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HIV DISCRIMINATION IN DENTAL CARE: RESULTS OF A TESTING STUDY IN LOS ANGELES COUNTY

Brad Sears, Christian Cooper,
*Fariba S. Younai & Tom Donohoe**

Thirty years after HIV was first identified, for the majority of those infected in the United States, effective combination therapies to combat HIV have turned the disease into a manageable chronic condition. But HIV discrimination has still proven intractable in the field of health care. For example, a series of studies has revealed that 46 percent of skilled nursing facilities, 55 percent of OB/GYNs, and 26 percent of plastic surgeons in Los Angeles County refuse to provide services to any HIV-positive patient, in violation of state and federal law.

This Study examines HIV discrimination among dentists in Los Angeles County. For people living with HIV/AIDS (PLWHA), dental care is particularly important because problems in the mouth may be the first symptoms of an HIV infection and can also signify disease progression; routine, proper dental care can have a significant impact on oral and general health. This Study reveals that 5 percent of dentists

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in Los Angeles County have a blanket policy of refusing to accept any HIV-positive patient, which is substantially lower than the finding for other health care providers. However, this Study also suggests that PLWHA who are poor and the most vulnerable, including women and people of color, face higher rates of discrimination. This Study goes on to explain that dentists can effectively and safely treat PLWHA, and it identifies why they are legally and ethically obligated to provide such care. After reviewing prior social science research on HIV discrimination by dentists, this Study presents its methodology and findings. Finally, it concludes by exploring potential reasons for why the documented discrimination rate is lower for dentists than it is for other health care providers in Los Angeles County, and it argues that future enforcement and education efforts should be targeted toward specific categories of dentists.

TABLE OF CONTENTS

I. INTRODUCTION 912
II. EXECUTIVE SUMMARY 913
III. MEDICAL BACKGROUND 916
IV. LEGAL AND ETHICAL DUTY TO TREAT PERSONS LIVING WITH HIV/AIDS 919
A. Legal Duty to Treat Persons Living with HIV/AIDS 919
B. Ethical Responsibility to Treat Persons Living with HIV/AIDS 924
V. RESEARCH DOCUMENTING HIV DISCRIMINATION BY DENTISTS AND OTHER HEALTH CARE PROVIDERS 926
A. Surveys of Dentists 926
B. Surveys of Dental School Faculty and Students 928
C. Surveys of Persons Living with HIV/AIDS 929
VI. METHODOLOGY 931
VII. RESULTS 937
A. Summary of Findings 937
B. Reasons Provided for Responses 940
1. Statements Accompanying "Yes" Responses 940
2. Reasons Given for "No" Responses 942
3. Reasons Given for Different Treatment Responses 943
VIII. DISCUSSION 945
IX. CONCLUSION 955

APPENDIX A: DELTA DENTAL ENGLISH CALLS SCRIPT 957
APPENDIX B: DELTA DENTAL SPANISH CALLS SCRIPT 959
APPENDIX C: DENTI-CAL CALLS SCRIPT 961

I. INTRODUCTION

When HIV was first identified thirty years ago, it created two great epidemics: one medical and the other of widespread fear and discrimination. Fifteen years later, the effective combination therapies to combat HIV became widely available. For those who have access to them, these therapies have turned the disease into a manageable chronic condition.

However, HIV discrimination has proven more intractable, particularly in the field of health care. For example, in a series of studies using UCLA law students posing as HIV-positive patients, we have found that 46 percent of skilled nursing facilities, 55 percent of OB/GYNs, and 26 percent of plastic surgeons in Los Angeles County refuse to provide services to any HIV-positive patient, in violation of state and federal law. Those studies were not conducted in the 1980s but between 2003 and 2007.

This Study examined HIV discrimination among dentists in Los Angeles County. We find that only 5 percent of dentists had a blanket policy of refusing to accept any HIV-positive patient. While having one in twenty practices closed to HIV-positive patients is far from ideal, the overall finding is substantially lower than that for other health care providers. Why? Although more research is needed, this Study suggests that, like HIV disease, HIV discrimination can be effectively combated through a combination of approaches that attack it in different ways. For over two decades in Los Angeles County, civil rights lawyers, government enforcement agencies, and educators have each played an important part in addressing HIV discrimination among dentists.

While the combination of civil rights litigation, government enforcement, and education efforts has reduced discrimination among dentists, like HIV itself, there are also reservoirs that are more difficult to reach. Our Study shows that HIV discrimination is higher in certain parts of Los Angeles, such as the San Gabriel Valley and South Central L.A., areas with higher proportions of HIV-positive people who are low-income, female, and people of color. We also find that HIV discrimination is higher among dentists who are older or who attended dental school outside the United States. These dentists are less likely to have received formal

education about treating HIV-positive patients. Our Study suggests that future enforcement and education efforts should be targeted toward these dentists.

Breaking with the traditional law review format, Part II provides an executive summary of the Study's findings for quick use and easy reference. We hope that it will facilitate the use of the Study in a variety of policy and legal contexts. Part III briefly discusses the medical background supporting that dentists can effectively and safely treat people living with HIV/AIDS (PLWHA), and Part IV presents the well-established legal and ethical obligations for dentists to provide such care. Part V reviews prior social science research on HIV discrimination by dentists, and Parts VI and VII present the Study's methodology and findings. The final part discusses these findings and explores potential reasons why HIV discrimination by dentists in Los Angeles County is lower than the rates of discrimination documented among other health care providers.

II. EXECUTIVE SUMMARY

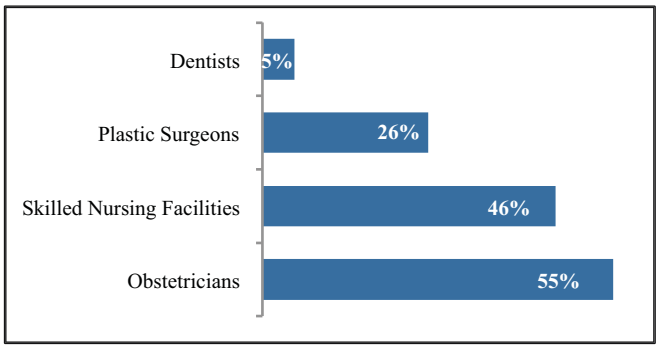
This Study used trained testers to measure the level of HIV discrimination by dentists in Los Angeles County. In total, 612 dentists' offices were contacted in 2007 and 2008. We find that levels of HIV discrimination are lower in dental care than they are in other health care services in Los Angeles County. However, levels of discrimination are twice as high for PLWHA who had Denti-Cal, and three times higher for those living in the San Gabriel Valley and South Service Planning Areas. Discrimination was also higher among older dentists and dentists who did not go to dental school in the United States. The findings suggest the need for more targeted education efforts to ensure equal access to dental services for all PLWHA.

Key findings include:

- Five percent of dental offices contacted (twenty-nine) had an unlawful blanket policy of refusing dental services to any PLWHA.
- An additional 5 percent of dental providers (thirty-two) indicated they would treat PLWHA differently than other patients in ways that could potentially violate state and federal antidiscrimination laws.

- Factors influencing the rates of discrimination were the caller's type of dental insurance, the geographic location of the dental practices, and when and where the dentist graduated from dental school.
- Ninety percent of all dental offices contacted in Los Angeles County (551) responded that they would treat PLWHA.

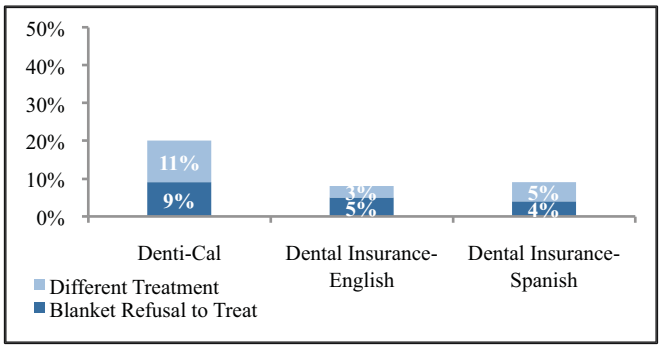
FIGURE 1. HIV Discrimination by Health Care Providers in Los Angeles County, Blanket Refusal to Treat Any Person Living with HIV/AIDS



Specific findings include:

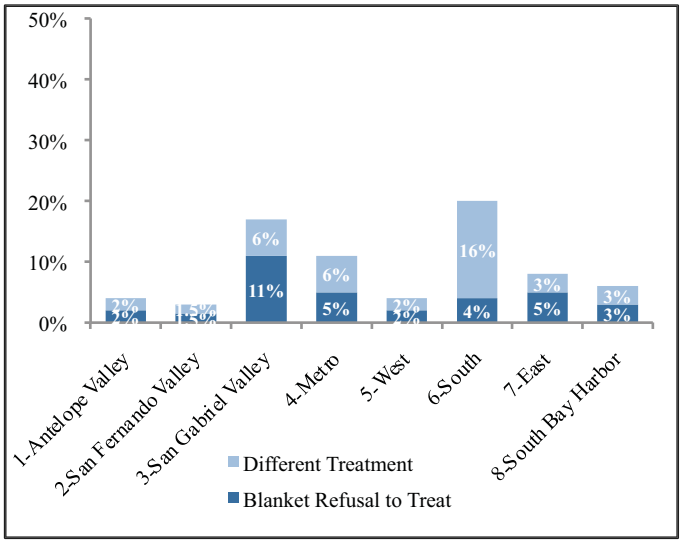
- Rates of discrimination were twice as high when testers indicated that they had Denti-Cal (a public benefit for poorer patients that was largely discontinued by California in 2009) as opposed to private dental insurance.

FIGURE 2. HIV Discrimination by Dentists in Los Angeles County, by Language Spoken by Patient and Type of Dental Insurance



- Rates of discrimination varied significantly in different parts of Los Angeles County, and rates were higher in areas of the county with higher rates of HIV-infection and with more low-income people, people of color, and women among the infected. The Los Angeles County Department of Public Health has divided Los Angeles into eight geographical regions, called Service Planning Areas (SPAs). When the blanket policies of refusal of service to all PLWHA are combined with differences in treatment that could be unlawful discrimination, the frequency of such responses was significantly higher for providers in the South (20 percent) and San Gabriel Valley (17 percent) SPAs.
- Eleven percent of providers in the San Gabriel Valley SPA indicated that they would not accept any PLWHA. This SPA accounted for one-third of all the blanket policies of refusal of service identified in the Study.

FIGURE 3. HIV Discrimination by Dentists in Los Angeles County by Service Provider Area (SPA)



- While only 68 percent of the dentists in the Study overall graduated prior to 1988, almost 90 percent of dentists whose responses were classified as discriminatory or potentially discriminatory graduated before 1988. In fact,

only two dentists who graduated from dental school after 1988 gave a response classified as "no" or "different treatment."

- While only one-fourth of the dentists in the Study graduated from a dental school outside of the United States, almost 40 percent of the "no" and "different treatment" responses were given by dentists who went to dental schools in other countries.
- The most common reasons for refusing service to all PLWHA were as follows:
    - The office was not equipped to treat PLWHA (38 percent).
    - Extra infection control precautions would be required (7 percent).
    - The office had never treated an HIV-positive patient before (7 percent).
- Over half of the dentists who refused services to all PLWHA (52 percent) told the caller they should seek services from another provider, a clinic, or a hospital.
- The rate of dentists having unlawful blanket policies of refusing service to all PLWHA is lower than that of other health care providers that have been studied. Similar studies of health care providers in Los Angeles County conducted between 2003 and 2006 found that 55 percent of obstetricians, 46 percent of skilled nursing facilities, and 26 percent of plastic surgeons had such policies.

III. MEDICAL BACKGROUND

Routine dental care is important for PLWHA. Such care can be provided with insignificant risks to dentists and their staff, and they have a well-established legal and ethical obligation to provide such care.

Routine dental care for PLWHA allows for early identification of inflammatory conditions and infections that, if untreated, can have significant impact on oral and general health and quality of life for PLWHA. In addition, problems in the mouth may be the first symptom of HIV infection, and they can also signify progression of

the disease.[1] Between 30 percent and 80 percent of PLWHA will have at least one oral manifestation at some time during the course of their infection.[2] Earlier in the AIDS epidemic, "oral lesions were frequently used as defining criteria for AIDS diagnosis and disease progression."[3]

The development and more widespread use of increasingly effective antiretroviral regimens, commonly referred to as highly active antiretroviral therapy (HAART), has substantially increased life expectancy and reduced the prevalence and severity of many HIV-associated oral lesions.[4] Although the frequencies of oral lesions, in the era of HAART, may vary, dental care for PLWHA in the United States has shifted from the management and treatment of these types of lesions "to providing overall comprehensive dental care as seen in the general population."[5] Antiretroviral agents and other medications have also meant a new set of issues for PLWHA.[6] For example, one of the most frequent problems linked with HIV-disease management is dry mouth. If left unaddressed, dry mouth can lead to dental decay, periodontal disease, and other problems.

In data collected in Los Angeles County during 2007 and 2008 from the Centers for Disease Control and Prevention's (CDC) Medical Monitoring Project, PLWHA reported assistance finding dental services as their top supportive-services resource need for the previous twelve months. Supportive services are services other than primary medical care. The need for dental services rated above all other supportive services, including HIV case management, mental health counseling, and transportation support.[7] In terms of unmet

1. David A. Reznick, *Oral Manifestations of HIV Disease*, 13 TOPICS HIV MED. 143, 143 (2005).

2. These oral manifestations include oral candidisis or thrush, Kaposi's sarcoma tumors, hairy leukoplakia, gingivitis, and periodontitis. *Id.*

3. Shilpa Kolhatkar et al., *Bilateral Vestibuloplasty Utilizing Palatal Soft Tissue Grafts in an HIV-Positive Patient*, 37 J. CAL. DENTAL ASS'N 467, 467 (2009).

4. *Id.*

5. *Id.*

6. Conditions such as xerostomia, or dry mouth, salivary gland disease, hyperlipidemia, increased risk for cardiovascular disease, diabetes, and osteonecrosis, have all been associated with HAART and can result in problems in the mouth, including "the risk of tooth loss due to increases in caries and periodontal disease." *Id.*

7. Amy Rock Wohl et al., *Barriers and Unmet Need for Supportive Services for HIV Patients in Care in Los Angeles County, California*, 25 AIDS PATIENT CARE & STDS 525, 530 (2011).

needs for the previous twelve months, assistance finding dental services ranked second only to shelter services.[8]

Dentists can provide routine dental care to PLWHA without specialized training and with insignificant risk when using standard infection-control procedures.[9] As the author of an article published in the *Journal of the California Dental Association* concluded in 2001,

> One golden rule can be applied in every situation: Treat a person with HIV/AIDS as one would treat anyone else. In other words, HIV itself is not a valid reason to deny, delay, or alter treatment . . . . [T]reatment modifications should be based on manifestations of HIV, not on HIV itself . . . . An asymptomatic patient with HIV should be treated the same as any other dental patient. The vast majority of dental patients with HIV require no treatment modifications.[10]

In 2003, the CDC developed a set of guidelines specifically for infection control in dentistry based on the standard precautions for all health care workers.[11] The CDC emphasized in these guidelines that the risk of occupational transmission for dentists is "extremely low," with no reports of occupational HIV transmission to a dental care provider since 1992.[12] The American Dental Association concludes in its policy statement that if dentists follow the CDC guidelines, the HIV-positive individual "can be safely treated in the private dental office," rendering denial of treatment based on HIV status unacceptable.[13]

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8. *Id.*

9. Eve Cuny & William M. Carpenter, *Occupational Exposure to Blood and Body Fluids: New Postexposure Prophylaxis Recommendations*, 26 J. CAL. DENTAL ASS'N 261, 265–66 (1998) (noting the minimal risk of occupational seroconversion to dental health providers because many "high risk" exposure situations are "not generally associated with dental exposures" and pointing out that the "relatively low risk of dental exposures is further illustrated by the fact that of the 49 documented occupational transmissions to date, none were among dental health care workers").

10. Ann M. Lyles, *What the Dentist Should Know About a Patient with HIV/AIDS*, 29 J. CAL. DENTAL ASS'N 158, 167 (2001).

11. WILLIAM G. KOHN ET AL., CTRS. FOR DISEASE CONTROL & PREVENTION, GUIDELINES FOR INFECTION CONTROL IN DENTAL HEALTH-CARE SETTINGS (2003), *available at* http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5217a1.htm.

12. *Id.* at 14.

13. *Policy Statement on Bloodborne Pathogens, Infection Control and the Practice of Dentistry*, AM. DENTAL ASS'N, http://www.ada.org/1851.aspx (last updated Mar. 15, 2005). Similarly, the California Dental Board has established its own set of precautions for infection control to be used when treating "all patients regardless of their diagnoses or personal infectious status." CAL. CODE REGS. tit. 16, § 1005(a)(1) (2010).

For these reasons, it is unlawful for dentists to deny patients dental care solely because the patients are HIV-positive, and professional associations for dentists have determined that it is unethical for dentists to have a blanket policy of refusing to treat PLWHA.

IV. LEGAL AND ETHICAL DUTY TO TREAT PERSONS LIVING WITH HIV/AIDS

A. Legal Duty to Treat Persons Living with HIV/AIDS

In the highly publicized 1998 case of *Bragdon v. Abbott*,[14] the U.S. Supreme Court determined that PLWHA, even if asymptomatic, were covered by the Americans with Disabilities Act.[15] The case involved a dentist who refused to provide services at his office to a woman living with HIV.[16] Since then, a number of federal and state courts have applied the Americans with Disabilities Act and state disability discrimination laws to dentists who have refused to provide services to PLWHA. The types of discrimination found unlawful in these cases include:

- having a blanket policy of referring out all PLWHA;[17]
- denying treatment to a patient who told the dentist that he had been exposed to the AIDS virus but was unsure if he contracted it;[18]
- referring patients to "special clinics" or other providers because of their HIV status;[19]
- asking a patient to submit to an HIV test prior to treating him;[20] and
- terminating an office space lease of a dentist for providing care to PLWHA.[21]

In addition, government enforcement agencies, such as the Office of Civil Rights of the U.S. Department of Health and Human

14. 524 U.S. 624 (1998).
15. *Id.* at 641.
16. *Id.* at 629.
17. United States v. Morvant, 898 F. Supp. 1157, 1159 (E.D. La. 1995).
18. Cahill v. Rosa, 674 N.E.2d 274, 275 (N.Y. 1996).
19. D.B. v. Bloom, 896 F. Supp. 166, 169 (D.N.J. 1995); Beaulieu v. Clausen, 491 N.W.2d 662, 664 (Minn. Ct. App. 1992).
20. Merchant v. Kring, 50 F. Supp. 2d 433, 434 (W.D. Pa. 1999).
21. Barton v. N.Y.C. Comm'n on Human Rights, 542 N.Y.S.2d 176, 177 (N.Y. App. Div. 1989).

Services, have also found discrimination by dentists against PLWHA to be unlawful. The types of discrimination found unlawful in these cases include:

- turning away two potential patients because they were HIV-positive;[22]
- denying continued treatment to a patient after the patient revealed that he was HIV-positive;[23]
- telling a patient to find treatment elsewhere after she told the dentist she had AIDS;[24] and
- refusing to perform a root canal for an HIV-positive patient.[25]

In general, California state[26] and federal[27] disability discrimination laws prohibit health care providers from refusing services to PLWHA. These laws protect PLWHA from discrimination from the moment of infection, including those who are asymptomatic.[28] They prohibit the denial of dental services to

22. *Enforcement Highlights: Fighting Discrimination Against Persons with HIV/AIDS*, CIVIL RIGHTS DIV., U.S. DEP'T OF JUSTICE, http://www.ada.gov/hivreprt.txt (last visited Nov. 21, 2011).

23. *Id.*

24. Cheryl P. Weinstock, *Public and Private Toll of Living with AIDS*, N.Y. TIMES, Oct. 21, 1990, at 12LI19.

25. Gwen Ifill, *Dentist Faces Fine over AIDS Patient*, N.Y. TIMES, Aug. 7, 1991, at A14.

26. California state laws that prevent health care providers from discriminating against persons living with HIV/AIDS include both the Unruh Civil Rights Act, CAL. CIV. CODE § 51 (West 2012), and sections 54 and 54.1 of the California Civil Code. Both laws incorporate violations of the Americans with Disabilities Act (ADA).

27. Title III of the Americans with Disabilities Act, 42 U.S.C. §§ 12181(7)(F), 12182(a) (2006); 28 C.F.R. § 36.104(6) (2010). Health care providers who receive "federal financial assistance," including payments under Medicaid and Medicare, are also prohibited from denying services to HIV-positive patients by section 504 of the Rehabilitation Act of 1973. 29 U.S.C. § 794(a) (2006).

28. Bragdon v. Abbott, 524 U.S. 624, 641–42 (1998) (holding that disability protections under Title III of the ADA protect persons living with HIV disease). While some courts have questioned whether people who are HIV-positive but "asymptomatic" are covered under the ADA, *see* Lisa Taylor Hudson, *The Duty to Treat Asymptomatic HIV-Positive Patients or Face Disability Discrimination Under* Abbott v. Bragdon*: The Scylla and Charybdis Facing Today's Dental and Health Care Providers*, 33 U. RICH. L. REV. 665, 666 (1999) (discussing complications created by the way in which *Bragdon* extended coverage to persons with HIV/AIDS); Equal Emp't Opportunity Comm'n v. Lee's Log Cabin, Inc., 546 F.3d 438 (7th Cir. 2008), the ADA Amendments Act of 2008 (ADAAA) made it easier for HIV-positive individuals to show that they are within the purview of the ADA because it liberalized the definition of "disability." *See* ADA Amendments Act of 2008, Pub. L. No. 110-325, 122 Stat. 3553 (to be codified at 42 U.S.C. § 12101). Some changes that the ADAAA made to the ADA that may be significant for HIV-positive individuals include a more expansive list of "major life activities" (which covers, among other things, the "operation of major bodily functions") and broader protection offered to those "regarded as" disabled. *See id.* The U.S. Department of Justice (DOJ)

PLWHA unless (1) dentists would not perform the requested service for a person who was HIV-negative and a legitimate referral is warranted; or (2) the requested services would pose a "direct threat" to the safety of the health care providers or the patient. In order to make a lawful referral or determine that a patient poses a direct threat, the health care provider must make an individualized inquiry about the health condition of the specific patient in light of the specific services being requested. A blanket policy of refusing services to all PLWHA is clearly unlawful under state and federal laws.

Under the Americans with Disabilities Act of 1990 (ADA),[29] a health care provider may refer a PLWHA to another provider if that individual is seeking treatment outside of the provider's specialization or if the provider would make a similar referral for an HIV-negative person seeking similar services.[30] In order to make a

and the Equal Employment Opportunity Commission (EEOC) have issued regulations and guidance on the ADAAA clarifying that HIV (even when asymptomatic) is a disability covered by the ADA. 28 C.F.R. § 36.104 (2010) (DOJ); 29 C.F.R. § 1630.2(j)(3)(ii), (iii) (2011) (EEOC). In administrative regulations issued by the DOJ implementing the public accommodations provisions of the ADAAA, HIV infection (whether symptomatic or asymptomatic) is a per se impairment. 28 C.F.R. § 36.104. In administrative guidance, the DOJ further explains that HIV infection "substantially limits a major life activity, either because of its actual effect on the individual with HIV disease or because the reactions of other people to individuals with HIV disease cause such individuals to be treated as though they are disabled." 28 C.F.R. § 36, app. B at 704 (2010) (citing Memorandum from Douglas W. Kmiec, Acting Assistant Attorney Gen., Office of Legal Counsel, U.S. Dep't of Justice, to Arthur B. Culvahouse, Jr., Counsel to the President (Sept. 27, 1988), *reprinted in Americans with Disabilities Act: Hearing Before the Subcomm. on the Handicapped of the S. Comm. on Labor & Human Res.*, 101st Cong. 346 (1989)). In administrative regulations implementing the employment provisions of the ADAAA, the EEOC has stated that HIV infection is an example of an impairment that "will, in virtually all cases, result in a determination of coverage" because HIV infection "substantially limits immune function." 29 C.F.R. § 1630.2(j)(3)(ii), (iii). In 2011, the Office of Federal Contract Compliance Programs in the Department of Labor launched a system for prioritizing and fast-tracking cases of employment discrimination based on HIV/AIDS status. THE WHITE HOUSE, NATIONAL HIV/AIDS STRATEGY: IMPLEMENTATION UPDATE 4 (2011), *available at* http://www.whitehouse.gov/sites/default/files/uploads/hiv_aids_july_2011.pdf. Additionally, discrimination on the basis of HIV status is explicitly prohibited under California law. *See* CAL. HEALTH & SAFETY CODE § 120990(f) (West 2008) (stating that California's disability discrimination laws "prohibit discrimination against individuals who are living with HIV, or who test positive for HIV, or are presumed to be HIV-positive"). The City of Los Angeles has its own ordinance that explicitly prohibits HIV discrimination. L.A., CAL., CODE § 45.84 (2010).

29. 42 U.S.C. §§ 12101–12213 (2006); 47 U.S.C. §§ 225, 611 (2006).

30. 28 C.F.R. § 36.302(b) (2010) ("(b) Specialties—(1) General. A public accommodation may refer an individual with a disability to another public accommodation, if that individual is seeking, or requires, treatment or services outside of the referring public accommodation's area of specialization, and if, in the normal course of its operations, the referring public accommodation would make a similar referral for an individual without a disability who seeks or requires the

lawful referral under the ADA, these providers must make "an individualized inquiry into the patient's condition" and the specific services requested.[31]

A health care provider may refuse services to PLWHA if providing those services would pose a "direct threat" to the patient or to others.[32] The provider has the burden of proving that the patient's

same treatment or services. (2) Illustration—medical specialties. A health care provider may refer an individual with a disability to another provider, if that individual is seeking, or requires, treatment or services outside of the referring provider's area of specialization, and if the referring provider would make a similar referral for an individual without a disability who seeks or requires the same treatment or services. A physician who specializes in treating only a particular condition cannot refuse to treat an individual with a disability for that condition, but is not required to treat the individual for a different condition."); *see, e.g.*, United States v. Morvant, 898 F. Supp. 1157 (E.D. La. 1995) (holding that a dentist who has practiced general dentistry for many years may not refuse to clean the teeth of individual patients on the basis of their HIV-positive status, instead referring them to another dentist who treats such patients, because professional dental associations (1) recognize neither teeth-cleaning nor the treatment of HIV-positive patients as specialties; (2) have defined universal precautions for the protection of patients, dentists, and their staff from blood-borne pathogens; and (3) in fact denounce such referrals as a breach of professional and ethical obligations).

31. Lesley v. Chie, 250 F.3d 47, 55 (1st Cir. 2001) (holding that a gynecologist lawfully referred an HIV-positive patient where he made a fact-specific and individualized inquiry before making his decision, and where his decision was confirmed by independent and knowledgeable persons at the time).

32. *See* Chevron U.S.A. Inc. v. Echazabal, 536 U.S. 73 (2002) (upholding an EEOC regulation extending a direct threat defense to a "threat to self"). The DOJ provides the following guidance on what constitutes a "direct threat":

> 7. Q: Can a public accommodation exclude a person with HIV/AIDS because that person allegedly poses a direct threat to the health and safety of others? A: In almost every instance, the answer to this question is no. Persons with HIV/AIDS will rarely, if ever, pose a direct threat in the public accommodations context. A public accommodation may exclude an individual with a disability from participation in an activity, if that individual's participation would result in a direct threat to the health or safety of others. "Direct threat," however, is defined as a "significant risk to the health or safety of others" that cannot be eliminated or reduced to an acceptable level by reasonable modifications to the public accommodation's policies, practices, or procedures, or by the provision of appropriate auxiliary aids or services. The determination that a person poses a direct threat to the health or safety of others may not be based on generalizations or stereotypes about the effects of a particular disability; it must be based on an individual assessment that considers the particular activity and the actual abilities and disabilities of the individual. The individual assessment must be based on reasonable judgment that relies on current medical evidence.

The guidance then provides the following example of unlawful refusal to treat:

> A gynecologist's refusal to treat an HIV-positive woman would be a violation. Health care providers are required to treat all persons as if they are infectious for HIV and other bloodborne pathogens, and must use universal precautions (gloves, mask, gown, etc.) to protect themselves from the transmission of infectious diseases. Failure to treat a person who acknowledges her HIV-positive status would be a violation, because so long as the physician utilizes universal precautions, it is safe to treat persons with HIV/AIDS.

disability presents a significant threat that cannot be eliminated by reasonable accommodation—changes in the provider's practices or procedures that would substantially reduce or eliminate the threat.[33] The health care provider must base his or her determination that an HIV-positive patient poses a direct threat on an individualized assessment of the threat.[34] A health care provider's failure to make an individualized assessment before denying services invariably results in a finding of discrimination.[35] Moreover, the health care provider's assessment of the direct threat must be "based on reasonable medical judgments given the state of medical knowledge."[36] The assessment cannot be based on stereotypic notions about PLWHA, even if such notions are maintained in good faith,[37] or on ignorance because of the provider's own failure to keep up with the current medical literature.[38]

Questions and Answers: The Americans with Disabilities Act and Persons with HIV/AIDS, DISABILITY RIGHTS SECTION, CIVIL RIGHTS DIV., U.S. DEP'T OF JUSTICE, http://www.ada.gov/pubs/hivqanda.txt (last visited Nov. 22, 2011).

33. 42 U.S.C. § 12182(b)(3) ("Nothing in this subchapter shall require an entity to permit an individual to participate in or benefit from the goods, services, facilities, privileges, advantages and accommodations of such entity where such individual poses a direct threat to the health or safety of others. The term 'direct threat' means a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids or services.").

34. 28 C.F.R. § 36.208(c) (2002).

35. Shultz v. Hemet Youth Pony League, Inc., 943 F. Supp. 1222, 1225–26 (C.D. Cal. 1996); Anderson v. Little League Baseball, Inc., 794 F. Supp. 342, 345–46 (D. Ariz. 1992); *see also Morvant*, 898 F. Supp. at 1162–65 (establishing that a dentist's referral of HIV-positive patients to another practitioner who supposedly specializes in treating HIV-positive dental patients may be a pretext for unlawful discrimination if neither the dentist nor the dentist's staff even examines the patients' mouths).

36. Federal regulations implementing the ADA state:

> In determining whether an individual poses a direct threat to the health or safety of others, a public accommodation must make an individualized assessment, based on reasonable judgment that relies on current medical knowledge or on the best available objective evidence, to ascertain: the nature, duration, and severity of the risk; the probability that the potential injury will actually occur; and whether reasonable modifications of policies, practices, or procedures will mitigate the risk.

28 C.F.R. § 36.208(c). In codifying "direct threat" in the regulations, Congress specifically adopted the four-part test established by the Supreme Court in *School Board of Nassau County v. Arline*, 480 U.S. 273, 287–88 (1987).

37. Bragdon v. Abbott, 524 U.S. 624, 649 (1998) ("The existence, or nonexistence, of a significant risk must be determined from the standpoint of the person who refuses the treatment or accommodation.").

38. *Morvant*, 898 F. Supp. at 1166; *see also* Abbott v. Bragdon, 912 F. Supp. 580, 595 (D. Me. 1995) (finding that a dentist's belief that an HIV-positive patient posed a direct threat to him and his staff could not be supported based upon the available medical knowledge and that implementation of universal precautions would significantly mitigate any risk posed by the

For example, in a case that settled in 2003, a New Jersey dentist was alleged to have told an HIV-positive patient that he could not work on the patient's broken tooth because of "health concerns," because his staff would not feel safe working with the patient, and because the office lacked sterilization equipment necessary to provide care for PLWHA.[39] The dentist offered to provide services after hours without his staff, although he cautioned that doing so would take longer and would be less comfortable, and offered to provide a referral to a clinic that was willing to treat PLWHA.[40] While the dentist settled the case, if the allegations were true, the refusal to provide service and the suggestion that treatment occur without staff after hours would have been unlawful discrimination, and none of the justifications offered for the difference in treatment would have been a legally sufficient defense. Notably, the discriminatory preferences of a dentist's staff do not justify discriminatory treatment by the dentist.[41]

Thus, when a health care provider would provide similar services to an HIV-negative patient, he or she cannot lawfully deny services to an HIV-positive patient or refer the patient to another provider based on a blanket policy of denying services to all PLWHA. The provider must first make an individualized inquiry into the patient's condition and the services requested.

B. Ethical Responsibility to Treat Persons Living with HIV/AIDS

The American Dental Association, the California Dental Association,[42] and the World Dental Federation[43] have incorporated

patient), *aff'd*, 107 F.3d 934 (1st Cir. 1997), *cert. granted in part*, 522 U.S. 991 (1997), *vacated*, 524 U.S. 624, 649 (1998) ("[A] health care professional . . . [has] the duty to assess the risk of infection based on the objective, scientific information available to him and others in his profession. His belief that a significant risk existed, even if maintained in good faith, would not relieve him from liability.").

39. *N.J. Dentist Privately Settles HIV Bias Case*, 11 HEALTH L. LITIG. REP. 11 (2003).

40. *Id.*

41. *Morvant*, 898 F. Supp. at 1165–67 (holding that a dentist discriminated against a PLWHA in violation of the ADA for referring the patient to another facility because the dentist feared that he would lose staff if he had to treat the PLWHA).

42. The California Dental Association's Code of Ethics states:

> A dentist has the obligation to comply with all state and federal laws and regulations. It is unethical for a dentist to violate any law of the state of California relating to the practice of dentistry or to engage in activity for which the dentist may be reprimanded,

dentists' responsibility to provide care to PLWHA into their ethical codes of conduct. Failure to abide by these standards can result in censure, suspension, or expulsion from the relevant association.[44] For example, the American Dental Association's ethical standards of conduct, as set forth in the Principles of Ethics and Code of Professional Conduct and the attendant advisory opinions, specifically address the need to provide care to PLWHA, stating:

> A dentist has the general obligation to provide care to those in need. A decision not to provide treatment to an individual because the individual [has AIDS or is HIV seropositive], based solely on that fact, is unethical. Decisions with regard to the type of dental treatment provided or referrals made or suggested should be made on the same basis as they are made with other patients. As is the case with all patients, the individual dentist should determine if he or she has the 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.[45]

In Los Angeles County, the Pacific AIDS Education and Training Center's (PAETC) Dental Steering Committee developed dental practice guidelines that have been officially adopted by the

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> disciplined, or sentenced by final action of any court or other authority of competent jurisdiction, when such action reflects unfavorably on dentists or the dental profession.

CAL. DENTAL ASS'N, CODE OF ETHICS § 4 (2005), *available at* http://www.cda.org/page/CDA_Code_of_Ethics#4. As discussed, it is a violation of the ADA for a dentist to discriminate against a person living with HIV and a violation of several provisions of California law under which HIV/AIDS is considered a per se disability. *See supra* notes 26–27. As such, member dentists of the California Dental Association are ethically obligated to provide care to people living with HIV.

43. The FDI World Dental Federation, one of the oldest professional organizations in the world, *About Us*, FDI WORLD DENTAL FED'N, http://www.fdiworldental.org/about-us (last visited Aug. 16, 2011), states in its code of ethics, "Patients with HIV and other blood borne infections should not be denied oral health care solely because of their infections." FDI WORLD DENTAL FED'N, DENTAL ETHICS MANUAL 48 (2007) (quoting FDI WORLD DENTAL FED'N, POLICY STATEMENT ON HUMAN IMMUNODEFICIENCY VIRUS INFECTION AND OTHER BLOOD BORNE INFECTIONS), *available at* http://www.fdiworldental.org/c/document_library/get_file?uuid=3e946266-5fbc-485c-b28a-d2f0d89ab736&groupId=10157.

44. AM. DENTAL ASS'N, PRINCIPLES OF ETHICS AND CODE OF PROFESSIONAL CONDUCT 17 (2011), *available at* http://www.ada.org/sections/about/pdfs/code_of_ethics_2011.pdf.

45. *Id.* at 8.

Los Angeles County Commission on HIV.[46] Entitled "Practice Guidelines for the Treatment of HIV Patients in General Dentistry," this document provides an overview of the legal and ethical issues in treating PLWHA and has been disseminated widely through PAETC trainings to dentists and dental hygienists in Los Angeles County.[47] It specifically states:

> It is a violation of the Americans with Disabilities Act, California law, and the law of some local jurisdictions, and of the ethical standards of the California Dental Association and the American Dental Association to refuse to care for patients with HIV because of fear of the risk of infection.[48]

V. RESEARCH DOCUMENTING HIV DISCRIMINATION BY DENTISTS AND OTHER HEALTH CARE PROVIDERS

Since the early days of the AIDS epidemic, researchers have documented discrimination against PLWHA in the provision of dental care. Although the research indicates that the level of discrimination has declined since the first published studies in the late 1980s, this research consistently finds that some dentists are unwilling to provide care to PLWHA. This part summarizes the three main types of studies that have measured HIV discrimination in dental care: surveys of dentists, surveys of dental school faculty and students, and surveys of PLWHA.

A. Surveys of Dentists

A number of studies published between 1986 and 1995 sought to measure the level of HIV discrimination in dental care by surveying dentists.[49] These studies found that between 33 percent and

46. L.A. CNTY. COMM'N ON HIV HEALTH SERVS., PRACTICE GUIDELINES FOR THE TREATMENT OF HIV PATIENTS IN GENERAL DENTISTRY 3 (2003), *available at* http://hiv commission-la.info/practice.pdf.

47. *Id.*

48. *Id.* at 12.

49. *See* M. Elizabeth Bennett et al., *Dentists' Attitudes Toward the Treatment of HIV-Positive Patients*, 126 J. AM. DENTAL ASS'N 509 (1995); Barbara Gerbert, *AIDS and Infection Control in Dental Practice: Dentists' Attitudes, Knowledge, and Behaviors*, 114 J. AM. DENTAL ASS'N 311 (1987); Herbert M. Hazelkorn, *The Reaction of Dentists to Members of Groups at Risk of AIDS*, 119 J. AM. DENTAL ASS'N 611 (1989); Carol Kunzel & Donald Sadowsky, *Assessing HIV-Related Attitudes and Orientations of Male and Female General Dentists*, 126 J. AM. DENTAL ASS'N 862 (1995); Donald Sadowsky & Carol Kunzel, *A Model Predicting Dentists'*

80 percent of dentists did not want to provide care to patients who were HIV-positive or at risk of being HIV-positive.[50] Even when dentists acknowledged that they had a responsibility or legal duty to treat PLWHA, they often expressed that they did not want to.[51] Reasons identified for not providing care included fear of infection,[52] concerns about losing other patients,[53] fear for their staff,[54] homophobia,[55] and a lack of prior experience treating PLWHA.[56]

For example, a survey of 671 members of the American Dental Association published in 1995[57] found that 33 percent of respondents were not willing to treat PLWHA, 84 percent believed it was their right to choose whether to provide care to PLWHA, and 75 percent were unwilling to "display" a willingness to provide care to PLWHA for fear of losing other patients.[58] When asked about their fear of occupational transmission of HIV, 80 percent agreed that HIV makes dentistry a "high-risk job," and 31 percent believed they would eventually acquire HIV if they often treated PLWHA.[59] Thirty-two percent said they would not choose to go into dentistry again if they had the choice, due to fear of HIV.[60]

One of these studies identified older dentists as more likely to discriminate[61] and another study identified female dentists as more likely to discriminate.[62] In contrast, one study found that the most important determinant of a dentist's willingness to treat PLWHA was his or her personal feelings of safety[63] and that another factor

Willingness to Treat HIV-Positive Patients, 5 J. ACQUIRED IMMUNE DEFICIENCY SYNDROMES 701 (1992); A. Carl Verrusio et al., *The Dentist and Infectious Diseases: A National Survey of Attitudes and Behavior*, 118 J. AM. DENTAL ASS'N 553 (1989).

50. *See* sources cited *supra* note 49.
51. Gerbert, *supra* note 49, at 313.
52. *Id.*
53. *Id.*
54. *Id.*
55. Hazelkorn, *supra* note 49, at 613.
56. Sadowsky & Kunzel, *supra* note 49, at 703–04.
57. Bennett et al., *supra* note 49.
58. *Id.* at 510 tbl.1, 511 tbl.2.
59. *Id.* at 510 tbl.1.
60. *Id.*
61. Verrusio et al., *supra* note 49.
62. Kunzel & Sadowsky, *supra* note 49.
63. Sadowsky & Kunzel, *supra* note 49, at 703; *see* Kunzel & Sadowsky, *supra* note 49, at 862.

associated with dentists' willingness to treat PLWHA was recognition that they had already treated PLWHA.[64]

A more recent study measured changes in dental care providers' knowledge, attitudes, beliefs, and behaviors with regard to providing care for PLWHA before and after taking a one-to-four-day continuing-education course.[65] The study was conducted with eighty-six dentists, dental hygienists, and dental assistants from Southern California who completed the clinical training between 1992 and 2003.[66] In terms of attitudes and beliefs, the study found that the participants in trainings began with a "moderately high baseline level of positive HIV-related attitudes/beliefs."[67] After the training, 86 percent of the participants had positively changed their attitudes and beliefs.[68] In addition, 86 percent of dentists in the sample had already treated HIV-positive patients before the training program, and an additional 9 percent reported treating HIV-positive patients six weeks after the training program.[69] However, the study did note that the dental workers who voluntarily enrolled in the continuing education program may be more interested in treating PLWHA.[70]

B. Surveys of Dental School Faculty and Students

Over the past two decades a number of surveys have also measured discriminatory attitudes against PLWHA by dental school faculty and students. These studies have found that between one-fourth and over one-half of dental students did not want to provide care to PLWHA.[71] Reasons associated with not wanting to provide this care include fear of infection,[72] homophobia,[73] and the belief that

64. Sadowsky & Kunzel, *supra* note 49, at 703–04.

65. Roseann Mulligan et al., *The Effect of an HIV/AIDS Educational Program on the Knowledge, Attitudes, and Behaviors of Dental Professionals*, 70 J. DENTAL EDUC. 857 (2006).

66. *Id.* at 861.

67. *Id.* at 862.

68. *Id.*

69. *Id.* at 861.

70. *Id.* at 864.

71. *See* Leonard A. Cohen & Edward G. Grace, Jr., *Attitudes of Dental Faculty Toward Individuals with AIDS*, 53 J. DENTAL EDUC. 199 (1989); Leonard A. Cohen et al., *Attitudes of Dental Hygiene Students Toward Individuals with AIDS*, 69 J. DENTAL EDUC. 266 (2005); Jason P. Seacat & Marita Rohr Inglehart, *Education About Treating Patients with HIV Infections/AIDS: The Student Perspective*, 67 J. DENTAL EDUC. 630 (2003); Robert J. Weyant et al., *Desire to Treat HIV-Infected Patients: Similarities and Differences Across Health-Care Professions*, 8 AIDS 117 (1994).

72. Cohen & Grace, *supra* note 71, at 199; Cohen et al., *supra* note 71, at 268; Seacat & Inglehart, *supra* note 71, at 631; Weyant et al., *supra* note 71, at 120–21.

PLWHA are responsible for their illness.[74] In contrast, one study found that students were more willing to provide treatment if they believed they had a professional responsibility to do so.[75] One study found that male students were more likely to express discriminatory attitudes than female students were.[76]

For example, a study published in 2005 summarized research based on a survey of 690 graduates from one dental school during a thirteen year period from 1992 to 2004.[77] While the more recent graduates who were surveyed were more comfortable treating PLWHA, overall only 47.4 percent of respondents indicated they were comfortable treating PLWHA.[78] When compared to other underserved groups, such as the poor, drug users, and homeless people, the students were least comfortable treating PLWHA of all groups included in the survey.[79]

C. Surveys of Persons Living with HIV/AIDS

In addition to the studies reviewed above, several studies have measured HIV discrimination in dental care by surveying PLWHA. One study published in 1996 found that of 272 PLWHA living in the Philadelphia area who had sought dental care in the previous five years, fifty-two had been refused treatment by a dentist.[80] In order to determine whether the treatment was discriminatory in a way that would violate the law, the researchers examined the responses in the context of the respondents' answers to other survey questions and applicable law.[81] Almost 80 percent of these refusals were classified as "probably discriminatory" and an additional 17 percent as "possibly discriminatory."[82] Thus, 15 percent of patients surveyed

73. Cohen & Grace, *supra* note 71, at 201; Cohen et al., *supra* note 71, at 266.

74. Cohen et al., *supra* note 71, at 267–68; Seacat & Inglehart, *supra* note 71, at 634.

75. Weyant et al., *supra* note 71, at 119–20.

76. Seacat & Inglehart, *supra* note 71, at 637.

77. Raymond A. Kuthy et al., *Students' Comfort Level in Treating Vulnerable Populations and Future Willingness to Treat: Results Prior to Extramural Participation*, 69 J. DENTAL EDUC. 1307, 1308 (2005).

78. *Id.* at 1309.

79. *Id.* at 1309 tbl.1. Other groups in the survey included people who were frail, elderly, homebound, medically complex, mentally compromised, Title XIX eligible, jailed, non-English-speaking, and from other ethnic groups. *Id.*

80. Scott Burris, *Dental Discrimination Against the HIV-Infected: Empirical Data, Law and Public Policy*, 13 YALE J. ON REG. 1, 20–24 (1996).

81. *Id.* at 24.

82. *See id.* at 24–25.

had experienced a refusal of care that was "probably discriminatory" when evaluated by lawyers.[83] In 60 percent of the "probably discriminatory" cases, the patient had been explicitly refused care when he or she attempted to make his or her first appointment.[84] In almost half of these cases, the dentist admitted that he or she had a blanket rule against treating PLWHA.[85] In the other 40 percent, the patients had been seeing their dentists for some time before being denied treatment when the dentist became aware of their HIV status.[86]

In an article published in 2005, the RAND Corporation used data from the 1996 HIV Cost and Utilization Study to research discrimination perceived by PLWHA in clinical settings.[87] Of the 2,466 respondents with HIV that were receiving health care in the United States, 26 percent reported having experienced at least one of four types of discrimination by a heath care provider on the basis of their HIV status.[88] Twenty percent reported that a health care worker acted uncomfortably with them when they sought medical care, 17 percent were treated as inferior by a health care worker, 18 percent reported that a health care worker preferred to avoid them, and 8 percent were refused service.[89] When asked which provider had discriminated against them, 32 percent reported that they had been discriminated against by a dentist.[90] This percentage was smaller than the share that attributed discrimination to physicians, nurses, and other clinical staff, but it was more than the share of those who attributed discrimination to hospital staff and case managers or social workers.[91] White respondents were most likely to report discriminatory treatment,[92] but the authors noted that respondents of color may have underreported HIV discrimination for

83. *See id.* at 24.
84. *See id.*
85. *Id.* at 29.
86. *Id.* at 24.
87. Mark A. Schuster et al., *Perceived Discrimination in Clinical Care in a Nationally Representative Sample of HIV-Infected Adults Receiving Health Care*, 20 J. GEN. INTERNAL MED. 807 (2005).
88. *Id.*
89. *Id.* at 809.
90. *Id.* at 810.
91. *Id.*
92. *Id.* at 809.

several reasons, including because they attributed the discrimination to another characteristic such as race.[93]

VI. METHODOLOGY

This Study presents the results of research that we conducted in 2007 and 2008 measuring HIV discrimination in dental care in Los Angeles County. We followed a methodology developed during three prior studies that we conducted to measure HIV discrimination in the provision of health care services in Los Angeles County.[94] Unlike the studies described in Part V, these studies used trained testers posing as PLWHA seeking care or other medical care providers to contact health care providers and ask them if they would accept PLWHA.[95] This methodology more closely replicates the incidence of actual discrimination that PLWHA face when they seek health care services. Of the several hundred health care providers surveyed by these three testing studies, 26 percent of plastic and cosmetic surgeons, 56 percent of skilled nursing facilities, and 47 percent of obstetricians indicated that they had blanket policies of refusing to provide services to all PLWHA.[96] In these prior studies, the most common reasons given by providers for denying services to PLWHA included lack of expertise or equipment, no prior experience in treating an HIV-positive patient, inadequately trained or uncooperative staff, and the referral of all HIV-positive patients to "specialists."[97]

This Study used two trained testers posing as potential dental patients who were HIV-positive. Testers called dental offices and asked if they would accept HIV-positive patients. Testers called a total of 612 dental offices using three different scripts. In each case, the testers posed as individuals with HIV seeking a regular dental checkup.[98] For most of the calls (480) the testers used a script stating that they had a common form of dental insurance in Los Angeles County, Delta Dental, and requested services in English. The pool for these calls was constructed to create a sample for each of Los

93. *Id.* at 810.

94. *See* Brad Sears, *HIV Discrimination in Health Care Services in Los Angeles County: The Results of Three Testing Studies*, 15 WASH. & LEE J. CIVIL RTS. & SOC. JUST. 85 (2008).

95. *Id.* at 86.

96. *Id.*

97. *Id.* at 87.

98. *See id.* at 87 app. A (providing the script used during the interviews).

Angeles County's SPAs. For another sixty-six calls, testers used the same script stating they had dental insurance (Delta Dental) but requested services in Spanish. For the final sixty-six calls, testers requested services in English but stated they had Denti-Cal, the dental segment of the Medi-Cal program, California's Medicaid program primarily for poor and low-income people.

One male tester conducted all of the tests in English. One female tester conducted all of the tests in Spanish. The testers were trained to be consistent in following a script for each type of call, recording responses as the calls were made and coding the responses. We used 90 percent confidence intervals for statistical comparisons.[99]

To create the sampling frame for the Study, we obtained a list of dentists practicing in Los Angeles County from the website of the California Department of Consumer Affairs (DCA).[100] The DCA issues licenses in more than one hundred businesses and two hundred professional categories, including doctors and dentists.[101] The DCA website features a search function that allows members of the public to search for dentists using several criteria, including by county.[102] Using this search feature, we retrieved the names and contact information for the 10,523 licensed dentists in Los Angeles County. We narrowed this list to the 7,932 dentists who hold licenses that are current and renewed.[103]

99. Calculation of 90 percent confidence intervals for estimates relies on three values: population size, sample size, and expected distribution of the variable in question. In the case of Tables 1 and 2, we assumed that we would find that 4 percent of the population would decline service and 5 percent of respondents would suggest different treatment. In Table 1, the underlying population of dentists from which the English-speaking calls were drawn was 6,592. The Spanish-speaking calls were drawn from an underlying population of 5,413 dentists. The Denti-Cal calls were drawn from a population of 1,825 dentists. In Table 3, population sizes for male dentists, dentists graduating before 1988, and dentists graduating from a dental school outside of the United States were assumed to be the percentages of each group in the sample (77 percent, 68 percent, and 25 percent, respectively) multiplied by the total population of dentists (6,592). Expected distributions were also assumed to be those of the full population of dentists (77 percent, 68 percent, and 25 percent, respectively). Calculations of margins of error and requisite confidence intervals were derived using the Raosoft sample size calculator, *Sample Size Calculator*, RAOSOFT, http://www.raosoft.com/samplesize.html (last visited Nov. 22, 2011).

100. *License Search for Dental License*, CAL. DEP'T OF CONSUMER AFFAIRS, http://www2.dca.ca.gov/pls/wllpub/wllqryna$lcev2.startup?p_qte_code=DDS&p_qte_pgm_code=3610 (last visited Nov. 21, 2011).

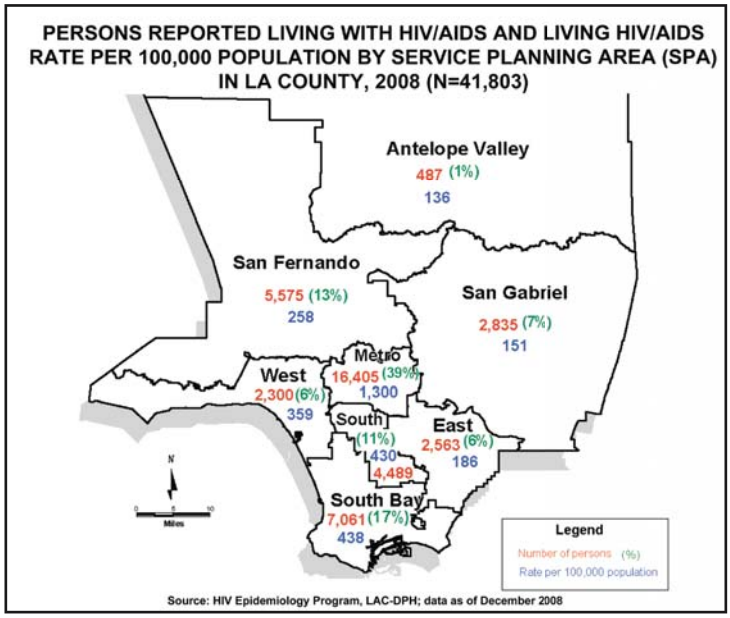
101. *See More About the Department of Consumer Affairs*, CAL. DEP'T OF CONSUMER AFFAIRS, http://www.dca.ca.gov/about_dca/morabout.shtml (last visited Nov. 21, 2011).

102. *License Search for Dental License*, *supra* note 100.

103. Only dentists with licenses that are current and renewed may legally practice dentistry in California. *See* CAL. BUS. & PROF. CODE § 462(b)(1) (West 2012).

From that group, we removed 1,324 dentists who only listed their home address.[104] We did this because we wanted to contact all dentists at their dental practices, in order to replicate the experience of an HIV-positive person looking for a new dentist. In addition, we wanted to determine whether different parts of Los Angeles had different rates of discrimination, and dentists may or may not practice near their homes. We also removed three dentists in military practice and twelve in institutional practice, leaving 6,592 dentists.
We then further organized the list of dentists based on Los Angeles County's SPAs. Like other diseases, "HIV/AIDS has not affected all areas of the county equally."[105] The Metro SPA has the highest concentration of PLWHA followed by the South Bay.[106] The Antelope Valley has the lowest concentration.[107]

FIGURE 4. Distribution of Persons Reported Living with HIV/AIDS in Los Angeles County by SPA



104. We removed dentists with only home addresses listed because dentists may reside in one SPA but practice in another. We assumed that there would be no qualitative difference by removing those names.

105. HIV EPIDEMIOLOGY PROGRAM, L.A. CNTY. DEP'T OF PUB. HEALTH, AN EPIDEMIOLOGIC PROFILE OF HIV AND AIDS IN LOS ANGELES COUNTY 2009, at 33 (2009).

106. *Id.*

107. *Id.*

The boundaries of SPAs are determined by ZIP codes.[108] Using the ZIP codes from the addresses we obtained from the DCA website, we coded those 6,592 dentists by SPA. For each SPA, we determined a sample size that would approximately result in a 10 percent margin of error, with a 90 percent confidence level.[109] In two cases, the indicated sample size was fewer than fifty dentists, so for each SPA we included the names of at least fifty dentists to increase accuracy.[110] Among all SPAs, we called a total of 480 dentists in English with the testers stating they had Delta Dental.

Next, the testers called an additional sixty-six dentists and requested services in Spanish. These dentists were randomly selected from Delta Dental providers who indicated that their offices provided services in Spanish (5,413).[111] Testing was done in Spanish because almost 40 percent of PLWHA in Los Angeles County are Latino.[112] In terms of people diagnosed with AIDS, Latinos have been the predominant racial and ethnic group impacted in Los Angeles County since 1997.[113] Overall, 45 percent of the Latino population in Los Angeles County is foreign born.[114] According to 2009 California Health Interview Survey (CHIS) data, over 12 percent of residents only speak Spanish in the home and over 28 percent speak Spanish and English in the home.[115]

Finally, because a large percentage of PLWHA have their medical and dental care covered through public benefits programs, an additional sixty-six dentists who indicated they accepted Denti-Cal were tested. These providers were randomly selected from Medi-Cal's list of dentists who participate in the Denti-Cal program in Los

108. UNITED WAY OF GREATER L.A., 2007 LOS ANGELES COUNTY ZIP CODE DATA BOOK (2007) (providing a list of which ZIP codes correspond to which SPAs).

109. *Sample Size Calculator*, *supra* note 99. This also assumes a 90 percent confidence level and 50 percent response distribution.

110. For SPA 1 (Antelope Valley), the population size of 96 resulted in a sample size of 40; increasing the sample size to 50 decreased the margin of error to 8 percent. In SPA 6 (South), the population size of 117 resulted in a sample size of 44; increasing the sample to 50 decreased the margin of error to 9 percent. *Id.*

111. *Provider Directory*, DELTA DENTAL, https://www.deltadentalins.com/PD/providerDirectory.do?action=s01 (last visited Nov. 28, 2011).

112. HIV EPIDEMIOLOGY PROGRAM, *supra* note 105, at 17, 74.

113. *Id.* at 27.

114. *Id.* at 5.

115. GARY J. GATES, WILLIAMS INST., HOW MANY PEOPLE ARE LESBIAN, GAY, BISEXUAL, AND TRANSGENDER? (2011), *available at* http://williamsinstitute.law.ucla.edu/wp-content/uploads/Gates-How-Many-People-LGBT-Apr-2011.pdf (using data from the 2009 CHIS conducted by the UCLA Center for Health Policy Research).

Angeles County.[116] Testers called these dentists and stated that they had Denti-Cal before requesting services and stating that they were HIV-positive.

At the time this Study was conducted, Denti-Cal was the dental segment of the Medi-Cal program.[117] However, due to budget cuts, routine care was eliminated from the Denti-Cal program for most adult Medi-Cal beneficiaries in 2009.[118] It is difficult to estimate, but as many as half of PLWHA in Los Angeles County could have been covered by Denti-Cal when the adult program was still funded. While, in general, 14 percent of all Los Angeles County residents eighteen years and over are enrolled in the Medi-Cal program and therefore would have qualified for Denti-Cal,[119] according to data from the Medical Monitoring Project of the CDC, 45 percent of PLWHA surveyed in 2007–2008 were covered by their state's Medicaid program at some point during 2007.[120] Similarly, the Los Angeles Coordinated HIV Needs Assessment (LACHNA) conducted

116. CAL. DEP'T OF HEALTH CARE SERVS., DENTISTS ACCEPTING NEW PATIENTS BY SPECIALTY REFERRAL LIST, LOCATION: LOS ANGELES COUNTY (2008), *available at* http://www.denti-cal.ca.gov/WSI/Bene.jsp?fname=ProvReferral.

117. Poor and low-income people receiving cash assistance through other means-tested benefits programs, including SSI/SSP, CalWorks, Refugee Assistance, or the Foster Care or Adoption Assistance Program, are automatically eligible for Medi-Cal. Poor and low-income people who do not receive cash assistance through another program may also be eligible for Medi-Cal based on limited assets and income if they are in a qualifying group. Qualifying groups include pregnant women, blind or disabled people, people under twenty-one, refugees, people in nursing facilities, women with breast or cervical cancer, and caretakers of children under twenty-one in some circumstances. CAL. DEP'T OF HEALTH CARE SERVS., MEDI-CAL DENTAL PROGRAM PROVIDER HANDBOOK 1-1 (2011) [hereinafter MEDI-CAL DENTAL PROGRAM HANDBOOK], *available at* http://www.denti-cal.ca.gov/WSI/Publications.jsp?fname=Prov Manual.

118. Some adult Medicaid beneficiaries are still eligible for Denti-Cal, including pregnant women and people in care facilities. Additionally, limited dental services for the relief of pain, infection, or trauma are still available to all other Medi-Cal beneficiaries through the Denti-Cal program. CAL. DEP'T OF HEALTH CARE SERVS., DENTI-CAL BULLETIN: ELIMINATION OF MOST ADULT DENTAL SERVICES 1 (2009), *available at* http://www.denti-cal.ca.gov/provsrvcs/bulletins/Volume_25_Number_22.pdf; CAL. DEP'T OF HEALTH CARE SERVS., DENTI-CAL FAQS: ELIMINATION OF MOST ADULT DENTAL SERVICES BENEFICIARY FREQUENTLY ASKED QUESTIONS (FAQS), *available at* http://www.denti-cal.ca.gov/provsrvcs/FAQs/Bene_FAQs.pdf (last visited Nov. 22, 2011).

119. UCLA CTR. FOR HEALTH POLICY RESEARCH, CALIFORNIA HEALTH INTERVIEW SURVEY, CHIS 2005 ADULT QUESTIONNAIRE (2010).

120. MEDICAL MONITORING PROJECT, CTRS. FOR DISEASE CONTROL & PREVENTION, CLINICAL AND BEHAVIORAL CHARACTERISTICS OF ADULTS RECEIVING MEDICAL CARE FOR HIV INFECTION 1 (2011), *available at* http://www.cdc.gov/mmwr/pdf/ss/ss6011.pdf.

in 2007–2008 found that 52 percent of respondents had their medical care covered through public programs such as Medi-Cal.[121]

For low-income PLWHA, another source of funding is the Ryan White system.[122] Currently, Ryan White-funded programs provide services in medical and supportive services clusters to over 18,500 clients in Los Angeles County.[123] Funding for dental services is available under Ryan White Care Act and supports services to roughly 2,500 PLWHA every year.[124] However, because the Ryan White-funded programs are specifically for PLWHA,[125] it was assumed that none of these programs would discriminate against PLWHA and they were not included in this Study.

The testers kept records of their conversations on a spreadsheet. Responses to the question about whether the dentist would accept PLWHA were recorded verbatim. Affirmative and ambiguous answers to the requests for treatment were noted, and negative answers received follow-up questions as to why the offices did not treat PLWHA. All of the original responses and the coding by testers were reviewed by the Authors of this Study to check for consistency and accuracy in the coding procedure.

The responses from the dentists as to whether they would admit a patient who was HIV-positive were broken down into three categories: yes, no, and different treatment.[126] An affirmative response was categorized as "yes." If the person answering the phone at the dental office said the dentist would not accept PLWHA, the response was categorized as "no," indicating a blanket policy of refusing services. In addition, the testers identified responses of providers that indicated that they would treat PLWHA differently than they would treat persons not infected, in many cases in ways

121. HIV EPIDEMIOLOGY PROGRAM, *supra* note 105, at 89.

122. OFFICE OF AIDS PROGRAMS & POLICY, L.A. CNTY. DEP'T OF PUB. HEALTH, HIV CARE AND TREATMENT SERVICE UTILIZATION: 2009 YEAR END REPORT 1 (2011), *available at* http://ph.lacounty.gov/aids/reports/ServiceUtilizationReport2009.pdf.

123. *Id.* at 6.

124. *Id.* at 19.

125. *See id.* at 1.

126. Unclear responses included, but were not limited to, the following: (1) statements that acceptance was discretionary; (2) statements that acceptance was dependent upon the availability of isolation rooms; (3) admissions representatives expressing reluctance to accept; (4) admissions representatives expressing unfamiliarity with the law; and (5) admissions representatives expressing a preference for elderly patients. Such responses may be evidence of a discriminatory practice of excluding individuals with HIV. However, because the surveyors limited the depth of their questioning to avoid suspicion, such responses are not conclusive of discrimination.

that would also violate antidiscrimination laws. These responses were coded as "different treatment." Finally, the testers also gathered qualitative information about the reasons why dentists either offer or refuse services to PLWHA. The focus of the Study was to measure the percentage of providers who had a blanket policy of refusing services to PLWHA without any individualized inquiry. As explained in Part II, these policies would clearly violate local, state, and federal antidiscrimination laws.

VII. RESULTS

A. Summary of Findings

Of the dentists contacted, 90 percent (N=551) responded with an unqualified "yes" to accepting PLWHA. Only 5 percent (N=29) stated that they would not accept PLWHA. Another 5 percent (N=32) provided responses that indicated that a PLWHA would be treated differently than a person who was not HIV-positive.

TABLE 1. Summary of Findings

Provider accepts dental patients living with HIV/AIDS?	Dental Insurance English		Dental Insurance Spanish		Denti-Cal Total		Total	
Yes	437	**91%**	61	**92%**	53	**80%**	551	**90%**
No	20	**4%**	3	**5%**	6	**9%**	29	**5%**
Different Treatment	23	**5%**	2	**3%**	7	**11%***	32	**5%**
No & Different Treatment Combined	43	**9%**	5	**8%**	13	**20%***	61	**10%**
Total	480	**100%**	66	**100%**	66	**100%**	612	**100%**

TYPE OF DENTAL COVERAGE. Rates of discrimination were higher when the testers stated that they had Denti-Cal compared to Delta Dental. When the "no" and "different treatment" responses are combined, testers indicating they had Denti-Cal were twice as likely to experience discriminatory or potentially discriminatory responses than those indicating they had Delta Dental.

LANGUAGE. There was not a statistically significant difference in responses depending on whether the tester requested services in English or Spanish. When the caller requested services in English and stated they had Delta Dental, they encountered discriminatory or potentially discriminatory responses 9 percent of the time, compared to 8 percent of the time when the caller requested services in Spanish.

CHARACTERISTICS OF DENTISTS. Further analysis of the 480 calls where the testers requested services in English and stated they had Delta Dental revealed that rates of discrimination varied in different parts of Los Angeles County and were higher if the dentist graduated dental school before 1988 or graduated from a dental school outside of the United States.

LOCATION. Eleven percent of providers in the San Gabriel Valley SPA indicated that they would not accept any PLWHA. By comparison, only 2 percent of providers in the Antelope Valley, San Fernando Valley, and West SPAs indicated they had such policies. For the Delta Dental calls made in English, the San Gabriel Valley accounted for one-third of all blanket refusals of care.

When the blanket policies of refusal of service are combined with differences in treatment, 20 percent of providers in the South SPA had such responses, five times the rates of such policies for providers in the Antelope Valley (4 percent), San Fernando Valley (3 percent), and West (3 percent) SPAs. Combined rates of unlawful and potentially unlawful policies were also high in the San Gabriel Valley SPA (17 percent). While the combined rates were higher in the Metro SPA (11 percent), this difference was not statistically significant as compared to any other SPA.

TABLE 2. Responses to Delta Dental Insurance Calls in English, by Los Angeles County SPA[127]

	Yes		No		Different Treatment		No & Different Treatment Combined		Sample Size
1-Antelope Valley	48	**96%**	1	**2%**	1	**2%**	2	**4%**	50
2-San Fernando Valley	63	**97%**	1	**2%**	1	**2%**	2	**3%**	65
3-San Gabriel Valley	54	**83%**	7	**11%**[a]	4	**6%**	11	**17%**[b]	65
4-Metro	55	**89%**	3	**5%**	4	**6%**	7	**11%**	62
5-West	62	**97%**	1	**2%**	1	**2%**	2	**3%**	64
6-South	39	**80%**	2	**4%**	8	**16%**[c]	10	**20%**[d]	49
7-East	56	**92%**	3	**5%**	2	**3%**	5	**8%**	61
8-South Bay Harbor	60	**94%**	2	**3%**	2	**3%**	4	**6%**	64
TOTAL	437	**91%**	20	**4%**	23	**5%**	43	**9%**	480

127. a. Statistically significant at P<0.10 as compared to SPAs 1, 2 ,5, and 8.
b. Statistically significant at P<0.10 as compared to SPAs 1, 2, and 5.
c. Statistically significant at P<0.10 as compared to all other SPAs.
d. Statistically significant at P<0.10 as compared to SPAs 1, 2, 5, 7, and 8.

For the dentists who were called by testers who indicated that they had private dental insurance, the online record forms of the dental insurance company included information about the gender, year of graduation, and the dental school of each provider. For the 480 dentists who were called in English, this information was collected from the online records where it was provided. Where this information was not provided in the online records, the dentists' offices were asked for this information either during the initial call or during a follow-up call.

GENDER. The gender of the dentist did not appear to influence the likelihood of discriminatory or potentially discriminatory responses. When "no" and "different treatment" responses are combined, 77 percent of dentists providing these responses were male. By comparison, 77 percent of dentists providing "yes" responses were also male.

YEAR OF GRADUATION. Dentists who graduated before 1988 were more likely to provide a discriminatory or potentially discriminatory response. Overall, 68 percent of these 480 dentists graduated prior to 1988. However, almost 90 percent of dentists whose responses were classified as "no" or "different treatment" graduated before 1988. In fact, only two dentists who graduated from dental school after 1988 gave a response classified as a "no" or "different treatment."

DENTAL SCHOOL OUTSIDE OF THE UNITED STATES. Dentists who graduated outside of the United States also were more likely to provide a "no" or "different treatment" response. While only one-fourth of the dentists in the Study graduated from a dental school outside of the United States, almost 40 percent of the "no" and "different treatment" responses were given by dentists who went to dental schools in other countries. Most of these dentists graduated from dental school in the Philippines or in India.

TABLE 3. Responses to Delta Dental Insurance Calls in English, by Response, and by Dentists' Sex, Year of Graduation, and Country of Dental School[128]

Characteristics of Dentists	All	Yes	No & Different Treatment Combined	No	Different Treatment
% Male	77%	77%	77%	67%	90%
% Graduating Dental School Before 1988	68%	66%	89%*	86%*	90%*
% Graduating From Dental School Outside the United States	25%	23%	39%*	30%	48%*

B. Reasons Provided for Responses

1. Statements Accompanying "Yes" Responses

The testers making the calls were also trained to gather information about the reasons why dentists refused to provide services to PLWHA or would treat PLWHA in a potentially discriminatory manner. However, one unexpected finding in the analysis of the qualitative responses was that a very high percentage of providers who would accept PLWHA (the "yes" responses) accompanied that willingness with very positive reassurances to the tester, including statements indicating familiarity with the law and standard precautions for preventing the transmission of HIV. These types of statements were almost entirely absent in the three prior studies of HIV discrimination among obstetricians, plastic surgeons, and skilled nursing facilities in Los Angeles County. These responses could indicate that many providers and their staff had received effective training about treating PLWHA and/or had prior experience working with such patients.

Overall, 90 percent of the dental offices indicated that they would accept PLWHA. In over one-fourth of these responses, the person responding to the tester went beyond merely saying "yes" and offered a more positive and reassuring response, often indicating that whether a provider takes PLWHA is a question that should not even be necessary to ask. For example, 12 percent of these responses were accompanied with assurances such as "absolutely," "definitely," "why not," "of course," and "he sure does."

128. * Statistically significant at P<0.10 as compared to Yes responses.

TABLE 4. Positive Statements Provided with "Yes" Answers

	Percentage Yes	"No problem" "Absolutely;" Definitely; "Why not?"; "Of course;" "He sure does"	We Don't Discriminate	We Use Standard Precautions	We Have Other HIV-Positive Patients	We Will Protect Your Confidentiality	Any Positive Statement
Denti-Cal (53 of 66)	80%	9%	8%	4%	4%	2%	26%
Delta Dental-English (427 of 480)	91%	12%	5%	4%	3%	1%	25%
Delta Dental-Spanish (61 of 66)	92%	15%	0%	0%	5%	0%	20%
TOTAL	90%	12%	5%	4%	3%	1%	25%

Some respondents even went further, assuring the testers that they did not discriminate (5 percent), used standard infection control precautions with everyone (4 percent), had treated or provided care to other PLWHA (3 percent), or would protect the confidentially of the patient's HIV status (1 percent).

Some of the other dental offices indicating that they would accept PLWHA displayed less certainty and knowledge. For 8 percent of respondents who would accept HIV-positive patients, the person answering the phone at the dental office did not know the answer and had to check with the dentist before responding to the caller. This percentage was slightly higher (11 percent) for those calls where the tester said he or she had Denti-Cal.

Two percent of providers who responded that they would accept PLWHA indicated that they had never treated an HIV-positive patient before, and 1 percent indicated that they would use extra infection control precautions beyond what they would use for patients who had not informed them that they were HIV-positive. The calls made in Spanish encountered these types of responses more frequently, with 6 percent stating that they had never treated an HIV-positive patient before, and 3 percent stating that they would use extra precautions. However, given the totality of the responses from these providers, they were conservatively classified as "yes" responses as opposed to "different treatment" responses.

Three percent of providers who responded that they would accept PLWHA stated that they would need a medical clearance from the patient's doctor or more medical information from the patient before providing services. The calls made in Spanish

encountered this request more frequently, with 8 percent of those providers stating that they needed a medical clearance. Such a request is consistent with good treatment of PLWHA by dentists.

TABLE 5. Qualifications Provided with "Yes" Answers

	Total Yes	Receptionist Checked with Dentist	Requested Medical Clearance or Specific Medical Information	Practice Had Never Treated PLWHA	Extra Precautions Would Be Used
Denti-Cal (53 of 66)	80%	11%	2%	0%	0%
Delta Dental-English (427 of 480)	91%	8%	3%	2%	1%
Delta Dental-Spanish (61 of 66)	92%	7%	8%	6%	3%
TOTAL	90%	8%	3%	2%	1%

2. Reasons Given for "No" Responses

Five percent (twenty-nine) of the dental offices contacted indicated that they would not provide dental services to any PLWHA. For one-third of these responses, the person at the dental office who spoke with the tester did not initially know whether the dentist would accept PLWHA and provided the negative response after checking with the dentist or someone else in the office.

When they encountered such a policy, the testers were trained to ask why the dentist would not take HIV-positive patients and for a referral. Over half of the time (52 percent), the respondent indicated that PLWHA were referred to specialists for all dental services. If asked what type of service they needed, the testers were trained to respond that they only needed a routine checkup and cleaning. Most often, no specific provider or clinic was named for the referral. More specific referrals included UCLA (five), USC (three), "LA County" (two), Loma Linda (one), and San Gabriel Dental Society (one).

Nearly 40 percent of the dentists who would not accept PLWHA said their offices were not equipped to treat PLWHA because the office lacked special equipment, adequate infection control procedures, or adequately trained staff. Often, these responses were accompanied by a statement that the tester should see a specialist or seek dental services at a hospital or special dental clinic for PLWHA.

For 10 percent of the "no" responses, the reason given was that the dentist was not accepting patients at this time. Since the first question that the testers asked the dental office was whether they

were accepting new patients, and the testers only proceeded with the call and revealed that they were HIV-positive if the dentist was, in fact, accepting new patients, it seems likely that this response was merely a pretext for discrimination. Finally, 7 percent of the "no" responses were accompanied by each of the following explanations: that the dentist only saw children, did not or could not take the extra precautions that were necessary to treat PLWHA, and had never treated an HIV-positive patient before.

TABLE 6. Statements Provided with "No" Answers

No Responses (29 of 612) **(Dental offices could provide more than one response)**	**Percent**
Respondent Checked with Someone Else Before Answering No	34%
PLWHA Referred to Other Providers	52%
Office Not Equipped to Treat PLWHA	38%
Evidence That "No Appointments Available" Was a Pretext	10%
Extra Precautions Would Be Required	7%
Office Had Never Treated a PLWHA Before	7%
Dentists Works Only with Children	7%

3. Reasons Given for Different Treatment Responses

Five percent (thirty-two) of the dental offices contacted responded with an answer that fell in between accepting PLWHA and denying care to all such patients. These responses were classified as "different treatment." For 21 percent of these responses, the person answering the phone had to check with someone else before providing an answer to the tester.

The different treatment indicated in 62 percent of these responses was a limitation on the services provided. Frequently, the dental office would provide a routine checkup or cleaning for PLWHA but would refer them to someone else for all other services. If the response clearly indicated that the dentist would only refer when the services needed were beyond his or her scope of care, and thus similarly situated HIV-negative patients would be referred as well, the response was coded as a "yes" and not a "different treatment." While no specific referral was indicated in most cases,

specific providers mentioned included UCLA (four), USC (three), "the West Hollywood Clinic" (one), and St. Mary's (one).

Nearly one-fifth of these responses (18 percent) indicated that PLWHA could only have appointments at certain times, either on certain days of the week or at the end of the day. Six percent of these responses indicated that only one dentist in the office (not the dentist requested) would provide services, and 3 percent of these responses indicated that PLWHA were treated in "isolation rooms."

Over one-fourth of these responses (26 percent) were accompanied with a discouraging statement for the tester such as "the law requires us to" or "it's up to you." Usually these statements were accompanied by other statements that indicated different treatment, but in a couple of cases such a statement by itself resulted in the response being coded as different treatment (e.g., "If I could avoid it, I would, but yes" and "Depends. We have to be more cautious. It's up to you.").

Almost one-fourth of these responses were accompanied with a statement that the provider thought that treating PLWHA required providing extra infection-control precautions beyond those provided routinely to patients who had not disclosed their HIV status. Nine percent of the providers who indicated that they would treat PLWHA differently also stated that they would need a clearance from the patient's doctor or more medical information before providing treatment.

TABLE 7. Different Treatment Responses

Different Treatment Responses 6% (34 of 612)	**Percent**
Respondent Checked With Someone Else Before Providing Answer	21%
Limit Services Only, Then Referral For All Else	62%
Extra Precautions Necessary; Isolation Room	24%
Office Not Equipped To Treat PLWHA	21%
Only Appointments At Certain Times	18%
Only One Dentist Would Treat PLWHA	6%
"Law Requires Us To"; "Up to You"	26%
Medical Clearance Required	9%

VIII. DISCUSSION

Overall, this Study suggests that PLWHA would encounter a discriminatory or potentially discriminatory response by almost one out of every ten dental practices in Los Angeles County. If the caller revealed his or her HIV status when making an initial appointment, the caller would be told by one out of every twenty practices that services were not available to PLWHA, contrary to state and federal law.

Not every PLWHA in Los Angeles County has an equal chance of encountering discriminatory treatment when seeking dental care. Those seeking services in the San Gabriel Valley and South SPAs, and probably the Metro SPA, would be more likely to encounter discrimination than those seeking services in other parts of Los Angeles County. These geographic differences are important because PLWHA are not evenly dispersed throughout Los Angeles County. Notably, almost 40 percent of PLWHA in Los Angeles County live in the Metro SPA.[129] The South SPA has the highest proportion of female AIDS cases, almost twice that of Los Angeles County overall, and the highest proportion of black PLWHA.[130] Among PLWHA in the South SPA, 53 percent are black and 42 percent are Latino.[131] Overall, the San Gabriel Valley (24 percent), South (3 percent), and Metro (22 percent) SPAs all have general populations that are less than one-quarter white.[132] This means that, to some extent, HIV discrimination by dentists is concentrated in areas with a higher proportion of PLWHA and where PLWHA are "special and emerging populations" with specific vulnerabilities, care, and service needs.[133] These include the overlapping populations of women, blacks, Latinos, and women of color.[134]

In addition, when the callers stated that they had Denti-Cal, they were twice as likely to encounter a discriminatory response. Although the adult Denti-Cal program is no longer available in California, this result may indicate that dentists serving poorer individuals are more likely to discriminate on the basis of HIV status.

129. HIV EPIDEMIOLOGY PROGRAM, *supra* note 105, at 33.
130. *Id.* at 45.
131. *Id.*
132. *Id.* at 10.
133. *See id.* at 73–76.
134. *Id.*

This conclusion is supported by the concentration of discriminatory responses in the South and Metro SPAs. The South SPA has the highest percentage of people living at less than 100 percent of the federal poverty level (45 percent), followed by the Metro SPA (34 percent).[135]

However, overall, the rates of discriminatory policies and treatment encountered in this Study compare favorably with the results of three similar studies of HIV discrimination in health care in Los Angeles County conducted between 2003 and 2006.[136] The rate of dentists who refuse treatment to all PLWHA in this Study was less than one-fifth of the lowest level of discrimination found in those prior studies.[137] Moreover, as noted above, the statements accompanying the responses from offices affirming that they would treat PLWHA indicated a level of knowledge about the legal obligation to treat HIV-positive patients and receptivity to providing such treatment that was not found in the prior three studies.[138]

While this lower rate of discrimination among dentists as compared to other health care providers is consistent with national data from the 1996 HIV Cost and Utilization Study described above, the significantly lower rate of discrimination among dentists found in this Study could also be attributable to intensive and consistent legal enforcement and targeted education efforts focused on dentists in Los Angeles County for almost two decades.

In Los Angeles County, highly publicized enforcement efforts preceded *Bragdon v. Abbott*, the 1998 Supreme Court case that established that PLWHA were covered by the ADA.[139] In 1992, four HIV-positive patients and a number of community and legal organizations brought suit against Western Dental, one of the oldest and largest dental corporations on the West Coast, for discriminating against PLWHA who were seeking care at Los Angeles branches.[140] The case was settled in 1993,[141] and the resulting consent decree

135. *Id.* at 9.
136. *See* Sears, *supra* note 94, at 86–87.
137. *Id.* at 96–104.
138. *Id.*
139. 524 U.S. 624 (1998).
140. Scott Harris, *Suit Claims Dental Chain Turned Away 4 with AIDS Virus*, L.A. TIMES, Mar. 6, 1992, at B3.
141. *Dental Chain Settles AIDS Discrimination Case*, UNITED PRESS INT'L (June 16, 1993), http://www.aegis.com/news/ads/1993/AD931126.html.

required Western Dental to conduct training sessions on caring for PLWHA for all of its providers and to establish written policies of nondiscrimination and confidentiality with respect to PLWHA in all of its offices.[142] The impact of this case and the resulting consent decree were considerable. Today, "Western Dental has over 200 dental offices and dental clinics throughout California and Arizona . . . , along with a network of over 1,700 dentists in 1,400 other dental offices throughout California."[143]

The organizations that were involved with the 1992 case against Western Dental included AIDS Project Los Angeles, the Los Angeles Gay and Lesbian Center, the American Civil Liberties Union, and Lambda Legal Defense and Education Fund.[144] These organizations indicate the range of organizations in Los Angeles County that were engaged in legal enforcement activities against dentists for HIV discrimination. Several of these organizations later founded the HIV & AIDS Legal Services Alliance (HALSA), which has filed a number of complaints against dentists since it was founded in 1997.[145] Those complaints resulted in settlements ranging from $2,500 to $50,000.[146] In 2008, HALSA brought a second suit against Western Dental for discrimination against PLWHA.[147] The two patients on behalf of whom the suit was brought were refused treatment at a Santa Monica office because they were HIV-positive.[148] That case successfully settled in February 2009.[149]

The enforcement efforts by nonprofit organizations in Los Angeles County were aided by professional organizations and government enforcement agencies. Representatives of the California Dental Association participated in a press conference to announce

142. *Id.*

143. *Your Leading Dentist, Orthodontist and Dental Care Specialist*, W. DENTAL, http://www.westerndental.com/about-us.aspx (last visited Nov. 22, 2011).

144. Harris, *supra* note 140.

145. *History*, HIV & AIDS LEGAL SERVS. ALLIANCE (HALSA), http://www.halsaservices.org/history.php (last visited Nov. 22, 2011).

146. Co-Author Brad Sears was involved in several of these settlements as the Discrimination and Confidentiality Attorney at HALSA and member of the HALSA Legal Advisory Committee.

147. *Goodman v. Western Dental Servs., Inc., Complaint, Superior Court for the State of California, HIV/AIDS Legal Services Alliance (HALSA)*, CTR. FOR HIV LAW & POLICY, http://www.hivlawandpolicy.org/resources/view/297 (last visited Nov. 22, 2011).

148. *Id.*

149. E-mail from Laurie E. Aronoff, Project Dir., L.A. Cnty. Bar Ass'n, AIDS Legal Servs. Project & HALSA, to Craig Konnoth, Williams Inst. (Aug. 11, 2011, 12:30 PST) (on file with authors).

the 1992 Western Dental lawsuit and condemned the discrimination.[150] In addition, the Los Angeles County Bar Association's AIDS Legal Services Project, founded in 1986, has referred thousands of legal cases involving PLWHA, including dental discrimination cases, to pro bono attorneys in Los Angeles County.[151]

Los Angeles County was also unique in having government enforcement agencies that were actively combating HIV discrimination early in the epidemic. In 1985, the City of Los Angeles enacted the first law in the county specifically prohibiting HIV discrimination.[152] That law became the basis for an AIDS Discrimination Unit of the Los Angeles City Attorney's Office, which engaged in a variety of enforcement and education efforts from 1986[153] to 2009.[154] One of that unit's earliest efforts was a 1987 hearing focused on discrimination by dentists that was held in response to a number of complaints that dentists were not accepting PLWHA. The hearing brought together local dental professional associations, professors from dentals schools at UCLA and USC, and HIV/AIDS medical experts. The hearing resulted in the creation of a coalition "committed to teaching dentists proper infection control techniques, combating AIDS fears among dentists, and raising money for a local AIDS dental clinic."[155]

In the late 1990s, another government enforcement agency in Los Angeles County began to play an unusually active role in enforcing federal laws that prohibited discrimination on the basis of HIV/AIDS, the Region IX Office for Civil Rights of the Department of Health and Human Services (OCR).[156] From 2001 to 2007,

150. Harris, *supra* note 140.

151. *See AIDS Legal Services Project*, L.A. CNTY. BAR ASS'N, http://www.lacba.org/showpage.cfm?pageid=13047 (last visited Aug. 16, 2011).

152. David I. Schulman, *AIDS Discrimination: Its Nature, Meaning and Function*, 12 NOVA L. REV. 1113, 1119 (1988).

153. *Id.* at 1125.

154. E-mail from David I. Schulman, Supervising Attorney, L.A. City Attorney's Office, to Brad Sears, Exec. Dir., Williams Inst. (Dec. 1, 2011, 15:12 PST) (on file with authors).

155. Schulman, *supra* note 152, at 1126.

156. Because the OCR handles only complaints that allege a violation of a civil rights statute by an agency that receives financial assistance from the Department of Health and Human Services (HHS), all of these cases involve dentists that accept Denti-Cal patients or receive other HHS money. E-mail from Brock Evans, Senior Equal Opportunity Specialist, Office for Civil Rights Region IX, Dep't of Health & Human Servs., to Christy Mallory, Williams Inst. (Feb. 11, 2010, 17:05 PST) (on file with authors).

thirteen complaints against dentists for discriminating against PLWHA were filed, investigated, and resolved by the OCR, in OCR's Region IX.[157] Ten of these were filed against dentists in Los Angeles County.[158] All thirteen complaints involved denial of treatment.[159]

Though case tracking is only available for cases filed between 2001 and 2007, Brock Evans, senior equal opportunity specialist at the Los Angeles OCR office, recalls a number of cases filed against dentists in the late 1980s and early 1990s.[160] Evans believes that there has been a decline in case filings against dentists since 2001 as a result of increased awareness of nondiscrimination laws and policies, better information regarding risks of transmission, and new medications.[161] For example, he noted that one particular discriminatory practice—scheduling PLWHA for the last appointment of the day—was rarely seen after it became standard industry practice to use heat sterilization for instruments used on each patient.[162]

These legal enforcement efforts not only resulted in monetary settlements for individual plaintiffs but also in newspaper stories that publicized the issue more broadly,[163] in coverage by publications directed at dentists,[164] and, as explained above, frequently in settlements that required education of dentists and their staff and permanent changes in policies.

However, if these legal enforcement efforts played a role in reducing discrimination by dentists in Los Angeles County, two questions are worth further exploration. First, why have similar

157. *Id.*

158. *Id.*

159. In six of the thirteen cases filed with the OCR, the OCR and the dentists reached formal Resolution Agreements, requiring that the dentist take corrective actions, including publishing and posting a policy of non-discrimination on the basis of a disability, including HIV status; training from experts; and an apology and an offer to reinstate services. In another six cases, the dentists agreed to voluntarily comply before a formal Resolution Agreement was in place. An informal agreement to comply with laws and regulations requires the dentists to demonstrate compliance through documentation and voluntary actions taken to resolve the alleged problem. *Id.*

160. *Id.*

161. *Id.*

162. *Id.*

163. Harris, *supra* note 140.

164. David I. Schulman, *The Dentist, HIV and the Law: Duty to Treat, Need to Understand*, 21 J. CAL. DENTAL ASS'N 45 (1993).

enforcement efforts not reduced HIV discrimination in other health care sectors in Los Angeles County? Second, is HIV discrimination in dental care currently as low in the vast majority of the United States that has not had a similar convergence of legal enforcement efforts by nonprofit legal organizations, professional associations, and government agencies?

In addition to legal enforcement efforts, there were extensive education efforts in Los Angeles County to train dentists about infection control and treating PLWHA. Dental schools in Southern California, such as those at USC and UCLA, have extensive didactic and clinical trainings on all aspects of treating PLWHA in their curricula. In addition, all dental students at USC and UCLA have an opportunity to provide dental care to PLWHA and learn, firsthand, how to manage these patients from dental, medical, and psychosocial standpoints. Moreover, until 2003, California required a course on HIV as part of the state's continuing dental-education curriculum. California dentists must periodically meet the continuing dental-education requirements to maintain a license.[165] While an HIV-specific course is no longer required, courses on infection control in general are still required.[166]

Many dentists and their staff in Los Angeles County have received trainings about treating PLWHA from the three local performance sites of the Pacific AIDS Education Training Center (PAETC) based at the medical schools at Charles R. Drew University, UCLA, and USC. The PAETC trains physicians, nurses, dentists, pharmacists, and their affiliates through a broad range of provider experiences, including didactic lectures, skills-building workshops, and direct clinical experiences with HIV-infected patients. It provides free continuing-education courses to dentists and their staff several times a year. "For example, from 2008 through 2011, the PAETC provided 86 training events for 1,132 dentists and 719 dental hygienists in Los Angeles County, totaling over 3,179 contact hours."[167] Some of these trainings were the direct result of lawsuits and complaints filed against specific providers or clinics while the majority of these events were part of the PAETC's ongoing

165. CAL. CODE REGS. tit. 16, §§ 1015, 1017 (2010).

166. *Id.* § 1016(2)(b)(1).

167. E-mail from Thomas Donahoe, Dir. of the Pacific AIDS Educ. Training Ctr., to Brad Sears, Exec. Dir., Williams Inst. (Sept. 8, 2011, 15:28 PST) (on file with authors).

efforts to improve HIV-infected patients' health outcomes by enhancing provider comfort and competencies over time. Additionally the PAETC sites based at the dental schools of USC and UCLA offered enhanced HIV experiences for dental students during this time, including coursework in HIV dental care, sexual-history taking, and diversity training.

A 2006 study of dental care providers surveyed before and after they had received training provided by PAETC between 1992 and 2003 concluded that the trainings were effective in changing HIV-related knowledge, attitudes and beliefs, and infection-control behaviors.[168] The providers' attitudes and beliefs toward PLWHA changed most significantly among the three components studied, with 86 percent of dental care providers indicating more positive attitudes and beliefs after the training.[169] Further, 65 percent of the providers demonstrated increased HIV-related knowledge after the trainings, and 55 percent reported that they used infection-control procedures more frequently or started to apply the principals of HIV-risk screening to their patients after the training.[170] The study also found that during the period of the study, best estimates of the number of HIV/AIDS patients treated by the dentists almost doubled for the dentists and nearly quadrupled for dental hygienists.[171] Most likely, this is a result of providers being more aware when they are treating PLWHA, although the study found that 9 percent more dentists reported treating any PLWHA than they did before the study.[172]

In addition, other studies have also found that "courses in HIV and AIDS have been found to be valuable in improving the dental care providers' knowledge of HIV and its oral manifestations, promoting more positive attitudes of providing care towards HIV-infected patients, and improving the dental care providers' infection control practices."[173] These courses also improve providers' ability to communicate with PLWHA and to counsel staff who are reluctant to treat PLWHA.[174]

168. Mulligan et al., *supra* note 65, at 857.
169. *Id.* at 862.
170. *Id.* at 862, 864.
171. *Id.* at 866.
172. *Id.* at 861.
173. *Id.* at 867.
174. *Id.*

Although the results of this Study suggest that legal enforcement and other education efforts may have reduced discrimination by dentists against PLWHA, this Study also suggests some topics that should be covered in future education efforts and where those efforts should be targeted.

In terms of content of trainings, the core materials in current trainings about standard infection control and occupational risks of transmission of HIV continue to be important. Almost 40 percent of the responses indicating a blanket refusal to accept any PLWHA were accompanied by statements that the office was not equipped to treat PLWHA or that some type of extra infection-control precautions would be required. Of the responses that indicated some sort of different treatment for PLWHA, 45 percent indicated that either the office was not equipped to PLWHA or some type of extra infection-control precautions would be necessary. In addition, the responses that indicated that the office had not treated an HIV-positive patient before, or that PLWHA could only be treated at certain times or by certain providers, also indicate misperceptions that could be addressed through general training about standard infection control and the risks of occupational transmission of HIV.

The responses from dentists also suggest some more specific topics for training. Further training about when referrals should be made appears to be needed. Over half (52 percent) of the dentists who refused services to all PLWHA told the tester that the tester should seek services from another provider, a clinic, or a hospital. Of those providing potentially discriminatory responses, over 60 percent stated that they would provide limited services but then the PLWHA would be referred for all other services.

In addition, training may be needed on collecting medical information from PLWHA before providing dental care. Best practices for providing dental care to PLWHA include obtaining a set of baseline hematologic lab data before engaging in the actual treatment. Typically, this means a medical consultation, as opposed to a "clearance," as part of the patient's initial assessment. Ideally, the patient should be scheduled for his or her first visit, and between that visit and starting treatment additional information would be collected. For example, such information would include the HIV medications the patient is taking and their potential side effects. For this reason, no response in the Study was classified as a "different

treatment" solely because medical information or even a medical "clearance" was required. However, 9 percent of responses otherwise classified as "different treatment" indicated that a medical clearance or more medical information would be required, as opposed to only 3 percent of the responses classified as "yes." This may indicate that requirements for more medical information are used as a hurdle to deter PLWHA. If so, training about what information should be collected from PLWHA, and how to collect that information, is useful.

In the study that evaluated the courses offered by PAETC, some of the largest improvements after training were in response to questions asking dental providers whether they knew how to screen for HIV, how to determine if patients were at risk for HIV, and whether they already had the skills to safely and effectively treat PLWHA.[175] On all of these questions, 30 percent or more of respondents provided the most correct answer, as determined by the researchers, after they had taken the training course.[176] In addition, after the course, at least an additional 10 percent or more of respondents provided the most desired answer to questions asking whether they would prefer to refer PLWHA, whether they would accept patients in high-risk groups for HIV infection, and whether they would be fearful treating PLWHA.[177] This study indicates that trainings in general, and the PAETC trainings in particular, are helpful in addressing the concerns raised by dental care providers in this Study.

Finally, going through specific examples with dentists and their staff of what types of conduct are unlawful may be helpful. In addition to unnecessary referrals, offices that responded that PLWHA could only be seen by certain dentists, in certain rooms, or at certain times, may not realize that such segregation of PLWHA is unlawful. In addition, some offices initially told the tester that they had available appointments, but then told the tester that they had no available appointments immediately after the tester disclosed that he or she was HIV-positive. Staff in these offices may benefit from learning that such pretexts would not hold up in court.

175. *Id.* at 866.
176. *Id.* at 865–66.
177. *Id.* at 863.

In addition to the content of training courses, this Study also suggests where future trainings should be targeted. In terms of who should be trained, perhaps the clearest lesson from this Study is the importance of training the person who is answering the phone. The need for training front line staff is indicated not only by what responders said but also by the frequent inability of the person answering the phone to answer the tester's inquiry without first checking with someone else. Over one-third of the blanket-refusal responses were from offices where the respondent first had to check with someone else before answering, as were over one-fifth of the potentially discriminatory responses. In 8 percent of the offices that indicated that they did accept PLWHA, the person answering the phone also had to check with someone else prior to responding.

Further, even when practices did indicate that they would accept PLWHA, often that acceptance was accompanied with off-putting remarks. One-fourth of the respondents in the different treatment category had their responses accompanied with statements such as, "If I could avoid it, I would, but yes," and "Depends. We have to be more cautious. It's up to you." This contrasts with the one-fourth of offices classified as accepting PLWHA where that acceptance was accompanied by statements such as "Absolutely," "We have other HIV-positive patients," or "We will protect your confidentiality." Both sets of responses indicate that dentists would see PLWHA, but the former provide support for a claim of discrimination if problems occur after the PLWHA makes an appointment, and the latter responses would make PLWHA feel more welcome, creating a better starting point for a relationship to promote the patient's health.

The survey responses also suggest other ways in which more targeted trainings might be effective. First, training efforts may need to be focused on dentists that might not have received effective instruction about HIV disease in dental school. The survey results indicate that dentists who graduated from dental school before 1988 and/or who graduated from a dental school outside of the United States were more likely to have a discriminatory response. Dentists who graduated from dental school prior to 1988 would have mainly graduated before the HIV virus was identified in 1985, the low risk

of occupational exposure had been documented, and the legal duty to treat PLWHA had been clearly established by *Bragdon v. Abbott*.[178]

Dentists serving poorer communities also might benefit from targeted-education efforts. Rates of discrimination were twice as high when testers indicated that they had Denti-Cal, as opposed to private dental insurance. If the adult Denti-Cal program is ever re-funded in California, since prospective providers in the program must be approved by the state,[179] perhaps this training requirement can be built into the approval process. For example, the current approval process already requires the dentist to sign a form that he or she will not discriminate in violation of California or federal law.[180] This form could be modified to explicitly include HIV discrimination and information about HIV and standard infection control. In addition, it could be covered in seminars and trainings that Denti-Cal offers to providers to meet continuing education requirements that are required of all dentists licensed to practice in California.[181]

The finding that discriminatory responses were higher in certain parts of Los Angeles County, such as the San Gabriel Valley and South SPAs, also suggests that education programs should be geographically targeted as well. Targeting training in the Metro area would also target the area where PLWHA are most concentrated in Los Angeles County, and targeting the South SPA would reach providers in the area serving some of the most concentrated populations of women, blacks, and Latinos living with HIV/AIDS.

IX. CONCLUSION

Overall, this Study indicates that one out of twenty dental practices in Los Angeles County has a policy of not accepting PLWHA in violation of state and federal law. One out of ten has policies or practices that are potentially discriminatory. However, this level of discrimination is lower than that found for other health care providers that have been studied in Los Angeles County. It is

178. *See* Abbott v. Bragdon, 912 F. Supp. 580, 595 (D. Me. 1995), *aff'd*, 107 F.3d 934 (1st Cir. 1997), *cert. granted in part*, 522 U.S. 991 (1997), *vacated*, 524 U.S. 624 (1998).

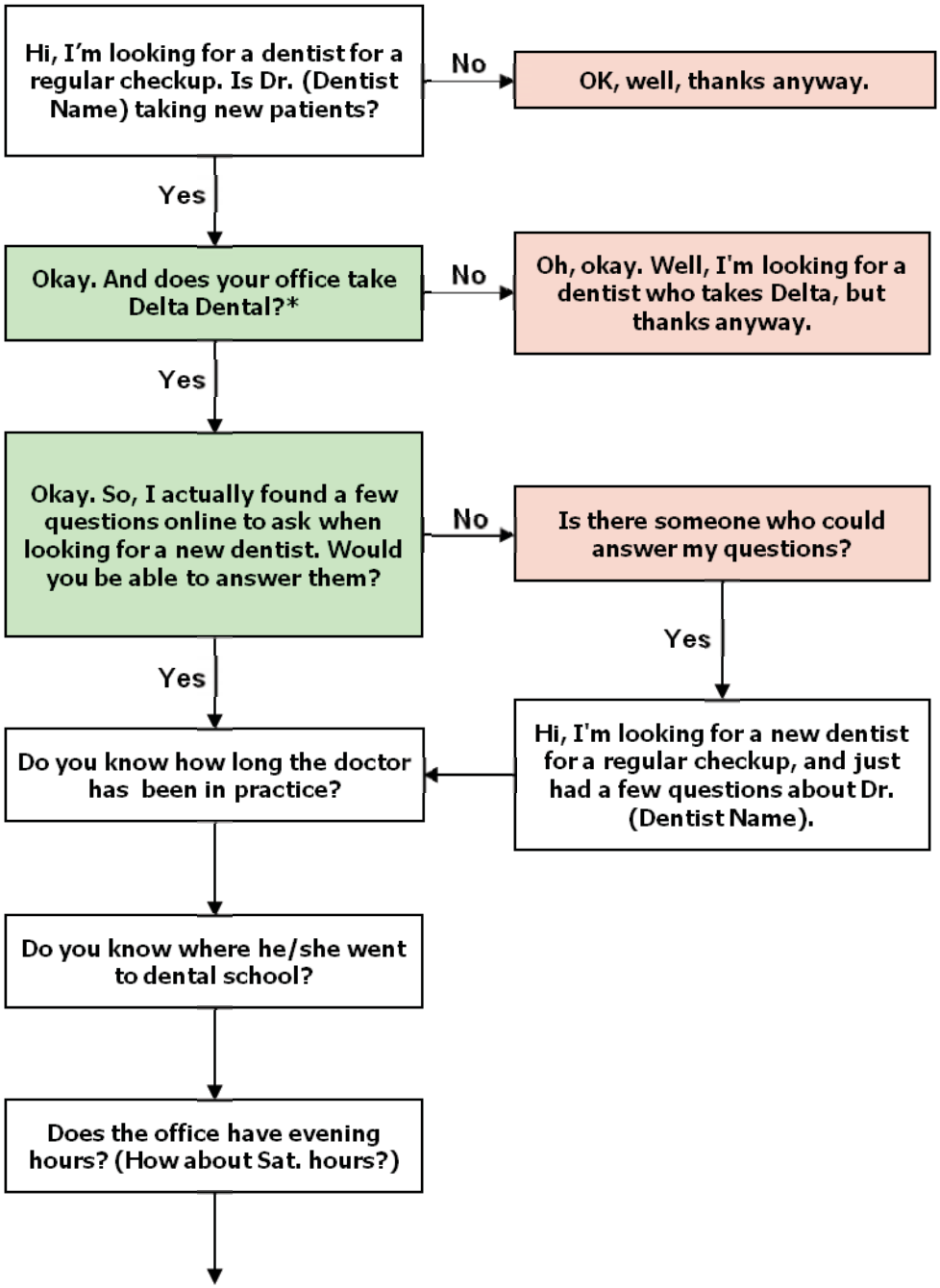
179. MEDI-CAL DENTAL PROGRAM HANDBOOK, *supra* note 117, at 3-1.

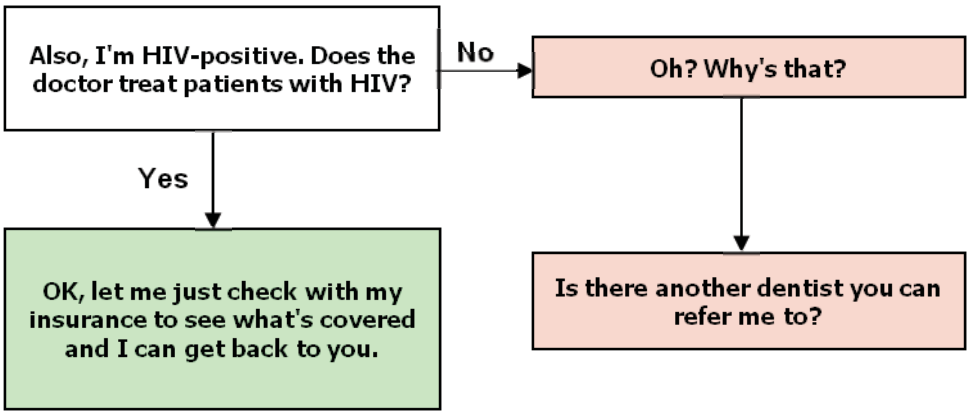
180. CAL. DEP'T OF HEALTH CARE SERVS., MEDI-CAL PROVIDER AGREEMENT (2011), *available at* http://www.denti-cal.ca.gov/provsrvcs/forms/dhcs6208_9106.pdf.

181. The California Dental Board requires continuing education for all dentists. *Continuing Education*, DENTAL BD. OF CAL., http://www.dbc.ca.gov/licensees/cont_education.shtml (last visited Nov. 22, 2011).

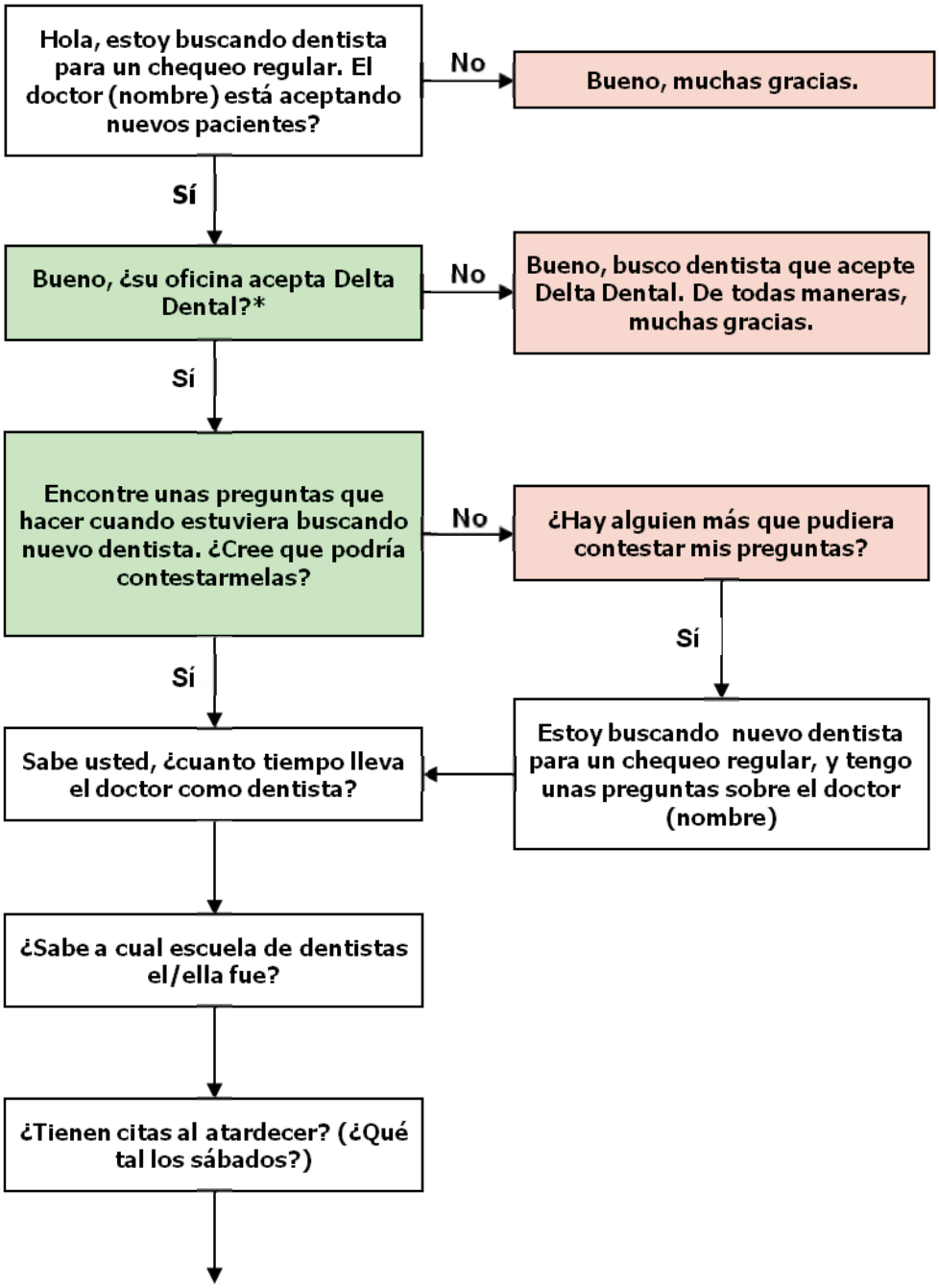
worth further study to determine whether these lower rates of discrimination are the result of the intensive and consistent legal enforcement and education efforts focused on dentists in Los Angeles County for over twenty-five years or because of the inclusion of HIV-related topics throughout the dental curricula of the major dental schools in the state, or both. These data also suggest that future enforcement and education efforts should target front line employees, dentists serving poorer and marginalized communities, and dentists who may not have received instruction about HIV in dental school, including dentists who graduated dental school outside the United States and/or prior to 1988.

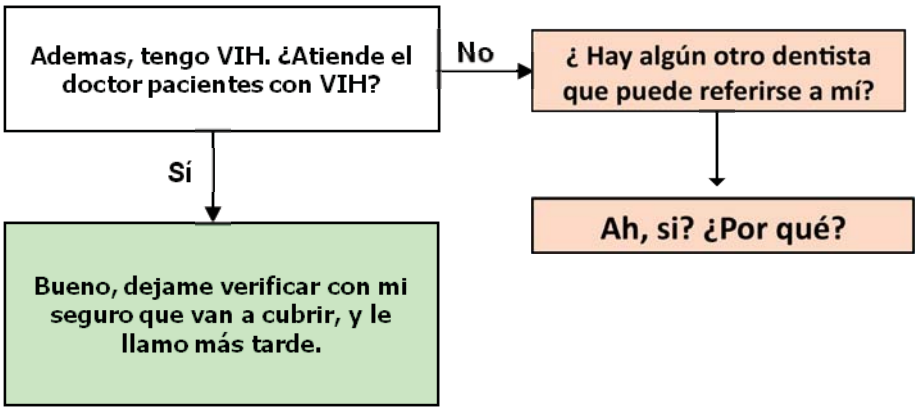
APPENDIX A:
DELTA DENTAL ENGLISH CALLS SCRIPT



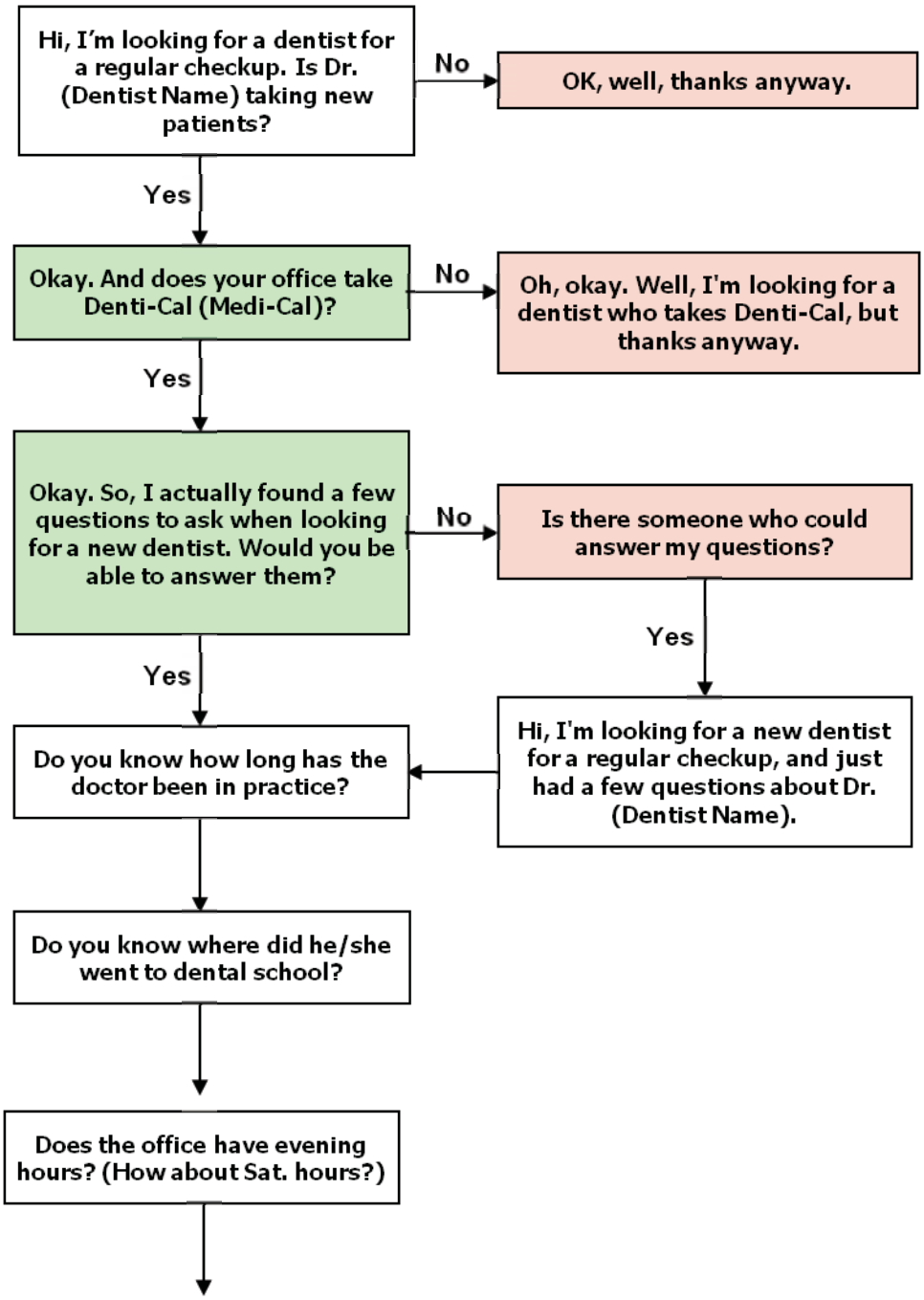

Also, I'm HIV-positive. Does the doctor treat patients with HIV?
No
Oh? Why's that?
Yes
OK, let me just check with my insurance to see what's covered and I can get back to you.
Is there another dentist you can refer me to?

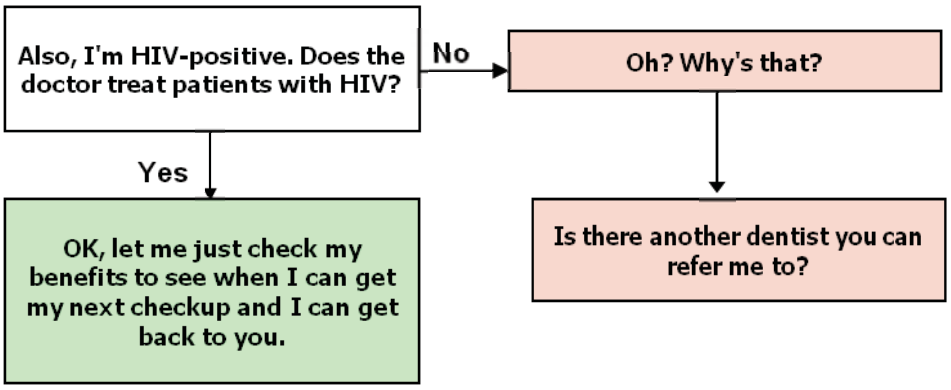
APPENDIX B:
DELTA DENTAL SPANISH CALLS SCRIPT




Ademas, tengo VIH. ¿Atiende el doctor pacientes con VIH?
No
¿ Hay algún otro dentista que puede referirse a mí?
Ah, si? ¿Por qué?
Sí
Bueno, dejame verificar con mi seguro que van a cubrir, y le llamo más tarde.

APPENDIX C:
DENTI-CAL CALLS SCRIPT




Also, I'm HIV-positive. Does the doctor treat patients with HIV?
No
Oh? Why's that?
Yes
OK, let me just check my benefits to see when I can get my next checkup and I can get back to you.
Is there another dentist you can refer me to?