

24. Green, supra note 9, at 30 n.18.
26. Id.
27. Id.
29. Id.
30. Id. Besides AZT, drug companies are testing approximately 100 other drugs to combat AIDS or related infections. Adler, Early Care Prolonging Lives of AIDS Patients, The Kansas City Star, Feb. 18, 1990, at 14A, col. 5.
31. Adler, supra note 30, at 14, col. 3.
33. Surgeon General’s Report, supra note 1, at 13. “There is no evidence that HIV can be contracted by touching, social kissing, shaking hands, breathing the same air, working in the same office, [or] being served food...” AIDS Health Crisis, supra note 32, at 34.
these bodily fluids has been reported. Provided that at-risk activities do not occur, sharing a household with an HIV infected person will not lead to the contraction of AIDS.

HIV is transmitted most often through sexual contact. The highest risk sexual practice for transmission is unprotected receptive anal intercourse. Oral-anal contact, oral-genital intercourse, and deep kissing are other sexual practices that can transmit the disease. HIV infection also can be transmitted during unprotected vaginal intercourse. The CDC states: "In general, a person's risk of acquiring HIV infection through sexual contact depends on 1) the number of different partners, 2) the likelihood (prevalence) of HIV infection in these partners, and 3) the probability of virus transmission during sexual contact with an infected partner." In addition, virus transmissions may be affected by "biological factors," such as concurrent sexually transmitted disease (STD) infections; "behavioral factors," such as type of sex activity practiced; or the level of infectivity in the partner carrying the disease.

Although HIV infection has affected the United States homosexual population most significantly, its incidence in the heterosexual population is rising. Among heterosexuals, HIV infection is most likely to occur when the person's partner is, or has had contact with, a member of a high risk group, such as bisexual males, prostitutes, or intravenous drug users.

The second major method of HIV transmission is through inoculation with HIV infected blood. Most commonly, this involves the sharing of needles among intravenous drug users. In this context, HIV transmission occurs when drug users share a

34. AIDS Health Crisis, supra note 32, at 33.
35. Id. at 34.
36. Id. at 20; Rosencrantz & Levy, supra note 23, at 95.
37. AIDS Health Crisis, supra note 32, at 21-22.
38. Id. at 22-24. Although most epidemiological studies have failed to show a strong consistent association between HIV transmission and oral-genital intercourse and deep kissing, these are still considered risk behaviors. Id.
39. Id. at 29-30. In the United States, vaginal intercourse is not yet as prevalent a method of HIV infection transmission as it is worldwide. See AIDS: Testing and Privacy, supra note 8, at 24-25.
41. Id. The CDC concludes that the risk of sexual transmission of HIV infection is the highest for a regular partner of an HIV infected person. Id.
42. AIDS Health Crisis, supra note 32, at 28; see also AIDS: Testing & Privacy, supra note 8, at 24-25.
44. AIDS Health Crisis, supra note 32, at 25.
needle and inject themselves with blood traces from an HIV carrier who previously used the needle.\textsuperscript{43} Persons exposed to HIV infected blood in the process of receiving a transfusion are also at risk.\textsuperscript{46} Since the initiation of blood screening of blood donors in 1985, however, this mode of transmission has decreased significantly.\textsuperscript{47} Finally, an HIV infected mother can give birth to an infant infected with the virus.\textsuperscript{48} Maternal-fetal transmission occurs in approximately 40\% of infants born to infected mothers.\textsuperscript{49}

\textbf{B. AIDS and People with Developmental Disabilities}

Persons with developmental disabilities who live in congregate settings, as well as the professionals who serve them, soon will begin to experience the impact of the AIDS crisis.\textsuperscript{50} A recent survey of state developmental disability agencies revealed that of the forty-four states responding, only twenty-one had policies specifically related to AIDS.\textsuperscript{51} Six of the states with known cases of AIDS in their developmentally disabled population have no such policies in place.\textsuperscript{52}

Not only will the number of AIDS cases in this population increase, but so will the number of lawsuits attempting to impose liability on professionals and their employers serving these AIDS patients. As discussed below, professionals serving this population have a responsibility to provide appropriate medical and other care to the person while simultaneously preserving the person's rights and minimizing the risk of contagion to caregivers, other clients, and the public. Liability can attach if the agency or the professionals fail to discharge their duty of care to persons with developmental disabilities and third parties. Agencies serving this population should not be allowed to take a step backward in time simply because they are afraid of liability or lack appropriate policies.\textsuperscript{53} Policies for residential programs are necessary and are

\begin{footnotes}
\begin{enumerate}
\item \textit{Id.} at 19.
\item AIDS: \textsc{The Legal Issues}, supra note 16, at 11.
\item AIDS: \textsc{Testing \& Privacy}, supra note 8, at 25.
\item AIDS Health Crisis, supra note 32, at 19.
\item AIDS: \textsc{Testing \& Privacy}, supra note 8, at 26.
\item National Survey, supra note 14, at 54.
\item Id. at 54.
\item Id. at 55.
\item See Gray, \textit{Opening Comments on the Conference on Developmental Disabilities and HIV Infection, 27 Mental Retardation} 199, 200 (1989) (statement by the former Commissioner on Developmental Disabilities in the U.S. Department of Health and Human Services: "[W]e must plan now for the reality that HIV infection will affect the future service delivery system."); see also Cohen, \textit{HIV Infection in Children: Introductory Re-}
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being developed by the National Association of Protection and Advocacy Systems. These policies include procedures and standards for testing without consent.

Finally, documented community responses to people with AIDS include segregation, denial of medical treatment, refusal of an appropriate education, and a demand for quarantine. These reactions are well-known to persons with developmental disabilities. Thus, it is imperative for agencies not to allow a double disability to emerge out of this fear of AIDS—the disability plus the handicap of societal reaction.

1. Definition of Population

The term "developmental disability" derives from the Developmental Disabilities Assistance and Bill of Rights Act. The term refers to a severe, chronic disability which (1) is attributable to a mental or physical impairment or combination of mental and physical impairments; (2) manifests before the person attains age twenty-two; (3) is likely to continue indefinitely; (4) results in substantial functional limitations in three or more of the following areas of major life activities—self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and (5) reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services of a lifelong or extended duration that are individually planned and coordinated.

The following disabilities are commonly included within the term "developmental disability": autism, cerebral palsy, epilepsy, and mental retardation. For the purposes of this Article, only those

marks, 27 MENTAL RETARDATION 207 (1989) ("The association of HIV infection with developmental disability clearly poses a problem for service providers in the developmental disability and human service systems."); Connelly, The Segregation of an Adolescent in Foster Care Who Is HIV Seropositive and Developmentally Disabled, 27 MENTAL RETARDATION 241, 242 (1989) (article suggests measures to balance all interests involved for a state foster care agency); HIV and Developmental Services, supra note 14, at 229 ("Without preparation, service delivery becomes crisis management, with an unacceptable drop in the availability and quality of services.").

55. Id.
accompanied by cognitive impairment are relevant, namely, autism, cerebral palsy, and mental retardation.

Autism is generally regarded as a physical disorder of the brain and can occur in conjunction with other disabilities, such as mental retardation, blindness, deafness, or epilepsy.\textsuperscript{59} Consensus is that autism is a biological or physical condition manifested by certain atypical behaviors.\textsuperscript{60} Autism usually is characterized by the following symptoms: failure to develop normal social relationships; disturbances in speech, language, and communication; unusual relationships with objects and events; abnormal responses to sensory stimulation; marked resistance to changes in the environment; developmental delays and differences; and onset during infancy or early childhood.\textsuperscript{61}

Cerebral palsy, often called chronic, nonprogressive necrologic injury, is a disorder of muscle control or coordination resulting from injury to the brain during its early stages of development, including development during the fetal, perinatal, or early childhood periods.\textsuperscript{62} Alternatively stated, cerebral palsy refers to any disorder of movement or posture that results from a nonprogressive abnormality of the immature brain.\textsuperscript{63} Some people who have cerebral palsy also have mental retardation, visual defects, and auditory disorders.\textsuperscript{64} An estimated 60% of persons with cerebral palsy have some degree of mental retardation.\textsuperscript{65}

Mental retardation refers to significantly subaverage general intellectual functioning that exists concurrently with deficits in adaptive behavior and is manifested during the developmental period.\textsuperscript{66} As a rule, significant subaverage intellectual functioning is determined by administration of general intelligence tests and is defined as an intelligence quotient (IQ) of approximately seventy or below. Adaptive behavior also is determined by a series of

\textsuperscript{59} W. Berdine & A. Blackhurst, An Introduction to Special Education 455 (2d ed. 1985); Schor, Autism, in Medical Aspects of Developmental Disabilities in Children Birth to Three 13 (J.A. Blackman Rev. 1st ed. 1984).

\textsuperscript{60} See B. Rideland, Infantile Autism 6-17 (1964).

\textsuperscript{61} Assistance to States for Education of Handicapped Children, 34 C.F.R. § 300.5(a)(7) (1990); American Psychiatric Ass'n, Diagnostic and Statistical Manual of Mental Disorders, 87-90 (3d ed. 1984) [hereinafter Diagnostic and Statistical Manual]; Berdine & Blackhurst, supra note 59, at 455.

\textsuperscript{62} Healy, Cerebral Palsy, in Medical Aspects of Developmental Disabilities in Children Birth to Three 31 (J. Blackman Rev. 1st ed. 1984).


\textsuperscript{64} Id. at 199; Healy, supra note 62, at 35.

\textsuperscript{65} Batshaw & Perret, supra note 63, at 199.

\textsuperscript{66} Classification in Mental Retardation 11 (H. Grossman ed. 1983).
examinations and is defined as the degree to which an individual meets the standards of personal independence and social responsibility expected for the person’s age and cultural group. The developmental period is the time between birth and the person’s eighteenth birthday.67

The field of developmental disabilities and mental retardation is ambiguous concerning classification of persons with cognitive impairments. The approach taken in the past by the nation’s oldest interdisciplinary association of professionals in the mental retardation field, the American Association on Mental Retardation (AAMR), represents one view. Under the current AAMR classification system, a person with a cognitive impairment may have mild mental retardation (IQ score between fifty to fifty-five on the low side and seventy to seventy-five on the high side); moderate mental retardation (IQ between thirty-five to forty and fifty to fifty-five); severe mental retardation (IQ of twenty to twenty-five and thirty-five to forty); or profound mental retardation (IQ below twenty to twenty-five).68

Typically, allowances are made for reasonable clinical judgments about the IQ score. Also, administering more than one test before a judgment about IQ is reached is recommended.69 All individuals classified as having mental retardation share the common characteristics of “low intelligence.”70 Yet some who have mild retardation are able to achieve a great deal of self-sufficiency in employment and personal life, and in other ways are independent and relatively indistinguishable from persons not classified as mentally retarded. Those with moderate, severe, or profound mental retardation will be less able to function independently. Depending on the degree of retardation and the efficacy of their education or other training and habilitation, they may be more or less capable in areas of self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency.71

The Association for Persons with Severe Handicaps (TASH) presents another view of classifying persons with cognitive impairments. TASH is a fifteen-year old association of professionals and family members that “addresses the interests of persons with severe handicaps who have traditionally been labeled as severely intellec-

67. Id. at 11.
68. Id. at 13; see also Diagnostic and Statistical Manual, supra note 61, at 39.
69. Classification in Mental Retardation, supra note 66, at 13.
70. Id. at 12.
71. Id. at 14.
tually disabled.' It defines the label as encompassing individuals of all ages

who require extensive ongoing support in more than one major life activity in order to participate in integrated community settings and to enjoy a quality of life that is available to citizens with fewer or no disabilities. Support may be required for life activities such as mobility, communication, self-care, and learning as necessary for independent living, employment, and self-sufficiency.23

TASH’s main focus is clearly on the person’s needs, not on the diagnosis.24 Moreover, it focuses on those intellectual disabilities that “interfere with functioning and that require external advocacy,”25 that “group of individuals who have very limited abilities and who will show serious skill deficits on the tasks that are required by our present society,”26 and on not describing individuals primarily “in terms of expected functional limitations” as inferred from or based (erroneously) on standardized measures of intelligence and adaptive behavior.27

Whatever the relative merits of the traditional or more recent approaches, both recognize that cognitive impairments are real, limit the abilities of people with them to avoid behaviors that are dangerous to themselves or others, and require intervention to improve the cognitive functioning and behavior-conforming capacities of those individuals.

2. Residential Patterns in Population

People with developmental disabilities increasingly reside in community-based settings, although a substantial population still resides in the states’ public residential facilities for people with disabilities. Over the past twenty-five years, the population of the large public institutions has dramatically declined, from an average daily population of 195,000 in 1967 to an average daily population of 87,000 in 1989.28 Alternatively stated, in 1967, 85% of the

73. Id.
74. The traditional perspective of cognitive impairment is diagnosis based. Evans, Testing and Diagnosis, in Critical Issues, supra note 72, at 25.
75. Id. at 26.
76. Id. at 39.
77. Id. at 40.
78. A. Amador, K. Lakin & J. Menke, 1990 Chartbook on Services for People with Developmental Disabilities 28 (1990) [hereinafter Chartbook]. There were precisely 88,112 persons with a developmental disability in large state institutions as of June 30, 1989. Id.
people in residential facilities for people with mental retardation and developmental disabilities were in large state institutions, while in 1988, only 34% were. 79 Similarly, the number of people with a primary diagnosis of mental retardation who are in state and county psychiatric institutions has dramatically decreased, from approximately 37,000 in 1960 to approximately 2,000 in 1988. 80

The decline in the residential population in large institutions has been accompanied by an increase in the population in private, community-based housing of fifteen or fewer residents. The population in those facilities has increased from approximately 40,000 in 1977 to more than 125,000 in 1988. 81

The shifts in residential patterns—from large to small, from institution-based to community-based—are reflected in the federal-state program that certifies residential facilities for federal-state funds. This program, established in 1971 as an amendment to the Social Security Act, is known as the Intermediate Care Facility for the Mentally Retarded (ICF/MR) program and was created under Title XIX of the Social Security Act. 82 The residents of ICF/MR certified facilities represent approximately 54% of all persons with developmental disabilities nationwide who are living in residential facilities specifically licensed, contracted, or operated by states. 83 This population also is increasingly based in community-located, small facilities (fifteen or fewer people). In 1977, only 4.2% of the total 40,400 people in small residential settings were in ICF/MR facilities; in 1982, this had risen to 15.2%; and in 1988, it was 22.1%. 84

There also has been a significant increase in the proportion of ICF/MR residents who live in small ICF/MR facilities (fifteen or fewer residents), from 1.6% in 1977 to 6.9% in 1982 and to 19.8% in 1988. 85

The smaller, community facilities are increasingly serving people with profound mental retardation (the number increased 150%, from about 6,000 in 1982 to approximately 16,000 in 1988). 86 Smaller facilities still are more apt to have mildly handicapped individuals; the larger ones, the more severely handicapped indi-

79. Id.
80. Id.
81. Id.
83. Chartbook, supra note 78, at 16.
84. Id.
85. Id.
86. Id. at 23.
 Nevertheless, 23.9% of all people living in facilities with six or fewer residents have severe mental retardation and 17.8% have profound mental retardation.

The average age of admission to residential-care programs has increased substantially, so that today more adults than children are being admitted. In fact, 51.6% of the population of residential facilities for people with disabilities consists of people in early adulthood (ages twenty-two to thirty-nine), and there is a significant middle-age population (ages forty to fifty-four)—approximately 21%.

Along with these shifts in residential patterns has come a shift in the locus of behavior problems. Behavior problems are defined as injury to self or others and self-exposure or other problem sexual behavior. Traditionally, problem behavior was associated primarily with residents of large institutions. Today, however, it exists in residents of both the institutions and smaller facilities. According to one estimate, 28.5% of residents of all residential facilities attempt to hurt others physically at some time. Approximately 22.4% sometimes attempt to hurt themselves, and about 12.4% expose themselves to others or exhibit other problem behavior. Aggression toward others and self-injury are higher among people with severe mental retardation than those with mild, moderate, or profound mental retardation. Self-injurious behavior is more apt to occur among people with severe and profound mental retardation (29.4% and 29.8% respectively) than among people with mild/borderline mental retardation or among people who have other developmental disabilities but not mental retardation (13.0% and 11.0%).

The larger the facility, the more apt it is to serve people with multiple disabilities. Epilepsy, cerebral palsy, deafness, or blindness are more apt to be found among the population of facilities with sixteen or more residents than among people living in smaller facilities. Accordingly, the smaller the facility, the more likely the residents are to have independent living capabilities such as

87. Id. at 27.
88. Id.
89. Id. at 25.
90. Id. at 26.
91. Id. at 28.
92. Id.
93. Id.
94. Id. at 34.
95. Id. at 30.
bathing/showering, toileting, getting into and out of bed, self-feeding, walking across a room, and dressing. 96

3. Special Risk Factors in Population

Unfortunately, "vulnerable adults with developmental disabilities go without the training that will prevent their falling victim to the infection." 97 The operators of a large community-based program of residential and vocational services for people with developmental disabilities in several boroughs of New York City's metropolitan area 98 note that the rate of HIV infection within that population "could be as high as the rate found within the United States population as a whole." They point to the special characteristics of this population that warrant policies which may differ in significant respects from policies applicable to other people. 99 These characteristics include poor judgment and poor impulse control, communal living situations, community-based residences, social skill deficits, cognitive problems, and difficulty in making decisions. 100 All of these factors affect the person's sexual activities and choices.

These characteristics are not universal for the population. They do, however, apply to some people with mental retardation and other developmental disabilities. 101 "[T]hese individuals are also more likely than others to have learned their sexual behaviors in 'unhealthy' ways (from the streets or television), and their disabilities make them vulnerable to sexual abuse." 102 Finally, persons with a developmental disability may be generally "accustomed to being dependent on others to either make decisions for them or greatly influence their decisions." 103

The risk within this population of contracting or transmitting HIV infection exists in three areas. First there is the potential for transmission through sexual behavior. 104 Institutional and com-

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96. Id. at 32.
97. Gray, supra note 53, at 199.
99. Id. at 233.
100. Id.
101. Id.
102. Id.
103. Id.
munity living settings, as well as settings where people with developmental disabilities work or recreate, present the risk of unprotected sexual interaction between people with developmental disabilities or between staff members and persons with developmental disabilities. Staff in these settings may be reluctant to address issues of sexuality and sexual behavior among clients with developmental disabilities. Client sexuality is rarely discussed, notwithstanding that "a significant number of persons with HIV infection now reside in public institutions."

Persons with a developmental disability living in the community demonstrate a greater potential for sexual contact outside their living setting. Persons with a developmental disability may be unable to understand or communicate about sexual behavior. They may engage in high risk sexual practices and not be aware of or able to communicate about the potential contraction of HIV infection.

A second area of transmission risk may occur through the provision of medical or other services, including blood transfusions and intravenous injections. These can also include nonmedical services, such as catheterization, personal care and hygiene, and behavior modification that requires direct personal contact with the individual, which creates risk of staff contact with the residents' body fluids.

The third area of transmission risk is when a person with a developmental disability is sexually or physically aggressive. Potential contact with the blood of an HIV-infected person could occur as a result of residents biting or scratching each other.

C. Procedures for Testing

The most common method of testing for the AIDS antibody currently used in the United States begins with an Enzyme Immunoassay (EIA) Test. It is used as an initial screening device of blood serum. If the EIA test is reactive, it is repeated either

105. Jacobs, supra note 98, at 234.
106. HIV and Developmental Services, supra note 14, at 230.
107. See Gostin, supra note 8, at 18-20 (discussing precautions in intimate care for HIV infected persons).
108. Currently, follow-up studies done after an HIV infected patient has bitten someone have not shown any evidence of HIV transmission. Id. at 18; see also Drummond, Seronegative After Being Bitten by a Patient with AIDS, 256 J. A.M.A. 2342, 2342 (1986) (letter to the editor).
109. AIDS: Testing & Privacy, supra note 8, at 34 (1989). This test is also known as the enzyme linked immunosorbant assay (ELISA) test. Id. at 32.
110. Id.
once or twice. If these test results are also reactive, the individual undergoes a confirmatory test such as the Western Blot.\textsuperscript{111} Problems associated with false positives from reactivity on a Western Blot test have decreased in recent years because of advancing technology and increasingly stringent requirements. The problems associated with indeterminate results, however, have increased.\textsuperscript{112} Because of the negative prognosis that accompanies a positive result, the questionable reliability of the tests is a factor in determining whether a person can be tested effectively.

There are three basic methods of testing or screening\textsuperscript{113} for HIV infection: voluntary, mandatory, and routine. Voluntary testing is currently advocated for people with and without developmental disabilities.\textsuperscript{114}

Mandatory testing in the general population has been opposed because of the questionable effectiveness of testing procedures, the concern for the privacy rights of patients, and the availability of alternative methods of controlling the transmission of the disease.\textsuperscript{115} These methods include mandatory precautions for handling blood and bodily fluids.\textsuperscript{116} Little support exists for compulsory screening of patients in the health care setting, even for the prevention and control of HIV transmission.\textsuperscript{117} There is no evidence to show that compulsory screening would protect the public from viral transmissions. The evidence indicates that counseling, not screening, is beneficial in reducing unsafe behavior.\textsuperscript{118}

The final proposed testing system is “routine testing,” a proposal that was popular with the Reagan administration. “Routine testing” is testing as part of the provision of certain services.\textsuperscript{119} For example, this would involve incorporating testing for HIV infection

\textsuperscript{111} Id. at 34.
\textsuperscript{112} Id. at 33; see also Howe, Why Mandatory Screening for AIDS is a Very Bad Idea, in AIDS: ETHICS AND PUBLIC POLICY 140, 141-44 (1988) (discussion of statistical properties of AIDS screening tests concludes that risk of false positives very high with any tests used).
\textsuperscript{113} Prevailing usage defines “testing” as the use of antibody testing procedures with individuals on a case by case basis and “screening” as the use of these procedures with a specified population. See Bayer, Levine & Wolf, HIV Antibody Screening: An Ethical Framework for Evaluating Proposed Programs, 256 J. A.M.A. 1768, 1768 (1986) [herein after Framework].
\textsuperscript{114} Surgeon General's Report, supra note 1, at 29.
\textsuperscript{115} See Brandt, Health Care Workers & AIDS, 48 Md. L. REV. 1, 5-6 (1989); AIDS: TESTING & PRIVACY, supra note 8, at 191-218.
\textsuperscript{116} Note, supra note 8, at 670-71.
\textsuperscript{117} Gostin, supra note 8, at 35.
\textsuperscript{118} Id.
\textsuperscript{119} See AIDS: TESTING & PRIVACY, supra note 8, at 41-42.
into the admissions procedure of a hospital. It is merely suggested that a routine procedure be established, not that services would be denied if the person refused to be tested.120 This proposal is criticized on two basic grounds. First, it does not involve an informed consent component to fully explain the ramifications of the testing procedure.121 Second, the person may feel compelled to agree to the test in order to gain access to much needed services.122

Testing or screening of persons with a developmental disability for HIV infection in residential or other congregate settings raises some difficult questions. One involves balancing the privacy and liberty interests of a person with a developmental disability with society’s interests in preserving the public health.123 Only one state developmental disability agency requires mandatory screening for HIV infection upon admission.124 None requires mandatory screening of current service recipients, and thirteen have voluntary screening for existing and newly admitted recipients.125 Leading professional organizations, including the CDC, the AMA, and the Presidential Commission on the Human Immunodeficiency Virus Epidemic, have recommended that testing only be performed when the patient has given fully informed consent and has access to counseling services.126 Whether the lack of mandatory testing of the developmentally disabled population in the agencies surveyed was premeditated, it is clearly within the consensus of current professional opinion.127 This does not, however, address the underlying issue of how to control the spread of HIV infection by identifying the person with a developmental disability who may transmit the disease.

Universal, mandatory testing for HIV infection of persons with a developmental disability is inappropriate.128 Screening is both

120. Id. at 42.
121. Id. at 42-43.
122. Id.
123. See Kastner, Hickman & Bellehumeur, The Provision of Services to Persons with Mental Retardation and Subsequent Infection with Human Immunodeficiency Virus (HIV), 79 AM. J. PUB. HEALTH 491, 492 (1989) [hereinafter Mental Retardation and HIV].
125. Id.
126. Gostin, supra note 8, at 39.
127. Although these professional organizations addressed hospital patients in general, there is no reason not to extrapolate to the developmentally disabled population.
128. See Mental Retardation and HIV, supra note 123, at 492-93; see also Gostin, supra note 8, at 30-42; Howe, supra note 8, at 144-48. But see Framework, supra note 113, at 1772 (suggesting routine screening in clinical and residential settings for person with mental retardation might be appropriate because of the possibility of sexual contacts among residents).
under and over inclusive—it cannot identify all individuals who would develop or could transmit the AIDS virus, and it may identify some who cannot. In addition, there is a great potential for infringement of privacy interests, which would itself impose potential liability on the caregiver. A person’s constitutional right to be protected from unreasonable searches and seizures could be violated when the intrusion is not based on a reasonable suspicion that the individual is infected.

The unique context for serving a population with developmental disabilities challenges the view that mandatory testing is always inappropriate. The CDC recognizes that required testing might be appropriate depending on the characteristics of the person in the particular setting, especially if an individual’s history indicates high risk. When a person with a developmental disability is symptomatic for HIV infection and has a history of engaging in behaviors that are known to be high risk for the transmission of the HIV infection, a facility has a duty to test that person, regardless of whether consent is given.

III. DUTIES AND LIABILITIES OF PROVIDERS AND RIGHTS OF THE POPULATION WITH DEVELOPMENTAL DISABILITIES

A major issue in mandatory testing of this population for AIDS is minimizing liability. Civil liability for the transmission of a communicable disease is normally imposed on service providers when the transmission results from negligence. To find a service

129. Howe, supra note 8, at 140-41.
130. “[H]ospitals can be found liable precisely because the overwhelming consensus of professional opinion is that informed consent is required before an HIV test.” Gostin, supra note 8, at 39.
131. Note, supra note 8, at 659. A patient in a private institution or community based setting would also have a constitutionally protected right of privacy. See id. at 659-61.
134. Obtaining consent prior to the testing always should be attempted. See infra Part III.
135. See, e.g., Hofmann v. Blackmon, 241 So. 2d 752, 753 (Fla. Ct. App. 1970) (failure to diagnose tuberculosis in father, resulting in child’s contracting the disease, would be negligence), cert. denied, 245 So. 2d 257 (Fla. 1971); Skillings v. Allen, 143 Minn. 323, 323-24, 173 N.W. 663, 663-64 (1919) (cause of action for negligence stated against a physician for failing to warn of dangers of scarlet fever); Edwards v. Lamb, 69 N.H. 599, 45 A. 480 (1899) (surgeon guilty of negligence for failing to inform patient’s wife that her
provider negligent, four elements must be proved. The first involves demonstrating that the service provider owed a duty to the client to conform to a standard of conduct that would prevent an unreasonable and foreseeable injury. In a residential program, it would not be difficult to demonstrate that staff and administrators have a legally enforceable duty to protect clients from unreasonable and foreseeable harm. A special relationship exists because the clients live in the facility and are often dependent on the staff to provide for their basic needs.

The second element requires that the duty owed to the plaintiff be breached by the defendant. To establish this, a court will determine the required standard of care, taking into consideration the mental ability of the clients with whom the service provider works. Because the clients have impaired judgment, the service provider will be held to a higher standard of care. Additionally, professionals generally are held to a higher standard because of their education, training, and expertise. The court would attempt to determine how a reasonable, prudent, and careful service provider would act in a particular situation, taking into consideration the client's mental ability and the potential risk of transmission of AIDS given the client's behaviors.

The third element in establishing negligence is a causal connection between the conduct of the administrator or service provider and the resulting injury. For example, if a service provider has reason to believe both that a client may have AIDS and that this client has had sexual encounters with nonconsenting clients in the residential facility, and the client gives AIDS to another client, one might argue that the service provider's failure to ascertain the

138. PROSSER & KEETON, supra note 136, at 164.
140. PROSSER & KEETON, supra note 136, at 185-93; see, e.g., Littleton v. Good Samaritan Hosp. & Health Center, 39 Ohio St. 3d 86, 95, 529 N.E.2d 449, 459 (1988) (adopted "professional judgment rule" in assessing psychiatric liability).
141. PROSSER & KEETON, supra note 136, at 263-72.
facts and act accordingly was a causal connection in the second client's contracting AIDS.\footnote{Cf. Tarasoff v. Regents of the Univ. of Cal., 17 Cal. 3d 425, 436, 551 P.2d 334, 343-44, 131 Cal. Rptr. 14, 23-24 (1976) (holding that psychotherapist who knew or had reason to know patient posed danger to third persons negligent for failing to warn of danger).}

Finally, actual loss, injury, or damage must occur.\footnote{Prosper & Keeton, supra note 136, at 165.} Obviously, this element is met if a person contracts AIDS, thus experiencing the resulting physical illness, emotional distress, and even death.

There are several theories about whether liability could be imposed in cases involving the transmission of AIDS in a residential facility. Although no cases bear directly on this issue, many cases can be considered by analogy.

A. Failure to Supervise and Adequately Protect from Harm

Failure of staff to supervise clients adequately and to protect them from foreseeable harm is a major area in which liability can be imposed on administrators and staff in residential facilities.\footnote{Associated Health Sys., Inc. v. Jones, 185 Ga. App. 798, 799-802, 366 S.E.2d 147, 149-52 (1988); Diedrich v. Minnesota, 393 N.W.2d 677, 682 (Minn. Ct. App. 1986); Evans v. New York, 117 A.D.2d 581, 497 N.Y.S.2d 949, 950 (1986).} The United States Supreme Court in\footnote{Id. at 317-18.} Youngberg v. Romeo\footnote{See Evans, 117 A.D.2d at 581-82, 497 N.Y.S.2d at 950.} found that clients with mental retardation living in a state residential facility have a constitutional right to live in a safe environment free from injury and undue bodily restraints.\footnote{See Milton v. State, 293 So. 2d 645, 647-48 (La. Ct. App. 1974) (failure to supervise mentally ill person who wandered off from psychiatric hospital and died of exposure); Reavey v. New York, 125 A.D.2d 656, 657, 510 N.Y.S.2d 14, 15 (1986) (state owes a duty of care to patient commensurate with patient's ability to provide for her own safety); Hilscher v. State, 64 Misc. 2d 368, 374, 314 N.Y.S.2d 904, 911 (1970) (failure to supervise mentally retarded adolescent with fire setting tendencies who set fire to a summer home).} Lower courts also have found that clients with developmental disabilities have a right to live in physically safe environments with adequate supervision and protection from dangerous situations. Service providers have been held liable for such things as failing to supervise clients adequately and failing to protect them from dangerous physical conditions, other dangerous clients, and even from self-inflicted harm.

With respect to AIDS, service providers have a duty to provide a physically safe environment in which a client is reasonably
protected from infection.\textsuperscript{149} In residential programs for individuals with developmental disabilities, clients might engage in aggressive behavior such as biting and scratching and in inappropriate sexual behavior such as entering another client's room and engaging in sexual contact without the consent of the other client.\textsuperscript{150} Although treatment programs are designed to eliminate these behaviors, staff members acknowledge that these behaviors may periodically occur, even in the best treatment programs.\textsuperscript{151}

The degree of protection offered to the clients often relates to the dangerousness of the behavior exhibited by a client.\textsuperscript{152} Thus, more protection is needed to address the behavior of a client who attacks other clients with a knife than a client who pulls another's hair. Likewise, more protection is needed if a client has AIDS and is known to engage in aggressive or inappropriate sexual behavior. To provide adequate protection, however, one must determine if a client having symptoms of AIDS or past sexual contact with a person infected with AIDS, in fact has AIDS.

\textbf{B. Failure to Provide for Adequate Assessments}

Liability may be imposed not only when staff know of a foreseeable risk of harm to a client, but also when the staff \textit{should have known} of the risk.\textsuperscript{153} When conditions exist that would indicate to a reasonable and prudent professional in a residential facility that an individual may be suffering from AIDS and may be engaging in high-risk behavior that may place other clients at risk, a failure to adequately assess this situation may constitute negligence.\textsuperscript{154}

Staff should develop assessment instruments to measure any of the high-risk behaviors that would be associated with transmitting AIDS.\textsuperscript{155} These assessment procedures should not be used in a random or discriminatory way, nor in a way that unduly invades

\textsuperscript{149} See Youngberg, 457 U.S. at 324 ("The state also has the unquestioned duty to provide reasonable safety for all residents and personnel within the institution.").

\textsuperscript{150} S. Haavik & K. Memminger, supra note 104, at 14-25.

\textsuperscript{151} Id. at 167-69.

\textsuperscript{152} A. Vandenbulcke & J. Sheldon-Wildgen, supra note 137, at 40.


\textsuperscript{154} See Hofmann v. Blackmon, 241 So. 2d 752, 753 (Fla. Dist. Ct. App. 1970) (when doctor knows of a contagious disease, doctor has duty to warn members of the patient's immediate family of the dangers of that disease).

\textsuperscript{155} CHECKLIST FOR ADVOCATES, supra note 8, at 8.
a client's privacy. The scrutinized and appropriate use of these procedures and instruments may, however, clearly indicate to staff which clients should have the more intrusive blood tests.

C. Failure to Have Adequate Procedures for Infection Control

It is a well-established rule of law that once health care professionals know or reasonably should know that an individual has a contagious disease, they should take the necessary steps to prevent the spread of the infectious disease. Liability could be imposed on staff in a residential facility for failure to take these adequate precautions or exercise reasonable care to ensure that AIDS is not spread among clients.

To adequately address the spread of AIDS, service providers need to have appropriate educational, medical, and behavioral procedures in place. Educational procedures involve informing staff and clients of the risks of the disease, how it is transmitted, and ways to prevent the spread of the disease, including the use of safe sex practices. For clients with developmental disabilities, concrete educational programs should be designed that clearly and simply provide the information. Clients should be presented with this information in a manner tailored to each person's level of understanding. Additionally, staff need to frequently assess whether clients are understanding the material.

Staff should be informed of appropriate medical procedures to be followed, as many facilities serving persons with developmental disabilities are required to provide certain medical procedures for the clients who reside in the facility. Not only do staff need to be instructed in proper procedures, but staff also should be monitored to ensure that they follow these procedures.

Finally, because the spread of AIDS may take place when clients engage in high risk behaviors, staff would be negligent if they did not monitor these inappropriate behaviors and handle them in a nonaggressive and nonharmful manner. Active treatment plans should be developed for all clients who engage in at-risk behaviors.

156. Id.
158. For suggestions on educational programming, see HIV EDUCATION, supra note 8.
159. Id.; CHECKLIST FOR ADVOCATES, supra note 8, at 4-6.
161. CHECKLIST FOR ADVOCATES, supra note 8, at 4.
These plans should be consistently executed and data should be taken on the implementation of these programs and the occurrence of the at-risk behaviors. To protect clients from any risk of contracting AIDS, staff should intervene in the least intrusive manner necessary to prevent any possible transmission.

D. Duty to Warn Third Parties

Staff in a residential facility who know that a client has a dangerous communicable disease such as AIDS may have a duty to warn third parties who may be at risk. Courts have held human service programs liable for failure to warn third parties about a client's violent characteristics and past record of violence. Courts have also found that human service personnel have a duty to warn individuals of a person's contagious disease if the person is in close contact with other individuals.

If a client presents a risk to a foreseeable third party, several courts have held that mental health professionals have to exercise reasonable care to protect the foreseeable victim. In Tarasoff v. Regents of the University of California, the California Supreme Court held that once a therapist determines or should reasonably have determined that a client poses a danger to others, the therapist must take reasonable steps to warn and protect the third party. Thus, if staff know, or should know, that a client has AIDS and engages in high-risk aggressive or sexual behavior, staff may be


163. McCall v. Department of Health & Rehabilitative Serv., 536 So. 2d 1098, 1100-01 (Fla. Dist. Ct. App. 1988) (cause of action stated against a state mental hospital for failing to warn patient who was attacked by another patient that the hospital knew was violent); Sylvester v. Northwestern Hosp. of Minneapolis, 236 Minn. 384, 389-90, 53 N.W.2d 17, 20-21 (1952) (hospital liable for damages to plaintiff resulting from violence of a drunk patient who was allowed to wander around); Greenfield v. New York, 130 Misc. 2d 161, 165, 495 N.Y.S.2d 611, 614 (N.Y. Ct. Cl. 1985) (84-year-old visitor to state mental health facility entitled to damages from state when she was attacked by a patient while visiting her son).


167. Id. at 431, 551 P.2d at 340, 131 Cal. Rptr. at 20.
required to protect the other clients and also warn them, or their guardians, of the potential danger. Obviously, staff in a residential facility must use prudent judgment in revealing confidential personal information.\textsuperscript{168}

IV. DISCHARGING DUTIES TO AND ENSURING THE RIGHTS OF THE POPULATION WITH DEVELOPMENTAL DISABILITIES

A. Consent and Testing

It is axiomatic that legally effective consent obviates any considerations with respect to mandatory testing for AIDS or, for that matter, any other interventions, including proposed therapies following a blood test that reveals the presence of an HIV virus.\textsuperscript{169} Consent cures all, but only if it is legally effective. To meet the test of legal sufficiency, consent must be informed, voluntary, and given by a legally competent person.\textsuperscript{170} Unless each of these three criteria is met, legally sufficient consent does not exist.

The information element typically consists of several components. These include: an explanation of the nature of the procedure, its purposes, and whether it is experimental; the usual risks and

\textsuperscript{168} See Rennert, supra note 4, at 55-63.


For a discussion of the principles of consent as applied to others with disabilities such as mental illness and senility, see Anderer, A Model for Determining Competency in Guardianship Proceedings, 14 MENTAL & PHYSICAL DISABILITY L. RPTR. 107-17 (1990); Guardianship: An Agenda for Reform, Recommendation of the National Guardianship Symposium and Policy of the American Bar Association, 13 MENTAL & PHYSICAL DISABILITY L. RPTR. 271 (1989) [hereinafter Guardianship: An Agenda for Reform].

\textsuperscript{170} Canterbury, 464 F.2d at 782-83; Salgo, 154 Cal. App. 2d at 578, 317 P.2d at 181; Natanson, 186 Kan. at 409, 350 P.2d at 1106; Kaimowitz, 2 Prison L. Rep. at 474.
benefits of the procedure; the alternatives to the procedure, including the alternative of no procedure at all; the right of a person to withdraw consent; the solicitation of any questions; and a statement of whether any consideration is involved and, if so, what. 171 The required information must be given in a way that is intended to inform the recipient of the information and must successfully do so. 172 "What" and "how" are the two indispensable elements of information.

Voluntary action is the second requisite in giving or withholding consent. Voluntariness exists in the absence of fraud, coercion, or duress. 173

Capacity to consent exists at two levels: legal status and mental capacity. The person must have the legal status to give or deny consent. An adult is presumed mentally competent. 174 That presumption is overcome when the adult has been adjudicated incompetent 175 or the facts concerning the person's mental capacity are such that competency may reasonably be said to be absent. 176 De jure and de facto incompetence to give or withhold consent thus overrides the presumed capacity of the adult.

A minor, on the other hand, is presumed incompetent to give consent. 177 A minor, no matter how sagacious, lacks capacity except in the circumstances of a "mature minor" consenting to abortion 178 or other medical interventions, 179 in the circumstance of legal emancipation, 180 or in the cases of a statutorily granted right to

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171. The general informed consent regulations are set out in Public Welfare, 45 C.F.R. § 46.116(a)-(b) (1990). For the regulations on consent on behalf of minors, see id. § 46.401-409. See Canterbury, 467 F.2d at 782-83; Salgo, 154 Cal. App. 2d at 578, 317 P.2d at 181; Rennert, supra note 4, at 42, nn.17-20 & 23-25; see also Natanson, 186 Kan. at 409, 350 P.2d at 1106.

172. Turnbull, supra note 169; see also Canterbury, 464 F.2d at 782-83; Salgo, 154 Cal. App. 2d at 578, 317 P.2d at 181; Natanson, 186 Kan. at 409, 350 P.2d at 1106; Kaimowitz, 2 PRISON L. REP. at 474.

173. See Kaimowitz, 2 PRISON L. REP. at 475-76.


176. See Braekel, supra note 169, at 376.

177. See, e.g., Macklin, supra note 169, at 57, 58-61.

178. Id. at 76-80; Planned Parenthood v. Danforth, 428 U.S. 52, 74 (1976).

179. Although a Michigan case first began the incursion into the minor consent issues, Bakker v. Welsh, 144 Mich. 632, 108 N.W. 94 (1906), it was not established that there is a mature-minor exception until the decision of the Kansas Supreme Court in Younts v. St. Francis Hosp., 205 Kan. 292, 469 P.2d 330 (1970); see also Macklin, supra note 169, at 69-75.

consent or refuse certain medical interventions. When the minor does not have legal and mental capacity to give or withhold consent, the minor’s parents or other natural guardians, or, in their absence, a court appointed guardian, may give consent. Thus, incapacity exists with respect to age and mental acuity.

Second, the person must have mental capacity. In the case of an adult with a cognitive impairment and a minor who has legal status to consent but also has a cognitive impairment, legal consent and capacity become problematic. If the person has been adjudicated incompetent and a guardian has been appointed who has the power to give or withhold consent for that person, legally effective consent flows only from the guardian and exists only if the three tests of consent—information, voluntariness, and capacity—are met with respect to the guardian.

If, however, the person has not been adjudicated and no guardian has been appointed, then capacity to consent may be present in whole or in part because situational capacity and limited capacity are recognized at law. The consent-seekers who rely on the consent of the person with a developmental disability do so at their own peril, risking the possibility that the person may later be found to have been incompetent to give or withhold consent. Thus, consent-seekers are compelled to make the following choices: seek an adjudication of incompetence and consent from the guardian; rely on the consent or assent of the person; or seek the person’s consent or assent as well as the consent of others (who have mental capacity) who are closely related to and involved in the life of the person. Indirect or third-party consent from the legal guardian is effective, assuming that the other elements of consent are present.

Problems exist with each kind of consent. Third party consent may overly restrict the person’s rights. The direct consent or assent of the de facto incompetent person may be legally flawed. Finally, the concurrent consent of the person and a related other may be legally insufficient because neither has true legal capacity to give or withhold consent.

Notwithstanding these considerations, the service provider who seeks to test a person with a cognitive impairment should, whenever

181. Id. at 73-76.
184. See Burgdorf, supra note 169, at 521-87.
185. See Turnbull, supra note 169, at 7-8, 13; Burgdorf, supra note 169, at 572-87.
186. See Turnbull, supra note 169, at 12-13; Burgdorf, supra note 169, at 572-87.
possible or practicable, seek the consent of the affected person. If the person is not adjudicated incompetent but there is or may be de facto incompetence, the provider should seek concurrent consent from the person and the person's nearest relative (the natural guardian). If the person has been adjudicated incompetent, the provider should seek consent from the legal guardian. If the provider is unable to obtain consent for AIDS testing from any of these individuals, the provider should consider seeking limited guardianship through proceedings in the appropriate court. Whenever practicable, the provider should seek approval for testing by judicial proceedings that only minimally restrict the person's liberty to consent to other activities in her life. That is, the provider should seek limited guardianship with respect to testing and intervention alone.

B. Tests and Retests

When the provider obtains legally sufficient consent for testing, the provider should proceed with the testing. Because AIDS testing consists, at the most, of three blood drawings, the provider should follow normal protocols for the testing. That is, the provider or the provider's physician should proceed with respect to the person with a developmental disability exactly as the provider would for a person who does not have a disability. Thus, a second test should be administered only if the first test yields positive results. If the second test produces negative results, the provider should desist from further testing. If the second test yields positive results, the provider should require a third test. If, however, the second test is negative, AIDS testing should cease. If any of the three tests yields negative results, the provider should make no changes in the program for the tested person. The provider should, however, initiate other programs for the facility as a whole in order to prevent any transmittal of contagious diseases from one person to another.

C. Interventions Following Positive Test Results

If the tests yield positive results, the provider should devise appropriate interventions. The same medical interventions that would be provided to any person who has AIDS should be provided to the person with developmental disabilities. Behavioral interventions should be provided to develop behaviors that minimize or prevent the risk of spreading the virus. Environmental changes also should be instituted. These changes should be based on expert judgment regarding the person and the protection of the public health. Changes should be made in the physical settings of the
person: residence, work, recreational, and social. Finally, training should be provided for the person, other people with disabilities who are part of the person's life, staff who regularly interact with the person, and staff and others who occasionally interact with the person.

The behavioral and environmental changes should take into account that the person has tested positively for AIDS and the person's behavior. If the person does not have a history of behavior that is substantially likely to infect others, then little or no change in the person's behavior, program, or settings should be made. If, however, the person has a history of or presently emits such behavior, a change in the person's behavior, program, or settings should be made.

An expert should determine whether the history of behavior is so recent that the behavior is likely to recur or whether factors other than recency—such as a change in behavior that poses problems of predictability as in the case of sudden or infrequent aggression directed toward the public generally or particular individuals—warrant the protection of others by behavioral or environmental changes.

Finally, any proposal for mandatory testing should be accompanied by a constitutionally satisfactory due process hearing, one that complies with the standards established in Mathews v. Eldridge. In all proceedings to obtain consent for voluntary testing or to undertake involuntary, mandatory testing, the person and the provider should have access to safeguards that include, at a minimum, notice, opportunity for hearing before an impartial decisionmaker, opportunity for appeal, and opportunity to present evidence by counsel or other advisors at the initial hearing. To provide due process, it may be desirable to have a full-fledged judicial hearing in a state or federal court, with an expedited docket to accommodate the serious consequences of transmission. Such a hearing, however, may not be constitutionally required. Some other neutral, third-party hearing may be constitutionally sufficient under the due process standards of Parham v. J.R.

The purpose of the due process safeguards in the fourteenth


190. Id. at 325 n.4; see also Parham, 442 U.S. at 606-07 (1979); O'Connor v. Donaldson, 422 U.S. 563, 580 (1974).

191. 442 U.S. at 607.
amendment is to provide a disinterested party an opportunity to balance individual rights and state interests before the state is permitted to take action that may adversely affect the individual. 192 That purpose can be served equally by full-fledged judicial or quasi-judicial hearings. If a minor may be admitted to a state psychiatric hospital or a state mental retardation institution after a quasi-judicial hearing, with all of the accompanying risk of error, stigma, and deprivation of liberty and opportunities for the person, then surely a person may be subjected to at least one and at most three blood tests in which the stakes for the person and others are so grave.

D. General Rule on Mandatory Testing of the Population with Developmental Disabilities

The general rule proposed here takes into account the person's residence, medical status, and behavior, along with individualized determinations, consent-giving capacity, and due process safeguards. In a nutshell, the rule should be as follows:

If persons with developmental disabilities:

1. live in congregate settings (including the large public or private institutions or community-based programs) where there is opportunity for personal contact of the type that is known to be a vehicle for transmission of the HIV virus; and
2. exhibit manifestations indicative of HIV infection; and
3. display behavior that involves others in at-risk-of-transmission interactions or relationships; and if:
4. reliable expert testimony from qualified physicians or others indicates that there are manifestations, behavior, and at-risk-for-transmission relationships that create or may imminently create a risk of HIV transmission from the person to others; and
5. other means of preventing transmission have been determined to be ineffective or nearly so; and
6. individualized determinations are made on a case-by-case basis, with opportunities for due process; and
7. legally effective consent to HIV testing is not obtainable on a voluntary basis;

Then, the state and its agents (providers) are:

1. justified in requiring compulsory testing and retesting as appropriate, with the justification increasing with the risk of transmission; and,
2. compelled, should the tests reveal positive results, to provide appropriate medical, behavioral, and environmental interventions, therapies, and changes in the person's life.

192. Id. at 606.
V. Precedents for the General Rule

The proposed rule responds to and is consistent with the issues raised in the case law on AIDS testing and on the provision of care to persons with AIDS or developmental disabilities. Candidly, the issues raised in the cases concerning AIDS and developmental disabilities are not clear cut or even fully apposite. Yet, they do provide some guidance.

A. AIDS Testing in Nondisabled and Developmentally Disabled Populations

The Massachusetts Supreme Judicial Court’s decision in the Guardianship of Anthony is described in the ABA treatise on AIDS and persons with developmental disabilities. The decision does not reach the substantive issue of permission for mandatory testing and should not be relied upon for that result.

The issue in Anthony was whether the state probate and family court, acting on its own initiative in the exercise of its general equity powers, had authority under Massachusetts law to assume “superintendence over the state department of mental health in order to affect the treatment of two residents of a state facility for persons with developmental disabilities. Anthony and another resident were homosexual partners. In exercising its statutory duty to provide appropriate medical care for Anthony, the state department of mental health petitioned the probate and family court for the appointment of a permanent limited guardian who would have authority to give permission to administer psychotropic medications. The court granted the department’s petition. Some time later, the department again petitioned the court for authority to amend Anthony’s medical treatment plan to remove a venereal wart that had been discovered on his body. The very day the department filed that petition, the court reappointed counsel and a guardian ad litem for Anthony.

During the hearing on the petition regarding the wart, the department filed an unopposed motion to dismiss its petition to remove the wart. The court inquired into how Anthony came to have the wart, Anthony’s sexual activity, and the threat of AIDS

194. Rennert, supra note 4, at 48, 49.
196. Id. at 724, 524 N.E.2d at 1362.
197. Id.
198. Id.
and venereal disease not only to Anthony but also to his sexual partner and other residents of the state facility.\textsuperscript{199} Upon learning that Anthony was being provided with a sex education program and had been trained in the use of condoms and the nature and method of transmitting AIDS, the court asked whether Anthony and his sex partner had been tested for AIDS. When informed that no such testing had occurred, the court found that there was a "grave" threat to the health of the facility's residents and ordered Anthony and his sex partner to be tested for AIDS.\textsuperscript{200}

Upon appeal by the state department, the state's highest court refused to reach the parties' argument on the substantive issue of whether the court had violated the state's statute\textsuperscript{201} against AIDS-testing without consent.\textsuperscript{202} It also declined to reach the substantive issue of whether the court gave appropriate weight to the public's interest as balanced against the individual's "interest in being free from non-consensual invasions of his or her bodily integrity."\textsuperscript{203}

In avoiding altogether these two substantive issues, the court reasoned that "it is clear that the Probate and Family Court judge did not have authority to assume control of the department and to order the department to conduct tests on Anthony and another party for the perceived benefit of the [facility]."\textsuperscript{204} "The judge, in effect and incorrectly usurped the function of the executive branch of the State government."\textsuperscript{205} The violation of the state's separation of powers doctrine caused an "impermissible 'poaching by the judicial branch on executive and legislative territories.'"\textsuperscript{206}

Nonetheless, the Anthony case is informative about the issue of testing. Clearly, the Massachusetts Supreme Judicial Court regarded the matter as one to be decided by balancing the individual's interests in avoiding nonconsensual bodily invasions with the interests of third parties to be protected from transmission.\textsuperscript{207} Although under state law the probate court must give the ward's "best interests" the primary consideration, there may be a warrant for nonconsensual testing if evidence in the record indicates that testing is an "appropriate, let alone the only, means by which the

\begin{thebibliography}{207}
\item \textsuperscript{199} \textit{Id.}
\item \textsuperscript{200} \textit{Id.} at 725, 524 N.E.2d at 1362.
\item \textsuperscript{201} Mass. Gen. L. ch. 111, § 70F (1986).
\item \textsuperscript{202} \textit{Anthony}, 402 Mass. at 726, 524 N.E.2d at 1363.
\item \textsuperscript{203} \textit{Id.}
\item \textsuperscript{204} \textit{Id.}
\item \textsuperscript{205} \textit{Id.}
\item \textsuperscript{206} \textit{Id.} at 727, 524 N.E.2d at 1364 (quoting Attorney General v. Sheriff of Suffolk County, 394 Mass. 624, 631, 477 N.E.2d 361, 365 (1985)).
\item \textsuperscript{207} \textit{Id.} at 726-27, 524 N.E.2d at 1363.
\end{thebibliography}
department may fulfill any of its statutory duties" of providing care to residents of the state institution.208

The record in the Anthony case did contain facts from which a court might have concluded that mandatory testing is justified. The trial court opinion recited that "it is acknowledged that the (institution) environment, the venereal wart of the Ward (Anthony), the Ward's homosexual activity with another in the (institution) and the unrestricted setting of the community was conducive to A.I.D.S. and the potential spread thereof." 209

In fact, the state probate court considered factors that are components in the rule this Article proposes: a medical condition that might suggest an AIDS infection; behavior known to cause AIDS; and a congregate living arrangement. The court then balanced the medical condition, the behavior, the public's interest, and the relatively innocuous proposed intervention, namely a blood test for AIDS.210

Another case, Leckelt v. Board of Commissioners of Hospital District No. 1,211 dealt with mandatory AIDS testing of healthcare workers, but enunciates principles that warrant mandatory testing of people with developmental disabilities. In Leckelt, a hospital discharged a health care worker who (1) had responsibilities for providing care that involved risk of transmission of AIDS because of the exchange of bodily fluids; (2) was known to have been a carrier of Hepatitis B and to have had a syphilis infection; (3) had failed to submit the results of an HIV blood test in compliance with a hospital policy based on policies recommended by the CDC and the AMA; and (4) was known to have been the sex partner of a homosexual who recently had died as a result of AIDS infections.212

The worker sued the hospital for wrongful discharge.213 He partially based his claim on a violation of section 504 of the Rehabilitation Act.214 Section 504 is the federal antidiscrimination law that prohibits a recipient of federal funds, such as the hospital, from discriminating in employment or other activities against a person with a disability solely on the basis of the disability.215 The

208. Id. at 727, 524 N.E.2d at 1363-64.
209. Id. at 725, 524 N.E.2d at 1362.
210. Id.
212. Id. at 1382-85.
213. Id. at 1378-79.
215. Id.
plaintiff was a person with a disability because of his perceived seropositive status. The worker also sued on the basis of the equal protection clause of the fourteenth amendment and the unreasonable search and seizure guarantees of the fourth amendment.216

The district court concluded that the hospital did not violate the Rehabilitation Act or any constitutional protections.217 The court supported the hospital's discharge of the employee because the employee failed to comply with the hospital's infection-control policies. These policies were found to be constitutional and non-discriminatory under the Rehabilitation Act and based on nationally followed guidelines.218

Upon appeal, the Fifth Circuit affirmed, stating that AIDS is an impairment protected under section 504.219 The court held, however, that Leckelt was not discriminated against "solely by reason of his handicap," but because he failed to comply with the hospital's policy for infection control.220 By refusing to submit the results of his test, "Leckelt prevented the hospital from knowing whether he had a handicap for which federal law arguably required reasonable accommodations."221

The court also affirmed that Leckelt's constitutional rights had not been violated.222 There was no equal protection violation because the hospital had a reasonable medical basis to suspect that Leckelt had been exposed to HIV infection and to require him to submit the test results. Moreover, the state had a compelling reason to enforce the infection control policies.223

A salient issue in Leckelt is the application of the nationally adopted infection-control policies to the major argument of this Article, namely, that under certain circumstances requiring mandatory AIDS testing of certain people is permissible. The policies permit a hospital to modify the duties of employees with certain infectious diseases, including HIV.224 To modify those duties, the


218. Id. at 1387-89. The guidelines referred to were established by the Centers for Disease Control for use by health care workers and adopted by the American Hospital Association. Id. at 1379.


220. Id. at 825-26.

221. Id. at 830.

222. Id. at 831-33.

223. Id. at 831-32.

hospital "may need to require medical testing for an employee whom it learns has a high medical risk of having (infectious) diseases."\textsuperscript{225}

To determine whether to apply the policies and require testing, the hospital must consider the medical risk associated with the employee (his medical condition) and his duties (his behavior).\textsuperscript{226} Moreover, the setting in which the issue arises—a hospital where exchanges of bodily fluids are likely—is not unlike the setting in which people with developmental disabilities reside, namely, one where intimate, albeit not necessarily sexual, personal contact is not only inevitable but also expected and justified as a consequence of discharging the setting’s obligation of care to persons within its care and control.

Finally, the hospital also must consider its "obligations to its employees and to the public concerning infection control and health and safety in general."\textsuperscript{227} Although the \textit{Leckelt} case did not involve mandatory testing of people with developmental disabilities, it did involve people whose behavior necessarily brings them into at-risk situations in which there is a possibility, if not a probability, of transmitting the AIDS virus.

The \textit{Leckelt} court, in approving the infection-control policies of the hospital and the CDC and AHA, endorsed an approach with elements that are substantially the same as those in the policies in this Article. These elements include expert medical judgment concerning the person’s medical condition and the risk of transmission to others;\textsuperscript{228} the use of least-drastic alternative means to balance the individual’s rights with the public's interest in safety;\textsuperscript{229} testing and retesting as necessary;\textsuperscript{230} consideration of the interpersonal relationships and behaviors that may create at-risk circumstances;\textsuperscript{231} steps for prevention of the transmission of the virus;\textsuperscript{232} not requiring invasive procedures when the risk of transmission is "extremely low";\textsuperscript{233} individualized determinations;\textsuperscript{234} testing of only those employees who meet certain criteria;\textsuperscript{235} balancing individual

\textsuperscript{226} Id.
\textsuperscript{227} Id.
\textsuperscript{228} Id. at 1379.
\textsuperscript{229} Id. at 1379-80.
\textsuperscript{230} Id. at 1380.
\textsuperscript{231} See id. at 1381.
\textsuperscript{232} See id.
\textsuperscript{233} See id.
\textsuperscript{234} See id. at 1382, 1389.
\textsuperscript{235} See id. at 1386.
rights with public safety concerns;\textsuperscript{236} careful delineation of the class of people subject to mandatory testing;\textsuperscript{237} and avoidance of non-individualized, non-class-specific testing, as prohibited by \textit{Glover v. Eastern Nebraska Community Office of Retardation}\textsuperscript{238} and by the due process concept generally.\textsuperscript{239}

The Eighth Circuit Court of Appeals recently decided another major case involving AIDS testing and individuals with developmental disabilities, \textit{Glover v. Eastern Nebraska Community Office of Mental Retardation}.\textsuperscript{240} Although the court held that a community-based program for people with developmental disabilities may not require all its employees to be tested for the AIDS virus, the decision does not dissuade the authors from the opinion that mandatory testing of some individuals who have developmental disabilities is a legally permissible and sound policy.

In \textit{Glover}, ENCOR, the provider, adopted policies that required all health care workers to undergo HIV and Hepatitis B testing and reporting as a condition of continued employment. The federal court of appeals struck down the policies on the basis that they violated the employees' fourth amendment rights against unreasonable searches and seizures.\textsuperscript{241} ENCOR's class of testing-affected employees included licensed practical nurses and registered nurses.\textsuperscript{242}

There are several distinctions between \textit{Glover} and the guidelines recommended in this Article. First, unlike the situation in \textit{Leckelt}, the \textit{Glover} policies affected all health care workers who came into direct contact with clients, whether or not the workers were in "safety sensitive" positions.\textsuperscript{243} This Article's recommendations, by contrast, affect only those individuals who are engaged in behaviors and who, on the basis of reasonable medical judgment, have the potential to transmit an infectious virus.

Second, the ENCOR regulations requiring universal mandatory testing were promulgated by an agency that was not a full service health care facility, as was the hospital in \textit{Leckelt}.\textsuperscript{244} This Article's

\begin{footnotes}
\item[236] See id. at 1391-92.
\item[237] See id. at 1390.
\item[239] See Leckelt, 714 F. Supp. at 1392.
\item[240] 867 F.2d 461 (8th Cir.), cert. denied, 110 S. Ct. 321 (1989).
\item[241] Id. at 464.
\item[242] Id.
\item[243] Id. at 462.
\item[244] ENCOR is a state agency covering a five county area in Nebraska. Id. at 462. The court found that the risk of transmission of HIV infection at ENCOR was "extremely low" because there was no incidence of "sexual abuse of clients by staff," no incidence
\end{footnotes}
recommendations, in contrast, address individuals who are in settings in which the risk of transmission is high simply because of the setting’s nature and the services offered.\textsuperscript{245}

Third, the invalid ENCOR regulations apparently were not based on CDC or AHA guidelines. Thus, unlike the policies sustained in \textit{Leckelt}, they were not sanctioned by national professional groups. This Article’s recommendations incorporate the principles of the CDC and AHA guidelines.

Fourth, the invalid regulations were not based on any reasonable or defensible criteria. All employees who came into direct contact with the clients, not just those whose medical condition and behavior would reasonably give rise to probable cause to require it, were forced to submit to HIV testing.\textsuperscript{246} This Article’s proposals require the type of individualized decisionmaking that conforms to due process standards and the CDC and AHA guidelines. Decisions are individualized according to setting, medical condition, behavior, and interpersonal contact.

Fifth, the ENCOR regulations did not require an initial expert judgment that a particular employee was apt for testing on the basis of her condition or behavior.\textsuperscript{247} This Article’s recommendations, to the contrary, advocate testing only if a reasonable, individualized medical basis for testing exists.

Sixth, the regulations did not address whether the combination of condition, behavior, and services created an at-risk situation for the employer’s clients. This Article’s recommendations do just that, by requiring an inquiry into and proof of interpersonal relationships or contact that constitute at-risk behavior.

Finally, the \textit{Glover} regulations applied to employees of the agency, not individuals served by the agency who meet certain standards, including the existence of a cognitive impairment. The recommendations in this Article target people who have cognitive impairments.

\subsection*{B. Prisoners and AIDS Testing}

Whether mandatory testing for AIDS is permissible has been raised and resolved in cases involving other populations in which

\begin{itemize}
  \item of "drug use or needle sharing," and because HIV infection is not contracted by casual contact. Further, the court found that the risk of transmitting AIDS at ENCOR by "a client biting or scratching a staff member" or "a staff member attending to a client's personal hygiene needs" was zero. \textit{Id.} at 463.
  \item \textsuperscript{245} \textit{Supra} notes 81-103 and accompanying text.
  \item \textsuperscript{246} \textit{Glover}, 867 F.2d at 462.
  \item \textsuperscript{247} \textit{Id.} at 461, 463.
\end{itemize}
the environment and the risks of transmission are comparable to those addressed here. In particular, the issues have been addressed in cases involving prisoners, whose environments are congregate-living settings and whose behaviors may pose risks for transmission of the virus.

Two cases establish the rule that mandatory testing is permissible when there is probable cause to believe that one or more prisoners may have the AIDS virus and may transmit it to others. In *Haywood County v. Hudson*, the Tennessee Supreme Court permitted the mandatory testing of a prisoner who made an apparently serious statement that he had AIDS, later said he did not have AIDS, and then objected to testing on first amendment grounds, claiming he was a Jehovah's Witness. The court found that testing was permitted because probable cause existed to believe that the prisoner had AIDS and because the public safety concern involved outweighed the prisoner's "alleged religious belief[s]."

Likewise in *Glick v. Henderson*, prisoners in Arkansas sued state prison officials under section 1983 of the Civil Rights Act to require prison officials to test other inmates for AIDS. The court affirmed the district court's dismissal for failure to state a section 1983 cause of action, holding that there was no reasonable cause for requiring testing of the entire prison population. The court suggested that a 1983 cause of action might have been successfully pleaded although there were only five seropositive prisoners in the entire population if expert testimony and a pleading of facts established that there could be contagion. Here, however, the complaint as framed showed "too remote" of a connection between testing and possibility of infection. The court dismissed the complaint without prejudice, in order to allow the plaintiffs to refile and plead facts giving rise to probable cause.

Another basis for mandatory testing also exists when there is a medical need that state physicians deliberately ignore. *Maynard v. New Jersey* involved a wrongful death action in which the decedent was treated for a cold but not for AIDS. The patient

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248. 740 S.W.2d 718 (Tenn. 1987).
249. 740 S.W.2d 718 (Tenn. 1987).
250. 740 S.W.2d 719 (Tenn. 1987).
251. 855 F.2d 536 (8th Cir. 1988).
252. 855 F.2d 538 (8th Cir. 1988).
253. 855 F.2d 539-40 (8th Cir. 1988).
254. Id.
255. Id. at 539.
256. Id.
then died from AIDS.\textsuperscript{258} The court held that although the state and its physician-agents are immune from liability under the eleventh amendment and state law to a section 1983 claim for wrongful death, the decedent's estate may proceed against the physicians.\textsuperscript{259} Under the immunity exception created by Estelle v. Gamble,\textsuperscript{260} the immunity defense fails when there is "deliberate indifference to serious medical need."\textsuperscript{261} In Maynard, there was a pattern of repeated refusals to provide treatment for AIDS symptoms and evidence concerning this prisoner\textsuperscript{262} indicated that the physician's failure amounted to such indifference.\textsuperscript{263} Physicians may not opt for an "easier and less efficacious treatment of the inmate's condition."\textsuperscript{264} As the court noted, medical need rises to the Estelle level of seriousness when either a physician mandates treatment or a lay person would easily recognize that a doctor's attention is needed.\textsuperscript{265} Thus the seriousness and prevalence of AIDS and the amount of information available to physicians and their staff justifies not only medical treatment, but also all necessary diagnosis for treatment, including testing for AIDS. This result is certainly consistent with the principles of Youngberg v. Romeo,\textsuperscript{266} in which the Supreme Court held that residents of a state facility for persons with developmental disabilities have a constitutional right to appropriate medical treatment, including, presumably, diagnostic testing for life-threatening conditions such as AIDS.\textsuperscript{267}

Finally, in Doe v. Coughlin\textsuperscript{268} the New York Court of Appeals ruled that the state has an interest in preventing the spread of any disease, especially AIDS, in congregate settings.\textsuperscript{269} Accordingly, the state may deny prisoners the right to conjugal visits without violating their rights under section 504 of the Rehabilitation Act not to be subject to discrimination solely on the basis of handi-

\begin{itemize}
\item \textsuperscript{258} Id. at 293-94.
\item \textsuperscript{259} Id. at 296-97.
\item \textsuperscript{260} 429 U.S. 97 (1976).
\item \textsuperscript{261} Maynard, 719 F. Supp. at 294-95.
\item \textsuperscript{262} The patient collapsed and the physician refused to treat the patient. Id. at 294.
\item \textsuperscript{263} Id. at 295-96.
\item \textsuperscript{264} Id. at 295.
\item \textsuperscript{265} Id.
\item \textsuperscript{266} 457 U.S. 307 (1982).
\item \textsuperscript{267} Id. at 324. The Supreme Court did not decide that there was "some general constitutional right to training [treatment] per se," but that based on the facts of this case, the respondent's liberty interests required the state to provide "minimally adequate or reasonable training to ensure safety and freedom from undue restraint." Id. at 318-19. In Youngberg, the state conceded a duty to provide appropriate medical care. Id. at 317.
\item \textsuperscript{268} 71 N.Y.2d 48, 518 N.E.2d 536 (1987).
\item \textsuperscript{269} Id. at 60, 518 N.E.2d at 544.
\end{itemize}
Prisoners are not "otherwise qualified" for conjugal visits because they have AIDS, and thus any denial of these visits does not violate their section 504 rights. Accordingly, a state or private agency that is a recipient of federal funds and thus bound by section 504 may, with impunity under section 504, deny rights available to other individuals in its custody to an individual who has a transmissible disease. It is not a far step to reach the conclusion that, in order to determine whether a person's rights should be restricted to contain the spread of AIDS, a federal funds recipient may test a person for AIDS, even involuntarily.

C. Students

Cases involving students with AIDS also are consistent with mandatory testing of individuals with disabilities who are or may be capable of transmitting AIDS to others and who are in settings in which the risk of transmission is significant. In these cases, the courts uniformly require individualized decisionmaking, reliance on expert medical judgment, and application of the Arline test for determining if a person is handicapped under section 504 and otherwise qualified for certain benefits. These are precisely the principles advanced in this Article.

One such case is Doe v. Dolton Elementary School District No. 148. In that case, an AIDS-affected student sought an injunction ordering the local educational agency to remove the student from a program of homebound instruction and to admit him to regular class instruction on a full-time basis. Applying the Arline standard to determine whether the student was "handicapped" under section 504, the court held that the student was entitled to the protection of section 504. The court then ruled that individualized decisionmaking, targeted on this student only, based on reasonable medical judgment, must control in deciding whether the student was otherwise qualified to be admitted to regular classroom settings. If the student posed a "significant risk of infecting teachers

270. Id. at 60-61, 518 N.E.2d at 544.
271. Id.
273. Doe v. Coughlin, 71 N.Y.2d 48, 61, 518 N.E.2d 536, 544 (because the inmate had a communicable disease, he was not "otherwise qualified").
276. Id. at 442.
277. Id. at 444.
278. Id. at 445-46.
and fellow students," he was not otherwise qualified for placement in regular classes. To determine the student's qualification for that placement, the court ruled that Arline requires courts to consider four factors: "(a) the nature of the risk (how the disease is transmitted), (b) the duration of the risk (how long is the carrier infectious), (c) the severity of the risk (what is the potential harm to third parties), and (d) the probabilities the disease will be transmitted and will cause varying degrees of harm." Noting that Arline warrants special deference to public health officials, the court found no significant risk of transmission in the classroom setting.

Similar approaches have been used by courts in other school placement cases. For example, in Board of Education of Plainsfield v. Cooperman, the New Jersey Supreme Court invalidated the local school boards' wholesale exclusion of AIDS students from regular school programs, but sustained state school board regulations that permitted the exclusion of those students who are not toilet-trained, are incontinent, are unable to control their drooling, or are unusually physically aggressive and have documented histories of biting or harming others. Individualized decisionmaking based on reasonable medical judgment is required, and any subsequent exclusion does not violate the students' right to a free appropriate public education. The state regulations also provided for a due process hearing before a Medical Advisory Panel established by the Department of Health if the district medical officer disagreed with the student's physician regarding whether the student fit the regulatory criteria.

The same approach and the same principles were applied in District 27 Community School Board v. Board of Education of the City of New York. There, a federal district court held that local school boards violate the students' section 504 rights against discrimination by excluding all students with AIDS from regular classes without individualized determinations based on expert judgment. Likewise, in Thomas S. v. Atascadero Unified School District, a court ruled that excluding those children who may

279. Id. at 445.
280. Id.
281. Id.
283. Id. at 657, 659-60.
284. Id. at 660.
285. Id. at 660-61.
287. Id. at 413-17, 502 N.Y.S.2d at 335-37.
have AIDS and who bite other students or teachers from school is not permissible. The "overwhelming weight of medical evidence is that the AIDS virus is not transmitted by human bites, even bites that break the skin." The "theoretical risk" of AIDS transmission is "so remote" on the basis of present evidence that exclusion violates the students' section 504 rights and the Education of the Handicapped Act.

Courts have reached the same result when the plaintiff is a teacher, instead of a student, with AIDS. In Chalk v. United States District Court Central District of California, Chalk, a special education classroom teacher, was diagnosed as having AIDS and subsequently reassigned to an administrative position and barred from teaching in the classroom. The district court denied his motion for a preliminary injunction ordering his reinstatement, but the Ninth Circuit reversed. The court stated that the Arline four-prong test must be applied before a person who is handicapped may be removed from a position for which he is otherwise qualified. The Arline test permits exclusion from employment as a teacher only if there is a significant risk of transmission; complete certainty that transmission will not occur would impose an impossible burden of proof on the agency.

The precedent for these cases is not Arline, but rather the Second Circuit's opinion in New York State Association for Retarded Children v. Carey. In that case, local educational agencies resisted the placement into their programs of students who had Hepatitis B and were being transferred out of the Willowbrook state institution for people with developmental disabilities under a court-ordered plan of deinstitutionalization and institutional reform. The court stated that there must be more than a remote possibility of transmission before Hepatitis B carriers may be excluded from public schools. Absent definite proof of transmission and the creation of a significant risk to others from including the carriers in class, exclusion was impermissible.

289. Id. at 381-82.
290. Id. at 380.
291. Id.
292. 840 F.2d 701 (9th Cir. 1988).
293. Id. at 703.
294. Id. at 712.
295. Id. at 705-06.
296. Id. at 707.
297. 612 F.2d 644 (2d Cir. 1979).
298. Id. at 646-48.
299. Id. at 650.
300. Id.
These cases stand for the proposition, which this Article advances in the case for mandatory testing of certain individuals with developmental disabilities, that the burden of proof is on the provider to justify any proposed intervention. The proof must be significant enough to justify the intervention. For example, the exclusion of a student from an educational setting may not be based on a remote possibility of the transmission of AIDS. Furthermore, behavior is relevant. Also, an individualized medical determination of the risk of transmission is required. If a person is otherwise qualified, no change of program or employment status is permissible. If, however, a person meets the Arline standard, the person will not be otherwise qualified and a service provider may make placement or employment status changes without violating section 504.

VI. JUSTIFICATIONS FOR THE PROPOSED GENERAL RULE

The rule in favor of mandatory testing and the consequent changes in medical, behavioral, and environmental interventions or settings are justified on several bases.

A. The Person Meets Objective Criteria

As Curtis L. Decker, executive director of National Association of Protection and Advocacy Systems, has stated in appealing for protection of an individual's confidentiality/privacy rights and other civil rights, "we must protect people's civil rights based on the knowledge of their HIV antibody status."301 Certainly that is the lesson of the Arline decision. The Supreme Court found that a teacher with recurring tuberculosis is handicapped under section 504 and entitled not to be discriminated against in employment solely on the basis of that handicap. The Court remanded the case to the district court for fact finding on how much of a threat, if any, the teacher's physical condition posed to the students assigned to the teacher.302 The Supreme Court directed the lower court to rely on competent expert medical opinion and other reliable evidence to make that determination.303

B. Mandatory Testing is Relatively Noninvasive

The standard testing procedure consists of three tests, involving the withdrawal of blood and its analysis. These tests are sequential.

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303. Id. at 288.
Unless the first test is positive, the second is usually not performed, and unless the second also is positive, the third is usually not performed. Thus, there is a possibility that only one test will be conducted. Additionally, the person’s blood samples are drawn for other testing purposes, including testing for such contagious diseases as Hepatitis B, as well as to monitor a drug regimen’s effects and diagnose medical conditions. Thus, mandatory testing for AIDS can accompany those diagnoses and reduce the number of blood samples that are drawn from a single person.

C. Mandatory Testing’s Benefits to the Tested Individual

Mandatory testing benefits the individual and advances the individual’s rights as a recipient of services from public or publicly funded providers. These rights were established by statutes in the states and by the Supreme Court’s decision in Youngberg v. Romeo,304 holding that the fourteenth amendment due process clause requires a state to provide appropriate medical treatment to residents of its institutions.305 Moreover, if the person is found to have the AIDS virus, the person may claim not only the right to adequate medical treatment under Romeo, but also a right to behavioral programming (designed to prevent the person from transmitting the virus to others), as established by the long line of right-to-treatment cases.306

Among a person’s rights is the constitutional and statutory right to placement in the least restrictive alternative setting.307 If the person is found to have the AIDS virus, the person who consequently receives medical and behavioral interventions thereby may be able to enjoy the opportunity to reside, work, and recreate in the least restrictive settings. Absent testing and appropriate interventions, the person who manifests AIDS symptoms may be restricted in personal interactions and possibly denied interventions that increase the possibility that the person may be placed in more integrated, less restrictive settings.

D. Mandatory Testing’s Benefits to Others with Developmental Disabilities

If testing determines that a person in a congregate setting has the AIDS virus, there will be benefits for the other people who

305. Id. at 324.
are at risk. For one thing, those who live in these settings and have a developmental disability, or their caregivers, will know that they should use protective measures to protect themselves from contagion. The name of the person with the AIDS virus need not be disclosed. The fact alone, unassociated with a name, is sufficient to enable others to take protective measures and does not violate the ABA standards for privacy.  

Persons in the facility will be on guard to practice safe sexual conduct and to avoid other kinds of dangerous conduct, such as health care interventions. If they are unable to take these precautions on their own, they will be able to receive assistance from facility staff in practicing these precautions. Finally, as residents of congregate settings that are operated under state authority, they have rights to the same kind of medical and behavioral programming and interventions as the person with the AIDS virus.  

E. Mandatory Testing’s Benefits to the Nondisabled  

Clearly, the general public has an interest in not being exposed to the AIDS virus by contact with an infected person. Yet the principles of normalization, which calls for the lives of people with mental retardation to be as normal as practicable, social role valorization, which calls for people with mental retardation to have socially valued roles, and general good practice within the disability profession results in persons with developmental disabilities who may have the AIDS virus participating in activities in which the person regularly comes into contact with members of the general public.  

Moreover, the professional staff who work with such persons, particularly in such activities as personal health care and behavior modification that requires direct personal contact, have an interest in not being exposed to the virus. Their interest is more than one of personal well-being; it includes their interest in working in their chosen profession and exercising their special skills for the benefit of individuals with a disability.  

F. Mandatory Testing’s Benefits to Providers  

As noted above, providers of service to individuals with a developmental disability have constitutional, statutory, and regu-
mandatory obligations to perform routine health diagnoses, render adequate and appropriate medical and behavioral interventions, and generally safeguard the person and the other people with whom the person may have contact. Moreover, service providers have an interest in avoiding liability for failure to discharge the duty of care owed to individuals with a developmental disability.312

Not only does the facility have an interest in these matters, but also the state, which funds, licenses, and sometimes operates the facility, has an interest. At its core, the state's interest is to achieve the proper balance between the rights of individuals and the public. The traditional paradigm for this balancing is the situation in which a person who does not have a developmental disability asserts fourth, fifth, and fourteenth amendment guarantees and, in doing so, resists mandatory testing but the public asserts its right not to be infected with the AIDS virus by a known or suspected carrier.

Even this formulation of the issue is inadequate to describe the challenging assertion of conflicting interests. Because the state has a constitutional duty to provide adequate medical care under Romeo,313 and because the state may not deprive a person's liberty if the person can survive safely outside state-supervised care,314 the state faces a difficult dilemma. "How can this state obligation to ensure safety be squared with whatever dangers exist in other residents who have HIV infection that might be further exacerbated by aggressive behaviors (for example, nonconsensual sex, biting)."315

The dilemma is more than a legal one. Preventing sexual encounters or aggression or enforcing blood-and-body-fluid precautions is not always possible in the case of some people who may have an HIV infection.316 The issue then becomes ethical in nature. If providers are denied an opportunity to test for AIDS or other

312. See infra notes 389-94 and accompanying text; see generally supra note 8.
314. See O'Connor v. Donaldson, 422 U.S. 563, 575 (1975) (stating that persons with a mental illness cannot be involuntarily committed to a state institution if they could survive safely being free).
316. Prevention is difficult because "many people with mental retardation/developmental disabilities are sexually active, some have poor judgment and poor impulse control, many live communally and within the community, some have social skill deficits, and most have cognitive problems and some difficulty in making decisions." Jacobs, Samowitz, Levy & Levy, Developing an AIDS Prevention Education Program for Persons with Developmental Disabilities, 27 MENTAL RETARDATION 233, 233 (1989).
contagious diseases, when is it appropriate for them to exclude a person from a program or facility or to deny a person the opportunity to participate in community based programs because of the potential harm that the person’s behavior may cause to another?317

G. Mandatory Testing’s Benefits to Public Fiscal Policy

Arguably, the public has an interest on a cost-benefit basis in knowing whether any person has an AIDS virus in order to make policy decisions involving research, training, intervention, and prevention. The public also has a particular interest in knowing about the prevalence, incidence, etiology, treatment, and prevention of AIDS among people with developmental disabilities. This is because that knowledge will affect professional practice and the cost of publicly supported professional practice.318 Moreover, when professionals who work with individuals with a developmental disability are barred from testing those individuals for HIV infection and thereby from acting on the basis of the results in ways that safeguard their own health, they may experience substantial disincentives to work with such individuals. Thus, increased costs of recruiting and retaining professionals may be projected.

H. Mandatory Testing Is Not Inconsistent with Provider and Public Health Practice

According to the immediate past Commissioner on Developmental Disabilities in the United States Department of Health and Human Services, “vulnerable adults with developmental disabilities go without the training that will prevent their falling victim to the infection.”319 Policies for residential programs are necessary and are being developed by the National Association of Protection and Advocacy Systems.320

I. Mandatory Testing Is Preventative

There is a documented association between AIDS and developmental disabilities.321 According to the immediate past Commis-

319. Gray, supra note 53, at 199.
sioner on Developmental Disabilities, "we must plan now for the reality that HIV infection will affect the future service delivery system." Her observations are underscored by a host of professionals in the field of developmental disabilities who also are experts on the medical treatment of those with such a disability.323

J. Mandatory Testing Is Appropriate in Cases of Population with Impaired Capacity

Although health and safety education programs to prevent the transmission of AIDS or other infectious diseases certainly are warranted and should be established within congregate-care settings where people with a developmental disability reside, some people with a developmental disability will not be capable of acquiring prevention knowledge or applying it if they can acquire it.324

K. Mandatory Testing May Prevent Unnecessary Segregation

The consequences of failing to test can be adverse to people with developmental disabilities. Already, there is evidence that integration efforts are thwarted, pledges of confidentiality are broken, staff refuse to continue to work with clients, and "frequently restrictive residential settings" are provided in lieu of less restrictive ones.325 Moreover, most of the HIV-infected people with developmental disabilities have lived in community-based settings, and some have become infected and infect others through either sexual contact or intravenous drug use.326 The likelihood that resegregation will gather force, undoing the progress made to deinstitutionalize people with a developmental disability and to establish programs and rights to programs in community settings, is too great to be ignored. Resegregation can be thwarted by limited mandatory AIDS testing and appropriate follow-up intervention.327

Moreover, knowledge about effective AIDS interventions for people with a developmental disability may reduce the possibility that segregative or overly intrusive, and therefore arguably more expensive, interventions will be required for persons with suspected, but not confirmed, AIDS infection. Absent mandatory testing, it

322. Id.
324. See supra notes 98-103 and accompanying text.
325. HIV and Developmental Services, supra note 14, at 229.
326. Id. at 230.
327. Id. at 230-31.
is likely that providers will begin to resegregate on a general, nonindividualized basis those members of the population with a developmental disability who engage in at-risk behaviors. That number could be fairly large and include those with more severe disabilities for whom community participation is increasing. Finally, the Surgeon General has noted that the cost of providing services to people with AIDS is already large and will grow immensely in the future.

L. Mandatory Testing Addresses Understated Prevalence Issues

Estimates of the number of people with developmental disabilities who have HIV infection are apparently understated. The prevalence of HIV infection in adults with developmental disabilities is unknown. This may constitute an argument against mandatory testing: when there is no clear evidence of a problem, there should be no efforts for compulsory testing and the concomitant restriction of the liberty rights of individuals with a developmental disability. This also may be an argument, however, in favor of mandatory testing: if it is true that the prevalence of AIDS in the developmentally disabled population is understated, mandatory testing of only some members of the population may result in more accurate prevalence data that in turn can form the basis for more informed public policy concerning AIDS prevention and treatment.

M. Mandatory Testing Policies Are Necessary for Providers

States are fairly unprepared to deal with issues surrounding AIDS in the population with developmental disabilities. First, states often lack the necessary policies. Only three states permit mandatory testing of people with developmental disabilities to determine HIV infection. Second, the service system may be inadequate

328. See Chartbook, supra note 78, at 28.
330. HIV and Developmental Services, supra note 14, at 229-30.
331. Id. at 230.
332. Id.; Gray, supra note 319, at 199, 200.
333. HIV and Developmental Services, supra note 14, at 230-31. These three states are Texas, Colorado, and Wisconsin. Id.
to meet the needs of HIV-infected people with developmental disabilities, particularly those who are "highly functional asymptomatic clients." This is because client sexuality is rarely discussed, notwithstanding that "a significant number of persons with HIV infection now reside in public institutions and the spread of the virus may occur during sexual contact." Finally, staff may be reluctant to address issues of sexuality and sexual behavior among clients with developmental disabilities. Accordingly, developing guidelines that "minimize the risk of transmission of HIV infection in service settings" is desirable in striking the balance between individual rights and public safety.

VII. OBSTACLES AND OBJECTIONS TO MANDATORY TESTING

There are several major obstacles to mandatory testing, even after determining that a person with a developmental disability meets the medical and behavioral criteria and that there are sufficient interests in obtaining AIDS testing.

A. Privacy

First, there are important issues involving privacy and confidentiality. Only limited reasons for disclosing the results of a positive finding on an AIDS test exist. Those reasons are to develop programs (such as sex education or behavior modification), provide medical treatment, and protect the interests of others. This Article recommends that upon a positive test result, appropriate educational, behavioral, and medical interventions should be provided for the individual and appropriate measures should be adopted to safeguard the interests of others.

One argument against mandatory testing is that it infringes upon a person's privacy right. A certain loss of privacy is a condition precedent to a person with a developmental disability receiving

334. Id. at 230.
337. HIV and Developmental Services, supra note 14, at 231.
338. Rennert, supra note 4.
339. See Note, supra note 8, at 658.
services in any agency. Most facilities require mandatory health screenings upon admission.340 In addition, most of the patient’s “private” life is documented in individualized treatment plans and charts.341 As long as the facility has policies in place that provide for adequate protection of a person’s rights after HIV infection is discovered, the person’s privacy rights could be balanced with the increased risk posed to society. It would not excessively invade the person’s privacy right to require testing for HIV infection when sufficient cause is shown.

One commentator argues against mandatory AIDS testing of hospital patients on the grounds that testing illegally invades their privacy.342 There are two bases for the argument. First, individualized suspicion is not present to justify wholesale testing.343 This Article’s proposal requires individualized suspicion and set criteria, largely based on and wholly consistent with Arline, for that suspicion’s existence. Second, the risk of transmission is insufficient to warrant mandatory testing.344 This Article argues that, for a population that is by definition disabled and less competent to exercise precautions to prevent transmission, there is a public health, as well as a private interest, in testing these members of the population.

B. Stigma

Any diagnosis of AIDS in an individual creates the possibility that the individual will experience discrimination based on that trait. With respect to the AIDS condition, disclosure of a positive test result obviously is a matter fraught with difficulty. Regrettably, the condition itself carries a stigma. Moreover, the AIDS stigma may be added to the stigma of developmental disabilities, thereby creating a dual stigma and increasing the likelihood of discrimination. These are substantial objections to mandatory AIDS testing, even of the population whose medical manifestations and behaviors are indicative of AIDS and its transmission. This Article contends that, for reasons set out above, the counter-balancing concerns are sufficient to off-set these objections.

341. Id. § 28-39-91.
342. Note, supra note 8, at 658.
343. Id. at 659.
344. See id. at 670-71.
C. Professional Consensus

The public policy affirmations adopted by a majority of the participants in a recent symposium on AIDS and developmental disabilities constitute a barrier to mandatory testing for AIDS of certain individuals with developmental disabilities. The physicians, lawyers, policy-makers, and providers who attended that symposium considered many issues involving people with developmental disabilities who have or may have HIV infection. Notwithstanding their careful balancing of many factors, including mandatory testing’s benefits and drawbacks, they adopted the following affirmations of public policy:

1. "The confidentiality of an individual’s HIV status shall be respected." 346
2. "Test results shall be disclosed only to the client/patient, surrogate decision-maker, and medical care provider." 347
3. "Antibody testing shall be voluntary and performed only with informed consent." 348
4. "Testing shall be performed only when medically indicated." 349
5. "Testing shall be accompanied by counseling and other supportive services." 350

Clearly, the third principle is an obstacle; it permits only voluntary testing and disapproves of any mandatory testing. This Article disagrees with the third principle for reasons set out earlier. Moreover, the third principle may be inconsistent with CDC and AHA policies on testing for AIDS; those policies permit mandatory AIDS testing under circumstances subsumed by this Article’s recommendations.

The fourth principle, however, is helpful to the argument for limited mandatory testing because it seeks to have testing done only when medically indicated, thus adopting an expert opinion approach. 351 Unfortunately, the fourth principle does not go far enough. Medical indications for testing might exist even when there are no behavioral indications or justifications for testing. Moreover, behavioral indications (such as sexual activity or aggression) may warrant testing in the absence of medical indications. Clearly,

346. Id. at 256.
347. Id.
348. Id.
349. Id.
350. Id.
351. Id.
neither alone is sufficient. This Article’s recommendation requires that both coexist, assuring that there will be not only necessity but sufficiency.

Simply put, there are conflicting policy recommendations concerning compulsory testing for the population with a developmental disability. The recommendations presented here are sufficiently narrowly tailored and justified by law and policy to form the basis of good professional practice. Few justifications advanced here seem to underlie the symposium’s third principle. The affirmations’ blanket ban on compulsory testing may do more disservice than service to this vulnerable population and its fundamental interests in good health and community based opportunities.

D. Testing, Setting, and Populations

Universal mandatory testing for HIV infection of persons with a developmental disability is not appropriate. As noted above, screening and testing cannot identify all and only those individuals who would develop or could transmit the AIDS virus. In addition, there is a great potential for infringing privacy interests, which would itself impose potential liability on the caregiver. A person’s constitutional right to be protected from unreasonable searches and seizures could be violated if the intrusion is not based on a reasonable suspicion that the individual is infected.

Yet, the unique context of serving a population with developmental disabilities raises some important questions that challenge the view that universal mandatory testing is always inappropriate. The CDC, for example, recognizes that required testing might be appropriate depending on the characteristics of the person in the particular setting. Persons whose individual histories indicate high risk are candidates for required testing under the CDC view.

352. See Mental Retardation and HIV, supra note 123, at 493; Howe, supra note 8, at 144-48; Gostin, supra note 8, at 30-42. But see Framework, supra note 113, at 1772 (advocating routine screening in clinical and residential settings for person with mental retardation because of the possibility of sexual contacts among residents).

353. See supra note 1 and accompanying text; see also Howe, supra note 8, at 140-41.

354. “[H]ospitals can be found liable precisely because the overwhelming consensus of professional opinion is that informed consent is required before an HIV test.” Gostin, supra note 8, at 39.

355. Note, supra note 8, at 659. A patient in a private institution or community based setting would also have a constitutionally protected right of privacy. See id. at 659-61.


357. Recommendations for Prevention, supra note 133, at 145; see AIDS: THE LEGAL ISSUES, supra note 16, at 86-87. Examples given of high risk hospital patients include hemophiliacs, intravenous drug users, and prostitutes. Id. at 87. These persons are all at high risk for conduct that could lead to the transmission of AIDS.
When a person with a developmental disability is symptomatic for HIV infection and has a history of engaging in high risk behaviors, a facility should test that person whether or not consent is given. 358

E. Alternatives to Mandatory Testing

Another argument against mandatory testing is that there are other alternatives sufficient to control the spread of the disease. Within a hospital setting, for example, use of the CDC guidelines for controlling the spread of the disease is an appropriate control mechanism. 359 Because of the risks involved with persons with a developmental disability, however, these control mechanisms may not be adequate in a treatment facility. 360 Persons with a developmental disability may not have the cognitive ability to control their own behavior or protect themselves from others who engage in at-risk-of-transmission behaviors. Moreover, the staff may not always be able to avoid contact with bodily fluids that may transmit the disease. Over the past twenty years, treatment facilities have come a long way from the sterile hospital environment of the past. 361 That progress should not be eroded by hysteria over the threat of HIV infection or by excessive compunction about non-absolute rights against compulsory procedures when those procedures are surrounded by probable cause and due process safeguards.

For the largest number of people with a developmental disability who live in a congregate setting, voluntary testing procedures should be adopted before any compulsory AIDS testing occurs. 362 Granted, a person who is asymptomatic, yet HIV positive, still poses a risk for transmission of the AIDS virus. In this context, however, there is no sufficiently compelling reason to require involuntary testing because there is no reason to believe that the person has the disease. As the person manifests physical symptoms, however, probable cause for mandatory testing arises if the person also emits certain at-risk behaviors. Indeed, for the person's own health, there may be probable cause for mandatory testing even in the absence of at-risk behaviors.

358. Obtaining consent prior to testing should always be attempted, however. See supra Part III.
361. "[T]he need to provide extra supervision for [persons with mental retardation] who are seropositive does not warrant isolation, stigmatization, or the deprivation of services." Id. at 1772.
362. See, e.g., Gostin, supra note 8, at 31-42.
F. Arguments Based on Testing Reliability and Ethical Considerations

Kenneth R. Howe counsels against mandatory testing of the general population. Howe makes two basic arguments: AIDS tests are not reliable and ethical considerations bar mandatory testing.

As to the technical issues, Howe’s argument is rebuttable in the context addressed by this Article. He assumes that mandatory testing will apply to the general, not the at-risk, population. By contrast, the argument here is for testing only within a very small population. Moreover, this Article argues for testing only those who meet certain criteria that give rise to probable cause to suspect HIV infection.

Howe also assumes that only one of the three available tests for HIV infection will be used. On the other hand, this Article argues for multiple tests, with retesting as appropriate. He argues that a “chain of inferences” based on test results will yield only a 10% chance that AIDS eventually would be manifested. Yet, what are the alternatives to testing a specified population in a congregate setting that manifests medical and behavioral symptoms suggestive of AIDS infection and transmission? Certainly the alternatives are less desirable than testing.

It is proper to answer Howe’s objections with a question and answer: If the tests indeed are built on a chain of inferences and yield unacceptably low positive results, would public policy best be served by creating a statutory immunity for the providers that do not test? If mandatory testing is unacceptable even for the high-risk population with developmental disabilities, immunity for failure to test should be forthcoming. With that immunity, there also should be the allocation of the cost of not testing; that is, the public should be willing to pay the cost of caring not only for the person with a developmental disability who acquires AIDS, but also for providers and others infected by the person. Yet, refusal to permit mandatory testing has costs in terms of legal liability and health risks. If public policy is to bar mandatory testing for a limited population, then public policy also should allocate the costs of that ban to the public.

363. See generally Howe, supra note 8.
364. Id. at 141.
365. See id. at 140-41.
366. See id. at 141-42.
367. Id. at 142.
368. See supra Part IV.
Next, Howe objects to mandatory testing because the person at risk of acquiring HIV virus or AIDS infection is able to benefit from education about at-risk practices.\textsuperscript{369} In general this is true, even as the argument applies to many people with a developmental disability. Some people with a developmental disability, however, lack that capacity; for them and their providers, education is not efficacious and therefore is not an acceptable alternative. When the medical manifestations and at-risk behaviors of these individuals give probable cause to believe that they may have AIDS, compulsory testing is warranted. These individuals may constitute a small number and a very limited exception to the general rule, but they nonetheless should be an exception.

Howe also contends that because no effective treatment for AIDS exists, testing to provide a cure and prevent infectiousness is not warranted.\textsuperscript{370} Under \textit{Romeo} and other law, however, the state has a pre-existing duty not only to attempt to prevent infection but also to treat any condition of persons within its care, custody, or control.

There have been recent advances in the prevention and treatment of AIDS and it is likely that these advances will continue.\textsuperscript{371} It is nonsensical to ignore these advances and then compound that blindness by denying the benefits to likely beneficiaries on the ground that they should not be compulsorily tested to determine the existence of the AIDS virus.

Howe uses the same argument to criticize the tests as a means of “contact tracing.”\textsuperscript{372} As suggested in \textit{Anthony}, however, the state has a duty to third parties with developmental disabilities who qualify as contacts. In both situations, despite its technical limitations, testing is so noninvasive that it is warranted.

Howe acknowledges that people, such as health care workers, who come into contact with contaminated blood have an interest in being protected against infection.\textsuperscript{373} Precisely for that reason, this Article argues for limited mandatory testing. Non-testing may create a disincentive to sustain a sufficient number of workers to care for people with disabilities. Because of the lack of assurances that these care providers will be able to protect themselves, they may seek work elsewhere.

\begin{itemize}
\item \textsuperscript{369} Howe, \textit{supra} note 8, at 144.
\item \textsuperscript{370} See id. at 144.
\item \textsuperscript{372} Howe, \textit{supra} note 8, at 144.
\item \textsuperscript{373} Id. at 146.
\end{itemize}
Finally, Howe contends that testing is not cost-beneficial.\textsuperscript{374} His argument is with the private insurer. This Article’s argument, that the cost of care will fall to the public, is of a different sort. Testing certain people in certain settings might be cost-effective and thus utilitarian because it creates a benefit for the person, the provider, the person’s associates, and the public.

G. Arguments Based on the Physician’s Right to Know

Howe is not alone in attacking mandatory testing for AIDS. Larry Gostin takes a similar position.\textsuperscript{375} He argues that physicians and patients do not have a right to know about each others’ health status, especially AIDS status, and he disapproves of both mandatory testing and publication of test results.\textsuperscript{376} Although his arguments may be persuasive within the context of physician-patient disclosure, they are not persuasive within the context addressed here.

Gostin asserts that the risk of transmission from patient to physician or physician to patient is so low that involuntary disclosure of seropositive status is unwarranted.\textsuperscript{377} Based on this conclusion, he states that health care professionals (HCPs) merely should be educated about the risks of transmission and trained to take every precaution.\textsuperscript{378}

There is a fundamental difference, however, between the HCP, who assumes certain risks in the ordinary course of employment and is educated and educable with respect to precautions, and the person with a developmental disability. The person with a developmental disability neither assumes nor explicitly consents to the risks of transmission. Indeed, the person has a right under constitutional and statutory law to be protected against those risks. Also, for some people with a developmental disability, the disability itself, because of its cognitive limitations, may be exactly the condition that prevents the person from being educated sufficiently about risks and trained about precautions. The very existence of the disability creates a distinction between the HCP and some people with a disability, justifying a different result. Gostin’s least drastic means approach—education and training in lieu of compulsory testing and disclosure—should apply to the HCP working with individuals with a developmental disability and generally to

\textsuperscript{374} Id. at 146-47.
\textsuperscript{375} Gostin, supra note 8.
\textsuperscript{376} Id. at 14-15.
\textsuperscript{377} Id. at 15-24.
\textsuperscript{378} Id.
that population as a whole.\textsuperscript{379} It is inapposite to some individuals with a developmental disability, however, because of the extent of their disability. Differences in capability have always made differences in result (as guardianship and involuntary commitment laws demonstrate).

Second, Gostin's advocacy for universal precautions presumes that every patient is or might be seropositive for HIV.\textsuperscript{380} Without that presumption, no cause for universal precautions exists. We do not make any presumptions with respect to an individual or all individuals with a developmental disability. Instead, this Article establishes certain criteria that must be met before probable cause exists to compulsorily test individuals with a developmental disability. Gostin's presumption is limited to justifying universal precautions and used as a shield against mandatory testing and disclosure. If a presumption must be made, however, it should be limited to situations in which people with a developmental disability meet certain criteria for mandatory testing. They should be tested first with consent if available and without it if it is unavailable.

Gostin next addresses the assumption that seropositive people will change their behaviors.\textsuperscript{381} He says that behavioral changes may be sensitive to the public's interest\textsuperscript{382} or insensitive to the public's interest.\textsuperscript{383} Ironically, Gostin's argument actually buttresses this Article's argument that compulsory testing is defensible for a limited number of individuals with special characteristics to determine if changes in behavior programming should be initiated. Few members of the general population are subject to regular, legally required behavioral programming. Many who have a developmental disability are, however. Simply because an opportunity for behavioral programming exists, testing the individuals for AIDS will be desirable and may be compulsory, especially if the programming relates to their health or the health of others. With individuals who have a developmental disability, in contrast to members of the non-disabled population, certain behavioral changes are more assured because rights and coexisting duties ameliorate the effects of the disability and protect others from harm. Thus, the doctrine of \textit{parens patriae} combines with the police power to yield different results for a very small number of those people.

\textsuperscript{379} See id at 24.
\textsuperscript{380} Id. For a description of the universal precautions approach, see id. at 24-28.
\textsuperscript{381} Id. at 35.
\textsuperscript{382} People may "altruistically refrain from high risk behavior." Id.
\textsuperscript{383} People may "act more dangerously because there is little left to lose." Id.
Gostin’s argument against involuntary HIV testing includes the criticism that testing is done for the benefit of others, not the person infected.\textsuperscript{384} This objection rests on two premises. First, “there is no evidence that others will in fact benefit.”\textsuperscript{385} Second, there is a general objection to “‘using our patients for the benefit of others.’”\textsuperscript{386}

Gostin’s third-party-benefit argument actually seems to support this Article’s approach. Testing a small segment of the population with a developmental disability benefits both the tested persons and others. The others include people with developmental disabilities, health care professionals, and the general public. In each case, the third-party benefit is premised on the fact that the person with a developmental disability who meets objective criteria poses a different risk of transmission than does a person without a developmental disability. When there is a higher risk of transmission, there should be a different result. A theory of beneficence actually supports such testing.

Gostin’s argument that health care workers use patients for their own benefit is inapposite in the context that this Article addresses.\textsuperscript{387} Third-party benefit is not the only ground for involuntary testing of some who have a disability. Indeed, the benefit to the person is an explicit reason for testing, and even Gostin acknowledges that testing benefits the person.\textsuperscript{388} The direct benefit rule, which Gostin advances, is well satisfied by involuntary testing and should be advanced when the state’s duty to provide treatment to the person is considered.

Gostin further objects to involuntary testing on legal grounds. He argues that a health care provider may be liable to an AIDS-carrier if the HCP fails to treat or provides substandard treatment.\textsuperscript{389} This Article contends, by contrast, that involuntary testing is justified so that providers can satisfy their duties to provide treatment and thereby avoid liability.

Next, Gostin objects to provider collection of HIV information because once providers have information, they could face liability for failing to notify a patient’s sexual or needle-sharing partner of the risk of contagion.\textsuperscript{390} This result does not obtain in the context

\begin{itemize}
\item \textsuperscript{384} See id. at 41.
\item \textsuperscript{385} Id.
\item \textsuperscript{386} Id. at 41 (quoting Gillon, \textit{Testing for HIV Without Permission}, 294 BRIT. MED. J. 821, 823 (1987)).
\item \textsuperscript{387} See id. at 40-41.
\item \textsuperscript{388} Id. at 33-34.
\item \textsuperscript{389} Id. at 42.
\item \textsuperscript{390} Id. at 42, 48-50.
\end{itemize}
addressed here. Precisely because a duty to notify exists, the providers to individuals with a developmental disability in state-funded or state-operated programs should be able to involuntarily test certain clients.391 Moreover, in the case of some individuals with a developmental disability, the extent of their disabilities may render them less competent to take protective measures even if they are warned. This incapacity for self-protection makes a difference; the very assumption in the duty-to-warn cases is that the target has the ability to take counter-measures.392 Additionally, the provider to individuals with a developmental disability has a special duty of care.393 The duty is to protect, and thus there exists a right to know how to protect others with whom the suspected HIV-carrier has certain relationships.

Moreover, the provider may be held liable for failure to supervise the suspected HIV-carrier if the carrier endangers nontargeted members of the general public.394 The duty to supervise necessarily implicates a right to know of those conditions that endanger others. In the situation of a person with a developmental disability who meets the objective criteria that this Article proposes, the provider cannot meet the duty to supervise and thus avoid liability unless the provider can obtain certain information about the individual. Mandatory blood testing, therefore, may be justified for the provider but not for a general hospital.

Another argument in the context of the “physician’s right to know” is made by The U.S. Department of Health and Human Services in The Public Health Service (PHS) Guidelines for Counseling and Antibody Testing to Prevent HIV Infection and AIDS.395 Unlike Gostin, the Guidelines explicitly use the third-party beneficiary rule: testing is “an important component of prevention strategy” to “help uninfected individuals initiate and sustain behavioral changes that reduce” transmission risks.396 Here the focus is on uninfected individuals. Their interests predominate public health considerations.

By contrast, Gostin’s focus is on individual autonomy, that is, direct benefit for the individual, not benefits for others.397 He does not attempt to balance the countervailing claims except when he

391. See supra notes 389-94 and accompanying text.
392. See id.
393. See id.
394. See id.
396. Id. at 509.
397. See Gostin, supra note 8, at 14.
deals with the liability for failure to warn, and even then he does not adequately address the issue with respect to individuals with a developmental disability and their providers.

Under PHS Guidelines, public health interests warrant testing to prevent the spread of infection "among persons who would not otherwise realize that they are at risk." This is precisely the consideration that this Article uses—prevention of transmission to nonknowledgeable people—to help justify mandatory testing of certain people who inherently cannot practice, because they do not know or, if knowing, cannot practice, self-protection.

I. Narrow Tailoring and Medical Compulsion

A student note in the Harvard Law Review on the constitutional rights of AIDS carriers acknowledges the necessity to balance the rights of individuals with AIDS or suspected of having AIDS, with the public's health interests. The note's author argues that mandatory testing, among other interventions, is defensible under the first, fifth, and fourteenth amendments only if it is "narrowly tailored (and) medically compelled." Initially, public health measures such as mandatory testing and reporting, with provisions for confidentiality, meet the requirement that any regulation must serve a legitimate public purpose, whether analyzed by fourteenth amendment strict scrutiny, intermediate scrutiny, or a rational relationship approach. Assuming that the state's interest in public health and in the health of people with developmental disabilities is the only basis for regulations that mandate testing for AIDS, and further assuming that the state's interest is articulated, based on a solid factual foundation, and logically warrants the particular regulation and its application to the designated population, mandatory testing will not be constitutionally impermissible if sufficient medical expert judgment warrants it.

Under the proposition advocated here, two factors must combine before mandatory testing of people with a developmental disability who live in congregate settings is warranted. The person's medical condition and at-risk behavior must exist concurrently before mandatory testing is justified.

398. PHS Guidelines, supra note 395, at 510.
400. See id. at 1280-81.
401. See id. at 1282-83.
The approach here assumes that the state of medical judgment is such that a qualified physician can accurately conclude that a person has or may have the AIDS virus. Yet, it may be, as the Harvard Law Review note pointed out, that "[p]hysicians are not yet able to determine when an AIDS carrier is infectious." To the note's author, this justifies the conclusion that state compelled regulations are generally indefensible.

To the contrary, a different conclusion can be derived from that statement. Precisely because medical judgment cannot determine when a person is infectious, required testing of those who meet the two criteria is warranted—not forbidden. When certain observable and measurable medical criteria that are well-known among the medical community to yield a diagnosis of one or more AIDS-condition states exist, the public health interest may not only permit mandatory testing, it may also require it. If medical knowledge is certain of some matters (diagnosis of the medical condition) but not others (prediction of infectiousness), uncertainty may be used in combination with certainty to permit mandatory testing.

Indeed, one flaw in the recommendations here may be that they are not inclusive enough. A gap exists between the time a person acquires the virus and thus becomes capable of transmitting it and the time the virus becomes medically manifest. Arguably, mandatory testing could be justified for individuals with cognitive disabilities who live in congregate settings and who emit behaviors that facilitate transmission. The authors hesitate to recommend that result because the person’s residential status and behavior alone may give cause for over-reaching and unnecessary testing or, in the absence of testing, resegregation of too many individuals.

Residential status alone is easy to determine and is objective. Behavior, however, is another matter. Behaviors of some individuals may be too easily construed to meet the criteria. To avoid liability, a service provider may construe some behavior as meeting the criteria when it does not. Even a due process hearing may not safeguard against over-reaching; error may occur in hearings and an expert may persuade a hearing officer to enter an order to test when there is contrary testimony.

The author of the Harvard Law Review note also objects to certain state regulation, such as quarantine, on the basis that prediction of future behavior of individuals suspected of having the AIDS virus "either could not be substantiated, or could not be made with sufficient certainty to meet the tests of close fit and

402. Id. at 1283.
AIDS TESTING

least restrictive means. Substantiation and certainty are requisite to state compulsion in cases of AIDS intervention, whether it be quarantine or testing. That arguably is why mandatory testing of those who have not yet manifested AIDS symptoms is unjustifiable, even when they live in congregate settings and engage in at-risk behaviors. Neither the setting nor the behavior alone justifies mandatory testing. The setting need not change simply because a person has certain at-risk behavior. What should change is the person's behavior-intervention program. New or more effective procedures to teach behavior that does not put others at risk is what is required. Only when the person living in congregate settings has engaged in at-risk behaviors that cannot be eliminated or significantly reduced by behavioral programs and has manifestations of AIDS is it permissible to conduct mandatory testing.

Mandatory testing should not be required unless there is evidence that at-risk behavior has occurred and is for that reason likely to recur. Prediction is not the basis for mandatory testing; overt, past acts are required. That is consistent with the case law and avoids the prediction without a reliable factual basis that the author of the Harvard Law Review note properly fears. In Leckelt v. Board of Commissioners of Hospital District No. 1, for example, there was an ample basis for believing that the plaintiff, who had engaged in a long-standing homosexual relationship with someone who had died of AIDS, may have been affected by AIDS. In Guardianship of Anthony, there was evidence of a long-standing homosexual relationship; again, behavior warranted probable cause, although the court lacked jurisdiction to order mandatory testing. In Glover v. Eastern Nebraska Community Office of Retardation, no evidence established that staff at-risk behavior was persistent, long-standing, and therefore likely to be repeated, or that the behavior itself was apt to put anyone at risk for transmission of the virus. Indeed, in Glover there was no evidence at all that any staff member at ENCOR posed a serious risk for transmission.

Moreover, the alternatives to not testing compulsorily—including potential involuntary civil commitment, transfer to more re-

403. Id.
404. 909 F.2d 820 (5th Cir. 1990).
405. See id. at 823 n.5.
407. See id. at 724-27, 524 N.E.2d at 1362-63.
408. 867 F.2d 461 (8th Cir.), cert. denied, 110 S. Ct. 321 (1989).
409. Id. at 463.
410. Id.
strictive, less normalized residential status, or imposition of physical restraints—are themselves unattractive and do not yield medical information on which to base treatment and habilitation decisions. When a person medically suspected of having AIDS lacks self-control, is prone to engage in unacceptable behavior, and is a danger to society for those reasons,\textsuperscript{411} mandatory testing cannot be objectionable.

Undoubtedly, the "minor personal invasion"\textsuperscript{412} occasioned by mandatory blood testing is minor except for the consequent "'disclosure of personal matters'" that might attend it.\textsuperscript{413} The issue, then, is not the testing itself but the use of the test results. It is on this basis that the author of the \textit{Harvard Law Review} note argues that "'[n]othing short of compelling necessity' warrants mandatory blood testing and reporting."\textsuperscript{414}

The state may satisfy the necessity standard by showing that the mandatory test is necessary to "advance the public health." This is shown if the state can demonstrate that more than "casual contact" exists between the person whom the state wants to test and members of the public.\textsuperscript{415} The recommendation here adopts precisely that approach. It requires not only a suspected medical condition but also proof of behavior that puts the public at risk.

Moreover, this Article's approach eschews the paternalistic notion, that "those individuals most at risk probably are already aware of the odds that they carry AIDS."\textsuperscript{416} The recommendation here addresses those individuals who—because of their mental disability and limited cognitive functioning and thus their probable ability to be aware of the odds—most likely do not fit into that category of sapient odds-takers.

Further, members of the general public who "probably are already aware of the odds that they carry AIDS" are not the objects of state intervention or duties of adequate medical care. The concern here is not with people with cognitive capacity and freedom from state custody or state subsidized private custody. The concern is with those who lack cognitive capacity and who are already within the state's protective ambit. When they or their legal representatives cannot or do not want to assess the odds and when they engage in certain risk-raising behaviors and meet certain

\footnotesize{\begin{itemize}
\item \textsuperscript{411} Note, \textit{supra} note 399, at 1284.
\item \textsuperscript{412} Id. at 1287.
\item \textsuperscript{413} Id. (quoting Whalen \textit{v. Roe}, 429 U.S. 589, 599 (1977)).
\item \textsuperscript{414} Id.
\item \textsuperscript{415} See id.
\item \textsuperscript{416} Id. at 1288.
\end{itemize}}
standards of medical probability for AIDS transmission, there is an altogether different dimension of risk-assessment and risk-assumption.

Finally, the *Harvard Law Review* note argues that mandatory testing, with consequent reporting, even on a limited basis, may deter people from seeking and receiving treatment.417 That may be correct, but the note does not cite data on point, and there is a different set of circumstances involving some people with a developmental disability. By definition, some lack the same cognitive capacity as noncognitively impaired people to assess their own health status and decide whether to seek medical care. Moreover, their rights to treatment, habilitation, and medical care create a duty to treat. Also, their behavior—consisting of at-risk interactions—may not easily be self-regulated and thus may pose a greater risk to the public health than behavior that nondisabled people may control voluntarily.

Moreover, if the mandatory testing is subject to *Matthews* due process scrutiny, whether by judicial proceedings or by quasi-judicial proceedings as approved in *Parham*, then due process requirements will have been satisfied and these individuals, as well as the state, will have been assured that a neutral fact-finder has balanced their respective interests through individualized determinations based on expert judgment.

VIII. CONCLUSION

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. These behaviors include shared use of needles, engaging in sexual behavior apt to cause transmission of the AIDS virus, biting, clawing, digging, and scratching.

The rule takes into account several critical factors involved in AIDS diagnosis, prevention, and treatment. These factors are (in addition to the congregate setting) the person’s condition and the person’s behavior. The person’s medical condition is an indispensable element. The progress of the HIV infection is such that a person moves along a continuum—from having “inferred” AIDS,

417. *Id.*
to being HIV positive and having AIDS-related conditions, to having full-blown AIDS and being an active carrier of the virus. At the point when the person's medical status is such that a reasonable medical expert would conclude that the person has inferred AIDS, and certainly at all subsequent points in the continuum, the person becomes a candidate for compulsory testing.

The person's behavior is another indispensable element. Again, there are different types of behavior that justify mandatory testing. There is increasing justification for mandatory testing as the person's behavior moves along a continuum from person-specific physical aggression, to general physical aggression, to potential contagion by the exchange of blood from needles or combined aggression and dangerous sexual activity, and finally to a combination of aggressions, shared needles, and unprotected sexual activity.

The person's behavior in relationship with others is dispositive. It is not enough that the person engages in certain behavior. What is important is that the behavior involves others and puts them at risk of acquiring the virus from the infected person. Behaviors that involve participants who are unable or unwilling to protect themselves from the risks of transmission warrant mandatory testing. Thus, a person whose medical manifestations meet the criteria and whose behavior involves at-risk elements would be subjected to mandatory testing if the person's sexual or needle partners or objects of aggression are unable or unwilling to protect themselves. This could be the case for nondisabled persons, such as staff, and especially for people whose cognitive, physical, or cognitive-physical disabilities render them particularly vulnerable. The rule is especially sensitive to the self-protection capacities of people with disabilities. It takes into account the cognitive and other capacities of the targeted population to engage in self-regulatory behavior and permits prediction, based on prior behavior that is likely to be repeated, of future at-risk-of-transmission behavior. Finally, the rule disregards casual contact and requires at-risk-of-transmission behavior.

The proposed rule also considers the setting in which the targeted population is located. The setting is limited to one in which people are in close proximity and relationships may develop that can involve at-risk conduct.

Although the rule requires interventions that are targeted on the person's condition, behavior and relationships with others, and environment, there is a presumption against any changes in the service provider's manner of dealing with the person unless these changes are based upon the person's medical condition and behaviors. The rule thus overcomes the likelihood that fear alone
may be the basis of provider decisionmaking, in violation of the admonitions of O'Connor, Cleburne, Davis, and Arline that fear itself is an unconstitutional basis for decisionmaking.

The rule relies on a risk-benefit calculation for determining whether to test. With respect to the population of persons with a disability, it balances the interests of the individual against unwarranted or over extensive invasions of bodily privacy and autonomy with the interests of the public, including persons with developmental disabilities, to be protected in their health.

The rule also guides the provider by giving three bases for decisionmaking—the person's condition, behavior, and environment—and by allowing the provider to consider the risk of liability that might occur if the provider does not intervene. Further, the rule draws attention to the individual's treatment rights and balances them and provider interventions with the rights of the public, staff, and other residents to be safeguarded against infection by a known or suspected carrier.

The rule takes into account the necessity for individualized determinations based on expert judgment, with emphasis on observable, measurable, and objective criteria. This is required as a component of due process and is consistent with the well-established principle of judicial deference to expert opinion. Moreover, it employs a less-drastic means approach by requiring evidence of the ineffectiveness of the other methods of determining if the person is HIV infected.

The proposed rule is largely consistent with the CDC and AHA approaches to testing and subsequent warranted interventions. It demands a test-retest procedure and thus does not rely on a single test for decisionmaking concerning programs and prevention.

Finally, the rule takes into account the fact that, without testing, there may be a disincentive to health care workers to work with the targeted population, and that, if the disincentive proves too powerful, it may result in a reduction of the state's ability to discharge its constitutional, statutory, or other duties of care to the population.

In sum, the limited mandatory testing proposal advanced here will promote the best interests of this population and of society.