Dental Discrimination
Against the HIV-Infected:
Empirical Data, Law and Public Policy

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Professor Burris argues that discrimination is not a single behavior explained by one grand theory, but rather a variegated phenomenon occurring in different social, historical and economic contexts. Each form of discrimination is illuminated by its own set of empirical data and each suggests different strategies for successful legal intervention. To illustrate this view, Professor Burris examines instances of dental discrimination against people with HIV. After reviewing empirical studies on dentists' attitudes and behaviors and the needs and experiences of patients with HIV, he concludes that many dentists are uncomfortable treating patients with HIV and many patients with HIV experience dental discrimination. He then analyzes the bases of these conclusions and considers potential regulatory responses to influence dentists' behavior, including federal disability discrimination law, professional ethics, the tort and professional licensure systems, health care financing regulations, and public health campaigns. Finally, he addresses critics of antidiscrimination laws, such as Richard Epstein, who view such laws as both wrong and ineffectual. Professor Burris argues that Epstein's theories of the market and discrimination are based on ideological premises and factual assumptions that are undermined when discrimination is examined in a particular context, such as the denial of dental care to people with HIV. He concludes that, although legal intervention is neither easy nor automatically successful, examining instances of discrimination on a case-by-case basis will help yield more effective and targeted antidiscrimination strategies.

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Introduction

This Article is about the denial of dental care to people with HIV, a common, damaging, and preventable form of mistreatment. This is also an article about the specificity of discrimination. In the midst of a debate about whether antidiscrimination law "works," I test the proposition that discrimination is far too variegated a phenomenon to be discussed or remedied purely on a grand scale. Rather, I suggest that oftentimes we may most profitably grapple with disaggregated forms of discrimination in their particular social, historical, and economic context as illuminated by specifically relevant empirical data. This Article, therefore, is an exercise in close attention to a single contemporary problem in discrimination law. The analytic method, however, is fully generalizable to other issues of legal policy, and so, finally, this is an article illustrating the importance of integrating empirical data and socio-legal analysis, not only in defining the problems to be addressed, but also in assessing how the law may best be deployed.

For both medical and psychological reasons, access to dental care is particularly important to people with HIV disease. Since the mid-1980s, there have been anecdotal reports of discrimination by dentists and a small number of lawsuits under state law. More recently, the United States Department of Justice (DOJ) has successfully enforced Title III of the Americans with Disabilities Act (ADA) in several dental discrimination cases. The actual frequency of discrimination, and its roots, have been the subject of unusually extensive empirical research, which has provided considerable data about the

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extent and the nature of the problem.

This Article begins with a brief description of the dental care needs of people with HIV and the service delivery patterns that have arisen to satisfy them. There is no doubt that any licensed dentist can safely and competently provide dental care to people with HIV. It follows that segregated clinics for the HIV positive, which are the major supplier of care to people with HIV in many areas, are not medically necessary for primary care. Clinics and practices dedicated to the dental care of patients with infectious diseases do, however, constitute an important part of a comprehensive system of service delivery and dental training.

Section II opens with a review of the extensive literature on dentists' attitudes and behavior, and on patients' experiences. The Article then reports the results of two new studies. The first surveys the dental care experiences of 272 HIV-infected people. Nearly one of five respondents reported a probably or possibly discriminatory refusal to treat, indicating that discrimination remains widespread in the second decade of the epidemic. Refusal was not significantly correlated with patient demographics or health. Instead it depended primarily on the dentist's awareness of the patient's HIV status. Most respondents felt morally obliged to inform dentists of their HIV infection and, rather surprisingly, almost a third believed that dentists had a right to refuse to treat people with HIV. The study also found that, despite the inconvenience and the stigma of segregation, patients attending an HIV-only clinic at an urban dental school were more satisfied with their care than patients of private dentists. The second study concerns the perceptions of discrimination and referral practices of Pennsylvania AIDS service organizations that assist clients in obtaining dental care. The results show a heavy reliance on hospital- and university-based clinics for HIV dental care. This reliance is due in part to discrimination and in part to indigent patients' lack of dental insurance.

Taken collectively, these data establish that many dentists are uncomfortable treating patients with HIV, and that many patients with HIV experience discrimination. The research indicates that dentists' unwillingness to treat flows from a combination of three concerns: fear of infection; fear of the negative reaction of other patients and employees; and uncertainty about their own competency to treat HIV-related oral conditions. The data also establish several other useful facts about HIV-related discrimination. Discrimination is not based on perceived homosexuality or drug use. Dentists are not using these or other traits as surrogate markers to weed out systematically HIV-positive patients. Discrimination seems to occur when the patient voluntarily reveals his or her HIV status, or, less frequently, when the dentist can diagnose HIV from oral or other symptoms. Thus, the problem of dental discrimination is unusual in its dependence on the voluntary revelation
of a hidden trait.

The dental literature offers several prescriptions for reducing discrimination. Training in HIV and infection control has been recommended for dentists and allied health workers such as hygienists. To a considerable extent, primary dental education has incorporated this training, though it has not been widely adopted as a mandatory requirement for practicing professionals. Studies have consistently found, however, that information alone will not eliminate discrimination rooted in psychological, social, or economic concerns. Recent work has emphasized the importance of both peer norms and actual experience in treating patients with HIV.

The dental literature is largely silent about legal issues. One could infer from dentists' candor regarding discrimination that law has not affected their behavior. Yet, gradual increases in professed willingness to treat could reflect the emergence of stronger legal rules, particularly the ADA. Unfortunately, we lack data regarding dentists' awareness of law and their opinions regarding the legitimacy of antidiscrimination rules.

With the nature and dimensions of the discrimination problem established, Section III addresses the principal question of legal policy: How, if at all, should government authority be used to eliminate or reduce discriminatory behavior? Powerful voices within and without the academy have recently mounted a sustained challenge to antidiscrimination law. This attack, exemplified by the work of Richard Epstein, holds that using law to eliminate discrimination is immoral and, worse, ineffective. I avoid an extensive survey of the abstract zones of this debate and, instead, use the particularly well-studied phenomenon of dental discrimination against the HIV-positive to test some of the competing hypotheses on solid ground.

This portion of the Article begins with an overview of the various regulatory systems that might be used to influence dentists' behavior. These include, in addition to federal disability discrimination law, professional ethics, the tort and professional licensure system, health care financing regulations, and the public health law authorizing behavioral change campaigns by health authorities. In each area, I discuss both the substantive rules and what we know about their application; on the basis of this review, I compile a set of measures that might, in theory, constitute a program to change dentists' behavior. Not surprisingly, I discover no panacea.

Having identified a large number of potential measures, I address the criticisms of antidiscrimination law in their largest form, as a critique of any intervention to change discriminatory behavior. Taking Epstein as the spokesman for the movement, I briefly illustrate the limited force of his principled arguments against regulation. If one does not accept his libertarian first principles, one need not accept his libertarian deductions about the immorality of state action to change discriminatory behavior. That much is
easy, indeed self-evident.

Epstein's utilitarian arguments against intervention require more discussion, and can be discussed well in this relatively fact-laden context. The first of these concerns whether or not the market will, if left alone, fix the problem, a claim underpinning the moral side of his libertarianism as well. I demonstrate that his assumption is wrong, and that in fact his theories of the market and discrimination suffer the flaw of their generality. Discrimination is not a uniform, diffuse or acontextual phenomenon, but rather a diverse and particular one. If a particular brand of discrimination, such as dental discrimination against the HIV-positive, can be shown to be more or less impervious to market correction, it may suggest that other forms of racial or gender discrimination, properly disaggregated and specified, may be equally so.3

Even if one believes that legal intervention is moral and necessary, one may share with its critics the conviction that it is neither easy nor automatically successful. The salutary aspect of the challenge to antidiscrimination law is its demand for something more than good intentions from proponents. In the final section of the Article, I argue that seeing discrimination as a specific behavior not only undermines claims about the general futility of antidiscrimination law, but also offers insights into how to use the law to change such behavior. I look at socio-legal research on compliance with law, the lessons of successful public health behavior change programs, and the dental studies to analyze the various regulatory options and construct a package of measures which stand a good chance of reducing discrimination at a low cost. The approach I propose rests on stronger, less ambiguous words and actions by authorities constituted by dentists themselves to establish the norms of treatment, changes in primary and continuing dental education, and broader efforts to educate dentists and their patients about HIV and infection control. The role of law in this approach, while important, is secondary and supportive.


The economic literature examining the effects of antidiscrimination law in broad terms of Black socio-economic improvement has tended to find uneven gains, over time, by region, and by occupational category. This supports the view that one must be particular in any serious discussion of whether or how antidiscrimination law "works." See infra note 307 and accompanying text. Kimberle Crenshaw makes the related point that varying constellations of different disfavored characteristics produce discrimination too complex to be analyzed simply in rigid terms of race or gender. Kimberle Crenshaw, A Black Feminist Critique of Antidiscrimination Law and Politics, in THE POLITICS OF LAW: A PROGRESSIVE CRITIQUE 195, 199-201 (David Kairys ed., 2d ed. 1990).

More generally, I share Ayres and Braithwaite's view that simplistic dichotomies about whether or how to regulate have few practical advantages apart from their simplicity. IAN AYRES & JOHN BRAITHWAITE, RESPONSIVE REGULATION: TRANSCENDING THE DEREGULATION DEBATE 3-4 (1992).
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to action within the sphere of the profession, but it includes more legal action against dentists who discriminate.

I. Dental Care for People with HIV

A. The Patient's Needs

Dental care is a serious medical need for people with HIV. Patients with HIV infection tend to have a higher incidence of disease arising from missing or filled teeth than non-HIV-infected individuals. In the course of their disease, over 90% of people with HIV experience oral manifestations associated with the disease, including such common opportunistic infections and cancers as thrush, herpes simplex, oral hairy leukoplakia, and Kaposi's sarcoma. Large, painful ulcers are also seen in patients with severe immune deficiency. These oral manifestations are related to general medical health. Oral manifestations are often early signs of immune deterioration and disease progression. Moreover, some dental conditions can be so uncomfortable as to interfere with proper eating and the taking of medication, both of which are plainly necessary for continued health.

Dentists, like other health care workers who care for people with HIV, face a low but measurable risk of infection through being cut by an infected needle or other sharp object. There is a lower, cautiously measurable risk of infection due to exposure of mucosa or broken skin to blood infected with HIV. The risk of infection from exposure of intact skin is theoretical. Patient-to-patient infection also could occur if instruments are not sterilized


6. Glick, supra note 4, at 174.

7. David K. Henderson & Susan Beekman, Management of Occupational Exposures to Blood-borne Pathogens, in DENTAL MANAGEMENT, supra note 4, at 275, 277 (estimating risk of approximately 0.3% per exposure).

8. As Henderson and Beekman report: The risk . . . is below the level of detection in clinical studies performed to date. Combining the data from 15 longitudinal studies attempting to measure the risk of occupational infection following a mucous membrane exposure, the 95% confidence interval for the risk of transmission associated with a single such exposure is 0 to 0.36 per exposure.

Id. (citations omitted).

9. Id.
or disposed of properly. Public health officials have treated these risks as acceptable and have recommended against special precautions for treating people with HIV. Instead, long-standing guidelines have established a system of universal precautions applicable to all patients regardless of HIV status. Widely adopted by dentists, these precautions have dramatically reduced occupational exposures to patient blood.

Nor does the course of treatment or the risks of complication differ substantially between HIV-infected and non-infected patients. As with any patient, the HIV-positive person’s prognosis and present health should be considered in developing a treatment plan. As a general matter, both the assessment and the treatment of patients with HIV are well within the zone of general competence of any licensed dentist.

Apart from medical need, going to the dentist is part of the normal routine of life for many people with HIV. Dental care has cosmetic benefits, and the patient may simply “want to feel like everybody else.” Being refused care, or the fear of it, can be corrosive to well-being. An HIV-positive attorney recently wrote:

As I began accepting myself as HIV-positive, medical care emerged as a preeminent concern. My usual doctor and my dentist treat many AIDS patients, so my concern was not about my immediate care. But the future, and the fear of serious illness raised many questions. If I need emergency care, will the paramedics treat me if they are aware of my HIV status? When I am travelling, which is quite often, will I be able to find a doctor, dentist or other health care professional to treat me, if necessary, wherever I go? . . . If I decide not to tell a doctor in order to receive treatment, will I be


13. Michael Glick, Modifications of Dental Care, in DENTAL MANAGEMENT, supra note 4, at 247, 247-48 (“Studies have indicated that the overall complication rate secondary to dental procedures, even with severely immuno-compromised individuals . . . is the same or even lower than that among patients without HIV.” (citing Michael Glick et al., Dental Complications After Dental Treatment of Patients with AIDS, 125 J. AM. DENTAL ASS’N 296 (1994))).


15. Glick, supra note 4, at 10 (quoting anonymous patient).
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compromising my health because he or she may be missing a vital piece of information which could change my course of treatment? Do I even have to tell them my HIV status?  

B. The Role of Dedicated Practices

The dedicated clinic plays a pivotal and problematic role in both fostering and preventing discrimination. Although the American Dental Association does not recognize a specialty in HIV care, most major cities have a clinic or practice, often affiliated with a major medical center, that has as its primary or sole mission the provision of care to people with HIV. These dedicated practices, staffed by practitioners knowledgeable in the care of seriously immunocompromised patients with severe HIV-related dental symptoms, serve three indispensable functions. First, they are a source of clinical advice for dentists in the community. The availability of a specialist for clinical consultation and moral support may encourage more dentists to treat patients with HIV and reduce unnecessary referrals. The dedicated HIV practice also plays a crucial role in dental education at all levels. An HIV practice affords dental students the opportunity for clinical rotations in HIV care, an experience which can substantially reduce resistance to providing such care later. On the same theory, the HIV practice can offer mini-residencies to practicing dentists in connection with continuing education programs. Advanced academic training in HIV care would be impossible without the clinical opportunities a specialized practice presents. Finally, the specialized practice can serve as a tertiary care center. While the vast majority of patients with HIV can be treated within existing dental practice patterns, specialists are required to treat patients with severe immunosuppression or difficult oral lesions.

Dedicated clinics and practices also have a negative impact. For a variety of reasons, clinics treat many patients who do not need specialized care. The

very existence of specialized clinics may reinforce the reported belief of some
dentists that patients with HIV should not be treated in private offices.21
Specialist practices known to accept patients with HIV may become the main
referral site of social service and case management providers, and attract
patients who have encountered difficulties in getting care. Specialized clinics
within dental schools may detract from dental education if, for example, all
patients with HIV are directed to the clinic and a rotation in the clinic is
elective.

As a legal matter, a dedicated clinic within a larger organization such as
dental school or a public health care system may be vulnerable to suit under
federal law. The provision of services for the disabled in an integrated setting
“is a fundamental tenet of nondiscrimination on the basis of disability.”22
With some specific exceptions, it is illegal under federal law to require people
with HIV or other disabilities to accept segregated services.23 The routine
assignment of HIV-positive patients to a specialized clinic, without regard to
the patient’s wishes or dental needs, would be difficult to defend at law.24

II. The Empirical Data

A. The Phenomenon of Discrimination: What Does a Review of the
Empirical Literature Tell Us?

Anecdotes of discrimination by dentists against patients with HIV
apparently had circulated widely through the legal and dental professions
by the mid-1980s, sparking numerous studies.25 For researchers, the principal
questions were the extent to which discrimination was actually occurring, and

21. Drew Morvant, the defendant in the first ADA dental case to result in a formal
judgment against a dentist, himself made this claim, according to a newspaper report. “Dental
schools, LSU’s among them, offer special procedure clinics for HIV-positive patients, Morvant
said. He said it was absurd for the government to argue he should treat AIDS patients just like
any other when doctors are being trained to treat them differently.” James Varney, Dentist to
24. Practical considerations substantially limit the potential liability of a dedicated clinic,
or at least of a system of mandatory referral to such a clinic. Patients who have had difficulty
getting care elsewhere, and who believe they are getting good care in the clinic, are not likely
plaintiffs. Nor are civil rights organizations likely to want to test the ADA’s application to
segregated facilities in a case against an institution that provides most of the care in a community.
The question of principle, however, remains an irritant for practitioners (and institutional lawyers).
25. Two studies, for example, pointed to a 1987 statement by the director of the Chicago
Dental Society that only three dentists in the area were willing to treat patients with HIV. Jay A.
Jacobson et al., Dental Care Experience of HIV-Infected Men in Chicago, 119 J. AM. DENTAL
ASS’N 605, 605 (1989); Herbert M. Hazelkorn, The Reaction of Dentists to Members of Groups
what its causes were. Studies investigated dentists' attitudes, dentists' behavior, and the experiences of patients with HIV.

1. *Studies of Dentists' Attitudes*

The research has primarily taken the form of attitudinal studies of dentists and other dental professionals. Studies have consistently found high rates of negative attitudes towards treating patients with HIV. In surveys conducted before 1987, Gerbert found that 75% of responding dentists in California were reluctant to treat people with HIV and would "prefer" to refer them to others. A 1987 study of dentists in Chicago found that, while 19% had treated a patient with HIV in the past year, 30% would refuse to treat a patient suspected of having HIV, 53% would refuse to treat a patient with symptomatic HIV or AIDS, and 80% would be unwilling to accept a referral of a patient with AIDS.

Avowed unwillingness to treat has decreased over time. A large national survey conducted in 1990 found that 60% of dentists were willing to treat patients with HIV, as did a Texas survey published in 1993. A 1991 study of dental students found over three-quarters agreeing that dentists have

26. Dental offices generally feature three kinds of professional: the dentist, the hygienist, and the assistant. All have some patient care responsibilities and face comparable risks of exposure to blood via splashing or needle stick. Richard J. Hastreiter et al., *Dental Health Care Workers' Response to the HIV Epidemic*, 5 AM. J. DENTISTRY 160, 163 (1992). While this discussion concerns dentists, behavior change is required in all three professions to reduce discriminatory behavior, and the distinct characteristics, roles and training of each must be addressed in training. See Joen I. Haring & Laura J. Lind, *Attitudes of Dental Hygiene Students Toward Individuals with AIDS*, 56 J. DENTAL EDUCATION 128 (1992). Legally, the tradition of making the employer responsible, and the dentist's insurance, makes the dentist the object of most attention. The various licensing and educational proposals considered in this article are generally applicable to all licensed allied dental personnel.

27. Barbara Gerbert, *AIDS and Infection Control in Dental Practice: Dentists' Attitudes, Knowledge, and Behavior*, 114 J. AM. DENTAL ASS'N 311, 312 (1987); see also Gerbert et al., *supra* note 4, at 853 (70% preferred to refer patients with or at risk of HIV).


29. Donald Sadowsky & Carol Kunzel, *Are You Willing to Treat AIDS Patients?*, 122 J. AM. DENTAL ASS'N 29, 29 (1991). Grace and colleagues found a similar rate of willingness to treat among general dentists in a survey conducted in Maryland in late 1988 and early 1989. They found, however, that more oral surgeons (about 58%) were willing to treat patients with HIV, but that fewer periodontists were (about 31%). Edward G. Grace & Leonard A. Cohen, *Attitudes of Maryland Dentists Toward AIDS and Hepatitis Patients*, 6 AM. J. DENTISTRY at 32, 33 (1993).

an obligation to treat patients with HIV or hepatitis B (HBV). Sixty-two percent said they would be willing to treat HIV-positive or HBV patients in their practices, though just over half (53%) said they would not treat patients with either condition if they had the choice. Two studies based on data gathered at least in part in 1993 found that almost 70% of dentists were willing to treat HIV-positive patients.

These developments tempted some researchers towards optimism. A closer look at the results suggests such optimism is misplaced. Questions about willingness to treat have often included loopholes. The recent Bennett study, for instance, limits its “willingness to treat” inquiry to “patients whose needs are within the scope of [the dentist’s] training,” a logical limit that nevertheless begs the key question of whether or not routine care for people without serious HIV-related oral complications is within the perceived scope of the dentist’s competence.

Many responses in these surveys reveal deep ambivalence or otherwise cast answers about general willingness to treat in an ambiguous light. In a Maryland study, only a third of general dentists agreed with the ADA ethical opinion holding all dentists to a professional responsibility to treat patients with HIV, a view shared by 52% of respondents in Bennett’s most recent study. Studies consistently find large numbers of dentists opining that a

31. Solomon et al., supra note 20, at 594.
32. Donald Sadowsky & Carol Kunzel, Measuring Dentists’ Willingness to Treat HIV-Positive Patients, 125 J. AM. DENTAL ASS’N 705, 707 (1994), surveying New York area dentists, found that 69% of respondents expressed a willingness to treat HIV positive patients. Building on the experience of previous studies, the authors tested this general willingness with more specific, context-laden questions. Seventy-five percent of respondents were willing to treat an asymptomatic HIV-positive patient of record, but only 62% were willing to treat a patient of record with AIDS. The same number would accept a new asymptomatic patient, but only 48% would accept a new patient with AIDS. See also Carol Kunzel & Donald Sadowsky, Assessing HIV-Related Attitudes and Orientations of Male and Female General Dentists, 126 J. AM. DENTAL ASS’N 862 (1995) (assessing same data for gender-based differences). M. Elizabeth Bennett et al., Dentists’ Attitudes Toward the Treatment of HIV-Positive Patients, 126 J. AM. DENTAL ASS’N 509 (1995), surveying 1000 dentists from throughout the United States, reported 67% of dentists agreeing with the statement “I will treat an HIV-positive patient whose needs are within the scope of my training, even if the option for a legitimate referral exists.” Id. at 511. Moreover, 45% reported treating at least one known HIV-positive person in the last year, and 85% reported treating at least one “suspected” person with HIV in the last year. Id.
33. “Indeed, when the question of treating HIV-positive patients is approached with a more sympathetic understanding of the psyche of the practitioner, we find that the willingness of 60 percent of the nation’s general dentists to treat these patients is commendable.” Sadowsky & Kunzel, supra note 29, at 32.
34. Bennett et al., supra note 32, at 511.
35. Grace & Cohen, supra note 29, at 33; cf. Curry et al., supra note 28, at 473 (finding that only about 20% of combined pool of medical and dental students agreed that a hospital should be able to terminate a health care professional who refused to treat patients with HIV).
36. Bennett et al., supra note 32, at 510. Almost half of the respondents in this survey also stated a preference to refer HIV-positive patients and not to have at-risk people as patients. Id. at 512.
private office is not the proper place to treat patients with HIV, a view that has changed far less over time than general willingness to treat. A large Minnesota survey conducted in 1989 found that only 21% of dentists believed that a private office was “the best environment for treating patients with AIDS or HIV infection,” while only 48% of New York dentists surveyed in 1992-93 thought that a private practice was an “acceptable” place to treat patients with HIV.

These attitudinal studies tell us very little about the actual frequency of discriminatory behavior. Negative attitudes might be common, but it does not follow that dentists with these attitudes will act on them. Indeed, studies of dentist behavior and patient experience indicate that the correlation is rather weak. Self-reported treatment of at least one patient with HIV has tended to lag considerably behind willingness to treat, though there is no data on the availability of patients to a given respondent. For obvious reasons, dentists are not asked if they discriminate. The studies have, however, been very helpful in specifying the negative attitudes and their roots. Three major factors associated with negative attitudes appeared as leading concerns in almost every study, though not necessarily in this order: (1) fear of infection; (2) business-based concerns about the effect of treating patients with HIV on other patients and staff; and (3) concerns about their competence to treat patients with HIV safely or effectively.

To the extent that dentists’ negative attitudes hinge on beliefs about the transmissibility of HIV and the complexity of its treatment, the data seem to

37. Hastreiter et al., supra note 26, at 163.
38. Sadowsky & Kunzel, supra note 32, at 709; see also Kunzel & Sadowsky, supra note 32, at 864 tbl. 1 (reporting that women dentists were significantly more likely to disagree that patients with HIV should be treated in private dental office).
40. See infra Sections II.A.1-2.
41. See, e.g., Bennett et al., supra note 32, at 511 (45% have treated one known HIV-positive patient in last year, and 67% express willingness to treat); Moretti et al., supra note 28, at 146 (“Nearly 20 percent of our respondents claim to have already treated an AIDS/ARC patient within the past year; more than 60 percent of the respondents indicate they would be willing to treat asymptomatic HIV patients . . . .”).
42. See, e.g., Grace & Cohen, supra note 29, at 34 (“The main reason for not wanting to treat AIDS or HIV-positive patients was the increased risk of infection. This was followed by loss of patients and staff fears about increased infection risk.”); Gerbert, supra note 19, at 312 (three-quarters of dentists believed that treating people with HIV put them at risk of infection, and more than 80 percent believed that their staff and other patients would react negatively); Hastreiter et al., supra note 26, at 165 (more than 50% of respondents “confided that they do not have sufficient information to safely and effectively provide care to HIV-infected patients”); Moretti, supra note 28, at 145 tbl. 3 (among the dentists who had not treated patients with HIV, the most common reasons were fear for the safety of self or staff (59%), fear that other patients might seek care elsewhere (48%), and ignorance about the proper treatment of HIV-positive patients (23%)).
indicate that knowledge and experience reduce them. Fear and a sense of incompetence tended to be less among dentists who were younger, had received more recent training on infection control, or who had actual experience treating patients with HIV (as, for example, in the course of training, when refusal was not an option). Dental students with treatment experience were significantly more likely to plan to treat HIV positive patients in the future, and they were more confident in their competence to do so. Gerbert found that dental health care workers (dentists, hygienists, and dental assistants) who practiced more thorough infection control were also more willing to treat people with AIDS or HIV. Whatever the source, misconceptions about the risk of HIV transmission are significantly associated with negative attitudes about treating patients with HIV. The potential importance of fear as a cause of non-treatment is emphasized in the most recent study which reports that dentists "still have a tremendous fear of contagion." Bennett and her colleagues found that 22% of respondents would not send their children to a school with an HIV-positive child, and that 60% would not eat at a restaurant with an HIV-positive chef.

Competency concerns were tied to evolving standards in infection control. When HIV first became prevalent, dentists as a group were rather lax in infection control, in spite of the chronic problems in the profession with

43. Gerbert et al., supra note 19, at 853. An exception was the study by Grace & Cohen, which found that "[d]ifferences in reported willingness to treat AIDS patients were not related to differential rates of continuing education on the subject of AIDS. For example, 61% of oral surgeons (the group most willing to treat AIDS patients [58%]) and 65% of periodontists (the group least willing to treat AIDS patients [31%]) had taken courses on AIDS." Grace & Cohen, supra note 29, at 33. They also found no correlation between willingness to treat patients with infectious diseases and the amount of continuing education on infection control. Id. at 34.
44. See Rankin et al., supra note 30, at 25.
45. Solomon et al., supra note 20, at 596.
46. Gerbert, supra note 19, at 314; see also Moretti et al., supra note 28, at 145 tbl. 3 (27% of the dentists who had not treated a patient with HIV stated that they did not have adequate training in infection control whereas only 9% of dentists who had treated such patients so stated).
47. Hastreiter et al. found that 51% of dentists were unable to identify correctly the risk of transmission via needle stick contaminated with HIV-positive blood is less than 1%, and that those who could were significantly more likely to be willing to treat. Hastreiter et al., supra note 26, at 162, 164; see also Gerbert, supra note 19, at 70 (finding inverse relation between age and knowledge, attitudes associated with unwillingness to treat, and use of infection control procedures).

Despite their training, dentists and students are not necessarily better than lay people at assessing the risks of HIV. Defining a "high" risk as 1 in 1000 or greater, one study found that 11% of dental students rated sharing a water glass a high risk, a third rated touching nonsterilized instruments as high, half thought blood of infected patient on skin was high, and 78% thought a bite from a patient with AIDS dementia was high. Solomon et al., supra note 20, at 596 fig. 3; see also Kunzel & Sadowsky, supra note 32, at 864 tbl. 1 (New York dentists continue to overestimate the risks of transmission by needle stick and danger of HIV relative to HBV).
48. Bennett et al., supra note 32, at 512.
49. Id.
Many dentists surveyed in the early studies expressed concerns about their ability to practice appropriate infection control or the efficacy of such measures in preventing infection. First through Centers for Disease Control and Prevention (CDC) and dental association guidelines, then through mandatory Occupational, Safety, and Health Administration (OSHA) standards, the use of barrier infection control methods with all patients became the standard of care in dentistry. Infection control has been firmly implanted in the dental school curriculum, so that all new professionals emerge from their training able to work comfortably in the gloves, masks, and eye protection that were daunting to dentists trained before the late-1980s. As a consequence, dentists became less resistant to these methods of infection control, although most dentists continue to bridle at the cost OSHA requirements impose.

Business-based concerns have remained robust. The most recent survey finds that 75% of dentists fear that a perceptible willingness to treat patients with HIV would drive other patients from the practice. Rankin’s findings hinted that dentists focus increasingly on economic concerns as they progress in their careers from students to practitioners. Only 35% of practitioners, in contrast to half of the students, were concerned with contracting HIV. On the other hand, a quarter of dentists were concerned about patients leaving the practice, versus only 18% of students, and practitioners were twice as concerned as students about negative staff reactions (10.8% versus 5.8%).

Two particularly well-designed studies raise important questions about the role of insufficient knowledge in causing discrimination. In a 1993 study of attitudes, conducted among University of Pittsburgh dental students, Bennett and colleagues, using a more sophisticated approach to differentiate among personality types and gauge the importance of professionalism, found that knowledge and experience were not significant predictors of willingness to treat. Rather, non-professional attitudes (evinced, for example, by a negative response to the statement “people in our profession have a responsibility to...”)

50. See Gerbert, supra note 27, at 311; Moretti et al., supra note 28, at 146-47.
51. See 29 C.F.R. § 1910.1030 (1995). The change did not come without opposition. The American Dental Association vigorously opposed the OSHA regulations all the way to the Supreme Court, which declined to hear the case. American Dental Ass’n v. Martin, 984 F.2d 823 (7th Cir.), cert. denied, 114 S. Ct. 172 (1993).
52. One implication of some of these early studies was that dentists were not concerned enough about HIV—i.e., while generally overestimating the risk of transmission from a known patient, they tended to discount the possibility of actually treating HIV or HBV patients who were not identified, an attitude reflected in their inattention to universal precautions. See Gerbert, supra note 19, at 72-73; Hastreiter et al., supra note 26, at 164.
53. Bennett et al., supra note 32, at 512.
54. Id. at 511.
55. Rankin et al., supra note 30, at 25. Almost 80% of dental school seniors surveyed by Solomon et al. in 1991 believed they were competent to treat patients with HIV. But 77% felt they were at increased risk, and 58 percent believed that treating patients with HIV would lead other patients to leave their practice. Solomon et al., supra note 20, at 595.
treat everyone who needs our help”), low levels of dispositional optimism, discomfort with homosexuality, and male gender were the best predictors of a belief that dentists had a right to refuse to treat people with HIV. 56

The same team of researchers compared attitudes of dental and medical students and found that dental students were more resistant than medical students to treating patients with HIV. Weyant and the other researchers offered two likely explanations. First, dental students actually spend more time than most medical students performing invasive procedures. Consequently, dental students’ attitudes about risk may more strongly affect their willingness to treat. “A second hypothesis, not directly addressed in this study, is that dental students select dental school because they are considerably less comfortable treating seriously ill people.” 57 To the degree that either perception of risk or discomfort with the ill is based on general personality traits, factual information alone will not change behavior. 58

Several studies have addressed the role of negative attitudes about homosexuality and drug use. A 1990 study found that “those unwilling to treat AIDS were more likely to have homophobic opinions than those willing to treat the disease.” 59 Gerbert found 36.7% of her sample opining that people with HIV should be quarantined. 60 Half the respondents in the most recent study reported feeling “angry at the homosexual community for imposing the risk of HIV/AIDS on the straight community.” 61 None of these surveys attempted to establish a causal connection between general attitudes and willingness to treat.

Studies of dental attitudes have rarely included questions concerning the law. Only 28% of Minnesota dentists surveyed in 1989, before passage of the ADA, believed that dentists had a legal obligation to care for patients with HIV. 62 By the time of Bennett’s survey in 1993, the situation seems to have changed dramatically. Only 31% of the respondents in a national survey were unsure of their “professional obligations to HIV-positive patients,” and only

56. Bennett et al., supra note 39, at 676-78.
57. Robert J. Weyant et al., Desire to Treat HIV-Infected Patients: Similarities and Differences Across Health-Care Professions, 8 AIDS 117, 120-21 (1994). For a discussion of the ethical implications of such attitudes, see Vincent Rogers, Dentistry and AIDS: Ethical and Legal Obligations in the Provision of Care, 7 MED. LAW 57 (1988).
58. The authors cautiously accept the hypothesis that “as students gain more intensive experience . . . they will become more comfortable and perceive a lower level of occupational risk.” Weyant et al., supra note 57, at 121.
59. Curry et al., supra note 28, at 473.
60. Gerbert, supra note 27, at 312.
61. Bennett et al., supra note 32, at 513. This study also found a significant correlation between positive attitudes towards treating patients with HIV and having friends with HIV. Id. at 512.
62. Hastreiter et al., supra note 26, at 163.
Dental Discrimination

37% were unsure of their specific legal obligations.63

Questions framed in terms of the dentist's "right" to decide whom to treat do not necessarily provide a good measure of dentists' awareness of specific legal rules. They may, however, be helpful in gauging the degree to which the legal rules requiring nondiscrimination correspond with dentists' preexisting normative views. In Bennett's recent survey, "84 percent of the sample maintained that it was their right to decide whether to accept an HIV-positive patient for treatment."64 Similarly, although dentists now commonly use infection control procedures and accept their medical value, almost all of them agreed that regulators have been insensitive to the financial burden OSHA requirements impose.65

2. Studies of Dentists' Behavior

Only one published study in the United States has directly tested dentists' behavior.66 This study used actual observations in dental offices to determine whether dentists discriminate against men who are perceived to be gay or intravenous drug users. A White male actor, posing alternatively as a heterosexual, a gay man and a drug user, appeared for care at the offices of 102 randomly selected dentists from the Chicago area. After each examination, the actor completed a questionnaire about his experience and the dentists were interviewed. Despite negative feelings towards homosexuality, only one dentist refused to treat the actor when he was perceived to be homosexual. One dentist also rejected him when he played the part of an IV drug user. This well-designed study strongly suggests that, while negative attitudes about gay men and drug users are common, they do not strongly influence dentists' behavior.67 It may, more generally, support the hypothesis that dentists are loath to refuse treatment to a patient who is sitting in the office.68

Inferential support for this latter hypothesis can be derived from the results of one other test of dentists' behavior, carried out for litigation rather

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63. Bennett et al., supra note 32, at 511.
64. Bennett et al., supra note 32, at 511; cf. Curry et al., supra note 28, at 473 (51.7% of medical and dental students agree that health care workers have right to refuse to treat patients with HIV).
65. Bennett et al., supra note 32, at 512.
67. But see Nancy E. Kass et al., Homosexual and Bisexual Men's Perceptions of Discrimination in Health Services, 82 AM. J. OF PUB. HEALTH 1277, 1278 tbl. 1 (1992) (reporting that 1-4% of gay and bisexual respondents had been refused dental care based on dentist's knowledge or perception of their sexual preference).
68. The finding that dentists were more willing to treat patients of record is consistent with this, see Sadowsky & Kunzel, supra note 32, at 706, although the fact that most patients suffering discrimination in the Burris-Glick study had a prior relationship with their dentist indicates the need for caution.
than research purposes. In 1990, several individuals with HIV cooperated with the author (then an attorney with the American Civil Liberties Union of Pennsylvania) in a “test” of Philadelphia area dentists. Thirty-seven dentists were selected randomly from the telephone book. A person with HIV called the office, established that the dentist was accepting new patients, and made an appointment. Some days later, the patient called again, asked to speak to the dentist directly, and informed the dentist of his HIV status. The patients and witnesses concluded that eleven of the dentists clearly refused to treat the patient (sometimes providing a referral to the Temple Clinic). Others expressed a reluctance to treat but did not utter a clear refusal. Another third of the dentists expressed a clear willingness to treat. It should be stressed that the test was conducted for the purpose of identifying individual dentists against whom legal complaints could be filed, not for research purposes.

3. Studies of HIV-Positive Patients’ Experiences

Studies of patients’ experiences have been less frequent than studies of dentists. An early, unpublished study from the late 1980s found that “more than 21% of a sample of AIDS patients reported being denied dental treatment because of their diagnosis. More than half of the AIDS patients who had a dentist had not told their dentist of their diagnosis, presumably because they feared they would be denied treatment.”

Interviews with sixty-one HIV-positive patients of three Chicago area HIV/AIDS clinics who had sought dental care since their diagnosis found that

69. The sample was drawn only from dentists who had paid for an enhanced directory listing. This criterion was imposed for legal reasons: in order to be classified as a public accommodation under the applicable Pennsylvania law, a dentist would, among other things, have to hold himself out as accepting the patronage of the general public. Because standard listings are free, they do not necessarily constitute advertising for new clients.

70. All dentists in the sample were male.

71. An almost identical method was used in a later study of Brazilian dentists which found that only 44% were willing to treat a patient with HIV. M.R. Sposto et al., Willingness of Brazilian Dentists to Treat an HIV-Infected Patient, 78 ORAL SURGERY ORAL MED. ORAL PATHOLOGY 175 (1994).


72. Moretti et al., supra note 28, at 146 (citing W.A. Ayer et al., Experiences of AIDS Patients in Seeking Out and Receiving Dental Care (unpublished manuscript)). In a more recent study of 146 British men with HIV, half of those who had been to a dentist since infection had not told the dentist of their infection. Concern about the dentist’s attitude and for confidentiality were the most frequently mentioned reasons. Of those who did disclose their status, half had been refused treatment. P. Robinson et al., Dental Visiting Behaviour and Experiences of Men with HIV, 176 J. BRIT. DENTAL ASS’N 175 (1994).
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only one patient had been refused treatment.\textsuperscript{73} Thirty-seven of the respondents had not told their dentist of their HIV status, however, and so should be excluded in assessing the frequency of refusal.\textsuperscript{74} Even excluding those patients, the adjusted refusal rate of 3% is quite low. The survey also found, however, that 32% of the patients who disclosed their status to their dentist were going to a dentist they had not seen prior to infection. The authors believed that "[i]nformed, nonrandom selection of dentists may have been the major explanation for their somewhat unanticipated success."\textsuperscript{75}

In an article published in 1989, Gerbert and colleagues reported on two surveys and a focus-group process.\textsuperscript{76} In two groups of HIV-positive men (men enrolled in two different longitudinal HIV studies, both of which tended to be comprised of better educated, higher income people), the rates of denial of care were 1.3% and 10.8%. The lower result, however, reflected the responses of both those who had and those who had not tried to get care. This, as the Jacobson study suggests, is a flaw. While only one of the twenty-seven participants in the focus group reported having been denied care based on HIV status,\textsuperscript{77} almost all the gay participants knew of someone with HIV who had. The authors quoted participants who described experiences suggestive of pervasive discrimination.

I know someone who was shopping for a dentist who felt that since he was in health care . . . he should tell them that he had AIDS. And so he called like 50 or 60 dentists in L.A. trying to find a dentist and was denied care. And so finally he just made an appointment with a dentist and before he went on he told him he had hepatitis so they would take the same precautions . . . .\textsuperscript{78}

A more recent study, by Kass and colleagues, of homosexual and bisexual men enrolled in another AIDS cohort study found that 16% of men with AIDS and 4% of seropositive men reported being refused treatment by a dentist.\textsuperscript{79}

\textsuperscript{73} Jacobson et al., supra note 25. The researchers interviewed a total of 125 subjects, just over half of whom had not sought care for one reason or another.
\textsuperscript{74} The survey could not detect whether the dentists of the thirty-seven patients who did not reveal their status were nonetheless aware of it from clinical signs.
\textsuperscript{75} Jacobson et al., supra note 25, at 607.
\textsuperscript{76} Barbara Gerbert et al., Dental Care Experience of HIV-Positive Patients, 119 J. AM. DENTAL ASS'N 601 (1989).
\textsuperscript{77} All the participants who were drug users reported discrimination based on economic status. One of these also reported that he had been refused care by a dentist, whom he had seen for years, when he came down with thrush. Id. at 602.
\textsuperscript{78} Id.
\textsuperscript{79} Kass et al., supra note 67, at 1278. The cohort participants did not all have HIV, an enrollment criterion being lack of infection at time of entry. Because of the small number with HIV in the cohort, fifty-nine additional patients with HIV from Johns Hopkins Hospital were also included. The higher rate of discrimination among patients with AIDS compared to those with
Three percent of people with HIV, and 4% of people with AIDS, reported being denied care by a dentist based on their sexual orientation. Among the non-infected participants, 1% each reported being denied dental care because of sexual preference and suspected HIV infection. The authors noted that "many participants volunteered that they had deliberately sought care from gay practitioners in order to avoid problems." The Burris and Glick study, reported here, found rates of discrimination consistent with the Kass study.

B. New Data: Patient Experiences

We created a survey to gather data on four main issues: the degree to which people with HIV experienced discrimination by dentists; whether such perceived discrimination was significantly linked to demographic characteristics of patients other than HIV; patients' moral beliefs about discrimination and confidentiality; and patients' attitudes about the care provided in dedicated clinics.

1. Background

We surveyed 272 people with HIV who had sought dental care in the past five years. Participants were solicited at a dental clinic established specifically to treat patients with HIV and at four community-based organizations (CBOs) providing case management and other support services for HIV-positive people. The sample loosely reflects the racial, age, and

HIV may be read to add some support to the theory that identified HIV disease is itself the most important factor in promoting discrimination. Id. at 1277.

80. Id. at 1279.
81. See infra Section II.B.1-2.
82. The data presented in this section were the product of a collaboration between the author and the following individuals. Michael Glick, D.M.D., Professor of Dentistry at the University of Pennsylvania School of Dental Medicine and formerly Professor at Temple Dental School provided expertise in dental care for people with HIV. The statistician for the project was Ellen Kurtz, M.A., of the Temple University Center for Public Policy. Edwin Greenlee, J.D. helped develop the survey instrument and conducted trial administrations. Temple Law Students Joshua Norris and John Lynde were of significant assistance in collecting the data. The author was the primary director of the survey and wrote the report. Responsibility for any errors or omissions rests with the author.
83. Three additional surveys were invalid.
84. At the time of the survey, the Temple University Infectious Disease Clinic provided about 2500 hours of dental care annually to clients from a large area of New Jersey, Pennsylvania, and Delaware. Thirty-four percent of patients were African American, 59% White, and 7% Hispanic. Eighty-nine percent were male, 11% female. The average age was 37.6 years. One hundred patients participated in the survey. One hundred nine patients who appeared for their appointments between June and September, 1993, were asked to complete a survey, yielding a response rate of 92%. Participants were paid $5 for completing the survey.

ActionAIDS is the largest case-management agency in the city, serving approximately 550 clients at the time of the survey, between August and October, 1993. The client population was
gender breakdown of the HIV-infected population of the Philadelphia region. (See Table I). This is the first study of its kind to include women in rough proportion to their actual numbers in the HIV-positive population. We designed an eleven page, forty-eight item questionnaire for the Clinic, and a ten page, forty-seven item questionnaire for the CBOs. The surveys differed approximately 57% African American, 34% White, and 8% Hispanic. Clients were 79% male, and ranged in age from infants to over 60 years old. Clients were approached to complete the survey when they appeared in the office for appointments, support group meetings, or other purposes. Participants, other than those approached through support groups were given a five-dollar food certificate for completing the survey. A total of 44 surveys were completed. There were 12 refusals (not including the members of the support groups who declined to participate). A response rate could not be calculated.

Philadelphia Community Health Alternatives/Philadelphia AIDS Task Force offers case management, testing, and other social services. It served approximately 221 regular clients at the time the survey was conducted (August to September, 1993), with additional walk-ins for emergency services and HIV testing. Clients were 52% White, 43% African American, and 5% Hispanic. Eighty percent of the clients were male. Clients were asked to participate when they appeared for appointments or other services, and were paid $5. Forty-seven surveys were completed. There was one refusal (a response rate of 98%).

We the People Living with HIV/AIDS in the Delaware Valley is an organization formed and led by people with HIV, offering support services, social amenities, and a drop-in center. Demographic information was not available. Between August and September, 75 members were asked to participate at the drop-in center and at a weekly dinner. Fifty-four agreed and there were 21 refusals (a response rate of 72%). A contribution was made to the organization to benefit the organization’s weekly dinner.

Congresso de Latinos Unidos provides services to people with HIV in the Hispanic community. At the time of the survey, it had 352 case management clients, in addition to walk-ins seeking testing or other assistance. Its population was 87% Hispanic, 9% African American, and 3% White. Eighty-five percent were males. Participants were recruited through support groups. Thirty surveys, some in Spanish, were completed. Response rates were unknown. Surveys were completed between August and December, 1993.

85. The proportion of women in the HIV-positive population has been increasing. While only 12% of the cumulative AIDS caseload, women comprised 18.9% of the AIDS cases reported in 1994. PHILADELPHIA DEPT. OF PUBLIC HEALTH, AIDS ACTIVITIES COORDINATING OFFICE, AIDS SURVEILLANCE QUARTERLY UPDATE 7, tbl. 3 (1995).

Our sample was also largely made up of low-income individuals, the majority earning less than $10,000 per year, and 80% earning less than $20,000. This is generally consistent with the trend in Philadelphia HIV cases, which has since 1987 shown a shift in new cases toward low-income groups and away from high-income ones. See Daniel Fife & Charles Mode, AIDS Prevalence by Income Group in Philadelphia, 5 J. ACQUIRED IMMUNE DEFICIENCY SYNDROMES 1111, 1114 (1992).

Ours was a convenience sample, and so deviated from the ideal of random selection. Such deviation, however, is common with studies of people with HIV, a population that is, for statistical purposes, unknown. We considered probability sampling options like random digit dialing, but the cost of obtaining a sufficiently large sample possessing an unusual characteristic was prohibitive. The study depends upon self-reported data, which could not be validated. Surveyors were present (except in surveys distributed through support groups) to read the survey to respondents who were unable to read, but no one required this assistance and, to our knowledge, no one declined to participate because of illiteracy.
Table I. Respondents' Age, Sex and Race

<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>13-19</td>
<td>.7% (2)</td>
<td>2% (1)</td>
<td>.5% (26)</td>
<td>.6% (8)</td>
</tr>
<tr>
<td>20-29</td>
<td>12% (32)</td>
<td>10% (5)</td>
<td>20% (1105)</td>
<td>18% (253)</td>
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<tr>
<td>30-39</td>
<td>48% (131)</td>
<td>57% (28)</td>
<td>44% (2388)</td>
<td>44% (628)</td>
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<tr>
<td>40-49</td>
<td>33% (89)</td>
<td>24% (12)</td>
<td>24% (1270)</td>
<td>26% (366)</td>
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<tr>
<td>50 and older</td>
<td>4% (12)</td>
<td>6% (3)</td>
<td>10% (524)</td>
<td>8% (114)</td>
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<tr>
<td>Gender</td>
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<td></td>
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<tr>
<td>Male</td>
<td>80% (219)</td>
<td>73.5% (36)</td>
<td>88% (4752)</td>
<td>81% (1146)</td>
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<tr>
<td>Female</td>
<td>19% (51)</td>
<td>26.5% (13)</td>
<td>12% (634)</td>
<td>19% (267)</td>
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<tr>
<td>Race</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>White, Non-Hispanic</td>
<td>24% (65)</td>
<td>45% (22)</td>
<td>32% (1730)</td>
<td>22% (312)</td>
</tr>
<tr>
<td>Black, Non-Hispanic</td>
<td>64% (175)</td>
<td>47% (23)</td>
<td>58% (3149)</td>
<td>65% (921)</td>
</tr>
<tr>
<td>Hispanic</td>
<td>8.5% (23)</td>
<td>4% (2)</td>
<td>9% (494)</td>
<td>12% (176)</td>
</tr>
<tr>
<td>Other</td>
<td>3% (9)</td>
<td>4% (2)</td>
<td>.2% (13)</td>
<td>.3% (4)</td>
</tr>
</tbody>
</table>


Table does not include missing cases. Percentages may exceed 100 due to rounding.
only insofar as the identity of the current dentist was known for the Clinic Group. Survey questions focused on the respondent’s most recent experience with refusal.\textsuperscript{86} Non-respondents were not surveyed, admitting the possibility that those who elected to participate had stronger opinions about dental care as a result of experiencing discrimination. The high response rates in some sub-samples, and the fact that support groups tended to make a collective decision on participation, makes this less likely. It is also possible that respondents falsely reported instances of discrimination in order to help dramatize a problem they perceived to be serious and underestimated.

### Table II. Respondents’ Income, Employment and Education

<table>
<thead>
<tr>
<th></th>
<th>Sample n = 272</th>
<th>Possible or probable discrimination n = 49</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; $9,999</td>
<td>64% (175)</td>
<td>59% (29)</td>
</tr>
<tr>
<td>$10 - 19,999</td>
<td>16% (43)</td>
<td>8% (4)</td>
</tr>
<tr>
<td>$20 - 34,999</td>
<td>10% (28)</td>
<td>8% (4)</td>
</tr>
<tr>
<td>$35 - 49,999</td>
<td>5% (14)</td>
<td>18% (9)</td>
</tr>
<tr>
<td>$50,000+</td>
<td>2% (5)</td>
<td>6% (3)</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than high school diploma</td>
<td>18% (49)</td>
<td>14% (7)</td>
</tr>
<tr>
<td>High school diploma</td>
<td>37% (102)</td>
<td>33% (16)</td>
</tr>
<tr>
<td>Post-high school</td>
<td>44% (120)</td>
<td>51% (25)</td>
</tr>
</tbody>
</table>

Table does not include missing cases. Percentages may exceed 100 due to rounding.

\textsuperscript{86} Opinion questions were posed on a five point Likert scale. Data were analyzed using SPSS for Windows software. A chi-square test was used to test the significance of relationships between variables. Relationships reported here were significant at the .05 level. The strength of significance was tested using gamma.
2. **Major Findings**

   a. **Frequency of Discrimination**

   Fifty-two individuals reported that they had been refused treatment by a dentist. "Refusal" encompasses any manner of non-treatment, including refusals that the dentists characterized as "referrals." A refusal to treat is not necessarily illegal discrimination. There are legitimate medical reasons for referral to a different dentist. We attempted to infer the nature of the refusal from other circumstances the patient reported. We classified refusals to treat as probably discriminatory if: (1) the respondent received no treatment after the dentist learned of his or her HIV status; and (2) the patient either (a) had never received care from the dentist before (for example, a new patient refused while attempting to make an appointment), or (b) having had a prior relationship with the dentist (patient of record), expressed the intention not to return to the dentist for any treatment in the future; and (4) the patient reported no other nondiscriminatory reason for the denial of care. These criteria are based on the assumption that a dentist is unlikely to have a nondiscriminatory reason for refusing even to examine a new patient with HIV or for suddenly terminating an existing dentist-patient relationship. While referral for a specific condition outside the dentist’s competence is appropriate, a “terminal referral” that ends the relationship entirely is suspect. In many cases, the dentists reportedly made no effort to conceal a discriminatory motive.

   Refusals that did not meet these criteria were classified as possibly discriminatory or nondiscriminatory based on (1) the respondents’ reported medical and oral health at the time of refusal, (2) the dentists’ reported reason for refusing, (3) the patient’s judgment about the reason for refusal, and (4) the patient’s responses to open-ended questions about the experience. We assumed that the referral of a patient reporting no significant health or dental problems was probably discriminatory, particularly if the patient reported feeling unwelcome. Forty of the refusals met our criteria for probably discriminatory. Dentists refused care to twenty-four respondents attempting to make a first appointment. One respondent, who reported six to ten refusals, commented: "Appointment was made, then I would mention I was HIV-positive, and all of a sudden they had a dozen excuses for not seeing me.” Sixteen refused respondents reported a prior relationship with the dentist. Six had been seeing the dentist for one to two years, and six for more than two years. One of the latter responded to the question as to whether he planned to return to the dentist, “Are you kidding? I would no longer trust his care now that I know how he feels about HIV.” One, who had been seeing the dentist for between one and two years, reported that he “was already in the chair” when he revealed his status and was refused further care.
Nine refusals were deemed possibly discriminatory. Three respondents reported both a prior relationship with the dentist and some treatment after they informed the dentist of their HIV status. Their referrals were classified as possibly discriminatory based on respondents' lack of oral symptoms, intention not to return to the dentist for treatment in the future, and negative comments ("I don't need to feel uncomfortable because of someone's ignorance"; "Why force a dentist to treat. I would not trust him or her"; "I felt unwanted at that office.").

One case met the first three criteria for a probably discriminatory referral but was classified as possible discrimination because the dentist reportedly gave as one of his reasons that he did not accept the patient's Medicaid HMO insurance. Two other refusals satisfied the criteria for probable discrimination, but each provided at least one internally inconsistent response. All three respondents believed that these dentists do not treat any patients with HIV. The last three respondents reported being refused care and receiving no treatment but did not respond to all survey questions.

We classified three refusals as nondiscriminatory. One respondent, who reported serious oral symptoms, believed that he received a legitimate medical referral from a dentist who treated other patients with HIV. The respondent intended to return to the dentist for care in the future. A second respondent, who reported five refusals since learning he was HIV positive, offered contradictory responses concerning the most recent referral, but he agreed that the refusing dentist was both competent to treat people with HIV and treated them with respect and understanding. He also stated an intention to return for further treatment. The third respondent stated that the referring dentist did not know of his or her HIV status, that the referral was to an oral surgeon, and that the reason the patient would not return to the dentist for treatment in the future was that the practice was located in a distant city. Thus forty-nine members of the sample (18%) experienced one or more probable or possible discriminatory denials of treatment. The refusal rate could not be determined based on our data.87

These findings support the view that discrimination by dentists remains a serious problem. The level of discrimination is at the high end of the reported data. This outcome likely reflects the fact that individuals who have trouble getting dental care in the Philadelphia region have tended to be directed

87. Reported refusals to treat were constant or slightly rising over time. Twenty-eight were refused between 1991 and 1993. Eighteen were refused between 1986 and 1990. Six respondents did not report a date of refusal.
to the Temple Clinic; it may also reflect our restriction on participation to people who had actually sought dental care in recent years. The level of discrimination would have been higher had we included other arguably discriminatory behavior, such as the assessment of an additional fee (for "dрапинг" the office) or the scheduling of patients with HIV outside normal office hours. Significantly, almost 80% of the patients reporting discrimination had had a prior dentist-patient relationship with the refusing dentist.

b. Causes of Discrimination

Our findings indicate that discrimination arises from the dentist's discovery that a patient has HIV and not from a dentist's suspicion that a person is "a member of a high risk group." Every respondent experiencing possible or probable discrimination reported that the dentist or a member of his staff was aware of the patient's HIV infection. Eighty-two percent had informed the dentist of their status. In the remaining cases, the dentist found out from the medical chart, an examination, or an HIV test.

While our data cannot be used to directly determine how the dentists perceived the sexual orientation or drug-use history of individual respondents, the discrimination experienced was not significantly correlated with age, gender, or high-risk behavior. Our findings are consistent with Hazelkorn's finding that dentists did not discriminate in the treatment of a person portraying a homosexual or a drug user, and with the several studies finding that far more dentists have treated patients they believe to be at high risk than have treated patients they knew to have HIV. Without denying the complex relationship between attitudes and behavior or the importance of addressing

88. Twenty-four percent of respondents at the Temple Clinic experienced probable or possible discriminatory refusal, compared to 14% of the individuals surveyed at the community-based organizations. Separating the two samples did not significantly change the outcome of our statistical analysis.

89. Ten respondents (3.7%) reported being charged a higher fee, and 22 (8%) said they had been asked to come "at the end of the day or other special time" because of their HIV status.

90. In one case, the respondent reported being informed by the "nurse" that the dentist did not treat patients with HIV.

91. Of those experiencing possible or probable discrimination, 49% reported male homosexual activity, and 33% intravenous drug use within the previous ten years.


93. See, e.g., Moretti et al., supra note 28, at 145 tbl. 2 (19% had treated one or more patients with AIDS or ARC in past year; 78% had treated one or more patients "who fell into one of the high-risk categories"); Bennett et al., supra note 32, at 511 (45% reported treating at least one known HIV-positive patient in past year; 85% reported treating at least one "suspected" HIV-positive patient).

attitudes in crafting programs to reduce discrimination, this may explain why
discrimination actually occurs far less than attitudinal studies would suggest.\textsuperscript{95} Negative attitudes about homosexuals or drug users may indicate a
predisposition not to treat people with HIV, but do not necessarily translate
into active efforts to screen out such patients. Dentists who only refuse to treat
known HIV-positive patients may, in fact, frequently treat HIV-positive people
whose infection is unknown to the dentist.

A significant correlation exists between suffering discrimination and
several socio-economic indicators. (See Table III). An individual’s chances of
experiencing discrimination increased slightly with the number of hours worked
per week. There was a statistically significant, but very weak, correlation
between rising income and discrimination. The chance of experiencing
discrimination decreased moderately if the respondent was receiving some
forms of public assistance. Refusal was moderately tied to not being on
Medicaid and was strongly tied to having private dental insurance.
 Discrimination was strongly correlated with being White. We do not take these
results to indicate that dentists prefer treating poor, uninsured people of color
to insured, employed Caucasians. They are, rather, an artifact of the greater
“opportunity” to be refused enjoyed by people who can afford to go to any
dentist they wish, as often as they need.\textsuperscript{96} Poorer people, dependent on
charity, are probably more quickly directed to a subsidized clinic. Those on
Medicaid have a limited choice of dentists, and dentists accepting Medicaid
are likely to be either more charitable or wanting for patients. In our sample,
Whites’ self-reported spending on dental care was not significantly higher than
non-Whites’ (P=.177),\textsuperscript{97} but Whites reported significantly more visits
(P=.000; \( \gamma =-.172 \)).

One legitimate explanation for a high rate of refusal to treat would be
that patients with HIV tend to present more complicated oral pathologies. This
was not borne out by our study. The majority of respondents who suffered
discrimination described themselves as HIV-positive and asymptomatic when
refused treatment.\textsuperscript{98} Most respondents reported no oral symptoms related to

\textsuperscript{95} See infra Section II.A.

\textsuperscript{96} Fife and Mode found that, among people with AIDS in Philadelphia, “[p]rivate medical
insurance increased with income, was more common among those who were White than those
who were non-White, and was more common among those with homosexual contact than those
with other modes of exposure to HIV infection.” Daniel Fife & Charles Mode, AIDS Incidence

\textsuperscript{97} These data, which depend upon patients, most of whom have some sort of insurance,
recalling their annual dental expenditures for the past five years, should be viewed cautiously.

\textsuperscript{98} Sixty-seven percent described themselves as HIV-positive and asymptomatic when
refused treatment. Twenty-seven percent reported that they were HIV-positive with occasional
or minor symptoms. Six percent described themselves as HIV-positive with serious symptoms.
These self-assessments were generally consistent with the individuals’ reported T-cell counts, a
rough marker of the state of their immune system and the progression of HIV disease.

27
Table III. Significant Correlations Between Reporting a Discriminatory Experience and Respondents' Socio-Economic Characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>$X^2$</th>
<th>P</th>
<th>$\gamma$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hours worked per week</td>
<td>10.21</td>
<td>.037</td>
<td>.281</td>
</tr>
<tr>
<td>Income</td>
<td>101.27</td>
<td>.000</td>
<td>-.103</td>
</tr>
<tr>
<td>Not on Medicaid</td>
<td>6.72</td>
<td>.035</td>
<td>-.349</td>
</tr>
<tr>
<td>Has private insurance</td>
<td>11.13</td>
<td>.004</td>
<td>.559</td>
</tr>
<tr>
<td>Has any insurance</td>
<td>16.21</td>
<td>.003</td>
<td>-.446</td>
</tr>
<tr>
<td>White race</td>
<td>16.10</td>
<td>.003</td>
<td>.569</td>
</tr>
</tbody>
</table>

Table IV. Patients' Reported Oral Health and Reason for Visit at Time of Discrimination

<table>
<thead>
<tr>
<th>Oral Symptoms at Time of Discrimination</th>
<th>Percent $n = 49$</th>
<th>Patient's Reason for Visit</th>
<th>Percent $n = 49$</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>63</td>
<td>Pain</td>
<td>39</td>
</tr>
<tr>
<td>Candidias</td>
<td>10</td>
<td>Check-up</td>
<td>65</td>
</tr>
<tr>
<td>Hairy Leukoplakia</td>
<td>6</td>
<td>Cosmetic need</td>
<td>10</td>
</tr>
<tr>
<td>Periodontal disease</td>
<td>6</td>
<td>Cavity</td>
<td>47</td>
</tr>
<tr>
<td>Aphthous ulcer</td>
<td>2</td>
<td>Dentures</td>
<td>18</td>
</tr>
<tr>
<td>Dry mouth</td>
<td>6</td>
<td>Oral lesion</td>
<td>4</td>
</tr>
<tr>
<td>Kaposi's sarcoma</td>
<td>0</td>
<td>Referred by physician</td>
<td>10</td>
</tr>
</tbody>
</table>
Dental Discrimination

HIV at the time of refusal, and had gone to the dentist for a check-up, or because of common complaints like pain or cavities. (See Table IV). Thus most of the respondents, including patients who ended up attending the dedicated dental clinic, were seeking routine care.

Most patients perceived that they were being discriminated against simply because they had HIV. Dentists were reportedly frank about their unwillingness to treat; almost half admitted that they did not treat HIV patients as a rule. Other frequent explanations reportedly given by discriminating dentists include a lack of knowledge needed to treat patients with HIV (29%), the need for patients with HIV to get specialist care (43%), the belief that the patient would get better care from a different dentist (25%), and the concern that staff or other patients would be upset if the dentist treated a person with HIV (13%).

Individual respondents identified other reasons dentists purportedly offered, including a lack of the proper equipment. One patient reported that the dentist said "he did not want to be in contact with the AIDS virus."

The reported explanations are remarkable for their generality and lack of any apparent effort to link refusal to specific medical or dental attributes of the patients. No patients reported that dentists attributed refusal to the patient's poor overall health, and only a few reported other medical reasons such as an unfamiliar dental condition too hard for the dentist to treat (four), or a patient's history of serious medical problems (two). Moreover, few of these patients reported serious health problems. Of the four patients who indicated that they were refused treatment because the dentist said that they had a specific symptom or condition that was related to HIV that was too hard or unfamiliar for the dentist to treat, two reported no oral symptoms at the time of refusal, and one reported having oral candidiasis. The fourth patient was having serious HIV symptoms by self-report, with oral hairy leukoplakia and recurrent major aphthous ulcerations. The dentist in that instance, however, also reportedly stated that he did not treat any patients with HIV. Both patients whose refusal was reportedly attributed in part to a history of serious medical problems also reportedly were told that the dentist did not treat anyone with HIV. Moreover, in one of the cases, the refusing dentist belonged to a major university dental clinic that ordinarily would be expected to accept patients with such a history.

99. Three patients reported being told that the dentist would not treat because he did not use protective infection control procedures. One reportedly said he did not treat gay people, and two said that they did not treat I.V. drug users.

100. Three dentists (6%) reportedly attributed their refusal to provide care to the fact that they did not accept the patient's form of insurance. In each case, however, the patient had received care from the dentist before the dentist learned of the patient's HIV and refused further care.
c. *Current Access to and Satisfaction with Dental Care*

In addition to the respondents from the Temple Clinic, seventy-seven of the respondents from CBOs reported that they were currently receiving care from a dentist, and fifty-eight of these identified that dentist. Fourteen identified the Temple Clinic as their current source of dental care. Thirty-eight other individual dentists or dental clinics were identified. With some caveats, these data support the conclusion that many local dentists are treating patients with HIV. The major limitation of this study is that the respondents at CBOs were not asked if their current dentist was aware of their HIV status. Given the finding that discrimination results from a dentist's knowledge of a patient's HIV status, rather than the HIV status itself, we cannot assume that a large number of dentists will knowingly treat people with HIV. Moreover, a quarter of the respondents at CBOs who identified a current dentist named the Temple Clinic.

Clinics dedicated to the care of people with HIV are problematic to the extent that they are, or are perceived as, "ghettos" for those patients whom no one else will serve. In addition to the stigma of separation, patients may be concerned that as "undesirables" they might receive second-rate care. Our study did not find evidence of these concerns. Most respondents were satisfied with their current dentist, but patients receiving care at the Temple Clinic were significantly more likely to agree or strongly agree that their current dentist was competent to treat patients with HIV (P = .000; γ = .471) and treated HIV-positive patients with respect and understanding (P = .000; γ = .575). Clinic patients were also significantly more likely to agree that patients with HIV are best cared for in special clinics (P = .000; γ = .422). None felt that the clinic dentists were not competent, whereas 8% of those receiving care outside the Temple Clinic disagreed or strongly disagreed that their current dentist was competent to meet the dental needs of a person with HIV. Respondents who had been refused treatment had a similar rate of approval of special clinics, but were much more likely than non-refused patients to disagree or strongly disagree with the statement. This suggests that what may be acceptable as a free choice is less desirable as one’s sole option.101

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101. Only one other published study, of British patients, has closely probed HIV-positive patients' satisfaction with clinic care. It found that patients attending a dedicated HIV clinic "expressed satisfaction with the technical competence of their treatment and the effective behavior of their dentist comparable with satisfaction expressed by patients treated by the same dentist in general dental practice." P. Robinson & R. Croucher, *The Satisfaction of Men with HIV Infection Attending a Dedicated Dental Clinic: A Controlled Study,* 6 AIDS CARE 39, 46 (1994).
Dental Discrimination

d. "Rights"

The issue of dental discrimination is often framed in terms of competing rights or interests, such as the rights of dentists to know the status of their patients and to refuse treatment versus the right of patients to maintain their privacy. Our data suggest that this is, in practice, a false opposition.

Respondents were asked for their opinions on two normative questions—whether a dentist should have the right to refuse to treat people whom the dentist does not wish to care for, and whether people with HIV are morally obligated to inform dentists of their infection. Over one-third of all respondents, and almost two-fifths of those who had experienced discrimination, agreed or strongly agreed that dentists should be able to decline to care for HIV-positive people. Less surprisingly, respondents who had experienced discrimination also disagreed with the statement in greater proportion than those who had not. (See Graph I).

The vast majority of respondents believed they had a moral duty to inform their dentist about their HIV status. Eighty-four percent of the overall sample, and 86% of those who had experienced discrimination, agreed or strongly agreed with the proposition. Again, those who had experienced discrimination were more likely to disagree or strongly disagree than those who had not (14% versus 8%). We know that virtually all the respondents experiencing discrimination had acted on this belief. We do not know how many of those who were not refused actually told their dentists. While disclosure of HIV may engender discrimination, it is also necessary to ensure optimum medical care. Fear of discrimination, rather than a more or less abstract concern for privacy, appears to be the main barrier to openness in the dentist-patient relationship. Rather than a dispute between dentists and patients about the need or right of dentists to ask medical questions, it is more accurate to characterize patients and dentists as equally hindered in achieving clinical openness by dentists' general reputation as unwilling to treat patients with HIV. This suggests that state statutes that require patients to announce their HIV status are both unnecessary and likely to produce discrimination.  

Patients' sense of the equities and rights of the issue notwithstanding, it is important to recognize that the rate of discrimination reported by the patients bears no relation to the volume of complaints brought before courts and human rights agencies in this area during this period. As far as can be determined from the public record, none of these patients ever filed a complaint under state or federal law arising from their experience.

103. The only dental discrimination cases brought in Philadelphia since the beginning of the epidemic were the cases brought by the ACLU and AIDS Law Project in 1990. See supra notes 70-71 and accompanying text. It is possible that one of the two surviving plaintiffs in those
cases was one of the respondents in the Glick-Burris survey.

Graph I: Normative Beliefs

Dentists' Agreements and Patients' Duties
C. New Data: Agency Experiences and Referral Patterns

In the Spring of 1994, Temple law students working under the supervision of the author surveyed fifty-five member agencies of the Pennsylvania Coalition of AIDS Service Organizations (PCASO) concerning their experiences in assisting clients with HIV to obtain dental care. These organizations generally assist clients in securing a wide range of medical and social services. Twenty-two agencies could be reached and were eligible to participate in the survey.

Nineteen respondents (86%) reported that they were aware of clients who had difficulty securing dental care. Of those respondents, more than half were aware of problems occurring within the past six months, and most were aware of more than five incidents. In their experience, however, the problem was as much one of finances as of animus. Only about 40% of the American population has private dental insurance, and dental health varies significantly with socio-economic status. While people with AIDS are often eligible for Medicaid, which can include dental coverage, the rates of reimbursement are so low, and the volume of paperwork so high, that only a small number of dentists participate in the program. Indeed, one respondent, an experienced case manager from a smaller city, commented that the discrimination issue was “moot” given the difficulty in finding providers who would accept Medicaid. While two respondents attributed the difficulty squarely to HIV discrimination, four had experienced the problem entirely as one of finances, and the majority (twelve) identified both discrimination and financial problems as limiting their access to care. (One complained of a general lack of services in his rural area.)

The respondents were asked where they refer clients for dental care. The most common response was to a clinic specializing in, or widely known to accept, HIV-infected patients. Although most of the agencies also reported

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104. The survey took the form of semi-structured telephone interviews, conducted by law students, combining closed- and open-ended questions. Respondents were agency staff who stated that they were familiar with agency practices concerning dental care.

105. Agencies that did not provide dental care referrals were excluded. No effort was made to determine the basis for non-participation of other agencies, though in most instances it was due to the surveyor’s inability to contact any person at the agency who had knowledge of the agency’s practices, if any, in relation to dentistry.

106. Seven agencies reported more than ten incidents; two reported five to ten; four reported two to five; one reported one; and five did not specify a number.


108. Dentists also complain about a higher rate of missed appointments among Medicaid patients. R. Venezie & W. Vann, Jr., Pediatric Dentists’ Participation in the North Carolina Medicaid Program, PEDIATRIC DENTISTRY, May-June 1993, at 175; Peter C. Damiano et al., Factors Affecting Dentist Participation In a State Medicaid Program, 54 J. DENTAL EDUC. 638 (1990).
having at least one private dentist available for referrals, responses still suggest a heavy reliance on clinics.

All the Philadelphia area agencies reported that they referred their patients to one of three local clinics. Most referred to the Temple Infectious Disease Clinic, but they also referred to the University of Pennsylvania School of Dental Medicine and a charitable clinic, ChesPenn, located in an economically depressed suburban town. The agencies reported limited or no referrals to dentists in private practice. One suburban agency had found it necessary to contract with three local dentists, using Ryan White funds, to care for its clients.109 In Pittsburgh, both respondent agencies reported relying on two clinics affiliated with the University of Pittsburgh, but the Pittsburgh AIDS Task Force also had 5-10 private dentists to whom it referred patients.

Fourteen of the respondent agencies were located in smaller cities and rural areas. Eight reported sending patients to clinics in Pittsburgh or Philadelphia. In some instances, this involved several hours of travel. Three reported relying on local hospital clinics, but two complained of long waiting lists. Only one agency reported exclusive reliance on a clinic. Eleven reported anywhere from one to five local private practitioners who would accept patients.

The major clinics all accepted Medicaid and/or provided free care to indigent patients. Among rural respondents, privacy concerns provided additional impetus to go to a distant urban clinic. Some clients in smaller communities preferred to receive some or all of their medical care in a place where confidentiality was protected by relative anonymity.

These data have serious limitations. The response rate to the survey was low, and the role of any agency in helping clients get dental care probably varies among clients and agencies. Presumably, many agency clients make their own dental arrangements without seeking a referral from the agency. This includes both patients who do not reveal their HIV status, and those who do and nevertheless receive treatment from a private dentist. Moreover, people with HIV or AIDS do not uniformly seek services from the PCASO agencies. Nevertheless, these data suggest that agencies have responded to problems in dental care access in the most immediately efficient way, by identifying one or more providers who will readily accept patients. Even in large urban areas, where there are private dentists who treat people with HIV, the main provider tends to be a clinic. Clinics are likely to be the only providers accessible to patients without insurance or on Medicaid. It follows that the attraction of clinics may not entirely be their willingness to or competence in treating, but their fee schedule.

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D. Conclusions

None of these studies, alone or in combination, allow reliable quantification of discrimination. The link between dental attitudes and actual behavior is elusive. HIV is often undetectable without a blood test, so many asymptomatic patients who do not know about or disclose their infection will not be eligible for discrimination, even if a dentist would refuse to treat if she were informed. The accuracy of patient reports of dentists’ statements or behavior is uncertain. Probability samples of patients cannot be feasibly obtained.\footnote{110. Convenience samples like those in the Burris-Glick or Kass studies, comprised of people who have sought out medical or dental care, may be biased in a way that increases their reliability. Such people may be more likely than the average person with HIV to seek care, and therefore to be refused, but obviously people who do not seek care are not eligible for refusal. Or the sample may lead to an undercounting of discrimination, because individuals who are committed to getting dental care may be more likely to identify a practitioner known to accept patients with HIV, and so avoid discrimination that a less determined patient might suffer.} Taking these limits into account, the studies reported here generally are well constructed, with adequate and in some cases ample samples\footnote{111. The tendency to limit samples to males is a common and regrettable aspect of HIV research generally. The problem also applies, to a lesser extent, to I.V. drug users. The Burris-Glick study, however, which did include women and I.V. drug users in the sample, did not find that either group was significantly more or less likely to suffer discrimination than gay men.} and high response rates. They cover patients and dentists from urban areas across the country. They establish beyond a reasonable doubt that many dentists are uncomfortable with and unwilling to treat patients with HIV, and that many patients with HIV experience discrimination.\footnote{112. Because the Burris-Glick study was limited to individuals who had actually sought dental care in the past five years, it certainly inflates the per capita rate of discrimination against people with HIV, though this seems sensible given that discrimination is not a problem for people who don’t seek care. Conversely, we would expect the development of formal and informal referral networks to reduce incidents of refusal even if the propensity to refuse remained unchanged.}

The data also show that despite widespread discrimination, patients with HIV can get care by going to dentists reputed to accept patients with HIV or by concealing their status. The studies do not measure the practical or psychic burdens this process imposed on patients, nor do they quantify how many people with HIV are deterred from seeking care by concerns about discrimination. Patients who conceal their HIV status may be compromising their care. Without derogating from the importance of confidentiality protection, the evidence suggests that most patients are not concealing their HIV status owing to abstract privacy concerns but because they fear that disclosure will result in denial of care.\footnote{113. For a thorough discussion of the moral and legal concerns of a patient considering disclosure, see Montoya, Jr., supra note 16.} Of course, the data also show that many dentists do not discriminate against people with HIV.

Fear of infection, fear of pecuniary loss, competency concerns, and
disdain for people with HIV all contribute to negative attitudes, and play some role in actual discrimination. The evidence points toward actual knowledge of a patient's HIV status as the main factor triggering refusal to treat. The large majority of patients who suffered discrimination in the Burris-Glick study had told the dentist of their HIV status. In Jacobson's study, about half the respondents did not disclose their HIV infection to their dentist, and none of these patients encountered difficulties in securing treatment. This conclusion is also supported by Hazelkorn's finding that dentists did not discriminate against a person pretending to engage in high-risk behaviors, and by the consistently wide divergence between the number of dentists reporting treatment of patients they suspect of being high risk and the number reporting treatment of patients they know have HIV.

Significantly, clinical complexity in either the patient's general health or oral condition does not seem to drive discrimination. The simplest explanation for this lack of correlation is that most dental patients with HIV do not suffer from complex conditions, but the finding has important implications. First, it undermines any claim that discrimination merely reflects valid patterns of specialization that are based on objective medical criteria. Second, it suggests that people with HIV do not as a group impose substantially higher, and practically unreimbursable, costs on dentists.

The studies to date have generally not addressed forms of discrimination more subtle than outright refusal to treat. The Burris-Glick study found that more than eleven percent of patients reported being charged more, or asked to come at a special time. A dentist who does not wish to treat patients with HIV can effectively deter return visits by all the forms of rudeness at his disposal. More significantly, unwillingness to treat a patient with HIV may affect a dentist's decision about a treatment plan. There has been no published research exploring whether or not HIV influences dental care choices in a way that significantly compromises the patient's care.

Several factors seem to reduce poor attitudes and, presumably, discriminatory behavior. The work of Bennett, Weyant, and colleagues is the most nuanced and ambitious, and its conclusions about the importance of that "professionalism"—an amalgam of peer esteem, example and ethical values—deserve considerable weight. This work suggests that professional and social authorities must project norms of nondiscrimination in addition to

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115. See supra Section II.A-B.2.
116. This assumes the routine use of barrier precautions for all patients.
118. Bennett et al., supra note 32; Weyant et al., supra note 57, at 57.
providing accurate information about HIV and infection control. As I discuss below, the influence of norms arising from within the dental culture is central to any coherent strategy to reduce discrimination through positive regulatory action.

Dentists' attitudes about HIV, like everyone else's, are complex. Attitudes about clinical competence, sex, risk, death, and disease mix with economic concerns in ways that are difficult to measure finely and which ultimately operate synergistically.¹¹⁹ Although education, like every other intervention, has its limits, the empirical literature generally supports the view that more thorough training in infection control, epidemiology, and treatment of HIV and other infectious diseases will produce dentists who are better qualified to care for all their patients and who may be more willing to treat people with HIV. Designing dental education to include actual treatment of patients with HIV appears to be valuable. Of great practical significance is the fact that changes in attitude based on experience seem to be permanent, offering hope that behavior change is self-reinforcing. Education itself sends the message that dentists are expected to treat patients with HIV.¹²⁰

The work of Bennett, Weyant, and colleagues,¹²¹ finding that education had a limited impact on negative attitudes and that generalized attitudes about risk and illness strongly affect willingness to treat, sounds a cautionary note but does not contradict other studies that find that education can matter. Facts do not dictate behavior, any more than comfort with HIV eliminates discomfort with homosexuality. Educational experiences that provide students insight into their own attitudes and heuristics about risk are a necessary element of any response.

Education of dentists does not directly address the frequently reported concern about the reaction of patients. Gerbert and colleagues, surveying 2000 adults in 1988, found that over 40% would switch dentists if they discovered their current provider also treated patients with HIV.¹²² In 1991, in the wake

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¹¹⁹. See Chen, supra note 94, at 710.
¹²⁰. If further research finds that perception of risk is a largely immutable personality trait, "then perhaps selecting [dental] students who are less 'risk averse' is the only solution." Weyant et al., supra note 57, at 121. A willingness to accept the treatment obligations entailed in professional qualification seems a reasonable, indeed salutary, criterion for dental school admission. Enforcing such a requirement would, however, be difficult.
¹²¹. See Bennett et al., supra note 39; Weyant et al., supra note 57.
¹²². Barbara Gerbert et al., Patients' Attitudes Toward Dentistry and AIDS, J. AM. DENTAL ASS'N, Nov. 1989, (Supplement) at 16S.
of the Acer case, almost 54% of patients said they would switch.\textsuperscript{123} On the other hand, more than half the patients in one study agreed that dentists should treat patients with HIV like any other patient, and more than 70% believed that dentists had a moral and ethical obligation to treat patients with HIV.\textsuperscript{124}

As in the studies of dentists’ attitudes, the expressed intention is not necessarily a good predictor of actual behavior. A survey of patients in a private practice found that almost 10% agreed with the statement, “I have been avoiding dental treatment because of my concern about contracting AIDS and/or other infectious diseases from my hygienist or dentist,” but every respondent was, in fact, seeing his or her dentist.\textsuperscript{125} Only a third of the respondents in Gerbert’s survey had ever thought about the possibility of contracting HIV from a dentist. Similarly, while almost 90% of patients expressed comfort at the prospect of talking with their dentist about HIV, less than 15% had actually done so.\textsuperscript{126} As with dental attitudes, the factors that would actually lead a patient to switch dentists, and therefore the objective magnitude of the switching problem for dentists who treat people with HIV, cannot be quantified. One study justifiably suggests that:

educational efforts that encompass HIV transmission as well as the procedures health-care professionals use to prevent HIV transmission are necessary not only to increase public understanding of HIV transmission in health-care settings, but also to combat and reduce unfounded patient fears and anxieties.

....

[A]ctive steps on the part of health-care professionals, such as acknowledging patients’ HIV transmission fears, maintaining visible infection control procedures, providing educational materials, and initiating discussions about infection control procedures are warranted to alleviate patient concerns.\textsuperscript{127}

We know relatively little about dentists’ attitudes toward legal constraints on their treatment decisions. First, we have no direct evidence of dentists’ specific knowledge of the ADA and other legal prohibitions against

\textsuperscript{123} Eileen M. Gentry et al., \textit{Addressing the Public’s Concerns About Human Immunodeficiency Virus Transmission in Health-Care Settings}, 153 ARCHIVES INTERNAL MED. 2334, 2338 tbl. 4 (1993); see also Leonard Horowitz & Robert Lipkowitz, \textit{Survey on AIDS, Fear and Infection Control: Attitudes Affecting Management Decisions}, CLINICAL PREVENTIVE DENTISTRY, Nov.-Dec. 1992, at 31 (reporting that nearly 70% of patients in small, single practices would be afraid if they knew their dentist was treating people with HIV).

\textsuperscript{124} Horowitz & Lipkowitz, supra note 123, at 31-32.

\textsuperscript{125} Id. at 32.

\textsuperscript{126} Gerbert et al., supra note 76, at 195.

\textsuperscript{127} Gentry et al., supra note 123, at 2340.
Dental Discrimination

discrimination. Bennett’s finding that 37% of dentists surveyed in 1993 were “unsure of their legal obligations” suggests a problem, but more research is needed. Second, we have a little more but still ambiguous evidence of dentists’ attitudes towards legal regulation in this area. Large numbers continue to claim a “right” to decide whom to treat. This opinion is clearly inconsistent with the protections of antidiscrimination law. High rates of refusal may indicate ignorance of the law, confidence in its inefficacy, disdain for its requirements, or a combination of all of the above. Similar views have been detected in dentists’ responses to questions about bloodborne pathogen regulations. These responses raise questions about the legitimacy of antidiscrimination rules. The fact that so many refusing dentists were so candid about their categorical unwillingness to treat patients in the Burris-Glick study strongly indicates that the law did not concern them, despite the recent and widespread publicity in the Philadelphia area and the dental press of law suits against dentists. This area clearly requires further research. Finally, we do not have data directly addressing why, if so many patients believe they have experienced discrimination, so few have filed legal claims. It is very unlikely that the rate of cases filed is a better indicator of patient experience than self-reported survey data. The widespread belief among patients that dentists have a right to decide whom to treat may be a factor, but we are unaware of how much patients know about the law and whether they trust the procedures or value the remedies it provides.

III. Using Law to Reduce Discrimination

Discriminatory behavior by dentists is potentially discouraged by several regulatory systems, including health care financing rules, professional licensure, tort law, disability discrimination law, and public health law. Yet although discrimination on the basis of HIV in routine care is illegal under the ADA and other federal, state, and local antidiscrimination statutes, we cannot simply assume that law either ought to or may be used effectively to reduce the rate at which dentists decline to care for patients with HIV. Both

128. The phrasing of questions in dental attitude studies was effective for identifying negative feelings but not for determining attitudes about the law. For example, asking dentists whether they would avoid treating patients with HIV “if they had the choice” may assume, but neither identifies nor quantifies, the legal limits on their choice.

129. See supra note 71 and accompanying text.

130. See Chen, supra note 94, at 714-15 (identifying other data needs).

131. I will use the term “regulatory environment” to denominate the constellation of substantive and procedural rules applicable to the dentist, and the administrative and professional structures that mediate them. For the process by which dentists construct and respond to legal rules, I follow Lauren B. Edelman, Legal Ambiguity and Symbolic Structures: Organizational Mediation of Civil Rights Law, 97 AM. J. SOC. 1531, 1531-32 (1992).
regulation and the antidiscrimination principle itself are under attack. Even assuming, as a matter of principle, that state power should be used against discrimination, we must address serious questions about how, or whether, this power may effectively be deployed. In this section, I will address both the questions of whether we should regulate, and, if so, how. For clarity's sake, I begin with an overview of the regulatory environment, identifying possible regulations and discussing their advantages and disadvantages. I then consider the leading objections to such legal interventions against discrimination. Finally, I apply socio-legal research on compliance with law and some of the experience in public health behavior change campaigns to identify a package of regulations that is likely to reduce discrimination significantly and at reasonable cost.

A. The Regulatory Environment: Options for Action

1. Dental Ethics

Ethics, as a system of regulation, operate largely through moral force diffused through the professional culture—what Weyant and colleagues studied under the rubric of “professionalism.” Ethics have some impact on customary legal standards, albeit indirect, as counsel for professional organizations in health care largely avoid drafting ethical advisories in any form that could be imported verbatim into a legal standard of care. Two questions follow: Does the dental profession have an ethical prohibition of discrimination, and if so, how is it conveyed to dentists?

Most ethicists in medicine and dentistry have posited a straightforward obligation to provide patients with HIV the care professionals routinely provide to other patients. As with antidiscrimination law, ethics does not require a dentist to provide care to a patient with HIV that is medically contraindicated, outside the bounds of his competence, or that he would not provide to a patient.

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without HIV. Ethical codes, which are premised on the special professional status of health care workers, also include an obligation to remain current in matters such as infection control and the diagnosis and care of prevalent health conditions.

The American Dental Association's ethical position is ambiguous. While its policy statement provides that "[a] decision not to provide treatment because the individual has AIDS or is HIV seropositive, based solely on that fact, is unethical," the policy leaves room for dispute over the full extent of the obligation:

Decisions with regard to the type of dental treatment provided or referrals made or suggested, in such instances, should be made on the same basis as they are made with other patients, that is, whether the individual dentist believes he or she has need of another's skills, knowledge, equipment or experience and whether the dentist believes, after consultation with the patient's physician if appropriate, the patient's health status would be significantly compromised by the provision of dental treatment.

The loophole appears in the term "believes." Perhaps the association intended to imply that the dentist's evaluation of her capacity and the patient's needs be objectively reasonable, but the canon's plain terms suggest a subjective


The position of the American Dental Association may be compared with both stricter and looser commandments issued by medical bodies. The American Medical Association's position, as articulated in 1988, by the Council on Ethical and Judicial Affairs, adds to language similar to the ADA's the proviso that "[p]ersons who are seropositive should not be subjected to discrimination based on fear or prejudice." In contrast, the Texas Medical Association took the position that "[a] physician shall either accept the responsibility for the care and treatment of a patient with AIDS . . . or refer the patient to an appropriate physician who will accept responsibility." Second Supplemental Report of the Texas Medical Association Board of Councilors (Nov. 20, 1987), quoted in Amir Halevy & Baruch Brody, Acquired Immunodeficiency Syndrome and the Americans with Disabilities Act: A Legal Duty to Treat, 96 AM. J. MED. 282, 284 (1994).

134. See Emanuel, supra note 133.

135. See AMERICAN DENTAL ASS'N, ADA PRINCIPLES OF ETHICS AND CODE OF PROFESSIONAL CONDUCT § 2 (rev. ed. 1988) ("The privilege of dentists to be accorded professional status rests primarily in the knowledge, skill and experience with which they serve their patients and society. All dentists, therefore, have the obligation of keeping their knowledge and skill current.").

136. Id.

137. Id.
standard. As George Annas has noted, allowing the psychological unwillingness to treat to qualify as the lack of objective competence to treat “is the same as saying a doctor must treat an AIDS patient if the doctor wants to treat an AIDS patient.”

Given the ambiguity in the standard, the association’s public statements, educational efforts, and overall example become particularly important in establishing an ethical norm against discrimination. The association’s public comments on discrimination cases have been circumspect regarding the extent of the dentist’s obligation. In response to the several suits initiated by the Department of Justice under the ADA, the dental association has repeated its low estimate of the risk of transmission in the dental setting and reiterated the need for dentists to treat patients with HIV in a compassionate manner.

Its words have been so cautious, however, that only one headline writer has interpreted these bromides on compassion and infection control as constituting outright support for the DOJ’s position in dental suits. Some of the dental association’s officers have appeared to cast doubt on the need for the project. A story on the filing of the Department’s first two cases, in 1993, reported that:

Mary Logan, the American Dental Association’s general counsel, said that while cases of discrimination against HIV-positive individuals have been found in ‘isolated instances,’ she does not believe it is widespread. ‘Universal precautions’ that require dentists to wear gloves and use disposable instruments have been required [by OSHA] for more than a year and are not considered controversial by the association’s 140,000 members, Logan said.

139. See John Pope, Dentist: Patients were Referred Because of AIDS, NEW ORLEANS TIMES PICAYUNE, Nov. 19, 1993, at B1.
141. William Pack, Experts: Fear of Patients Loss Leads to Refusal, HOUS. POST, Oct. 6, 1993, at A18. The statement is remarkable for the fact that the dental association had finally lost its attack on the universal precautions rules only two days before, when the Supreme Court denied certiorari. American Dental Ass’n v. Martin, 114 S. Ct. 172, denying cert. to 984 F.2d 823 (7th Cir. 1993); see supra note 51.

The clearest explication of a rule against discrimination by anyone connected with the association came in a declaration provided to the Justice Department for use in a dental discrimination case by Enid A. Neidle, Ph.D., of Columbia University, who was formerly Assistant Executive Director, Scientific Affairs of the Association. As described by the court, her affidavit stated unambiguously that the dentist’s “policy of sending all patients with HIV or AIDS to another general dentist—regardless of their then-current medical status, dental condition, or dental needs—is in direct contravention of the Association’s policies and constitutes a breach of [the dentist’s] professional and ethical obligations.” United States v. Morvant, 898 F. Supp. 1157, (E.D. La. 1995) (citing Plaintiff’s Exhibit 60, at 15). One is left to wonder whether Dr. Neidle
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The association has taken a position that can be read as condemning discrimination, but has avoided an unambiguous criticism of the practice, even in cases where illegal bias was admitted or adjudicated. Like the AMA’s, the dental association’s ethical position mirrors rather than resolves its members’ ambivalence about treating patients with HIV. For those dentists who believe that nondiscrimination is a requirement of professionalism, the association’s statement offers its general words. For those dentists who do not wish to treat, the statement offers its lacunae. A serious and effective ethical system would entail not only a less ambiguous norm, but also a thoroughgoing effort to propagate and support the rules through education, public positions on cases, and example.

2. Financing

Where, or whether, one receives health care largely depends on who pays. A major reason people with HIV, and Americans generally, cannot get dental care is inability to pay for it. By one estimate, 150 million Americans lack dental insurance. Medicare has no provision for outpatient dental care. Medicaid mandates it only for recipients under eighteen, and most state Medicaid programs do not provide dental benefits for all participants. Those individuals receiving benefits find that few dentists will accept their coverage. The majority of dentists decline or severely limit program participation. More than a decade ago, when dental benefits were more common, a study found that only a quarter of the million people in Michigan with Medicaid dental benefits were receiving dental care, despite the fact that 40% of dentists surveyed, including 40% of dentists who did not take Medicaid, reported a need for more business. Not surprisingly, dental care
is not evenly distributed in society. Poverty reduces a person's ability to obtain dental care. People with HIV, many of whom tend also to be poor (either from the start or because of their illness), frequently face a double burden in getting care.

The present financing system presumably encourages patients with HIV to get their care in dedicated clinics. Most HIV patients depend on Medicaid or charity to obtain private dental care. Some social service agencies charitably pay the market rate for individual clients in need of dental care, but these resources are limited. Clinics tend both to accept Medicaid and to provide free care to those unable to pay.

Could financing be used to improve dentists' willingness to treat patients with HIV? Obviously, for patients whose access is limited primarily by poverty (caused by HIV status or otherwise), universal dental insurance, or augmented coverage for low income and indigent patients, would expand market access. Short of that, providing dental benefits to all Medicaid and Medicare recipients would address some of the problems of the indigent uninsured. Reimbursement rates that were competitive with market levels, even accounting for the bureaucratic costs of participating in the program, would also contribute to better access. By the same logic, above-market reimbursement rates for HIV-infected patients would give dentists a positive incentive to provide treatment. Better financial support for dedicated clinics would also be helpful. Funding for these dedicated services is often precarious since it depends on annual appropriations to health care and social service organizations that face many competing priorities.

Injecting some experience into this logic confronts us with a case of market economics foundering on the shoals of public choice. Universal dental insurance is simply not going to happen in the foreseeable future. There is even less chance that current financing reforms will widen Medicaid and Medicare eligibility or increase reimbursement rates. In some states, a focused effort to get dental coverage, paying market rates, only for people with HIV, based on their medical needs and the discrimination problem, might face better political odds, but, in addition to the usual problems of special pleading, it

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EDUC. 647 (1988); Venezie & Vann, Jr., supra note 108, at 180; Damiano, supra note 108. 
149. The Temple Clinic, for instance, accepts Medicaid and private insurance and seeks grants from public and private agencies. Clinic personnel conduct funded research and receive some salary and other support from the host institution. Telephone Interview with Michael Glick (May 8, 1995).

150. Ian Ayres suggests that the government might provide an economic incentive to provide care, and help educate dentists and the public about the low risk of HIV transmission, in one cheap, fell swoop, by offering free HIV-infection insurance for all dentists who treat patients with HIV. This is a nice illustration of the ideal of complementary reinforcement of educational and regulatory interventions. See infra Section III.B.3.
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would require advocates for people with HIV to argue that care for HIV patients is more expensive. In this light, the importance of dedicated clinics in providing care may reflect the greater ability of advocates for HIV dental care to fund specific programs at the margins than to fundamentally alter social insurance.

In theory, health care financing tools could dramatically increase basic access to care for indigent people with HIV. In practice, however, public financing tends to support segregated care, and so, paradoxically, may actually encourage private dentists to refer rather than treat.

3. Licensing Law

Every state has laws or regulations governing the licensure of individuals to practice dentistry. Licensing rules generally impose substantive standards of professionalism, competence and good conduct. As an element of license renewal, thirty-four states require practitioners to meet continuing professional education standards, generally leaving to the discretion of the dental board the specific subject matter. State licensure law has the potential to articulate and enforce clear norms of nondiscrimination against the HIV-infected, and to promote education that reduces fear and other negative attitudes.

a. Discipline

A survey conducted in 1993-94 asked state dental licensing boards to summarize their policies with respect to HIV-based discrimination. Eighty-five percent of the fifty-four state and territorial boards responded. The authors interpreted the responses of 26% of the boards as indicating a formal policy against HIV-based discrimination, although for the most part this consisted of
a citation to a state statute generally prohibiting HIV discrimination. Only one state, Maryland, has an explicit antidiscrimination provision in its dental licensure statute. The law authorizes the Board of Dentistry to reprimand, place on probation, suspend, or revoke the license of any licensee who “[r]efuses, withholds from, denies, or discriminates against an individual with regard to the provision of professional services for which the licensee is licensed and qualified to render because the individual is HIV positive.”

A few other states have included a specific prohibition against health care discrimination in their HIV testing and confidentiality statutes, which include reference to licensure law. Vermont prohibits health care providers, including dentists, from refusing to provide care based on HIV and, in addition to a private right of action for damages and injunctive relief, provides that “[f]ailure of a health care provider to comply with any provision of this section shall constitute grounds for disciplinary action or any other regulatory action authorized by law.” Wisconsin law prohibits dentists, among other health care providers, from “[r]efusing to treat [a person with HIV], if his or her condition is within the scope of licensure . . . of the health care provider,” or to “[p]rovide care to the individual at a standard that is lower than that provided other individuals with like medical needs.” Penalties include actual damages, costs, and exemplary damages of up to $5,000 for wilful violation.

Against a background of general antidiscrimination law and the more specific ethical pronouncements of the American Dental Association, an unjustified refusal to treat a patient with HIV arguably could be prosecuted under many states’ licensure law as “unprofessional” or “dishonorable”
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conduct.\textsuperscript{160} Such terms could derive their meaning from a variety of sources apart from a dictionary definition, including the standards of the profession, the intent of the legislature, or the rules and decisions of the dental board.\textsuperscript{161} Given the lack of action by dental boards so far, and the significant prevalence of discrimination in the profession, recourse to professional custom or dental board actions is problematic. Further, resort to ethical standards would not necessarily cure the problem. The dental association’s acceptance of a dentists’ subjective evaluation of his ability to treat in assessing a referral provides a major loophole.\textsuperscript{162}

The enforcement of an obligation not to discriminate would be a departure from common practice for dental boards. Assuming that dental boards operate like medical boards,\textsuperscript{163} their main concerns are seriously incompetent practitioners, practitioners impaired by substance abuse or other physical or mental disorders, and practitioners who violate prescription laws.\textsuperscript{164} Professional boards have occasion to discipline practitioners who have been found guilty of a crime, and they may also consider the outcomes of malpractice actions. They have not themselves engaged in what is essentially the application of legal rules of antidiscrimination to professional conduct, and may find the process both unfamiliar and unpalatable. Even if a board is willing to treat discrimination as unprofessional conduct, there is the question of whether a board would undertake to apply discrimination law in the first instance, rather than awaiting a decision in a court or human rights agency. If it waits, the utility of the board as a source of initial control is lost. If it

\textsuperscript{160} See Annas, supra note 138, at 847-48. Unprofessional, Dishonorable or Immoral Conduct, 70 C.J.S. Physicians and Surgeons § 39 (1987), provides a list of unprofessional conduct including drunkenness, failure to keep complete and accurate records of controlled substances, conviction of a crime, abandonment, deliberate falsification of patient’s medical records, sexual imposition, intentional dishonesty, and failure to supply subpoenaed patient records. Some states’ licensing schemes do not authorize discipline for simple “unprofessional” or disreputable conduct. New Jersey, for example, authorizes discipline for a licensee convicted of a crime of moral turpitude, or for willful and gross malpractice. N.J. REV. STAT. § 45:6-7 (1993).

\textsuperscript{161} See Megdal v. Oregon State Bd. of Dental Examiners, 605 P.2d 273 (Or. 1980).

\textsuperscript{162} Indeed, in the late 1980s, the Arizona State Board of Medical Examiners took the position that refusal to treat patients with AIDS may only be deemed unprofessional conduct in the absence of reasonable efforts to find another physician. Annas, supra note 138, at 848; MDs Can Refuse AIDS Patients, AM. MED. NEWS, Nov. 6, 1987, at 37.

\textsuperscript{163} Information about the activities of dental licensing boards is sparse, so I have relied upon data concerning doctors or that does not differentiate between doctors, dentists and other licensed practitioners.

\textsuperscript{164} See, e.g., James Gray, Why Bad Doctors Aren’t Kicked Out of Medicine, MED. ECON., Jan. 20, 1992, at 126; Richard P. Kusserow et al., An Overview of State Medical Discipline, 257 JAMA 820, 822-23 (1987). Public Citizen reported that only 11% of medical actions involved incompetence or negligence, the rest being fraud, criminal convictions and drug abuse and the like. Linda Oberman, Focusing on Quality: Medical Boards Increasing Commitment to Competency Cases, AM. MED. NEWS, Apr. 12, 1993, at 2. See generally Timothy S. Jost, Regulatory Approaches to Problems in the Quality of Medical Care: Diagnosis and Prescription, 22 U.C. DAVIS L. REV. 593 (1989).
simply piles more punishment on a dentist who has already been sanctioned under antidiscrimination law, the marginal utility of the board action may be slight, and may constitute overdeterrence.

In some jurisdictions, "unprofessional conduct" disciplinary actions could offer a legally viable antidiscrimination mechanism, since constitutional challenges for vagueness almost never succeed, and courts frequently uphold charges of unprofessional conduct based on poor patient care. Significantly, however, medical boards rarely extend the concept of unprofessional conduct to embrace behavior not closely related to the practice of dentistry or medicine, and when they have, courts have shown a reluctance to accept the move. If discrimination is seen as a matter of general civil law, rather than as an element of professional practice, this theory could preclude successful disciplinary actions against discrimination.

Even were a large number of state boards to articulate a clear rule against discrimination or medically unjustified refusal to treat, a dentist who discriminates might not feel compelled to change her behavior. Friedland and Valachovic found that of eight boards presented with a total of thirty complaints of possible discrimination, only one board had ever taken action, twice "admonishing" the defendant dentists.

More generally, the state boards that regulate health care professions have a reputation for laxity and inefficiency. Available statistics indicate a low rate of action. The National Practitioner Data Bank (NPDB) is the repository of nationwide data on disciplinary actions, including malpractice suits, collected pursuant to the Health Care Quality Improvement Act (HCQIA) of 1986. The 1968 licensure actions reported by state licensing agencies in

165. Friedland and Valachovic's findings suggest this might be the common response. See supra note 153.


168. In an Oregon case, for example, the state supreme court refused to interpret the term to cover fraud in the securing of malpractice insurance, holding that the board should have issued prospective rules defining the conduct in question as unprofessional. Megdal v. Oregon State Bd. of Dental Examiners, 605 P.2d 273 (Ore. 1980).

169. Friedland & Valachovic, supra note 153, at 38 tbl. 1, 39.

170. Kusserow et al., supra note 164, at 821. In one extreme instance, California's state medical board literally shredded hundreds of uninvestigated case files in an effort to eliminate its backlog. David Azevedo, A Bloodied Medical Board Fights for a Comeback; Medical Board of California, MED. ECON., Sept. 27, 1993, at 36.

171. Pub. L. No. 99-660, 100 Stat. 3784 (codified as amended at 42 U.S.C. §§ 11,101-11,137 (1994)). In addition to payments made by or on behalf of a doctor or dentist, the Bank collects actions affecting a practitioner's license by a state medical or dental board, actions affecting a practitioner's clinical privileges that arise as a result of peer review action at a health
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the first year of the NPDB's operation included 694 sentences of probation (35.3%), 338 sentences of suspension (17.2%), 249 revocations (12.7%), and 164 reprimands (8.3%). Although the rates vary significantly from state to state (exhibiting an inverse relation between the number of practitioners in a state and the rate of discipline), the mean rate of license actions per 1000 physicians in the United States was 2.7. (By way of comparison, the Harvard Malpractice Study found that the 1984 rate of malpractice claims against doctors in New York was 70 per 1000 licensed physicians, and 130 per 1000 in active practice.) The Federation of State Medical Boards also compiles statistics on physician discipline. In 1993 the Federation reported a total of 3707 cases resulting in disciplinary action against a physician, up 337 from the year before. Sanctions ranged from license revocation to reprimand.

Critics of medical regulation, such as Dr. Sidney Wolfe of Public Citizen, claim that the prevalence of incompetence and impairment is much higher than...
the disciplinary rate. The Department of Health and Human Service's Office of Inspector General conducted a study in the late 1980s that concluded that, while no definitive data allowed the quantification of incompetent and impaired physicians, the data do "suggest quite strongly that even when all appropriate caveats are taken into account, the universe of potentially actionable events far exceeds the number of disciplinary actions actually imposed by the boards." Even when professionals are ultimately disciplined, few state boards make a sustained effort to publicize misconduct or its punishment.

While the unwillingness of professionals to police their peers is a likely suspect, the low rate of disciplinary action can also be explained by fiscal and legal impediments to enforcement. Such actions are often procedurally cumbersome, involving lengthy appeals and high burdens of proof. Most states require "clear and convincing evidence" of a licensing violation. This is a higher standard than is applicable under antidiscrimination statutes such as the ADA, which requires only a preponderance of the evidence to establish discrimination. Litigating a disputed complaint can be expensive and protracted, particularly if the dentist is fighting for her professional life. The cost, for the agency, can run into six figures. A board's first application of an antidiscrimination rule might well be litigated to the fullest extent possible.

Licensing boards have not fared well in the appropriations process. In the recent recession, many suffered substantial budget cuts. Between 1990 and 1992, for example, Connecticut's medical licensing board lost about a fifth of its staff. During the same period, license fees were tripled, but the money went into the state's cash-starved general fund. In Massachusetts, the board lost a

176. Gray, supra note 164, at 128.
177. Diane M. Gianelli, IG Report Suggests Medical Boards Don't Discipline Enough Doctors, AM. MED. NEWS, June 15, 1990, at 1 (internal quotation omitted); see also Kusserow et al., supra note 164 (earlier Inspector General's investigation).
178. State Boards Fail to Disclose Their Record; Physician Discipline, PEOPLES MED. SOC'Y NEWSL., Apr. 1992, at 8; see also Linda Oberman, Release of Disciplinary Data Highly Charged: the Disclosure of Physician Misconduct Proceedings, AM. MED. NEWS, Mar. 15, 1993, at 7 (reporting that only 28 states medical boards publish newsletters identifying disciplined professionals).
179. Gray, supra note 164, at 144-46; Kusserow, supra note 164, at 823.
180. The higher standard would be particularly burdensome in cases turning on the propriety of a "referral," where arguments about the patient's dental needs and the dentists' knowledge and competence could cloud the issue of intent.
181. On average, medical boards in the United States require almost 27 weeks to dispose of or dismiss a complaint. Entering into a consent agreement averages 37 weeks, and disposition through a full disciplinary hearing requires an average of 46.9 weeks. Marwick, supra note 175. But "[i]t's not unusual for an accused doctor to practice through two years of investigation and board hearings, and another five in appeals—sometimes a quarter of a career between the original complaint and the ultimate implementation of board discipline." Gray, supra note 164, at 146.
182. Gray, supra note 164, at 146.
third of its staff between 1988 and 1992. Perhaps the most extreme example of legislative indifference to dental regulation came in 1994, when the Texas Board of Dental Examiners was allowed to lapse under a state Sunset law.

Despite the bleak prospects for actual enforcement of a rule against discrimination by dental boards, clearer licensing regulations against dental discrimination may still have significant value. A complaint, even if it does not lead to discipline, may frighten an individual practitioner and, if publicized, have some deterrent effect. "Weak" sanctions may also be seen as flexible sanctions that shame but also reintegrate the wrongdoer into the professional community, with consequent benefits for acceptance of the norm and long-term behavioral change. Practitioners may also fail to assess correctly their actual chances of being disciplined. More important, dental boards are substantially constituted by dentists themselves. In setting a norm of nondiscrimination, they wield the power of professional regard. The mere existence of the norm, even if enforced by other authorities in other forms, has the capacity to legitimate the same rule promulgated by non-dentists.

b. Primary and Continuing Education

Given the impact of education on dentists' behavior, the educational requirements of licensure law could prove useful in reducing discrimination against patients with HIV. Dental boards in most states have the authority to require regular continuing education for dentists and allied health personnel on precisely the subjects researchers deem to be most relevant to the treatment

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183. Leigh Page, Hard Times in States Afflict Underfunded Licensure Boards; Medical Boards, AM. MED. NEWS, Mar. 2, 1992, at 1; see also Gray, supra note 164, at 143-44 (funding for medical boards inadequate in many states).
185. "Many complaints that don't lead to sanctions do, however, clean up marginal behavior. Both the accused doctor and the colleagues who knew he was being investigated become aware of being watched. We can't quantify it, but subliminal regulation does occur-and it works." Gray, supra note 164, at 148 (quoting M. Roy Schwarz, AMA Senior Vice President for medical education and science).
186. See infra text accompanying notes 335-40.
187. The Harvard Malpractice Study found that doctors systematically and substantially overestimate their chances of being sued. Weiler et al., supra note 174, at 124-25. A far less rigorous survey of readers conducted by American Medical News found that eighty-three of ninety-eight doctors responding were deterred by fear of licensing action or criminal sanctions in their prescription of pain medication for patients, giving less than they otherwise would. Flora Johnson Skelly, Fear of Sanctions Limits Prescribing of Pain Drugs: Survey of American Medical News Physician Readers, AM. MED. NEWS, Aug. 15, 1994, at 19.
of patients with HIV.188

Florida is the only state that requires dentists and other professionals to complete a course on HIV/AIDS. Its statute, passed as part of a comprehensive HIV bill that included privacy, criminal and other provisions, orders state licensing boards to:

require each person licensed or certified . . . to complete a continuing educational course, approved by the board, on human immunodeficiency virus and acquired immune deficiency syndrome as part of biennial relicensure or recertification. Such course shall include information on the modes of transmission, infection control procedures, clinical management, and prevention of human immunodeficiency virus and acquired immune deficiency syndrome and its impact on testing, confidentiality of test results, and treatment of patients.189

Continuing education should also include training on communicating risk to patients, many of whom are uncertain about the facts and how to interpret them.190 We should not assume that health care professionals are themselves comfortable talking about HIV, or that they are able by virtue of their general training to educate patients effectively about this particularly volatile matter. Training in risk communication may also increase dentists’ confidence in treating patients with HIV in so far as it equips them to understand and address their other patients’ fears, and so diminishes dentists’ own concerns about losing business.

Professional education in infection control is also justified as a means of promoting compliance with infection control rules. Once in practice, dentists in private offices are largely unregulated. Although subject to OSHA rules on infection control,191 the chances of any particular dentist being monitored are astronomically low. Once in private practice, dentists are not subject to review by peers or others, are not exposed to new information or standards through collegial work, and are left to their own devices in obtaining

188. Dental boards set the requirements for initial licensure, usually in broad terms that defer to the specific requirements of accredited dental schools. Infection control is now part of all dental school curricula, but dental schools have not uniformly required students to take one or more courses in the treatment of patients with infectious diseases. Telephone Interview with Michael Glick (May 8, 1995). Given the evidence that suggests a relation between actual experience treating patients with HIV and subsequent willingness to treat, licensing authorities may consider clearly requiring such training as a condition of initial licensure if, in the next few years, dental schools do not themselves begin to require such training.
190. See Gentry et al., supra note 123, at 2339-40.
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continuing education.

No board can "enforce" learning or screen out those practitioners who do not accept the message offered. In setting basic standards of knowledge, however, boards could help legitimate and continually reinforce norms of treatment. No other policy would do more to create conditions under which these norms would take root.

4. **Tort Law**

The tort system is the major legal regulator of health care worker behavior. It is also politically controversial, unpopular among the regulated, and underutilized by those it is designed to protect. For all that, its workings are, in important areas, largely unknown.

There are several tort theories under which dentists who refuse to treat patients with HIV have been or may be sued, including abandonment, malpractice, and intentional infliction of emotional distress. Although the common law does not require a dentist to contract with a patient, the tort of abandonment does limit a dentist's capacity to terminate a patient relationship at will. Abandonment, however, is a limited constraint on dentists' behavior, barring only the withdrawal of presently necessary assistance without giving a patient sufficient notice to find another provider. Presumably, it would apply only to patients with very acute dental needs, and then only for the immediate care required to take care of the emergency aspects of a patient's condition. While some dental care is long term, dentists are fungible enough that, with reasonable notice, a patient would be hard put to make out a case that a refusal to treat constituted abandonment. This is not to say that

192. See Jost, supra note 164, at 601 ("Licensure exams screen out candidates ... who lack basic knowledge or cognitive skills, but the exams do little to address the interpersonal element of care.").

193. See generally WEILER ET AL., supra note 174.

194. For a thorough account of what is not known, see Michael J. Saks, *Do We Really Know Anything about the Behavior of the Tort Litigation System—And Why Not?*, 140 U. PA. L. REV. 1147 (1992).


196. See, e.g., Ricks v. Budge, 64 P.2d 208, 212 (Utah 1937) ("A physician has the right to withdraw from a case, but if the case is such as to still require further medical or surgical attention, he must, before withdrawing from the case, give the patient sufficient notice so the patient can procure other medical attention if he desires.") Abandonment is not necessarily an independent tort in all jurisdictions. See, e.g., Woolfork v. Duncan, No. CIV. A. 94-1532, 1995 WL 11976 (E.D. Pa. Jan. 5, 1995) (abandonment a species of negligence under Pennsylvania law). For a discussion of the tort as it might apply to a patient with HIV, see Troyen A. Brennan, *Ensuring Adequate Health Care for the Sick: The Challenge of the Acquired Immunodeficiency Syndrome as an Occupational Disease*, 1988 DUKE L.J. 29, 35-36 (1988).
a plaintiff who got that far could not, with a sympathetic story of rude and inconvenient treatment, convince a jury to find abandonment under the general cover of "reasonableness."197

Similarly, one can imagine circumstances in which the description of a refusal to treat when presented to "an average member of the community would arouse his resentment against the [dentist], and lead him to exclaim 'outrageous'."198 This tort of outrage (also called intentional infliction of emotional distress), with its declamatory test, has been applied to instances of racial discrimination, and would take into consideration the dependent relationship between patient and dentist. Its effectiveness depends, however, upon the "average member of the community’s" attitudes toward people with HIV.199

Like other professionals, dentists are subject to liability for harms to a patient arising from an unreasonable failure to provide the level of care customary to the profession.200 A dentist whose discrimination took the form

197. Depending on the nature of the treatment, there might also be a breach of contract.
198. RESTATEMENT (SECOND) OF TORTS § 46 cmt. d; see, e.g., Gomez v. Hug, 645 P.2d 916 (Kan. Ct. App. 1982). Such a claim was made in Howe v. Hull by a patient refused admission to a hospital because he had HIV. In denying summary judgment for defendants, the court reasoned that refusing to care for someone because of HIV was an act sufficiently bad to justify a jury in finding both that the act itself was outrageous and that it was performed with reckless disregard of a high probability that harm would occur. Howe v. Hull, No. 3:92CV7658, 1994 U.S. Dist. LEXIS 17,417 at *28-34 (N.D. Ohio 1993); accord Miller v. Spicer, 822 F. Supp. 158, 169-70 (D. Del. 1993). The jury subsequently found for the defendants on the intentional infliction of emotional distress claim, though the plaintiff prevailed on ADA and section 504 claims. Howe supra, at 17,443; see also Woolfork v. Duncan, No. CIV.A. 94-1532, 1995 WL 11,976 (E.D. Pa. Jan. 5, 1995) (denying summary judgment on patient's intentional infliction claim).
199. HIV litigation is subject to general influences, like the race, class and sexual preference of plaintiffs, and the social power of institutional or otherwise privileged defendants. Studies of litigation have found that "have-not" plaintiffs with HIV tend to lose more often than they win (at the appellate level), but that they nevertheless win more often than a cold view of their social status might predict. See Jane Aiken & Michael Musheno, Why Have-Not's Win in the HIV Litigation Arena: Socio-Legal Dynamics of Extreme Cases, 16 LAW & POL’Y 267 (1994); Michael C. Musheno et al., Court Management of AIDS Disputes: A Sociolegal Analysis, 16 LAW & SOC. INQUIRY 737 (1991).

The case law affords room to fashion other more or less far-fetched claims as well. For example, a few decisions have suggested, in cases involving emergency rooms, that a clearly stated public policy requiring a facility to provide care, or even a well-established custom, could ground a duty to do so in tort law. See Guerrero v. Copper Queen Hosp., 537 P.2d 1329, 1332 (Ariz. 1975); Wilmington Gen. Hosp. v. Manlove, 174 A.2d 135, 140 (Del. 1961); Brennan, supra note 196, at 38-39. It might be argued that the Americans with Disabilities Act and similar state statutes constitute such a policy, though the existence of specified modes of relief under these statutes would raise the question of the propriety of a parallel action in tort. The Emergency Medical Treatment and Active Labor Act also speaks to this behavior, 42 U.S.C. § 1395dd(d)(2)(A) (1994), but would simply not apply to private dentists, no matter how urgent the patient’s needs were.
200. See, e.g., O'Brien v. Stover, 443 F.2d 1013, 1017 (8th Cir. 1971); Morrison v. MacNamara, 407 A.2d 555, 561 (D.C. 1979). For an overview of the common law of medical malpractice, see FRANK M. MCCLELLAN, MEDICAL MALPRACTICE: LAW, TACTICS, AND ETHICS
of providing inferior care—not performing a necessary procedure, or substituting a simpler treatment for a better one—could be alleged to have breached the professional standard of care, but only if the alternative treatment caused the patient harm. At least one such case, against an obstetrician who refused treatment to a woman with HIV and advised her to have an abortion, has survived summary judgment.

Damages would be limited in most tort cases involving dentistry. Few dental problems are immediately life threatening, so a person in need of care will normally have the time to find a dentist who can provide proper treatment. Moreover, the alternative treatment offered by the dentist may effectively stabilize or even eliminate the patient’s problem. In that case, the damages will mostly be dignitary. Patients with HIV do on occasion recover substantial sums for dignitary harms, notably in the realm of privacy. Given the public’s ambivalence about dentists treating people with HIV, however, the sympathy factor may not loom large in dental cases, particularly where no physical harm was suffered.

While tort claims are available to victims of discrimination, their effect on dental behavior is uncertain. A rule against discrimination articulated by judges and enforced in the tort system is likely to be accorded little legitimacy by dentists. The Harvard Malpractice Study found that physicians did change their self-reported behavior in response to concerns about malpractice liability, but the implications for dental discrimination are not straightforward given the weak analogy between negligence and intentional discrimination. The incidence of discrimination and discrimination-based claims will never remotely approach the rate of malpractice litigation. Indeed, the behavioral analogy with malpractice may hold only in negative terms. In response to malpractice fears, physicians’ behavior tends to involve greater

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201. Proving causation in a case of omitted treatment can be difficult, particularly in the case of an individual with a serious, multifaceted and fatal illness like HIV. Some jurisdictions relax the ordinary rules of causation, see, e.g., Hamil v. Bashline, 392 A.2d 1280 (Pa. 1978), or allow recovery for a “loss of chance,” see, e.g., O’Brien, 443 F.2d 1013 (applying Iowa law). But see Cooper v. Sisters of Charity of Cincinnati, N.E.2d 97 (Ohio 1971). See generally McCLELLAN, supra note 200, at 43-44.

202. Doe v. Abitbol, 608 N.Y.S.2d 518 (App. Div. 1994). In this case, the availability of a tort claim helped the plaintiff maintain a suit against an individual who was held not to be covered by federal antidiscrimination law.

203. See, e.g., Multimedia WMAX, Inc. v. Kubach, 443 S.E.2d 491 (Ga. Ct. App. 1994) (awarding $500,000 for breach of privacy to man whose family and friends were already aware of his infection); see also Scott Burris, Testing, Disclosure and the Right to Privacy, in AIDS LAW TODAY, supra note 195, at 115, 139 (describing other cases).

204. WEILER et al., supra note 174, at 124-29.
use of "defensive" measures and more paperwork rather than the increased care the tort model predicts.\textsuperscript{205} The effect of tort liability on dentists who discriminate may likewise be more careful discrimination rather than nondiscriminatory treatment.

Even if they do not help legitimize the norm against discrimination, nor directly deter dentists from discrimination, tort claims have important consequences in lawsuits that are based primarily on antidiscrimination law. Malpractice and intentional tort claims may add to the stigma of the antidiscrimination suit.\textsuperscript{206} In addition, intentional tort suits may expose a dentist to personal liability outside the limits of her insurance policy. Given the breadth of the antidiscrimination laws, an independent tort claim will rarely be needed to establish liability, but tort claims may make up for the absence of monetary damages under the ADA.\textsuperscript{207}

5. \textit{Antidiscrimination Law}

The legal response to the HIV epidemic has been shaped by the conceptualization of communicable disease as a disability, subject to protection under federal and state law.\textsuperscript{208} Although the Supreme Court has reserved decision on the issue, lower courts have uniformly held that HIV and AIDS are disabilities under a range of state and federal statutes.\textsuperscript{209} Several states

\begin{itemize}
  \item \textsuperscript{205} \textit{Id.} The study was unable to find a statistically significant correlation between malpractice litigation and levels of negligently caused injury. \textit{Id.} at 129-31.
  \item \textsuperscript{206} See Jost, \textit{supra} note 164, at 605-06.
  \item \textsuperscript{207} There are also disadvantages to tort law. Tort claims, particularly those like malpractice that would depend on expert testimony on the professional standard, may be more difficult to prove and somewhat more costly to prosecute than claims under the ADA and other antidiscrimination statutes. In Miller v. Spicer, 822 F. Supp. 158 (D. Del. 1003), for example, plaintiff's discrimination claims survived summary judgment, while his negligence claim (cast as breach of contract) was dismissed for lack of expert testimony, among other grounds.
\end{itemize}

This is not to say that every state disability statute would prohibit the form of discrimination at issue here. For example, the Louisiana Attorney General opined that a dentist could refuse to treat a patient with HIV despite the Louisiana Disability Discrimination Law because a dentist can
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have amended their general disability discrimination statutes to include HIV.  

In addition to covering HIV and AIDS under disability discrimination statutes, several states have passed HIV-specific antidiscrimination statutes or statutes explicitly prohibiting HIV discrimination in health care.  

The most important prohibition against dental discrimination lies in Title III of the Americans with Disabilities Act (ADA), governing public accommodations.  

210. See Leonard, supra note 208, at 297-98; Josephine Gittler & Sharon Rennert, HIV Infection Among Women and Children and Antidiscrimination Laws: An Overview, 77 Iowa L. Rev. 1313, 1383-85 (1992). These, like Title I of the ADA, are frequently enforced at least initially through an administrative procedure, and like the EEOC, many state agencies have a substantial backlog. In 1990, the ACLU of Pennsylvania and the AIDS Law Project of Pennsylvania brought eleven cases against local dentists to the Pennsylvania Human Relations Commission, in part to test the efficacy of the procedure. At the time the cases were settled, after three years, the Commission had not yet held a single hearing on the matter and had a backlog of 7000 cases. Lawsuits, supra note 71.  

211. See, e.g., FLA. STAT. ch. 760.50(4)(a) (1994) (prohibiting discrimination based on HIV in public accommodations); N.C. GEN. STAT. §§ 130-148(i) (1992) ("[I]t shall be unlawful to discriminate against any person having AIDS virus or HIV infection on account of that infection in determining suitability for ... the use of places of public accommodation, as defined in [N.C. Gen. Stat.] 168A-3(8). . . .").  

212. ARK. CODE ANN. § 20-15-905(d) (Michie 1991), prohibits denial of "appropriate care" but establishes no penalty or civil action. ME. REV. STAT. tit. 5, § 19,203-A(3) (West 1991), prohibits denial of care based on a patient’s refusal to take an HIV test, and § 19,206 provides for liquidated damages of up to $5000 for a willful violation; OHIO REV. CODE ANN. § 3701.245 (Baldwin 1995), prohibits denial of health care based on the patient’s refusal to consent to an HIV test or disclose his status; W. VA. CODE § 16-3C-6(a) (1991) forbids the use of an HIV test result to deny "quality care" but provides no penalty.  

213. The ADA states: "No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation." 42 U.S.C. § 12,182(a) (Supp. II 1990). The Rehabilitation Act, where applicable, contains essentially the same limits, though few dentists accept Medicaid, the necessary "federal financial assistance" to trigger coverage. See Howe v. Hull, No. 3:92CV7658, 1994 U.S. Dist. LEXIS 17417, at *28-30 (N.D. Ohio 1994).  

of a health care provider.\footnote{42 U.S.C. § 12,182(b)(3) (1994). In two cases concerning allegedly excessive infection control}

Denial of routine care based on HIV is certainly a violation of the ADA. In \textit{United States v. Morvant}, the first ADA dental case to reach a decision, the court found against a Louisiana dentist who had declined to treat at least two patients because they had HIV.\footnote{42 U.S.C. § 12,181(7) (Supp. II 1990). Early decisions suggest that the term will be read broadly. See, e.g., \textit{Carparts Distribution Ctr., Inc. v. Automotive Wholesaler's Ass'n}, 37 F.3d 12 (1st Cir. 1994) (holding that insurance plan qualifies as "public accommodation"); \textit{cf. Atkins v. St. Helena Hosp.}, 843 F. Supp. 1329 (N.D. Cal. 1994) (holding that physician working as independent contractor in hospital does not operate a public accommodation).} Two other major cases have already settled,\footnote{42 U.S.C. § 12,181(7) (Supp. II 1990). Early decisions suggest that the term will be read broadly. See, e.g., \textit{Carparts Distribution Ctr., Inc. v. Automotive Wholesaler's Ass'n}, 37 F.3d 12 (1st Cir. 1994) (holding that insurance plan qualifies as "public accommodation"); \textit{cf. Atkins v. St. Helena Hosp.}, 843 F. Supp. 1329 (N.D. Cal. 1994) (holding that physician working as independent contractor in hospital does not operate a public accommodation).} and there have been several judgments for HIV-positive patients who suffered discrimination at the hands of doctors.\footnote{42 U.S.C. § 12,181(7) (Supp. II 1990). Early decisions suggest that the term will be read broadly. See, e.g., \textit{Carparts Distribution Ctr., Inc. v. Automotive Wholesaler's Ass'n}, 37 F.3d 12 (1st Cir. 1994) (holding that insurance plan qualifies as "public accommodation"); \textit{cf. Atkins v. St. Helena Hosp.}, 843 F. Supp. 1329 (N.D. Cal. 1994) (holding that physician working as independent contractor in hospital does not operate a public accommodation).} The \textit{Morvant} decision rejected a justification commonly offered by dentists for discrimination—that HIV is too complicated, and too dangerous, for the average dentist to treat.\footnote{42 U.S.C. § 12,181(7) (Supp. II 1990). Early decisions suggest that the term will be read broadly. See, e.g., \textit{Carparts Distribution Ctr., Inc. v. Automotive Wholesaler's Ass'n}, 37 F.3d 12 (1st Cir. 1994) (holding that insurance plan qualifies as "public accommodation"); \textit{cf. Atkins v. St. Helena Hosp.}, 843 F. Supp. 1329 (N.D. Cal. 1994) (holding that physician working as independent contractor in hospital does not operate a public accommodation).} In pre-ADA litigation, courts have also rejected the "harm-to-self"
variant of the risk gambit, in which the provider contends that treatment would pose a significant risk of harm to the patient.\textsuperscript{221}

In addition to outright refusals to treat, disability discrimination law has also been applied to cases in which the defendant's judgment about what sort of treatment was necessary seemed to be improperly influenced by the patient's disability.\textsuperscript{222} These cases potentially raise complex questions of professional

precautions in the mid-1980s, New York courts overturned agency findings of discrimination on the grounds that the medical judgments involved were reasonable when made. North Shore Univ. Hosp. v. Rosa, 600 N.Y.S.2d 90 (Sup. Ct. App. Div. 1993), aff'd, 1995 N.Y. LEXIS 3553 (Oct. 24, 1995) (draping consistent with professional practice when acts occurred in 1985); Syracuse Community Health Ctr. v. Wendi A.M., 604 N.Y.S.2d 406 (Sup. Ct. App. Div. 1993) ("[P]roof adduced at the factfinding hearing demonstrated that draping of surfaces that might become contaminated by blood or saliva is an acceptable precaution against the spread of HIV infection. It was also established that the treatment rooms are not visible from the waiting area, that the doors to the treatment rooms are kept closed except when staff members go in and out, and that no one but the patient and clinic staff members were aware that the precaution of draping had been utilized.").

\textsuperscript{221} See, e.g., Minnesota ex rel. Beaulieu v. Clausen, 491 N.W.2d 662 (Minn. Ct. App. 1992). It was accepted to a degree in the \textit{Wendi} and \textit{Rosa} cases, cited supra note 220, insofar as it was taken to justify the use of some special precautions to protect the patient from infection.

The deliberate refusal to learn about HIV in order to be able to claim lack of competence also ought to fail. Gittler & Remnant, supra note 210, at 1372-73.


In medical discrimination cases, some defendants have argued that courts should not substitute their views for an independent professional evaluation of the patient's needs or the provider's own competency. Cases in several circuits have posited a doctrine reflecting this concern, under which a Rehabilitation Act plaintiff may not invoke disability discrimination law in the medical context to challenge treatment decisions arising from the disabling condition itself. See United States v. University Hosp., 729 F.2d 144, 157 (2d Cir. 1984) ("Where the handicapping condition is related to the condition(s) to be treated, it will rarely, if ever, be possible to say with certainty that a particular decision was discriminatory"); \textit{accord} Johnson v. Thompson, 971 F.2d 1487 (10th Cir. 1992); Toney v. United States Health Care, 840 F. Supp. 357 (E.D. Pa. 1993). \textit{See generally} Mary A. Crossley, \textit{Of Diagnoses and Discrimination: Discriminatory Nontreatment of Infants with HIV Infection}, 93 COLUM. L. REV. 1581, 1606-12 (1993) (discussing this line of cases in HIV context). The Supreme Court has neither adopted nor rejected this doctrine, which grew out of the controversy over denying treatment to catastrophically disabled newborns, Bowen v. American Hosp. Ass'n, 476 U.S. 610 (1986), but its relevance is limited in the realm of dental discrimination, as both the empirical research and the case law suggest that most dental discrimination arises in the course of providing routine care for common dental conditions that are not meaningfully related to HIV disease.

judgment about precisely what care is needed and who ought to provide it. So far, however, courts have been able to distinguish between discrimination and disagreement over the course of care.\textsuperscript{223}

Antidiscrimination doctrine thus seems capable of recognizing the most prevalent forms of dental discrimination. While some have gone so far as to say that the ADA “has rendered moot the inconclusive debate over the ethics concerning the obligation of individual practitioners to treat HIV-infected individuals,”\textsuperscript{224} the data on discrimination indicate that antidiscrimination law has not yet solved the problem. The ultimate effectiveness of the ADA will depend upon the degree to which dentists feel compelled, by moral beliefs or fear of punishment, to obey it.

The legal risk of discrimination is probably very low for dentists, both because of the low rate of claims filed and the remedies the law provides. Fewer than ten cases have been brought against dentists under the ADA. Title III of the ADA does not offer strong remedies. There is a private right of action under Title III, but only for equitable relief, including attorney fees.\textsuperscript{225} This makes a certain amount of sense under the paradigm of barrier removal—for example, to require the construction of a wheelchair ramp—but it has obvious problems when requiring a dentist to put sharp instruments unwillingly into the plaintiff's mouth. Indeed, all the law offers the individual plaintiff, besides moral vindication, is dental care, and, high rates of discrimination notwithstanding, that could probably be secured in most places with far less effort by identifying the local dentists and clinics who are willing to treat.\textsuperscript{226} This at least partially explains why so few complaints have been filed.

The attorney general may also bring suits, and the relief available in such

\textsuperscript{10,641} (D.C. Comm'n on Human Rights July 1, 1993).

\textsuperscript{223} In Toney v. U.S. Healthcare Inc., 838 F. Supp. 201 (E.D. Pa. 1993), the plaintiff felt that he was being neglected and mistreated, though it was not disputed that his HMO doctor “treats HIV positive patients other than plaintiff, that she knew of plaintiff’s HIV status when she accepted him as a patient, that she saw him for appointments nine times in approximately ten months, that she referred him to specialists three times, and that she or a member of her staff returned thirteen of plaintiff’s telephone calls.” \textit{Id.} at 203. Summing up, the court held narrowly “that a determination by a physician of when her regular patient’s condition warrants an additional office visit is a medical treatment decision not subject to judicial review.” \textit{Id.} at 204. On the other hand, in Howe v. Hull, 873 F. Supp. 72 (N.D. Ohio 1994), the court had no difficulty finding a jury issue on whether or not a diagnosis of “probable toxic epidermal necrolysis” was a pretext for a discriminatory transfer decision. \textit{Id.} at 75. For a thorough discussion of how to treat these sorts of cases, see Crossley, \textit{supra} note 222, at 1643-60.

\textsuperscript{224} Halevy & Brody, \textit{supra} note 133, at 287.


\textsuperscript{226} It may be possible in some cases to couple an ADA claim with one under § 504, or state tort law, to get monetary damages. Since the Supreme Court's decision in Franklin v. Gwinnett County Pub. Sch., 503 U.S. 60 (1992) (monetary damages available under Title IX), courts have generally held that compensatory damages are available under § 504. \textit{See, e.g.,}, Miller v. Spicer, 822 F. Supp. 158, 166-68 (D. Del. 1993).
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cases includes a civil penalty not greater than $50,000 for the first and $100,000 for each successive violation.227 Government enforcement of Title III of the ADA is centralized in the Department of Justice in Washington. The Public Access Section (PAS) of the Department of Justice has approximately twenty-four lawyers to investigate and prosecute cases under Titles II (covering state and local governments) and III throughout the nation.228 By March 1995, the PAS had received 6200 complaints, most having to do with barrier removal in facilities. It was conducting between thirty and forty active investigations of Title III discrimination against people with HIV, most having to do with dental or medical care.229 The PAS had filed two suits and intervened in two others.230

In the early stages of enforcement, a few cases can have a large impact because of the widespread press coverage they receive. In the long-term, however, enforcement at such a low level of frequency is probably insufficient to influence dentists’ conduct substantially. A review of the status quo suggests several changes that could increase the volume of cases. Staffing levels in the Department of Justice could be increased, given the problems other agencies have had in handling the additional workload created by the ADA.231 The PAS does not appear to be swamped by dental discrimination complaints, but it may not have sufficient staff to investigate the profession affirmatively.

The empirical data presented above suggests that HIV-based dental discrimination may share features with racial discrimination in housing. Both appear to be more widespread than the level of complaints would indicate.232 In both contexts, the individual who has suffered discrimination may not be

227. 42 U.S.C. § 12,188(b)(2) (1994). In Morvant, which was one of the most egregious violations prosecuted to date, the court did not impose a civil penalty requested by the Justice Department. United States v. Morvant, 898 F. Supp. 1157 (E.D. La. 1995).
228. Telephone interview with Liz Savage, Special Assistant to the Assistant Attorney General, Civil Rights Division, Department of Justice (Mar. 16, 1995). The Section also has six investigators, numerous paralegals, and a technical assistance staff of about twenty.
230. See supra note 2.
231. For example, the Equal Employment Opportunity Commission has been overwhelmed by increases in case load attributable to, among other things, its responsibilities under Title I of the ADA. See U.S. GENERAL ACCOUNTING OFFICE, EEOC’S EXPANDING WORKLOAD: INCREASES IN AGE DISCRIMINATION AND OTHER CHARGES CALL FOR NEW APPROACH 3-4 (1994).
sure discrimination has actually occurred (in housing, because of the plausibility of not getting a dwelling in a tight market; in the HIV case, because of the evocation of medical necessity) or may prefer to move on to the next provider rather than become involved in protracted litigation. The desire to avoid litigation may be even stronger for people with HIV, who may feel more keenly the opportunity costs of devoting time to litigation and who may also wish to avoid becoming public figures. To increase the level of enforcement, the Department of Justice and state human rights agencies could develop or fund testing programs under their general authority to investigate widespread discriminatory behavior. Testing, which is well accepted in the enforcement of the Fair Housing Act, is a generally useful way of uncovering prevalent discriminatory treatment. As both a research method and an enforcement technique, it has been recognized as useful outside the housing realm. Testing has proven workable in the enforcement of antidiscrimination laws against dentists. It is, perhaps, ideal for detecting the outright refusal to treat that has been the most common form of discrimination reported. Given the reluctance of individuals who have actually suffered discrimination to come forward and bring actions, testing may be the only means of developing a significant number of cases. The Department of Justice has not provided any funding for research on testing methods, or

233. See U.S. DEP’T OF HEALTH & HUMAN SERVS., supra note 232, at 14-15. The same desire for anonymity that may drive a rural patient to prefer a distant urban clinic would, presumably, deter litigation if the patient suffered discrimination. See supra Section II.C.


235. See Havens Realty Corp. v. Coleman, 455 U.S. 363 (1982) (testers have standing). For an excellent overview of testing and the economic rationale for increasing its use and the damages for testers, see generally Navarro, supra note 232.

236. See Ayres, supra note 3.

237. See supra notes 69-71 and accompanying text (describing ACLU tests in Philadelphia).

The main barrier to use of testers under the ADA lies in the question of tester standing. See Fair Employment Council of Greater Washington v. BMC Marketing Corp., 829 F. Supp. 402 (D.D.C. 1993) (upholding tester standing in Title VII case), rev’d in part and aff’d in part, 28 F.3d 1268 (D.C. Cir. 1994) (testers are not entitled to damages under § 1981 or Title VII and lack standing to seek injunctive relief from employment agency); see also Equal Employment Opportunity Comm’n, Decision No. N-915-062, 1990 WL 271407 (Nov. 20, 1990) (concluding that testers have standing under Title VII). Whatever the merits of the dispute under other civil rights laws, there is a reasonable case for tester standing under Title III of the ADA. The statute authorizes investigation and enforcement by the attorney general, and provides the remedies and procedures of 42 U.S.C. § 2000a-3 “to any person who is being subjected to discrimination on the basis of disability in violation of this subchapter or who has reasonable grounds for believing that such person is about to be subjected to discrimination.” 42 U.S.C. § 12,188(a) (1994). The attorney general may be able to justify testing as a bona fide investigatory technique. Like the Fair Housing Act, the ADA protects those who are not disabled but are perceived to be. 42 U.S.C. § 12,102 (1994).
supported testing\textsuperscript{238} by any state, local or private entities.\textsuperscript{239}

The ADA and state law should also be amended to allow compensatory and punitive damages for individuals denied the benefits of public accommodations based on disability. If only a small proportion of dentists who discriminate are being detected and sued, economic theory accepts the justice and possible deterrent value of awarding exemplary damages. The availability of damages will also increase the incentive for the individual to sue, thereby reducing concerns about tester standing.\textsuperscript{240}

As will be discussed more thoroughly below, efforts to publicize the norm and its enforcement are as important as the number of cases prosecuted. Lack of suits may result from uncertainty among the protected class as to the availability of relief or the complaint mechanism.\textsuperscript{241} In its report on nursing home discrimination against people with HIV, the Department of Health and Human Services Office of Inspector General recommended a public information campaign targeting “state and local governments, hospitals, HIV/AIDS clinics, health facility discharge planners, medical societies, professional associations, and HIV/AIDS social service and advocacy organizations” with the message that HIV discrimination (in that case, by nursing homes) is illegal and identifying the proper agencies to which complaints may be brought.\textsuperscript{242} The DOJ has used its technical assistance staff to produce basic educational materials about Title III, which it provides along with other assistance to trade organizations whose members it wants to reach. It has worked with the American Dental Association and has sent a mailing about Title III and HIV discrimination in health care to some 500 local AIDS service organizations.\textsuperscript{243} Its efforts have not conformed with well-established principles of public education, including frequent reinforcement of the message in a variety of media, but that has not been its project.\textsuperscript{244} The Public Access

\textsuperscript{238} While potentially effective, [a] properly administered testing program is quite expensive. The process of assembling a testing program is elaborate. This process consists of several parts: designing a program, creating manuals and forms for the testers, recruiting testers, training, debriefing, producing affidavits, and analyzing the results. Indeed, there are less than fifty fair housing groups in the United States that have developed the capacity to engage in testing activities. Navarro, supra note 232, at 2737 (citations omitted).

\textsuperscript{239} Interview with Liz Savage, supra note 227.

\textsuperscript{240} See, e.g., RICHARD A. POSNER, ECONOMIC ANALYSIS OF LAW § 22.1 (4th ed. 1992); see also Navarro, supra note 232 (applying standard economic theory to damages under FHA).

\textsuperscript{241} This was a problem for individuals and social service agencies experiencing discrimination in nursing homes. See U.S. DEP’T OF HEALTH AND HUMAN SERVS., supra note 232, at 13.

\textsuperscript{242} Id. at 16.

\textsuperscript{243} Interview with Liz Savage, supra note 228.

\textsuperscript{244} One study, of the effect of the barrier removal requirements of Titles II and III, has found improved accessibility between January, 1992 and April, 1993, and a “notable” increase in awareness of the ADA among business owners and managers (from 69% to 92% reporting they
Section has a budget of approximately three million dollars and a staff of twenty to produce materials, make speeches, and provide case-by-case technical assistance to the entire nation on all access questions under Titles II and III. A search of the Westlaw newspaper database found that stories about the ADA’s prohibition against discrimination by dentists were confined almost entirely to reports of the filing of the first two cases, Castle and Morvant, and their outcomes. Coverage was widespread in the lay media, with stories appearing in at least twenty-nine local newspapers and on the major wire services, but no relevant stories were found on Medline (the complete periodical index of the National Library of Medicine) or Westlaw’s Health Periodicals Database. The dental trade papers have, however, provided ongoing coverage of these cases.

Apart from its value in establishing and publicizing the law, traditional enforcement litigation is not well-suited to resolving individual cases. Given that discrimination arises from an amalgam of misinformation, prejudice, fear, and financial pressure, and a goal of “reforming” dentists who discriminate, alternative dispute resolution (ADR) techniques such as mediation appear far more useful. Mediation makes particular sense in a dispute within a therapeutic relationship. Rigid legal arguments may obscure the underlying concerns of both parties, which may best be resolved by encouraging the development of a relationship in which traditional norms of ethical care can take root. If a testing program or other systematic enforcement effort were to produce a significant number of cases, mediation might well be a more effective, and would certainly be a less expensive, way of resolving them than litigation. This less punitive approach could also palliate the perception of unfair prosecution or entrapment that testing can inspire.

The ADA encourages the use of ADR methods to resolve disputes arising under the law. In 1993, DOJ awarded grants for five trial Title II mediation programs in San Francisco, Chicago, Boulder, Boston, and Atlanta. In the past, ADR methods have been misused as docket-clearing devices by state human rights agencies and the EEOC, suggesting that they were familiar with the law and its requirements. U.S. GENERAL ACCOUNTING OFFICE, AMERICANS WITH DISABILITIES ACT: EFFECTS OF THE LAW ON ACCESS TO GOODS AND SERVICES 5-11 (1994). We do not have baseline data about dental discrimination rates before the effective date of Title III, much less an extensive, direct review of current discrimination.

The searches had the following basic structure: discrim! and (AIDS or HIV or acquired w/3 syndrome) and (Department w/3 Justice) and (Americans w/3 disabilities). The searches also produced one story about a Department of Justice investigation of a dentist in San Francisco. Louis Freedburg, 2 S.F. Doctors Suspected of AIDS Bias, S.F. CHRON., Sept. 24, 1994, at A4.

247. Interview with Liz Savage, supra note 228.
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ought to be used selectively and with care by DOJ. 249 While there is not likely to be a high volume of dental discrimination cases even with the various reforms suggested here, general ADA mediation programs would be useful for resolving those cases that do arise.

The ADA is the foundation of any policy against HIV-based discrimination by dentists, but it is no panacea. The construction of dentists' refusal to treat as "discrimination" is itself potentially problematic, 250 particularly to those dubious about discrimination law generally. The level of enforcement and the sanctions available are not sufficient to command obedience, nor is it clear that more vigorous enforcement would lead to changes in dentists' behavior on a large scale. Section III.B will examine these questions more closely.

6. Public Health Law

Protecting public health is among the core duties of the state. The combination of "education" and regulation to bring about healthy behavior has been recognized as a crucial tool of health promotion since the birth of public health as a discipline, 251 and was early recognized as the chief means of preventing HIV transmission. 252 All states have the authority to educate and to fund education promoting health, although a duty to do so is neither explicitly stated nor enforceable. 253

Discrimination is thought to deter people at risk of HIV from seeking education, testing, and treatment, and, in a larger sense, to construct the disease in a way that promotes denial and risk-taking over acceptance and behavior change. 254 Acting on this belief, health officials have used public

254. See National Commission on AIDS, AIDS: An Expanding Tragedy 10 (1993) ("Discrimination, stigmatization, or other callous and inappropriate responses to people living with HIV often arise out of unwarranted fear from lack of knowledge. Increased general awareness of basic facts can reduce such ignorant responses substantially and lay a foundation for preventive efforts."); see Don C. Des Jarlais et al., Targeted HIV-Prevention Programs, 331 NEW ENG. J. MED. 1451 (1994); see also David Chambers, Gay Men, AIDS and the Code of the Condom, 29
information programs like America Responds to AIDS to change public attitudes about HIV. This sort of educational work has been going on for years and has succeeded in inculcating basic facts about HIV in the population.255

The research suggests that dental discrimination may be attributable in substantial part to dentists' perception of the attitudes of their patients. Patients' fears can be addressed directly in no way other than by education. In many respects, fear of transmission through dentistry is a good candidate for a public information campaign.256 The substance of the message (though not necessarily its presentation) is simple: with universal precautions, it is safe to go to the dentist no matter who else she treats. The factual messages—that HIV is not easily transmitted through dental care and that universal precautions protect everybody—can be linked to concrete actions the patient can take to achieve a sense of control in coping with the fear of HIV in the dental setting. The patient can be taught to observe the dental staff's compliance with barrier precautions, and be encouraged to speak to the dentist about sterilization practices and fear of infection generally.257 This would have the added advantage of helping to police dentists' compliance with infection control guidelines. A campaign focusing on dentistry would be a logical next step for public education about HIV, given general concerns about HIV in healthcare, and that the marginal returns for basic information are decreasing with repetition of the message.

Authorities on HIV prevention recommend that these “universal” messages about the medical facts and the evils of discrimination be linked to “targeted” messages designed to change the actual behaviors of specific communities where the risk of HIV are the highest.258 In this model, a campaign focusing on dentists and their staffs, using elements like mailings, training videos, and advertisements in dental trade journals, would be an

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255. For discussions and descriptions of the program, see Scott Burris, HIV Education and the Law: A Critical Review, 20 L. MED. & HEALTH CARE 377, 380-81 (1992); Alan J. Bush & Gregory W. Boller, Rethinking the Role of Television Advertising During Health Crises: A Rhetorical Analysis of the Federal AIDS Campaigns, J. ADVERTISING, Jan. 1991, at 28. Survey research suggests that the public has a high degree of knowledge of the official “facts” of HIV, but also a fair amount of misinformation. The latter is reflected in the large percentage of people who would be afraid to go to a dentist who also treats patients with HIV. See supra notes 83-86 and accompanying text.

256. See Gentry et al., supra note 123.

257. See Bush and Boller, supra note 255, at 28. (“[F]ear and worry are emotional reactions to threatening situations that individuals feel are beyond their control. That is, individuals experience fear when they believe that they lack adequate coping responses to a perceived threat.”).

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important supplement to the information conveyed through mass media. The infrastructure for this training already exists in the form of a network of regional AIDS education and training centers that provides education for health care professionals and whose methods have become quite sophisticated.259

Public health professionals have lately tried to assert authority over major social problems, such as violence and drug abuse, by calling them "public health" problems. Thinking of dental discrimination itself as a public health problem also provides some insight into how best to reduce it. First, it allows us to see discrimination as a socially undesirable but personally gratifying behavior. To the extent discrimination is like smoking, or riding a bicycle without a helmet, there is a wealth of research and practice that can be applied in constructing a program to change how dentists behave. This analogy will be discussed at greater length in Section III.B.

In looking to other major public health campaigns to change behavior, we can also glean a second important insight about public health work, the crucial role of the private sector. This paper largely concerns what government can do through law to change behavior, but past public health work strongly suggests the need for action by private philanthropies and professional organizations. By exhortation and example, religious leaders and other socially and economically prominent individuals can have an important impact on public perceptions.260 As will be discussed more below, the norm of nondiscrimination must be strongly and consistently reinforced from within the dental profession itself. Health philanthropies—in this case, health care charities such as the Kaiser Foundation, the Robert Wood Johnson Foundation, and AmFAR—also have a role in supporting research on attitudes about law and its enforcement in the health care setting, and in contributing to the public information effort.

B. For and Against Regulation

The syllogism that leads from discrimination, through law, to regulation has come under determined and not altogether unjustified challenge. Although Richard Epstein perhaps overstates the degree to which he is breaking Forbidden Grounds, his book does raise an unusually thorough academic challenge to the antidiscrimination principle.261 Part of this challenge is

260. See Des Jarlais et al., supra note 254, at 1451.
261. RICHARD A. EPSTEIN, FORBIDDEN GROUNDS: THE CASE AGAINST EMPLOYMENT DISCRIMINATION LAWS 5-7 (1992). Attacking antidiscrimination law is certainly nothing new, though Epstein's claim that he is driven by Adam Smith rather than Jim Crow sets him apart from those who resisted the Civil Rights Act when first it passed. Epstein operates as a thinker of the right attacking a normative pillar of the liberal left, but his approach has much in common with
empirical, an argument about the supposedly demonstrable disutility of specific legislation. Notwithstanding its attention to data, however, Epstein's is a fundamentally normative critique: without undue simplification, his view is that antidiscrimination laws are an improper departure from a proper regime of free contract. Epstein thus poses two basic questions about the regulation of discrimination: ought we to regulate, and if so, can we regulate effectively? Considering these questions in the context of dental discrimination not only illuminates the choices for policy-makers desirous of reducing the phenomenon, but also the limits of Epstein's attack.

that of the critical and law-and-society scholars who have analyzed the way law is used to legitimate (or reify, or construct—choose your jargon) patterns of power and authority. His strategy of showing that the notion of discrimination is used to justify an attack on liberty, and then using empirical evidence to "show" that the actual effects of the principle in practice are quite distinct from the normative claims of its proponents, reflects, albeit through a glass darkly, the practices of critical scholars. See Crenshaw, supra note 3.

262. See Epstein, supra note 261, at 22-27. "There is . . . a strong reason to think that the set of rights so developed at common law should exhaust the universe of rules on original entitlements, their protection, and their exchange. The antidiscrimination laws should be understood as an assault on the completeness of these common law rules and the intellectual foundations on which they rest." Id. at 26-27. Although he here speaks of the employment contract, the principle is equally applicable to the contract to provide a service in a place of public accommodation.

Although he purports to be "test[ing] the foundations of the antidiscrimination principle using the available tools of economic . . . theory," id. at 7, the normative nature of his critique is apparent in his presumption against regulation, based on the principle that government should ordinarily not intervene to restrict the choices of individuals. He writes:

It is not enough to show that there is some residual level of discrimination in a market to make the case for regulation. It has to be shown as well that the proposed cure can identify and isolate the evils in some cost-effective fashion. In light of the avenues of self-help that are available to all customers, it seems unlikely that regulation could ever accomplish a net social good.

Id. at 54. Ian Ayres incisively identifies the implications of this position:

This quotation -- which tends to epitomize much of Epstein's scholarship -- fails to explain why the burden of persuasion should rest with those who want to eliminate discrimination. Although Epstein maintains the theoretical possibility that an empirical "showing" might justify regulation in some instances, I have the impression that no empiricism about the workings of a free market could falsify his theories to the extent that he would actually reach the second question of whether regulation could be cost-justified.


Epstein himself states that he has undergone a gradual transformation "from a natural rights libertarian to a limited government utilitarian," Richard A. Epstein, Standing Firm, on Forbidden Grounds, 31 SAN DIEGO L. REV. 1, 2 (1994), but while he surely is a utilitarian, too, he wears on his sleeve a "powerful absorption—verging on romance—with the idea of contract at will," Richard Delgado, Rodrigo's Second Chronicle: The Economics and Politics of Race, 91 MICH. L. REV. 1183, 1184 n.3 (1993).

Perhaps the most accurate judgment on this is Jerry Mashaw's: "As when reading J.S. Mill, one often has to ask whether Richard Epstein is really a libertarian or a Benthamite utilitarian. In fact, like Mill, he is both, because he defines each principle in terms of the other. This leads to an abstract unity, but also a simple tautology, at the base of the Epstein argument." Jerry L. Mashaw, Against First Principles, 31 SAN DIEGO L. REV. 211, 213 (1994).
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1. **Faux Epstein: The Case Against Intervention**

Rather than rehearse Epstein’s argument in abstract form, I will state what I would take to be an Epsteinian case for a libertarian approach to dental discrimination.\(^{263}\) The starting point is faith in a system of unencumbered contracts. If dentists are classic small business operators, offering a service for a fee to the public, we should expect that they and their customers will, if left alone, come to a mutually advantageous mode of operation. “Freedom of association works because it means that both sides stand to gain from the transaction.”\(^{264}\)

It is unclear whether dental discrimination is a real problem. While there has certainly been discrimination and prejudice against the disabled, Congress and the courts exaggerate it in writing and applying laws like the ADA. Disability is not like prior protected conditions, because while only some people will ever be Black or female, and they know who they are, anyone can become disabled. “There is thus a powerful insurance feature that leads everyone to think that some assistance for the disabled may not be solely an act of disinterested benevolence but one of prudent self-interest as well.”\(^{265}\) “[P]lays, stories, and movies” about the disabled that “tug knowingly at the heartstrings” support the view that animus against them is limited. Indeed, “[t]he entire apparatus of charitable giving and charitable service would be unintelligible if public attitudes were as harsh and archaic as Congress and the commentators so easily assume.”\(^{266}\)

Moreover, some different treatment may be rational. While the money of the disabled is as good as anyone else’s, “business is harder to conduct as the pace of transaction slows.”\(^{267}\) If a dentist must be more careful, if only for psychological reasons, in treating a patient with HIV, yet cannot charge for the excess time, is he not being cheated? What if he finds it “inconvenient, unpleasant, or awkward” to deal with patients who are seriously ill?\(^{268}\) To write this off as mere bigotry is to assume that any decision about how most effectively to conduct one’s business is merely a rationalization for animus.

It is also a drastic oversimplification. A dentists’ decision to treat is complicated, based on economic, emotional, medical, even religious considerations. Some dentists treat patients with HIV, some do not. Some treat

\(^{263}\) For a general attack on the ADA, see Mashaw, *supra* note 262, at 217-21.

\(^{264}\) Epstein, *supra* note 261, at 487.

\(^{265}\) *Id.* at 481. It has also been argued that disability discrimination law is a special case because it is not antidiscrimination law at all, but “rules requiring compensatory treatment of certain classes of employees.” Andrew Kull, *The Discrimination Shibboleth*, 31 San Diego L. Rev. 195, 195 (1994).

\(^{266}\) Epstein, *supra* note 261, at 486.

\(^{267}\) *Id.*

\(^{268}\) *Id.* at 486-87.
only patients with HIV; others integrate such patients into a general practice. Why is this really any different than some dentists choosing to do root canals and others choosing to install braces? Why, if we discard the antidiscrimination principle and concern ourselves with efficient access, is a choice motivated by animus more problematic than a choice based on one’s taste in procedures?  

If we leave the market alone, we can expect that some dentists will choose to treat patients with HIV for reasons that maximize their own satisfaction. If the demand exceeds the supply, an unregulated price will emerge at which the demand can be satisfied. Indeed, this price may actually "tax" discrimination by either the dentist or a non-infected customer.  

This is not a problem like racial segregation in Southern accommodations, where there were “barriers to entry ... from the strong government control over land use, labor relations, zoning, and police regulation, and the full apparatus of segregation.” In that situation, the "antidiscrimination principle could work wonders as a second-best solution." Here, however, the main objections to serving patients with HIV come from dentists themselves and from other patients. Dentists who wish

269. Writing of the “taste for discrimination,” Epstein observes that “it is not strictly necessary to decide whether” discrimination exists, or what toll it takes, because the operative question is the effect of discriminatory behavior on efficient outcomes. Id. at 43. (The notion of discrimination as a taste is Gary Becker’s. See GARY BECKER, THE ECONOMICS OF DISCRIMINATION 14 (2d ed. 1971)). In Epstein’s normative world, prejudice is simply not a wrong; or, if a wrong, it is a wrong without a remedy. A man who begins with the social vision of Hobbes, Epstein is interested in conduct, not motivation. EPSTEIN, supra note 260, at 15-19. This is not to concede that Epstein has his Hobbes right. See Richard H. McAdams, Epstein on His Own Grounds, 31 SAN DIEGO L. REV. 241 (1994) (arguing that Hobbes took broad view of behaviors properly subject to police regulation). Certainly, in evoking a golden age of limited common law regulation he misapprehends the vitality of regulation in the first century of the United States. See William J. Novak, Public Economy and the Well-Ordered Market: Law and Economic Regulation in 19th-Century America, 18 LAW & SOC. INQUIRY 1, 7 (1993).

270. Robert Cooter summarizes the process: If sellers refuse to deal with some buyers, the discriminatory sellers may experience additional costs. In perfect competition, all goods sell at cost, so discriminatory sellers will charge more than nondiscriminatory sellers for the same good. Nondiscriminatory buyers will purchase from the sellers with the lowest prices. Thus, perfect competition eliminates discriminatory sellers, just as it eliminates discriminatory employers. For example, a restaurateur who insisted on segregated dining facilities might have higher costs, which nondiscriminatory patrons would refuse to bear. Now consider the case of discriminatory buyers. Once again, product markets strictly parallel labor markets. Specifically, consumers who prefer discriminatory sellers will pay a surcharge for the products they buy relative to nondiscriminatory consumers. The surcharge will equal the additional cost of segregating buyers. For example, diners who discriminate will pay the extra cost of segregating their facilities.


271. EPSTEIN, supra note 261, at 127.

272. Id.
to treat are not legally prevented from doing so, and evidently can structure their practices and maintain the privacy of the clients to avoid losses. For those with HIV who cannot pay the market price, charity is perfectly appropriate, and, indeed, exists in the form of the HIV-specific and hospital-based clinics that provide so much care for people with HIV. Under a deregulated regime, there would be more money for such providers, because we would not be spending money coercing all dentists, a project which in any case is not likely to be successful if the problem is really as widespread and deeply rooted as proponents of regulation assert. One can go so far as to say that the problem is not the level of access but its distribution. Apparently, a system of specialization or niche marketing is arising, one that is common in medicine generally, and not clearly bad. If we understand HIV care as a niche market, isn’t the goal in most places, where there are enough dentists and enough people, not that everyone treats anyone, but that someone treats everyone? If we want for some positive reason to promote an integration of practices beyond what the market would otherwise produce, the burden is on proponents to argue why this is good and how the policy can be efficiently promoted.

In sum, discrimination is not so pervasive as to pose an insurmountable barrier to care for individuals with HIV, and the market is, in fact, developing to provide these services to those who can afford them. Given all this, the best approach to solving the problem is through non-intervention, or through education only, letting the market develop practice patterns in which those who wish to treat patients with HIV can tap that market, and not wasting money on making the unwilling grudgingly perform the unnecessary.

2. *Ought We?*

If one does not accept that a free market is the regime that optimizes social well-being, much of Epstein’s moral vision evaporates. At a fairly

273. *Id.*
276. While Epstein attacks the Jim Crow system of involuntary separation of the races, he defends voluntary segregation as the sort of free choice liberty affords and a rational market allows. Epstein, *supra* note 261, at 67-69, 262-66.
278. My interest is in using rather than doing theory, so this will necessarily be a cursory and perhaps for that reason unsatisfactory canvass of the issues. At least, however, it will make clear my normative starting point in both collecting and using the empirical data.
high level of abstraction, we can question his account of libertarian theory, or reject the libertarian position altogether. The notion that people ought to have a fair opportunity to achieve their goals without arbitrary hindrance based on accidentally disfavored characteristics, has been well-defended in liberal accounts of justice; the same basic values animate discussions of discrimination from Republican and communitarian perspectives. Or one might adopt the approach of socio-legal and critical theory, in which principles and preferences are entirely stripped of their privileged analytic position, becoming dependent variables in a process of social construction and control of reality.

At a lower analytic level, one can challenge the validity of a theory whose proponent seems to ignore history. Epstein's suggestion that the social treatment of people with disabilities has been moderated by a sense of common vulnerability strikes me as intuitively dubious for the disabled generally, and at any rate flies in the face of a well-documented history of discrimination against people with communicable diseases. This history
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has been marked by what the Supreme Court in Arline called "accumulated myths and fears about disability and disease."286 Today, discrimination against people with HIV continues to occur in situations in which the subjects do not pose a real threat of transmission or other harm.287 HIV is not leprosy or plague, but the impulse to shun and denigrate the sick is as much a product of its history and its social legacy as the belief in Black inferiority. It is hardly a disputed proposition, even in libertarian theory, that present justice cannot be soundly based on past injustice,288 hence Epstein's diligence in questioning the history of disability discrimination.

Even if one does not share the belief that the social norms concerning disease both reflect and reinforce social attitudes, it is difficult to rebut the evidence that discrimination against people with HIV looms as the product not of utilitarian logic but social accident. If the preference for avoiding the sick is not privileged, and the harm caused is substantial, it would seem morally justified under a number of theories to act. For example, a utilitarian could argue that prohibiting discrimination is justifiable to the extent controlling discrimination improves access to care and helps educate the population about social reaction to sickness and the sick has tended to be complex, dependent on numerous variables such as the expression of the disease, the social status of the subgroups most affected, and theories of disease causation and control. In addition to the above, see, e.g., SUSAN SONTAG, AIDS AND ITS METAPHORS (1988); Elizabeth Fee & Nancy Krieger, Thinking and Rethinking AIDS Implications for Health Policy, 23 INT'L J. HEALTH SERVICES 323 (1993); Daniel M. Fox, Chronic Disease and Disadvantage: The New Politics of HIV Infection, 15 J. HEALTH POL., POL'Y & L. 341 (1990).

286. School Bd. of Nassau County, Fla. v. Arline, 480 U.S. 273, 284 (1987). “Imperfect information” is a common justification for intervention, even for economists. See Sunstein, infra note 293, at 1166-69. As Sunstein observes, however, people generally do not gauge risk by “objective” probability. It follows that justifying intervention to alter preferences on the ground that the public’s risk assessment is wrong begs the question of the nature of risk. A “reasonable person” — defined as a person of normal intelligence, education and experience — is frightened of all sorts of things (arbitrarily selected) that pose a smaller risk than any number of other things the person encounters. I observe this to be clear in my rejection of the notion that dentists’ or patients’ fears of HIV positive people can be turned into simple questions of correct information and incorrect information. See generally STEPHEN BREYER, BREAKING THE VICIOUS CIRCLE (1993) (analyzing political problems raised by different forms of risk assessment and management).


288. See Larry Alexander, What Makes Wrongful Discrimination Wrong? Biases, Preferences, Stereotypes, and Proxies, 141 U. PA. L. REV. 149 (1992) (arguing that history is a major factor in how we distinguish morally between acceptable and unacceptable discrimination); cf. Sunstein, supra note 282, at 2433 (“[A] history of discrimination is not a necessary condition for status as a lower caste, though in practice such a history is highly probable. No group is likely to become second class in the sense used here unless it has been subject to past discrimination. The discrimination may take the form of legal and social practices that are not discriminatory on their face but that translate certain characteristics into a systemic basis for disadvantage.”).
true risks.\textsuperscript{289} Or one could assert that the antidiscrimination principle in this context reflects a norm of inclusion of the chronically ill which is consistent with the view that membership and participation in a self-defining community, rather than liberty of contract, is the fundamental good.\textsuperscript{290}

This suffices to establishes the existence of a rebuttal to an argument that prohibiting HIV discrimination is itself a wrong, which is as much as I can attempt in this article.\textsuperscript{291} I agree with Larry Alexander that moral philosophy and discrimination enjoy a low level of correspondence:

[T]he line between wrongful and acceptable discrimination is, in most cases, difficult to locate with precision because it is historically and culturally variable. This line is historically and culturally variable because it is, in most cases, a function of consequentialist considerations rather than deontological norms. That is, in most cases, discrimination, when it is wrongful, is contingently but not intrinsically so.\textsuperscript{292}

Arguably, legal economics is the wrong tool to measure even this sort of contingent morality. Scholars from a variety of perspectives have objected to the use of the market to value all goods, however intangible.\textsuperscript{293} This literature, which rejects the notion that preferences are independent of social, political and economic arrangements,\textsuperscript{294} notes among other problems the legitimating effect of economic analysis. Dental discrimination seems to depend significantly upon dentists' belief that they have the right refuse to treat people with HIV. Changing that behavior, in turn, depends upon convincing dentists that that right is a wrong. To neutralize law as a normative force in that cause, in favor of a calculus of unfettered rational choice, is to eliminate the primary

\textsuperscript{289} See INST. OF MEDICINE, NATIONAL ACADEMY OF SCIENCES, CONFRONTING AIDS, UPDATE 1988 at 6, 62-63.
\textsuperscript{290} See Michelman, supra note 282, at 1528-37.
\textsuperscript{291} As Mashaw puts it, "That there is an alternative foundation for a statute like the Americans With Disabilities Act suggests only the implausibility of concluding from other, dissimilar, first principles that the statute cannot be justified. This form of argument, however, simply leads us back to a debate about first principles—a debate that I have argued is unlikely to lead to consensus." Mashaw, supra note 262, at 220-21.
\textsuperscript{292} Alexander, supra note 288, at 153.
vehicle for organized, secular expression of collective values.\textsuperscript{295} In a profound sense, market valuation begs the question.

At the same time, economics’ premise that preferences are not subject to change by market or other forces undermines any effort to systematically change dentists’ behavior through education and regulation. If we reject the assumption that preferences cannot be changed, and accept the evidence that treating patients with HIV tends to eliminate the preference not to, behavioral change seems to impose only a short-term cost on dentists, and even potentially to provide a benefit.

If the contingent morality of regulation depends on market failure, as Epstein suggests in his utilitarian mode, the evidence still justifies action. The data leave no doubt that many dentists continue to refuse treatment on the basis of HIV, and the economics of discrimination by dentists against the HIV-infected are hardly straightforward in suggesting that the market will solve this problem. The standard associational account, relied on by my ersatz Epstein and by the original, holds that discrimination adds to the cost of doing business, putting the discriminator at a competitive disadvantage that must ultimately discipline him to end the practice. Here, though, we have a variety of deviations from the model or its assumptions.\textsuperscript{296}

If satisfying a preference for avoiding people with HIV is a cost like anything else, discrimination may be “efficient.” The cost of discriminating in this instance may be substantially lower than the cost of treating. HIV-infected patients constitute only a small segment of the market, so that forgoing their custom may impose only a slight marginal cost. Moreover, the data indicate that dentists do not discriminate against people suspected of having HIV, or even patients who have HIV but conceal that fact, so the actual refused population is not even all HIV-positive people, but only those whose status is known. Because knowledge of the patient’s HIV status is usually obtained voluntarily, or by diagnosis of symptoms, the cost of identifying these people is essentially nil. Meanwhile, third-party preferences, such as not patronizing a dentist who treats the HIV infected, can create strong market

\textsuperscript{295} The need for collective expression of values and the rational irrationalities of collective choice are both indicated by the large majority of patients who claim they would prefer not to be treated by a dentist who treats patients with HIV. While this is consistent with a view of the ADA as special interest legislation, it is also consistent with a complex view of “rationality” in a democratic polity. See Pildes & Anderson, supra note 293, at 2143-83.

\textsuperscript{296} We also now have a challenging new economic theory of discrimination. Richard McAdams argues that individuals seek, and groups can provide, status as a good in itself, and that groups produce status in part by subordinating other groups. See Richard McAdams, \textit{Cooperation and Conflict: The Economics of Group Status Production and Race Discrimination}, 108 HARV. L. REV. 1003 (1995). While I, perhaps predictably, disagree with Richard Epstein on the merits of McAdams’ work, see Epstein, supra note 274, the theory in its present stage of development is not readily applicable to discrimination based on disease.
pressure for discrimination, quite apart from the costs to the dentist of stifling her own preferences and those of her staff.

The classic model may not work as advertised in a situation in which the cost of treating is a fear of catastrophic harm rooted in a misassessment of the risks posed by the person seeking care. Epstein's abstract analysis of a preference not to treat fails to account for the visceral urge to shun "plague carriers." Dentists who are afraid of being infected may not accept any economic price for treating. Nor may there be any price that an HIV positive patient can pay that will induce a dentist to run the risk of all his other patients taking flight to a new dentist. Indeed, one may ask how, when the refusal to contract is based on a reflexive desire to flee or shun, bargaining is even going to occur.

Even if treating is more efficient than not, this discrimination may fall into that class of inefficient behaviors that are too small to trigger market correction. Because there are so few HIV positive people relative to the overall dentist-visiting population, dentists are relatively much less hurt by refusing to deal than HIV-positive patients, who may have a hard time

297. See Sunstein, supra note 282, at 2415-16 ("[I]n some important sectors, and for important lengths of time, the existence of third-party discrimination can ensure that inequality persists even in free markets. The extent of the effect is of course an empirical question.").

298. While in theory a dentist who declines to treat is at a competitive disadvantage with a dentist who will, the fact that those refused treatment comprise so small a segment of the market means that the disadvantage will be too small to significantly affect dentists' profitability. Cf. David A. Skeel, Rethinking the Line Between Corporate Law and Corporate Bankruptcy, 72 TEX. L. REV. 471, 520 (1994); Lucien A. Bebchuck, Federalism and the Corporation: The Desirable Limits on State Competition in Corporate Law, 105 HARV. L. REV. 1437, 1461-67 (1992).

It might be argued that in the absence of discrimination laws, dentists would be able to charge their true costs of operating to HIV infected patients. That is, the price of care for an HIV-positive person would rise to the level necessary to bring a dentist to treat, and at that price dentists would suffer a cognizable cost if they were to discriminate. This argument seems to ignore the lessons of the current price structure of dentistry. Patients with HIV may require more complicated procedures more often than other patients, but dentists are not precluded from charging more for such procedures than for routine care. On the other hand, even if treating a patient with HIV sometimes, or even often, would require more time than treating a patient without HIV for the same condition, such variance between patients is built into the pricing structure: dentists generally price by the procedure, not the patient, with the overall price reflecting an average cost. Presumably, this custom reflects the fact that standard pricing is more efficient than setting individual prices for common procedures.

A larger problem with this approach is that it obscures the degree to which the "cost" of treatment is constituted by the taste for discrimination. Under the universal precautions approach required by OSHA and urged by public health and dental authorities, no special precautions are required in treating HIV-positive patients, and equal precautions are required even if the dentist has no knowledge of an HIV-infected person in her practice. If dentists proceed with significantly greater care (i.e., more slowly) or use more precautions, that is best seen as a matter of taste. Similarly, the "cost" of treating most often mentioned, negative customer reaction, is entirely a matter of taste rather than material inputs. There is nothing wrong in economic theory with assigning a value to the satisfaction of a taste, but by the same token nothing in Epstein's theory explains why the market would discipline anyone to stop doing so. On the contrary, it looks a happy bargain for the dentist or customer whose taste for avoiding people with HIV is so satisfied.

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replacing the refusing dentist. This form of discrimination may also pose a collective action problem: large numbers of dentists being willing to treat, but worried about significant patient flight if they are among the first to break the treatment barrier.

Nor is the argument carried by moving the focus from discrimination to access. While the overall dental access problem seems largely linked to poverty rather than HIV status per se, the data do not support the view that people with HIV have no problems of access related to discrimination, much less that the market has created a workable system of specialization. If we leave aside the preference not to treat, there are few if any sound arguments for the efficiency of the status quo. Patients with HIV are generally seeking the same sort of care as other patients, and, since the advent of universal precautions, there is no difference in the manner of treatment based on HIV status alone. Dentists who refuse to treat known HIV patients may still be treating patients who are unaware of or have not revealed their condition. Conversely, the refusal of general dentists to treat entails the development of a system of specialists, whose additional training and scarcity presumably result in higher costs to patients (even assuming that individuals with HIV constitute a large enough customer base in the local market to support a specialist). Even if the costs of treating HIV-positive patients are identical in specialist and general practices, the costs to patients required to endure the longer waits and longer journeys to specialists probably make segregation inefficient. From a social point of view, the additional transaction costs arising from separating the known HIV-infected from other patients might make segregation inefficient even if the cost of treating patients with HIV is slightly higher than referring for the general dentist.

The claim that the market has already met the demand of people with HIV for dental care is belied by the evidence that subsidized clinics provide a major proportion of it. Specialized clinics would have a role even were there no discrimination, providing specialized and some indigent care, but specialized clinics exist in almost every major American city because private dentists have not met the demand for routine dental services, even among

299. In this, there is an analogy to the standard explanation of why discrimination is harder economically on Blacks than Whites, and therefore unfair. See Posner, supra note 240, §§ 26.1-2.

300. Epstein himself suggests that antidiscrimination law is an appropriate corrective for this kind of problem. Epstein, supra note 261, at 127. Arguably, we have not a collective action problem but a problem of collective action, in that the majority of dentists are truly unwilling to treat and feel insulated in that behavior by the support of their peers.

301. One could argue that a rule forbidding discrimination aims to create a pooling equilibrium to replace a less efficient separating equilibrium. See, e.g., Ian Ayres & Robert Gertner, Filling Gaps in Incomplete Contracts: An Economic Theory of Default Rules, 99 Yale L.J. 87, 111-14 (1989). This is perhaps an uncommon phenomenon in the world of corporate regulation, where pooling equilibria tend to produce inefficient behavior, but it makes some sense here, where it is the separation rather than the pooling that is based on poor information.
insured or otherwise paying customers. The Burris-Glick study found that almost a quarter of the patients of the clinic in Philadelphia were there because they had been refused care elsewhere, not by their own choice. Moreover, the insured and self-paying patients are either enjoying a subsidy (because their fees do not pay the entire cost of operating the clinic) or are being taxed for their disability (because their fees go in part to support free care for indigent patients). Few if any clinics can operate without a subsidy, which means that federal or state budget cuts threaten to close them for both paying and non-paying patients.

Any defense of a market solution based on niche care ignores a variety of tangible and intangible costs to people with HIV. Clinics provide care, and patients are satisfied with the quality of care they receive, but clinics are also often oversubscribed, leading to long waiting lists for care. Many patients outside urban centers must travel long distances to get to a clinic. Most significantly, patients may suffer considerably in developing their taste for segregated care. Most patients in the Glick-Burris study did not believe that dentists have a right to refuse treatment to patients with HIV, while the majority view that patients with HIV are best cared for in specialized clinics may well be understood as a criticism of the behavior of other dentists. These views reflect the stigma of separate but equal facilities. Those who do not yet know the rules of the current system will suffer the pain (for some, trauma) of one or more refusals to treat. In their case, the dentists’ liberty of contract is a zero sum game, undermining the assumption that the market will efficiently unite those who want to treat with those who want to be treated.302 All this suggests that clinics operate as evidence of market failure, not efficiency. If discrimination is only a wrong in Epstein’s book if it corrupts the market, dental discrimination would still seem to qualify.303

302. Epstein is unconvinced by arguments about the psychological harm done by discrimination, arguing that it is not distinguishable as harm from other forms of unjustified humiliation, and ought to be compensable, if at all, as a matter of general tort law. Epstein, supra note 262, at 18-22. This view arises in part from his presumption that antidiscrimination law is a poor idea, but also from a refusal to acknowledge the educative, norm-setting aspects of legal rules. We have antidiscrimination laws because of a belief that certain forms of harm are more pervasive and in some respects worse than others. Discrimination works as a form of social control in part by the instruments of humiliation and shame. The power to deny access need not be used if the fear of denial keeps the undesirable customer away. Law can influence those behaviors not only by directly sanctioning them, but by making them illegitimate and shameful for the perpetrators, and by changing them from sources of shame to sparks of resistance in the objects.

303. Even if more general dentists are treating patients with HIV, and that is one reasonable inference from the various data, we cannot necessarily conclude that the market will eventually heal itself to the point at which specialized clinics are not needed to provide routine care. The various regulatory provisions described above may be among the causes of the change, justifying continued government action. In fact, given the limits of state law prior to the ADA, one may argue that the market had its chance between 1983 and 1991, and failed to correct discrimination. Thus, Epstein cannot claim, as he does with respect to racial discrimination, that the market solution was never tried.
Finally, we are only choosing between the market and regulation if we assume substantial compliance with the regulation. As the remainder of this Article makes clear, I make no such assumption. I assume that rather than displacing the market—replacing dentists’ contract regime with one in which they have no choice but to treat—the ADA merely changes the market. By raising the cost of not treating by the dentists’ estimate of the costs of avoidance, and therefore lowering the price at which they would be willing to treat patients with HIV, the ADA can be seen in practice as a tax, not an absolute limit on the freedom to contract, and so as a short-term stimulus to hasten the market’s eventual correction of the discriminatory behavior.\textsuperscript{304}

Epstein’s libertarian first principles ultimately cloud his vision of discrimination in our society, and he simply does not comprehend the unquantifiable pain of discrimination, particularly as it is felt by the disabled. He ignores the history of disability discrimination altogether. But all that goes only to the choice to treat HIV discrimination as a wrong, rather than a “taste.” A belief that discrimination is wrong is insufficient justification in this day for legal action against it. No one is well-served unless state power is used in a manner that can effectively address the problem and include both the regulated and the protected in a new, sustainable relationship.\textsuperscript{305}

3. Can We?

The question of whether law can effectively be used to eliminate discrimination variegates the analytic picture. This is really several different questions, some germane to this article and some not. One inquiry goes to the effectiveness of antidiscrimination law or of litigation as a medium of social change in general. In addition to Epstein’s, the work of Gerald Rosenberg\textsuperscript{306} and of the many scholars who have tried to model and investigate the effects of antidiscrimination addresses this issue.\textsuperscript{307} This scholarship is concerned

\textsuperscript{304} This was the theory advanced by Donahue concerning Title VII. See John J. Donahue III, \textit{Is Title VII Efficient?}, 134 U. PA. L. REV. 1411 (1986). \textit{Contra} Richard Posner, \textit{The Efficiency and the Efficacy of Title VII}, 136 U. PA. L. REV. 513 (1987). More generally, my approach tracks that of Ayres and Braithwaite, who argue that an intellectual or political debate framed in narrow terms of pro or no regulation ignores the potential and need for what they label responsive regulation. \textit{See Ayres & Braithwaite, supra} note 3.

\textsuperscript{305} This position is thoroughly aired in yet another contribution to the \textit{San Diego Law Review}'s review of Epstein’s principle thesis. Cooter, \textit{supra} note 270; \textit{see also Ayres & Braithwaite, supra} note 3, at 4-7.


not with whether a particular behavior, like refusing to serve Blacks at lunch
counters, has been eliminated or changed but with whether and to what extent
litigation-driven reform has resulted in overall gains for members of the
protected classes, gains which are frequently measured in economic terms. In
the present discussion, the literature on the general effectiveness of
antidiscrimination law might speak to the issue of whether the treatment of
HIV as a protected disability has "worked" in enhancing the general social and
economic position of people with HIV, but the relevance is limited.\footnote{308}
In any event, my analysis neither depends upon nor proves the proposition that
antidiscrimination law "works" in this larger sense.\footnote{309}

308. People with HIV are hardly a discrete social class, who have suffered a regime
of explicit and pervasive legal subordination as people with HIV, and whose relatively homogenous
socio-economic status could be charted over time. As Mashaw puts it, "while it may well be the
case that the disabled lack human capital that others have, there is no historical story of the type
easily told in the cases of race or sex discrimination—that is, of a pre-existing legal regime that
systematically disadvantaged the disabled class." Mashaw, \textit{supra} note 262, at 218. \textit{But see} Robert
L. Burgdorf, Jr., \textit{The Americans with Disabilities Act: Analysis and Implications of a Second-
empirical data that influenced Congress in passing ADA). HIV, like other faces of death, is
actually a great leveller, joining in stigma and impoverishment highly privileged White men and
poor urban women of color.

309. Nonetheless, I believe that antidiscrimination law has had a positive effect on the lives
of people with HIV. Survey research indicates that public attitudes about HIV have shown a
general trend to better knowledge and more tolerance. \textit{See}, e.g., Robert J. Blendon et al., \textit{Public
Opinion and AIDS: Lessons for the Second Decade}, 267 \textit{JAMA} 981 (1992); Barbara Gerbert &
Thomas Bleecker, \textit{AIDS in the Public Eye: Is the Epidemic Viewed as a Crisis?}, 18 \textit{J. COMMUNITY
HEALTH} 335 (1993); cf. Gregory M. Herek & John P. Capitanio, \textit{Public Reactions to AIDS in
study of the impact of the ADA on people with developmental disabilities has shown improvements
in economic status, employment opportunities and personal growth. \textit{See} Blanck, \textit{ADA, supra} note 132.

The direct effects of legal rules on social conditions may be slight, but indirect, synergistic
effects are no less important. Schuck, \textit{supra} note 132, at 1775-76. When we consider the
unprecedented level of organized advocacy by and on behalf of people with HIV, \textit{see}, e.g.,
and the very existence of a vigorous public debate about discrimination against people with HIV
(as opposed to an acceptance of it), it seems reasonable to infer that the construction of HIV as
a disability worked to empower people with HIV and define the disease as protected. The volume
of litigation by people with HIV is indicative both of oppression and resistance. \textit{See} Lawrence
Gostin, \textit{The AIDS Litigation Project: A National Review of Court and Human Rights Commission
Decisions, Part II: Discrimination}, 263 \textit{JAMA} 2086 (1990). The fact that traditional "have-nots"
are often successful in HIV litigation, Aiken & Musheno, \textit{supra} note 199, is further indication
of the force of the antidiscrimination principle in changing status.

Delgado makes the point that racism gets worse rather than better, because systematic, or
at least pervasive, negative images of the other operate over time to widen the divide between
the races. He criticizes law and economics scholars for tending to focus on individual transactions
and leave out the way the context informs the very vision of individuals about what costs are
relevant and how to value them. Delgado, \textit{supra} note 262, at 1195-99. I like Rodrigo's comment:
"I don't know how . . . to show someone who believes all diseases are individual that there is
such a thing as social pathology." \textit{Id.} at 1198.
Answering this larger question is only one way to measure the effectiveness of antidiscrimination law. Discrimination varies in the nature and intensity of its expression, over time, in different places, and in different sorts of employment or accommodation. Reducing it to a national abstraction, to be judged by broad socioeconomic markers, necessarily obscures perhaps significant differences in the costs and benefits of enforcement.\textsuperscript{310} If discrimination affects “markets” differently, because women are discriminated against in different ways than men, or because the forms of discrimination vary in blue-collar and white-collar jobs, or because the culture of particular areas tends to promote more discrimination than others, focusing on the national bottom line can mislead whether it shows a positive or negative number. Great positive effects in one area could mask smaller, but distinctly negative results in another, and vice versa. The “shadow effect” of the law, in the form of voluntary changes in the dental practice and culture might also evade or compound the analysis.\textsuperscript{311} Moreover, some forms of discrimination—and denial of dental care is one—are almost entirely constituted by the overt discriminatory act itself. If the discriminatory behavior is changed, the problem is largely solved, even if associated socio-economic conditions do not change.

In considering how to use the law to prevent discrimination by dentists, I will therefore begin with a narrower inquiry: can law change particular behaviors at a reasonable cost, and if so, how? Although neoclassical economics assumes that law \textsuperscript{312} cannot, this position is only supportable in the form of the tautology of exogenous preferences.\textsuperscript{313} There are countless...
examples of state power helping change preferences, even deeply held ones, even compulsive ones, on a mass level. I will cite a few examples from the field of public health: alcohol consumption,\textsuperscript{314} cigarette smoking,\textsuperscript{315} riding a motorcycle without a helmet,\textsuperscript{316} and driving without seat belts.\textsuperscript{317} Determining whether a reasonable investment in law\textsuperscript{318} can help change the specific behavior of dentists refusing to treat patients with HIV requires us to consider the research on how law operates to bring about behavioral change.

Here, as in most other areas, law will "work" only if most people will obey without being individually forced to.\textsuperscript{319} Over the years, considerable research has been done in an effort to understand why people obey the law. As Austin Sarat has written:

\begin{quote}
[T]he question of why people obey the law focuses attention on the complex character of the law itself . . . . For positivists, the question of why people obey can be subsumed under more general concerns about the relationship of attitudes and behavior . . . or about the deterrent effect of particular penal sanctions. For adherents of Critical Legal Studies . . . this question resonates with their interest in legitimation, mystification, reification, and the role of law in reproducing hierarchy. For interpretivists, it can be
\end{quote}

\footnotesize{has a psychological cost to the individual. To illustrate, many people now refrain from smoking in public places, even though the laws are seldom enforced formally. Apparently, smoking ordinances have been internalized by many smokers. Economics needs a predictive theory of internalization in order to analyze the educative role of law in crucial areas such as discrimination.

Cooter, supra note 270, at 167 (footnotes omitted).


315. See Alan Blum, Strategies to Reduce Cigarette Sales: Excise Taxes and Beyond, 255 J. AM. MEDICAL ASS'N 1049 (1986).


318. The question of the cost of intervention is difficult to answer. Inasmuch as I assume that preferences can be changed, and that dental discrimination does not have a measurable market effect, I assume away the most obvious costs. We are left with the administrative costs of enforcement, and the psychic costs of dentists forced to change their preferences or confronted with litigation or professional discipline. The latter, like the psychic benefits of avoiding discrimination to people with HIV, are not reliably quantifiable.

319. TOM R. TYLER, WHY PEOPLE OBEY THE LAW 24-25 (1990). As Arendt observed, the use of force to exact compliance is the negation of authority. HANNAH ARENDT, BETWEEN PAST AND FUTURE EIGHT EXERCISE IN POLITICAL THOUGHT 93 (2d ed. 1968). This might be said to be the problem that law as a discourse of power solves. See, e.g., MICHEL FOUCAULT, DISCIPLINE AND PUNISH (Alan Sheridan trans., 1979).}
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rephrased as an inquiry into the social meaning of law or into the dynamics of domination and resistance.\textsuperscript{320}

Two recent additions to the literature help analyze the options for state action against dental discrimination.\textsuperscript{321} Tom Tyler's work, based on studies of compliance with routine law like traffic rules, emphasizes the importance of normative elements to compliance, and strongly ties legitimacy to the perception of procedural justice.\textsuperscript{322} John Braithwaite, emphasizing the role of community participation in creating and enforcing norms, has stressed the role of shame (and, with Ian Ayres, has convincingly applied his work in envisioning an effective regulatory system that combines public and private regulators, and mixes persuasion and punishment tit for tat in the face of cooperation and resistance).\textsuperscript{323} While the relative weight of these factors is a matter of considerable importance in the construction of a theoretical model of compliance, for our purposes a catholic approach is in order.

A broad approach to the question of compliance also must recognize that law constructs and is itself constructed by social reality. The positivist question of why people obey the law can be restated as one of how the "regulated" consume, resist, or redefine it.\textsuperscript{324} This is particularly true in an approach that looks to public health interventions as a model. Cigarette smoking has declined because it has been made undesirable, not illegal, but law has been used to add to the inconvenience and stigma of the behavior. Thus, in the case of law as an antidote to the taste for discrimination, we need to keep in mind how legal interventions will operate within a larger process of the construction of the human and behavioral objects of the regulation. How will the legal use of concepts like discrimination, disability, and freedom of contract affect the identities of dentists and patients, their understanding of their behavior and options, their standing in their communities? In the following analysis, I draw

\textsuperscript{320} Austin Sarat, \textit{Authority, Anxiety, and Procedural Justice: Moving from Scientific Detachment to Critical Engagement}, 27 \textit{LAW \\ & SOC'Y REV.} 647, 649 (1993) (citations omitted) (reviewing \textsc{Tom Tyler}, \textit{Why People Obey the Law} (1990)).

\textsuperscript{321} Both of the works I rely on here remain in an essentially positivist, liberal framework that assumes the legal system is more or less just and that its legitimizing function is thus an acceptable cost if not a benefit. For a very thoughtful discussion in this vein, see Austin Sarat's review of Tyler's book. Sarat, supra note 320.

\textsuperscript{322} See \textit{Tyler}, supra note 319.

\textsuperscript{323} \textsc{Braithwaite}, supra note 310; Toni Makkai \\ & John Braithwaite, \textit{Reintegrative Shaming and Compliance with Regulatory Standards}, 32 \textit{CRIMINOLOGY} 361 (1994); \textsc{Ayres \\ & Braithwaite}, supra note 3, at 16-53.

\textsuperscript{324} For a review of recent scholarship, and a suggestion that a "moderate" social constructionist approach combining critical theory and empirical observation can accept "the constructed character of social categories and understandings" without leading to "epistemological or moral nihilism," see Elizabeth Mertz, \textit{A New Social Constructionism for Sociolegal Studies}, 28 \textit{LAW \\ & SOC'Y REV.} 1243, 1260 (1994).
on all these approaches, synthesizing without, I hope, trivializing.\textsuperscript{325}

a. \textit{The Stick}

What negative consequences would the application of the various rules I have suggested have on dentists' sense of the personal cost of discrimination? The literature examines a variety of costs, which can be reduced to three: the chance of being actually caught and punished by the regulator; the pain of being caught doing something one's social or professional peer group would condemn, termed "shame,"\textsuperscript{326} and the moral or emotional stress of doing something that runs counter to one's own internalized values, termed "guilt."\textsuperscript{327}

Although this is an important question for future research, there is reason to believe that dentists perceive themselves to be at very low risk of prosecution and punishment. The high rate of discrimination reported in the studies discussed here implies that those who are discriminating are not deterred. This is borne out by the Burris-Glick study, in which most dentists who declined to treat were quite open in attributing this to the patient's HIV status. Nearly half the refusing dentists reportedly stated that they did not treat any patients with HIV, a confession of illegal discrimination that a prudent dentist concerned about the law would presumably avoid. (This openness may also suggest that dentists did not feel that their behavior was wrong or illegal.) Although we know that the mass and trade media have publicized the few dental cases filed so far, we do not know the degree to which a dentist in rural Minnesota regards a Department of Justice suit in Texas as evidence of a serious enforcement threat.

Dentists who believe that they are unlikely to be seriously sanctioned for a refusal to treat are probably right. As discussed above, none of the regulatory mechanisms currently in place detect more than a handful of cases of discrimination, at best. If we assume that one million Americans have HIV, that half of them have sought dental care since infection, and that only 5\% of them have been refused care because of their status, a rough calculation

\begin{footnotesize}
\begin{itemize}
  \item \textsuperscript{325} Thus I follow Braithwaite's observation that "the main use of good general theories in an applied field such as criminology is in supplying policy practitioners with a set of explanatory frameworks worth scanning for application to a particular context." John Braithwaite, \textit{Pride in Criminological Disensus}, 18 \textit{LAW \& SOC. INQUIRY} 501, 501 (1993).
  \item \textsuperscript{326} This is not to suggest that peer disapproval has only psychological consequences. Peers have the power to cut off referrals of patients and to prevent advancement or membership in professional organizations. See \textsc{Tyler}, \textit{supra} note 319, at 23-24.
  \item \textsuperscript{327} The distinction between "shame" and "guilt" is discussed in \textsc{Braithwaite}, \textit{supra} note 310, at 57. This distinction illustrates the tenuous quality of the line between rational-choice-oriented and legitimacy-oriented theories. Deterrence theory has generally recognized the importance of individual and social values in influencing behavior. One theory's motivation is another's cost. See \textsc{Tyler}, \textit{supra} note 319, at 23-27.
\end{itemize}
\end{footnotesize}
suggests over 25,000 instances of discrimination. Yet, the number of discrimination complaints of all types is in the low hundreds.\textsuperscript{328} As dentists become more concerned about enforcement, we may also see the use of simple but effective strategies to avoid being caught. Rudeness, long waits, and manifestations of incompetence—or polite solicitude and a referral—triggering diagnosis—may all be marshalled to move a patient on. More risky for the dentist and the patient would be the avoidance of diagnosing any condition that would require care beyond a cleaning or other simple procedure.\textsuperscript{329}

It is less clear that the punishment, when it comes, would be perceived as insignificant. Settlements and jury awards in refusal to treat cases have reached the six figures, and the cost of defending a discrimination action can be substantial. Even if an insurance company indemnifies a dentist for the cost of defense, the psychological toll of defending a discrimination action may be as great as the fear of a damages award.\textsuperscript{330} Moreover, litigation exacts a financial toll on health care providers even if there is insurance to cover any ultimate recovery.\textsuperscript{331}

The deterrent effect of antidiscrimination law could, in theory, be enhanced by making the penalties greater, or by increasing the number of cases brought. For reasons discussed below, the research does not support the theory that harshly punishing a few dentists would be the most effective way to change the population’s behavior. If classic deterrence is to work at all, then it seems clear that there have to be rule and policy changes that increase the incidence of complaint. Several changes in the regulatory environment would tend, at least in theory, towards achieving this goal. Clarifying dental licensure policies to create a new rule of law would increase potential liability to

\textsuperscript{328} The most thorough count was published in 1990, before the passage of the ADA. It reported a total of 46 health care discrimination claims, filed by patients with HIV against their physicians, and by health care workers with HIV against their employers. Lawrence O. Gostin, \textit{The AIDS Litigation Project: A National Review of Court and Human Rights Commission Decisions, Part I: The Social Impact of AIDS}, 263 JAMA 1961, 1961 tbl. 2 (1990). Most cases against dentists under the ADA have been widely publicized, and are included in this estimate. Dental board complaints are less commonly reported. Friedland and Valachovic’s finding of 32 complaints, in a nationwide survey with an 85\% response rate, is probably a fair count as of 1993. \textit{See} Friedland and Valachovic, \textit{supra} note 153, at 38-39 & tbl. 1.

\textsuperscript{329} In one “test” in the author’s experience, a patient who needed a filling was diagnosed by one friendly dentist as requiring extensive oral surgery, outside his usual realm of practice. A second dentist was willing to provide the filling, but drilled the cavity without anaesthetic to avoid using a needle. \textit{48 Hours: Fatal Secret} (CBS television broadcast, 1991).


\textsuperscript{331} The Harvard Malpractice Study found that New York physicians spent an average of $7,000 per malpractice claim in lost work. \textit{Weiler \textit{et al.}, supra} note 174, at 126. Dentists in private practice could be exposed to equal or greater costs of taking days off of practice.
complaint. Aggressive enforcement of the ADA by the Department of Justice, and by state and local human rights agencies, would result in many more cases being prosecuted and publicized, and could increase dentists’ sense of vulnerability to suit.

Significantly increasing the number of actions, however, probably depends on getting more people who have suffered discrimination to come forward and make complaints. The addition of compensatory damages to the relief available under the ADA and state antidiscrimination law would provide a greater incentive to individuals to file suits. Increasing the ease of access to and speed of the complaint process under both licensure and antidiscrimination law could help. Provisions to ensure anonymity of the complainant throughout the litigation would reduce the disincentive to sue among potential plaintiffs. Potential plaintiffs, however, may be as alienated from the legal system, and as averse to the stress of litigation, as potential defendants. Given this, the essential fungibility of dentists, and the marginal importance of being cared for by a particular dentist, waiting for plaintiffs to come forward on their own may not generate a sufficient level of litigation to influence dentists’ behavior. The Department of Justice and state agencies can address this problem by using their investigative authority to deploy testing or other techniques to identify dentists who illegally discriminate. The same authorities, or private foundations, may fund private testing and education programs similar to those funded under the Fair Housing Act.

It remains questionable that the many barriers to legal action against dentists who discriminate could be overcome to a sufficient degree that such action, by itself, would substantially change dentists’ perception of the risk of punishment. This is not, however, as serious a problem as it might seem. The immediate goal, after all, is not to raise the number of enforcement actions, but to increase dentists’ sense of vulnerability to prosecution. This goal can be significantly advanced by a public information campaign, linked to changes in rules and to actual enforcement, that is designed to change dentists’ legal risk assessment. Individuals tend to judge risks by factors other than the objective chances of their occurrence. Publicity targeted at dentists that portrays the painful consequences of being caught may increase both the aversion to being caught and the estimate of the “risk” of it happening. This insight has emerged as important in other behavior change campaigns, such as the reduction of drunk driving. Indeed, Ross’s review of research suggests that publicity is more important in effecting change than is the


333. Tyler, supra note 319, at 23 (citing H. Laurence Ross, Deterring the Drinking Driver: Legal Policy and Social Control (1982)).
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severity of punishment.\textsuperscript{334} From this view both changes in legal rules and enforcement action derive a substantial amount of their potential impact from the occasion they create for "normative publicity,"\textsuperscript{335} and continuing enforcement efforts provide the opportunity for ongoing reinforcement of the public message.

Braithwaite's work finds that feelings of shame and guilt can "raise the cost" of discrimination independently of the level of legal threat. In early work in this vein, Braithwaite and Makkai found that a method of "reintegrative shaming," analogous to professional peer pressure, had a significant effect on nursing home compliance with regulations governing health care, privacy, and safety. The authors concluded that the surprising strength of the relation resulted from the diffusion of the norm through involvement of the entire staff in addressing regulatory deficiencies.\textsuperscript{336} Braithwaite's theories emphasize the "reintegrative" use of shaming, in which clear and strong disapproval is purged by repentant correction in a general climate that avoids alienation or stigmatization of the wrongdoer. "Shaming" is most effective in situations of interdependence, as between regulators and their professional subjects.\textsuperscript{337} "It would seem," he writes, "that sanctions imposed by relatives, friends, or a personally relevant collective have more effect on ... behavior than sanctions imposed by a remote legal authority."\textsuperscript{338} Under this theory, however, consensus in the "relevant collectivity" on the wrongfulness of the conduct is essential.\textsuperscript{339}

This work yields particularly important insights for changing dentists' behavior. In some respects, dentists are unusually independent. They tend to

\textsuperscript{334} Ross, supra note 332, at 99-115.

\textsuperscript{335} To accept that the state can change preferences, and can do so most effectively by a judicious combination of fear and persuasion, should start another kind of philosophical debate. Although it is beyond the bounds of this paper, health propaganda and health law raise basic questions about the degree to which we want the state to manipulate our preferences, even if the goal is our general health. See Scott Burris, Thoughts on the Law and the Public's Health, 22 J. L. MED. & ETHICS 141 (1994).

\textsuperscript{336} Makkai & Braithwaite, supra note 323, at 380.

\textsuperscript{337} Id. at 379-81. Makkai and Braithwaite observe: The effective [regulators] are those who believe in strong expressions of disapproval combined with strong commitments to burying the hatchet once such robust encounters are over, to terminating disapproval with approval once things are fixed, to tempering disapproval for poor performance on one standard with approval for good performance on other standards, to avoiding humiliation by communicating disapproval of poor performance within a framework of respect for the performer. Id. at 379.

\textsuperscript{338} Braithwaite, supra note 310, at 69.

\textsuperscript{339} Id. at 38; see Makkai & Braithwaite, supra note 323, at 366. For example, Braithwaite explains, in a society where disapproval of marijuana use falls to 50 percent, "increased capacities to shame reintegratively will not predict marijuana use because subcultural shaming to encourage marijuana use will be just as powerful as mainstream shaming to discourage use." Braithwaite, supra note 325, at 504.
operate as sole practitioners or in small partnerships, cut off from day-to-day contact with peers. They are loosely regulated. Aside from the lightning strike of an OSHA inspection, their experience with regulatory authorities is probably limited to renewing their license by mail. On the other hand, they are linked to patients in a relationship of relative intimacy, at least physically, and one that is, as the strength of concerns about losing patients shows, characterized by some degree of dependence. Moreover, the formal goal of legal action on the nondiscrimination model is the creation of a new relationship between the dentists and the refused patient. Finally, the physical isolation of dentists does not necessarily lessen their concern for professional peer validation, hence the finding of Weyant et al. that high professionalism scores, embracing the degree to which the respondent was involved in a network of peers, were inversely associated with discriminatory attitudes.340

If Braithwaite is correct, we should see the dental professional subculture itself as the key to defining dental discrimination as a wrong. This is the group whose views will be deemed by dentists as most relevant on the issues of professionalism, risk, competence and economic practicality. While encouraging disapproval of dental discrimination in other subcultures to which dentists belong would be helpful, the issue is hardly one that will interest most people as even worth having an opinion about.341 Thus, though the diffusion of dentists makes the connection relatively weak, we must rely on the dental profession itself as the primary developer and enforcer of a consensus for treatment. It follows that we should encourage the expression of strong norms of competency and nondiscrimination in all settings where dentists interact with their peers, beginning with initial training, and continuing through strong and frequent disapproval of discrimination by licensing boards and professional organizations.

To suggest that it is important to have explicit norms of nondiscrimination set by the profession is not to suggest that there is no role for law in setting norms or enforcing them. On the contrary, even a strong partisan of the independence of professionals has recognized that the AMA’s ethical guidelines

340. Weyant et al., supra note 57. The Harvard Malpractice Study found that physicians were more influenced by professional training and contacts than legal rules in changing practices. WEILER ET AL., supra note 174, at 128 tbl. 6.3.

341. There is broad support for the general norm of non-discrimination, allowing considerable latitude in the definition of what constitutes discrimination. A dentist may be subject to shaming by public exposure as a discriminator, even without a legal finding that the dentist was a wrong-doer. Although its activities have subsided of late, Act-Up activists have frequently “zapped” public and private figures for alleged mistreatment of people with HIV. Public exposure, particularly if the object feels shame and humiliation, is a serious sanction. For an account of Act-Up’s activities in influencing medical research, see WACHTER, supra note 309. For a discussion of the evidence for public shaming as a force for regulatory compliance, see AYRES & BRAITHWAITE, supra note 3, at 20-27.
on treating patients with HIV have not been successful.\textsuperscript{342} The general research has found that even guidelines on practice created within the profession, and transmitted by respected opinion leaders directly to physicians, are not enough to change professionals' behavior on their own.\textsuperscript{343}

Discipline to enforce the consensus should, however, be informed by a reintegrative philosophy. An apology, additional training, and a commitment to treat in future are more important than fines and suspension, both in changing the individual dentist's behavior and in reinforcing the norm in others. Harsh punishments and stigma, even from within the profession, may tend to increase resistance.\textsuperscript{344} As the legal rule against discrimination under the ADA becomes clearly established, Braithwaite's work suggests that mediation and conciliation, relying on injunctive relief, will be more effective than trials and fines. Indeed, and perhaps contrary to the conventional wisdom of civil rights litigators, settlements of high profile cases, provided they include a frank confession of error and a reconciliation between patient and dentist, may be as or more effective than a final judgment of liability and the imposition of punitive fines.

This returns us to the question of how dentists themselves perceive the situation, the law and their obligations. Regardless of the level of actual and perceived enforcement, the degree to which both "shame" and "guilt" figure as costs depends upon whether or not the individual who discriminates perceives himself as a beast or a hero in his own and others' eyes. We thus move to the questions of dentists' perception of the morality and legitimacy of a rule against dental discrimination.

\textbf{b. The Superego}

Regulation that assumes its objects are either "bad," susceptible only to punishment, and regulation that assumes all its objects are "good," requiring only persuasion, are equally naive.\textsuperscript{345} We can safely assume that many if not


\textsuperscript{344} See BRAITHWAITE, supra note 310, at 127-33 (discussing role of stigma in creating sub-culture of white collar criminals).

\textsuperscript{345} "When regulators wade in with a punitive model of human beings as essentially bad, they dissipate the will of well-intentioned actors to comply when they treat them as if they are ill intentioned. The problem with the persuasion model, however, based as it is on a typification
most dentists would like to do what is “right,” and that persuasion therefore can help us achieve our behavioral goals. The complexity of the construction of “right” in dentists' minds, however, requires a sophisticated evaluation of both dentists' current attitudes and the tools of persuasion at our disposal.

Despite the volume of research, there are limits on what we know. A dentist's sense that it is morally wrong to refuse patients with HIV has many potential sources, including religious faith, professional values, and the importance of the rule of law. The research on attitudes to date has been secular in character, and has focused on refusal to treat as a professional decision. It has weaknesses when used to describe the moral views of dentists about discrimination. Shame is one of the “biases” attitudinal studies are designed to overcome, in the sense that they are structured to minimize the degree to which the respondent gives the answer she thinks the surveyor thinks is “right.” Dentists' attitudes about the legitimacy of the legal rule against discrimination have likewise not been directly examined, but the data suggest that dentists are dubious about government interference with their professional decisions.

The evidence indicates that dentists, as a group, are ambivalent about caring for people with HIV, and that this is true of many who do discriminate as well as of many who do not. While one study found that most dentists did not agree with their professional organization that they had an ethical obligation to treat, more studies have found a majority agreeing with some variation of the proposition that they “ought” to treat. Of course, this belief was rejected by a substantial minority of dentists, and even of those who embrace it, many also “preferred” not to treat patients with HIV. Perhaps the clearest indicator of ambivalence in the research data is the evidence that dentists, while frequently refusing to treat patients known to have HIV, make no effort to screen out unknown HIV-positive patients in their practices. We do not know the degree to which dentists who do discriminate or “prefer not to” treat feel the sting of immorality. We also see ambivalence in the enforcement of the ethical and legal rules against discrimination by dentists. The wording of the ethical codes, and the failure to take strong public positions, may indicate enduring uncertainty about the substance of the rules, or, as likely, an unwillingness to criticize professional colleagues.

If there is a Holmesian “bad man” in this issue, it is the highly risk averse dentist who doesn’t give a damn about ethics and has no interest in learning anything new about his profession. Very little in the way of education, as Weyant et al. observe, can be done to affect such individuals. Even

of people as basically good—reasonable, of good faith, motivated to abide by the law—is that it fails to recognize that there are some who are not good, and who will take advantage of being presumed to be so.” Ayres & Braithwaite, supra note 3, at 25.

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ferocious litigation might not bring a change. Most dentists who do not treat probably do not sink to this level, however, and will be persuadable that discrimination is wrong. (We nevertheless must keep in mind that the issue is hardly clear cut, and that questions of personal risk, customer preference, and the moral worth of the infected can provide the material for an elaborate structure of justification.)

Those dentists who treat, or express a willingness to do so, seem to be strongly influenced by education, experience, peer values, and personality traits. Indeed, this combination of knowledge, commitment to professional values, and willingness to take risks attendant upon professional status could be said to constitute "good" in this context. Establishing that discrimination is wrong thus entails a model of the good dentist that the less-than-ideal dentist will aspire to emulate.

The best source of a norm against discrimination is the profession itself, acting through the explicit and urgent adoption of a rule against discrimination by national, state and local professional organizations, and state licensing boards. Tyler’s research on obedience to law helps explain why. The goal is to have dentists accept and practice a behavior that they perceive to be contrary to their immediate self-interest, to abandon their current views and practices and to adopt new ones. Securing this sort of change is, in Tyler’s view, one of the main instrumental purposes of legitimacy, and success, therefore, depends upon the degree to which dentists accept the new rule of behavior as legitimate. Tyler’s research, which measured the independent force of factors like support for established authority in either its institutional or individual manifestations (i.e., for Congress or for Congressperson Jones), and faith in the fairness of lawmaking and adjudicatory procedures, supports the primacy of professional regulation in this instance. Tyler found that:

| fairness of procedures enhances or diminishes the legitimacy of legal authorities and future compliance with the law. When legal authorities attempt to implement policies, public conceptions of fair procedure are particularly important. According to a perspective based on procedural justice, people will accept or reject policies according to how they assess their fairness rather than in terms of costs and benefits. |

Although we may assume that dentists, who are generally well off and enjoy high status in society, support the law as it constitutes their status and

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347. "If legitimacy is an important concept, it should lead citizens to behave in ways not always consistent with their short-term self interest." TYLER, supra note 320, at 29.
348. Id. at 110.
protects their property, dentists are less likely to obey a controversial regulation that intrudes upon their professional autonomy. In a matter like dental discrimination, which involves medical facts as much as, or more than, ethical or legal rules, it is very likely that dentists will perceive as most legitimate a professional decision-making process carried out by individuals with the proper medical and dental qualifications.  

Some professionals strongly object to any extra-professional limits on their discretion to choose whom to treat:

Any doctor who is . . . compelled by law to make any decision he would not otherwise have made, is being forced to act against his own mind, which means forced to act against his own life. He is also being forced to violate his most fundamental professional commitment, that of using his own best judgment at all times for the greatest benefit of his patient.

This view may or may not be linked to another common objection—doubts that the authority promulgating or interpreting the regulation has the requisite knowledge and competence to do so. Dentists, schooled in non-legal methods of resolving professional conflicts, are not likely to be convinced by practice guidelines and pronouncements about risk that emerge from legislative debate or adversarial proceedings.

The fact that the norm comes primarily from within the profession by no means suggests that the norm can be entirely enforced by the profession alone. When professional guidelines have been followed, success depended upon the deployment of a variety of context-specific incentives and enforcement measures. Orentlicher concluded that “. . . successful implementation of standards for anaesthetic monitoring was a result of a combination of mandates from both hospitals and licensing boards for their use.

349. In pedagogical terms, the development of the norm through professional procedures, and its explication by professional peers and opinion leaders, increases the credibility and acceptability of the message. For a summary of the elements of successful HIV education, see Burris, supra note 255.


351. For a roster of professional objections to regulation, see Orentlicher, supra note 342, at 583-90.

352. Daniel M. Fox described the methods physicians use to resolve professional conflicts: The first method is the assertion of authority from the top of a hierarchy in which power is, in theory, derived from knowledge. The second method is peer review—discussion to consensus among experts of roughly equal standing and attainment. Both methods, the hierarchical and the consensual, rest on the assumption that truth is best determined by experts.

and reductions in malpractice premiums that were conditioned on their use. 353 Orentlicher also found that strict regulatory oversight has been effective. 354 Reviewing the literature on six general methods 355 of changing physicians' behavior, Greco and Eisenberg also concluded that "interventions that rely on more than one method appear to be the most successful." 356 This is consistent with the approach advocated by Ayres and Braithwaite. 357

Dentists are no more likely to accept legislative and judicial judgments about whom they must treat than they are to accept those judgments in the malpractice or other regulatory realms. However, much of their concern about regulators' competency may be allayed by maximizing the coherence between legal and professional rules. To the degree that the state is merely enforcing a rule that has emerged from or been adopted by the profession generally, the objections from competency and autonomy can be overcome. This suggests the importance of focusing on the lack of valid professional reasons for not treating, rather than on the arbitrary (to dentists) social decision to confer a right of nondiscrimination upon people with HIV by calling them "disabled."

Even if dentists perceive the norm as coming from within their profession and accept the legal regime as legitimate, one can anticipate their doubts about the legitimacy of non-professional enforcement. Dentists will not like being sued or disciplined, and it is important to recognize that coercion may engender resistance as well as provide deterrence. Although I believe that, at any level of enforcement, the costs will not outweigh the benefits, I also believe that we should conduct disciplinary and litigation efforts with an awareness of this concern and the larger goals of the campaign. We should not ordinarily demonize dentists who discriminate; their reformation, rather than their ruin, should be the express goal that guides settlement, publicity, and other decisions.

4. **Summary: The Elements of an Effective Regulatory Response**

I can now set forth my proposals for action that will maximize the chances of dentists changing their behavior. The claim that law cannot change preferences is insupportable. It can and does so in a variety of ways. On the other hand, the effect of law is dependent on a large number of co-factors, and the effect of any single intervention may be difficult to identify or

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353. Orentlicher, supra note 342, at 601 (citations omitted).
354. Id. at 602 (citing state regulation of coronary bypass surgery in New York, and federal regulation of antipsychotic drug use in nursing homes).
355. The six are "education, feedback, participation by physicians in efforts to bring about change, administrative rules, financial incentives, and financial penalties." Greco & Eisenberg, supra note 343, at 1271.
356. Id.
357. **AYRES & BRAITHWAITE, supra note 3.**
disaggregate from others. Moreover, although law plays an important role in a campaign to reduce dental discrimination, the project cannot depend on state action. Experience suggests that no one measure can be expected to produce behavior change. The best candidate for success is a strategy using an array of measures aimed at changing attitudes, information levels, and incentives.

Thus, the goal of a systematic intervention includes both attitudinal and behavioral components, and is best described as persuading dentists that discrimination is wrong (i.e., inconsistent with social and professional norms), and bringing them to act consistently with that belief. There are three principal means to achieve this goal: 1) clear normative and behavioral messages from legitimate sources; 2) perceptible incentives for compliance and disincentives for noncompliance; and 3) continuous reinforcement of the desired behavior. In the remainder of this Section, I will propose mechanisms for achieving attitudinal and behavioral changes.

a. Establishing the Wrongfulness of Discrimination

The program as a whole depends upon establishing that discrimination is wrong, in any of the many ways it might be: unprofessional, unnecessary, cruel, illegal, un-Christian and so on. It depends, that is, on clearly stated, unambiguous, vigorous norms that individual dentists can understand and with which they can identify. Although I am putting forth a "legal" strategy, I see the law operating at a deep level in ways I will describe. To begin with, I have not phrased the goal in terms of persuading dentists that discrimination is illegal; the legal rule against discrimination can readily be seen to depend upon the prior judgment that discrimination is medically unnecessary and unethical. We may wish to phrase the rule that way because of the substantial evidence that antidiscrimination law is probably perceived by dentists as the least legitimate source of the norm among our alternatives, and conversely that professional values are very influential in reducing discriminatory attitudes.

It follows that authorities constituted by dentists can most effectively advance the cause of establishing clear norms of nondiscrimination. On the key issues that underlie discriminatory behavior—fear of infection, uncertainty about competence, and concern about patient and staff attitudes—no other authority will be as credible in an effort to change dentists’ attitudes and behavior. The norm itself should be as forthright and unambiguous as possible.

Recommendation 1:

Dental ethical codes and licensure regulations should be amended to make it unprofessional (or otherwise actionable) conduct for a dentist to refuse, withhold from, deny, or discriminate against an
individual with regard to the provision of professional services for which the licensee is licensed and qualified to render because the individual is HIV positive.\textsuperscript{358} Such conduct includes providing care to the individual at a standard that is lower than that provided other individuals with like medical needs. Rules should clearly state that a subjective belief that one is incapable of treating, without evidence of a condition outside ordinary competence, cannot justify discrimination, and that any referral based on general health or HIV-related conditions should be made only after consultation with the patient’s physician, if any.

A professional standard will not be established by mere words. Vigorous action consistent with an ethic of treatment is also required. The adoption of various educational and social marketing proposals, discussed below in the section on reinforcing the norm, are crucial to establishing the norm in the first place. The same is true of the deployment of incentives. Rewards and punishments signify a commitment to the norm of treatment. Their absence is readily perceived as a wink at the rule.\textsuperscript{359}

A “clear” norm will be a public norm. If dental authorities are perceived as afraid to address publicly the issue of HIV in dentistry, individual dentists afraid of customer reaction will be justifiably skeptical of the professional commitment to nondiscrimination. To the extent that discrimination reflects a collective action problem, the perception of collective change is essential to reassure individual dentists that treatment of HIV positive patients will not jeopardize their practice. Dentists must perceive that their patients have the impression that all dentists treat people with HIV.

The legal norm of nondiscrimination has a secondary, but still important role: It invokes powerful ideas like fairness and equal treatment. Although legal rules may not be as legitimate to dentists as professionally-based ones, dentists are hardly a lawless band of anarchists and will be affected to some degree by legal rules. Moreover, legal rulings against discrimination may reassure the public that the risk of transmission in a dental practice is acceptably low.\textsuperscript{360}

\textsuperscript{358} This language is based on Md. Code Ann. Health Occ. § 4-315(a)(27) (1991). The recommendation speaks of regulatory changes by dental boards themselves, where possible, rather than legislation, because of the greater legitimacy of professionally produced rules to those passed by politicians.

\textsuperscript{359} Nevertheless, dental licensing boards can be effective in setting norms even if enforcement is left to other bodies, provided the norm is clear enough, the lack of prosecution is based on a policy of referring such cases to human rights agencies, and the referrals are actually made.

\textsuperscript{360} See Burris, supra note 255, at 386-87.
Recommendation 2:

Department of Justice, state human rights agencies, and civil rights attorneys should continue a strategy of establishing and defining the extent of a legal rule against discrimination through impact litigation.

b. Establishing Incentives

In addition to validating the norm, incentives for treatment and against discrimination, if they are perceived as significant enough by dentists, will contribute to behavior change. The research of Weyant and Bennett supports the inference that enhanced professional status for those who treat HIV positive patients would encourage treatment by many dentists sensitive to professional regard. Role models exemplifying the good are needed, not only for symbolic purposes but also to provide adequate care for patients and education for dentists. Two recommendations follow.

Recommendation 3:

Professional organizations, local governments, and philanthropies should seek or create opportunities to recognize dentists who are willing to be publicly identified as treating patients with HIV, actively promote the virtues of treating, and praise those who treat HIV patients.

Recommendation 4:

Rather than routine care, clinics or practices specializing in care for people with communicable diseases should provide clinical advice to local dentists, leadership in professional education at all levels, and care for patients requiring specialized procedures or facilities.

If professional regard and institutional support are the carrots, professional discipline and legal action constitute the sticks that are sometimes necessary to induce change in a heretofore gratifying behavior. Legal action should, in the words of Ayres and Braithwaite, be both “ferocious and forgiving,” clearly demanding compliance with the norm but seeking and recognizing the reformation of the wrongdoer.361 The level of punishment

361. Ayres & Braithwaite, supra note 3, at 27.
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theoretically available seems more than sufficient to provide a disincentive for discrimination. The problem lies more in the levels of litigation and publicity, leading to several recommendations intended to encourage those who experience discrimination to come forward, or otherwise to increase the actual and perceived volume of litigation.

I will begin with dental licensing boards. Their problems have led to some common suggestions for improvement. These include increasing fees to allow the hiring of more staff, reducing the burden of proof to preponderance of the evidence, and streamlining the investigation and appeals process.362

Further:

**Recommendation 5:**

*Dental licensing boards should make their complaint procedures sufficiently expeditious and user-friendly to be a viable alternative to litigation. The opportunity to file complaints before dental boards should be better publicized, perhaps by requiring dental offices to post information about the process and to supply forms. Dental boards should vigorously and swiftly investigate and adjudicate complaints, without awaiting the results of parallel actions under the Americans with Disabilities Act. The procedures for filing and investigating complaints should be simplified and should provide for the use of a pseudonym by the complainant, even once the action is final and public, as well as on appeal.*

In the short term, taking steps to appear more willing to take cases increases deterrence and consciousness of the norm, even if the changes have no significant impact on the volume of cases filed or sanctions imposed.

**Recommendation 6:**

*Dentists should also perceive a meaningful threat of suit under the Americans with Disabilities Act and state antidiscrimination law. The Department of Justice and state human rights agencies should conduct or fund testing in communities throughout the country where no litigation has been brought, in order to enhance the deterrent effect of antidiscrimination law.*

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362. See Kusserow et al., supra note 164.
Recommendation 7:

To increase the incentive for individuals who have suffered discrimination to bring actions, state and federal antidiscrimination law should be amended to provide for damages in public accommodations cases, specifying a minimum liquidated amount of at least $5,000. Testers should explicitly be allowed to recover damages.

Under Section 504 of the Rehabilitation Act, the Office for Civil Rights of the Department of Health and Human Services has the authority to investigate discrimination in programs funded by that department, including many, if not all, of the major university hospital and dental school clinics. While I am not suggesting a harsh crackdown on institutions operating HIV-only clinics, there are at least two important roles for regulators.

Recommendation 8:

First, the Department of Health and Human Services should take steps necessary to ensure that no federally funded institutions refuse to provide dental care for people with HIV. Second, the Department of Health and Human Services should use its authority to bring institutions with HIV-only clinics into compliance with legal rules prohibiting mandatory segregation and to promote the model clinic role described below.

Increasing somewhat the volume of cases brought should not be taken as a suggestion that we “get tough” on discrimination. A program perceived as “punishing” dentists may be counterproductive, leading to organized resistance among dentists. Although the destruction of a career may have its attention-getting side, beyond the short run the achievement of behavior change may better be served by a positive example that enhances the legitimacy of the legal rule. Thus:

Recommendation 9:

The goal of any complaint or lawsuit should be publicly changing the behavior of the dentist, rather than placing blame or exacting punishment. Therefore, dispute resolution procedures ought to be expeditious and reintegrative more than stigmatizing and punitive.

363. See Ayres & Braithwaite, supra note 3, at 25.
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Settlement should be encouraged, provided its terms are public and include an acceptance of wrongdoing and a commitment to change. Education on HIV treatment and infection control, whether ordered by a dental board or as part of a settlement in a lawsuit, is perhaps the ideal sanction.

Despite the current inefficacy of licensing boards, we should not conclude that professional discipline has no power to deter dentists from misconduct. Indeed, action by dental regulators has several notable advantages over other forms of legal action. In general, sanction from within the dental profession will be more readily accepted by individual dentists. In addition, dental boards generally possess the authority to impose flexible, intermediate sanctions designed to repair defects in a dentist’s training or skills. Dental boards could require continuing education in treating patients with HIV, or require some kind of community service treating patients with HIV, either outside or within the dentists’ practice.364

c. Reinforcing the Norm and Behavior Change

Changing behavior requires different types of intervention at many different levels. A permanent, systematic program of dental education in infectious disease dentistry and HIV is fundamental to our goal of reinforcing the norm of nondiscrimination.

Recommendation 10:

Dental licensure laws and/or regulations should be amended to require training in both infection control and infectious diseases dentistry as requirements of initial licensure in dentistry and allied fields. All licensed and certified dentists and allied health professionals should be required to complete continuing education on the dental care of people with HIV and other infectious diseases, and infection control generally, as a condition of relicensure or recertification. Training should include the communication of risk information to patients and other staff members.

To the degree that dentists are refusing to treat out of concern for the economic impact of their patients’ fears, a broader public information campaign will reduce the need for discrimination while conveying and

364. For example, the Pennsylvania board can require counseling and education (and may use probation as a stick.) PA. STAT. ANN. tit. 63, § 123.1(b)(s) (1994).
reinforcing a norm of nondiscrimination to both dentists and patients. A mass effort, perhaps a unit in the ongoing America Responds to AIDS campaign, will respond to the public concern about transmission of HIV and enlist the public in the enforcement of dentists' observance of universal infection control procedures. A targeted campaign, designed to reach patients in the dental office and funded primarily by philanthropies and dentists themselves, is feasible and would be quite effective. Such a targeted campaign would benefit from the experience and organizational powers of the Centers for Disease Control and Prevention (CDC).

**Recommendation 11:**

*The CDC, working with health philanthropies, as well as dental boards and associations, should develop a public information campaign on HIV transmission in dentistry, with separate components targeted to dentists, dental staffs, and dental patients.*

One of the greatest virtues of legal activity is its capacity to generate free publicity. In addition to raising dentists' perception of the costs of discrimination, an active litigation program, bringing "routine" cases in communities across the country and making sure that they are publicized in local and national dental trade papers, will reinforce the norm at an affordable cost. This requires a departure from a traditional focus of civil rights lawyers on "impact" cases that formally establish the rule once and for all. Even cases that break no new legal ground are important because they will eventually penetrate the consciousness of new communities of dentists. Routinized, continual, and well publicized legal action diffused throughout the nation will establish the nondiscrimination norm. Legal action can reinforce nondiscrimination in other important ways. The process of proposing, debating, and implementing the various initiatives described here puts dental discrimination on the public agenda and creates opportunities for engaging and educating dentists and their patients.\(^\text{365}\) Testing programs or other investigatory devices may also be used to document the extent of the problem.

d. **Other Measures**

This article has identified important steps not directly related to changing dentists' behavior. There is a need for research on dentists' attitudes about antidiscrimination law, which might well be appropriately funded by the Department of Justice as part of its effort to implement the ADA. As a general

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\(^{365}\) See Burris, *supra* note 335 (discussing educative role of lawmaking).
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...matter, I have suggested here that we ought not to assume that the law works, but rather attempt to assess and explain its effectiveness. There should be more support for, and scholarly interest in doing, work to assess the impact of interventions on discriminatory behavior. I have also noted the degree to which the cost of dental care limits the access to care of people without the means to pay. States should seriously consider widening the availability of dental care under the Medicaid program and increasing reimbursement rates.

Research also suggests a few things that are not advisable. Governments and health planners should not address the discrimination problem by fostering routine care in dedicated HIV clinics. If clinics are not clearly limited to tertiary care, consultation, and training, their existence will undermine efforts to reduce discrimination. Finally, we should avoid the tendency to talk about dental discrimination as if it poses a conflict of rights. There is surprising consensus between dentists and their patients that the dentist should be aware of the patient's HIV status. In the end, patients want their teeth cleaned, and dentists want to be physically and economically secure.

e. Some Thoughts on Cost

Funds are by definition scarce. I cannot lay out a budget for the program suggested here; however, a few general observations indicate that a concerted effort to reduce HIV discrimination would not be prohibitively expensive. This project relies heavily on existing regulatory and professional institutions. Given the severity of dental discrimination, the Department of Justice and state human rights agencies should redeploy existing staff to concentrate on dental cases. Of course, human rights agencies at all levels are backlogged, and the addition of new staff would be better for all concerned. A high profile campaign of investigation and litigation could be carried out, at a cost of about $10 million per year, by adding one to two lawyers and the same number of investigators to human rights agencies in each state and the Public Access Section of the Department of Justice. Fortunately, a high-profile campaign conducted by only five or six states and the Department of Justice could have national impact for little over $1 million per year. Grants in the neighborhood of $150,000 per year to private agencies for testing would be additional. Although changes in dental licensure laws would entail no new line item costs, improving the budgets of licensing boards obviously would.

Educational efforts would also impose costs, many of which would be borne by the private sector. Although setting HIV-related continuing education

366. For a critique of this construction of HIV disputes, see Burris, "AIDS Exceptionalism", supra note 208.
367. This assumes a cost of about $200,000, based on attorney salaries of $45,000, investigator/support staff salaries at $30,000, 25% for benefits and $13,000 in expenses.
requirements imposes a substantial cost on dentists—the hourly cost of training plus the time lost—this would not be a new cost if HIV-related education is substituted for currently required training in other subjects. Even if it imposes a new cost, the growing importance of infection control in dentistry, and the lack of other regulatory interventions, makes this a justified cost beyond its impact on HIV care.

The production of training materials for continuing education could be included in the cost to dentists, or it could be subsidized by governmental and private contributions funnelled through the existing AIDS education and training centers for health care workers. Both governmental and philanthropic financing and expertise will be needed to produce public service ads and brochures for dentists and their patients. These costs could be minimized by incorporating the dental discrimination campaign into existing public information programs, such as America Responds to AIDS. Additional funding from the organized dental profession would also be useful for symbolic as well as fiscal reasons.

Reducing discrimination will improve the quality of life and oral health for people with HIV, but money should not be taken away from either HIV prevention or care programs to fund dental discrimination control. Dental discrimination should be controlled primarily because it is wrong, an insult to civility and fair treatment, and clearly illegal. Discrimination control should not be balanced against other HIV programs, but is justified by the larger social cost of indulging wrongful behavior.

Conclusion

Law scholarship is addicted to grand theories. This approach not only often produces elegant results, but also has the additional advantage of allowing considerable leeway for convenient factual assumptions. These grand theories tend to be supplanted by new grand theories well before they can be validated or falsified in the field. This pattern is in danger of cutting off a productive debate about the use of state power to eliminate discrimination. Having stated the broad question of whether and how antidiscrimination rules work, legal scholars ought now to specify and test their theories.

I have used empirical data, and theories about compliance with authority, to identify a series of measures that the dental profession and the state should deploy to reduce the level of discrimination against people with HIV. I have not proven that the particular package of changes proposed will work or determined the relative importance of the various proposals. Much needs to

368. Though at this writing, in November, 1995, the funding of the ETC program is in peril.
be specified by professionals in dentistry and health education. Prior research suggests that behavior change of this kind involves far too many variables and contingencies to allow for confident prediction of the results of any serious policy intervention. Nevertheless, there is value to the analysis. In a world of imperfect information, it is ultimately no objection to a policy proposal that it has not established a high likelihood of success. Indeed, there is no immediately apparent proper definition of success. I doubt that dental discrimination can be wiped out; I would regard an intervention as successful if it seemed to reduce the level of discrimination over the next decade by, say, half.

The advantage of the proposals offered here is that they are, by and large, inexpensive and have collateral benefits. Changing ethical rules and licensing regulations has some cost, but it is not likely to be very high. Likewise, increased enforcement of the ADA and better publicity would not be prohibitively expensive. Public education would require the outlay of cash, but the burden could be divided among public and private funders and, assuming dental discrimination is deemed an important issue for people with HIV and the dental profession, it may be met through the use of funds already earmarked for public education. Beyond cost, the approach I have outlined has the virtues of patience and an underlying presumption that dentists are not bad men and women when it comes to caring for patients with HIV. Regulation that follows my advice will be used responsively, particularly, and doggedly.

I conclude that we should and may use state power to reduce discrimination by dentists against people with HIV. Discrimination can reasonably be seen as an evil, the hurtful exercise of arbitrary market power by misguided individuals against an emotionally and physically vulnerable group of people. It derogates from ideals of responsible risk assessment and inclusion of the sick and disabled. It will not go away with a wave of the invisible hand.

Leaving aside first principles, I have shown that relatively modest changes in law and practice stand a reasonable chance of substantially reducing discrimination. The current scholarly and political debate about the value of antidiscrimination law has largely ignored the substantial body of theory and data showing that government is powerful, and that citizens, in the end, are responsive to this power. When the dust of the current debate settles, we are still going to have a country exhibiting racial, gender, and other more or less arbitrary divisions. Advocates of collective action to deal with these social divisions should not be expected to defend the proposition that "government" or law provide a complete solution. Nor, in defending the value of government action, should we underestimate the practical problems and empirical lacunae that activist policies entail. Indeed, we may find that beyond first principles, considerable common ground can be found in the torturous, mundane
unravelling of the problems themselves.