

HIV Discrimination in Dental Care: Results of a Discrimination Testing Study In Los Angeles County



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December 2011

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 other health care services in Los Angeles County. However, levels of discrimination are twice as high for people living with HIV/AIDS (PLWHA) who had Denti-Cal, and three times higher for those living in the San Gabriel Valley and South SPAs. 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 (29) had an unlawful blanket policy of refusing dental services to any PLWHA.
- An additional 5% of dental providers (32) indicated they would treat PLWHA differently than other patients in ways that could potentially violate state and federal anti-discrimination 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.

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

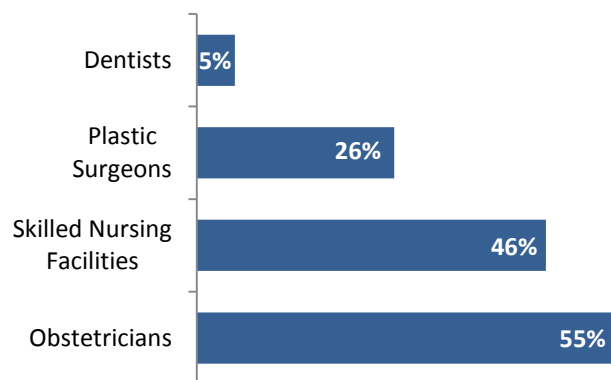
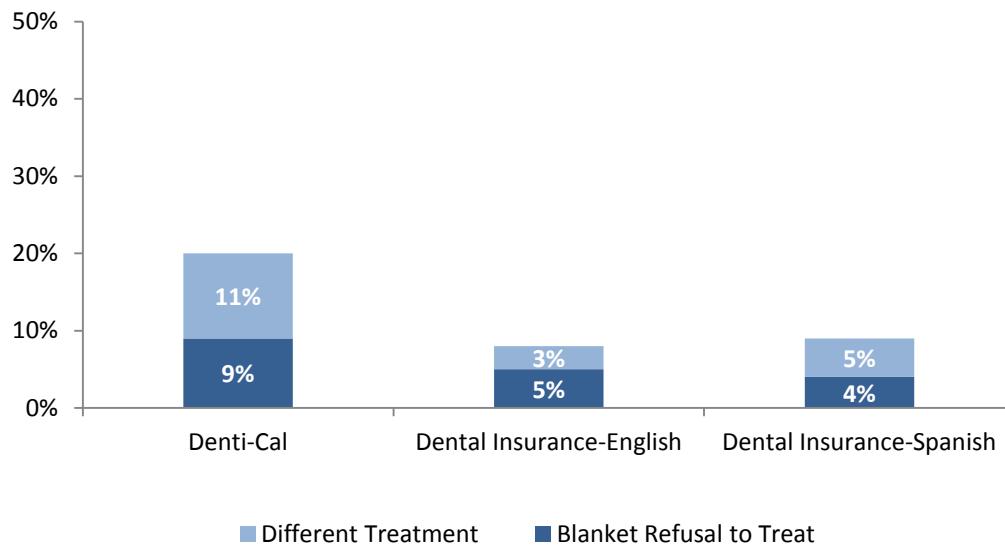
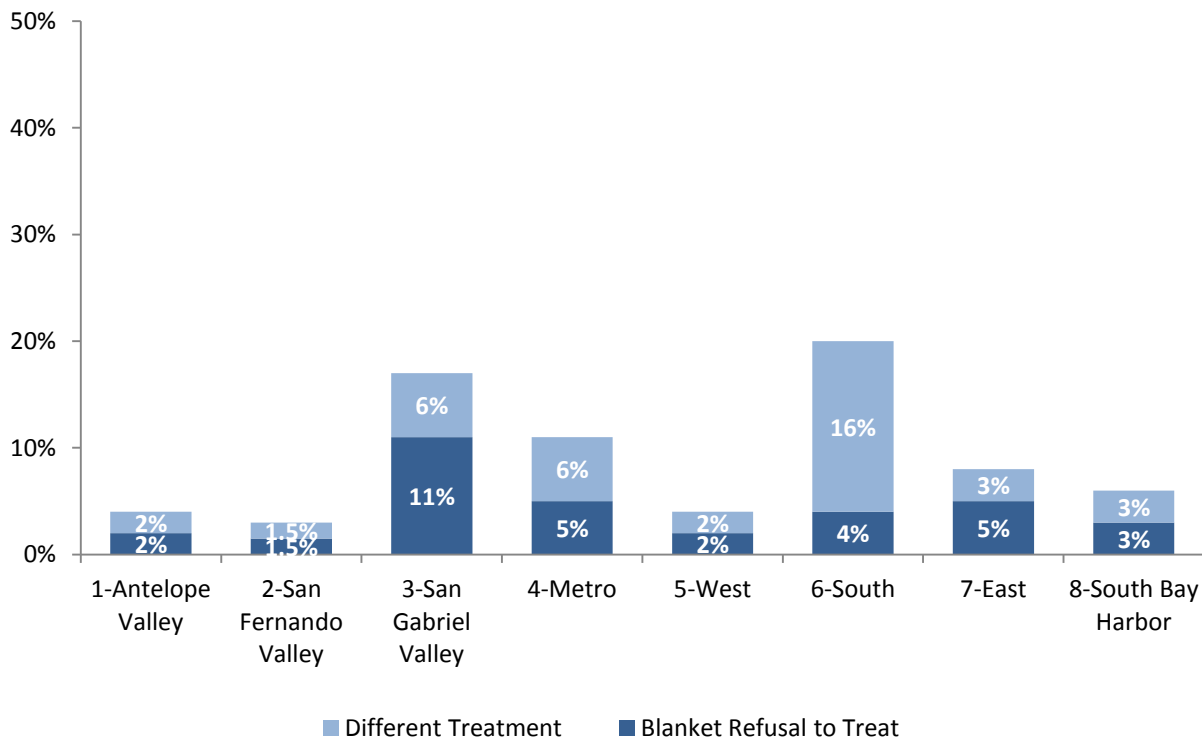


Figure 2. HIV Discrimination by Dentists in Los Angeles County, by Language Spoken by Patient and Type of Dental Insurance



- 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%) and San Gabriel Valley (17%) 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% of the dentists in the study overall graduated prior to 1988, almost 90% 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% 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%).
 - Extra infection control precautions would be required (7%).
 - The office had never treated an HIV-positive patient before (7%).
- Over half of the dentists who refused services to all PLWHA (52%) 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% of obstetricians, 46% of skilled nursing facilities, and 26% of plastic surgeons had such policies.

Ethical and Legal Obligation to Provide Dental Care to HIV-Positive Patients

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.

Medical Background

Routine and proper dental care is very important for PLWHA. Routine dental care is important for PLWHA for the same reasons it is important for anyone's health. It 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. Between 30% and 80% of PLWHA will present with at least one oral manifestation at some time during the course of their infection.¹ Earlier in the AIDS epidemic, oral lesions were frequently used as defining criteria for AIDS diagnosis and disease progression.²

The development and more widespread use of increasingly effective anti-retroviral 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.³ 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."⁴ Anti-retroviral agents and other medications have also meant a new set of issues for PLWHA.⁵ 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 Medical Monitoring Project, PLWHA reported assistance finding dental services as their top supportive services resource need for the previous twelve months. Supportive services are

those 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.⁶ In terms of unmet needs for the previous 12 months, assistance finding dental services ranked second only to shelter services.⁷

Dentists can provide routine dental care to PLWHA without specialized training and with insignificant risk when using standard infection control procedures.⁸ 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.⁹

In 2003, the CDC developed a set of guidelines specifically for infection control in dentistry, based on the Standard Precautions for all healthcare workers.¹⁰ 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 1992.¹¹ The American Dental Association concludes in its policy statement that by following the CDC guidelines, the HIV-positive individual "can be treated safely in the dental office... rendering denial of treatment based on HIV-status unacceptable."¹²

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

Legal Duty to Treat Persons Living with HIV/AIDS

In the highly publicized 1998 case of *Bragdon v. Abbott*¹³, the United States Supreme Court determined that PLWHA, even if asymptomatic,

were covered by the Americans with Disabilities Act. The case involved a dentist who refused to provide services to a woman living with HIV. 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;¹⁴
- 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;¹⁵
- referring patients to “special clinics” or other providers because of their HIV status;¹⁶
- asking a patient to submit to an HIV test prior to treating him;¹⁷ and
- terminating office space lease of a dentist for providing care to PLWHA.¹⁸

In addition, government enforcement agencies, such as the Office of Civil Rights of the U.S. Department of Health and Human 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;¹⁹
- denying continued treatment to a patient after the patient revealed that he was HIV-positive;²⁰
- telling a patient to find treatment elsewhere after she told dentist she had AIDS;²¹ and
- refusing to perform a root canal for an HIV-positive patient.²²

In general, California state²³ and federal²⁴ 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.²⁵ They prohibit the denial of dental services to 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),²⁶ 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.²⁷ In order to make a lawful referral under the ADA, these providers must make “an individualized inquiry into the patient’s condition” and the specific services requested.²⁸

A health care provider may refuse services to PLWHA if providing those services would pose a “direct threat” to the patient or to others.²⁹ The provider has the burden of proving that the patient’s 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.³⁰ 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.³¹ A health care provider’s failure to make an individualized assessment before denying services invariably results in a finding of discrimination.³² Moreover, the health care provider’s assessment of the direct threat must be “based on reasonable medical judgments given the state of medical knowledge.”³³ The assessment cannot be based on stereotypic notions about PLWHA, even if such notions are maintained in good faith,³⁴ or on ignorance because of the provider’s own failure to keep up with the current medical literature.³⁵

For example, in 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. The dentist did offer to provide services after-hours without his staff, although 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.³⁶ 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.³⁷

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 of the patient's condition and the services requested.

Ethical Responsibility to Treat Persons Living with HIV/AIDS

The American Dental Association, the California Dental Association,³⁸ and the World Dental Federation³⁹ have incorporated 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. 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 a 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 in such instances, should be made on the same basis as they are made with other patients, that is, whether the individual dentist believes he or she has need of another's skills, knowledge, equipment or experience and whether the dentist believes, after consultation with the patient's physician if appropriate, the patient's health status would be significantly compromised by the provision of dental treatment.⁴⁰

In Los Angeles County, the Pacific AIDS Education and Training Center (PAETC) Dental Steering Committee developed dental practice guidelines that have been officially adopted by the Los Angeles County Commission on HIV. Entitled "Guidelines for the Dental 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. 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."⁴¹

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, these studies consistently find that some dentists are unwilling to provide care to PLWHA. This section 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.

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. These studies found that between one-third and 80% of dentists did not want to provide care to patients who were HIV-positive or at risk for being HIV-positive.⁴² Even when dentists acknowledged that they had a responsibility or legal duty to treat PLWHA, they often expressed that they did not want to.⁴³ Reasons identified for not providing care included fear of infection,⁴⁴ concerns about losing other patients,⁴⁵ fears of their staff,⁴⁶ homophobia,⁴⁷ and a lack of prior experience treating PLWHA.⁴⁸

For example, a survey of 671 members of the American Dental Association published in 1995⁴⁹

found that one-third of respondents were not willing to treat PLWHA, 84% believed it was their right to choose whether to provide care to PLWHA, and 75% were unwilling to “display” a willingness to provide care to PLWHA for fear of losing other patients.⁵⁰ When asked about their fear of occupational transmission of HIV, 80% agreed that HIV makes dentistry a “high-risk job,” and 33% believed they would eventually acquire HIV if they often treated PLWHA.⁵¹ Thirty-two percent said they wouldn’t choose to go into dentistry again if they had the choice, due to fear of HIV.⁵²

One of these studies identified older dentists as more likely to discriminate⁵³ and another study identified female dentists as more likely to discriminate.⁵⁴ 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,⁵⁵ and that another factor associated with dentists’ willingness to treat PLWHA was recognition that they had already treated PLWHA.⁵⁶

A more recent study measured changes in dental care providers’ knowledge, attitudes and beliefs, and behaviors with regards to providing care for PLWHA before and after taking a one to four day continuing education course.⁵⁷ The study was conducted with 86 dentists, dental hygienists and dental assistants from Southern California who completed the clinical training between 1992 and 2003.⁵⁸ 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.”⁵⁹ After the training 86% of the participants had positively changed their attitudes and beliefs.⁶⁰ In addition, 86% of dentists in the sample had already treated HIV-positive patients before the training program and 93% reported treating HIV-positive patients 6 weeks after the training program.⁶¹ However, the study does note that the dental workers who voluntarily enrolled in the continuing education program may be more interested in treating PLWHA.⁶²

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

to over half of dental students did not want to provide care to PLWHA.⁶³ Reasons associated with not wanting to provide this care include fear of infection,⁶⁴ homophobia,⁶⁵ and the belief that PLWHA are responsible for their illness.⁶⁶ In contrast, one study found that students were more willing to provide treatment if they believed they had a professional responsibility to do so.⁶⁷ One study found that male students were more likely to express discriminatory attitudes than female students.⁶⁸

For example, a study published in 2005 summarized research based on a survey of 670 graduates from one dental school during a twelve year period from 1992-2004.⁶⁹ While the more recent graduates who were surveyed were more comfortable treating PLWHA, overall only 52.3% of respondents indicated they were comfortable treating PLWHA.⁷⁰ 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.⁷¹

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, 52 had been refused treatment by a dentist.⁷² 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.⁷³ Almost 80% of these refusals were classified as “probably discriminatory”, and 95% as either “probably discriminatory” or “possibly discriminatory.”⁷⁴ Thus, 15% of patients surveyed had experienced a refusal of care that was “probably discriminatory” when evaluated by lawyers.⁷⁵ In 60% of the “probably discriminatory” cases, the patient had been explicitly refused care when attempting to make his or her first appointment.⁷⁶ In almost half of these cases, the dentist admitted that he or she had a blanket rule against treating PLWHA.⁷⁷ In the other 40%, the patients had been seeing their dentists for some time before being denied treatment when the dentist became aware of their HIV status.⁷⁸

In an article published in 2005, the RAND Corporation used data from the 1996 HIV Cost and Utilization Study to study discrimination perceived by PLWHA in clinical settings.⁷⁹ Of the 2,466 respondents with HIV that were receiving health care in the United States, 26% reported having experienced at least 1 of 4 types of discrimination by a health care provider on the basis of their HIV status.⁸⁰ Twenty percent reported that a health care worker had been uncomfortable with them when they sought medical care, 17% were treated as inferior by a health care worker, 18% reported that a health care worker preferred to avoid them, and 8% were refused service.⁸¹ When asked which provider had discriminated against them, 32% reported that they had been discriminated against by a dentist.⁸² This percentage was smaller than the share who attributed discrimination to physicians and nurses and other clinical staff, but more than those who attributed discrimination to hospital staff and case managers or social workers. White respondents were most likely to report discriminatory treatment,⁸³ but the authors noted that people of color respondents may have underreported HIV discrimination for several reasons, including because they attributed the discrimination to another characteristic such as race.⁸⁴

Methodology

This report presents the results of a study conducted in 2007 and 2008 measuring HIV discrimination in dental care in Los Angeles County. It is based on three studies conducted between 2003 and 2006, and used a similar methodology as those studies to measure HIV discrimination in the provision of health care services in Los Angeles County.⁸⁵ Unlike the studies described above, 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. This methodology more closely replicates the incidence of actual discrimination that PLWHA face when seeking health care services. Of the several hundred health care providers surveyed by these three testing studies, 26% of plastic and cosmetic surgeons, 46% of skilled nursing facilities, and 55% of obstetricians indicated that they had blanket policies of refusing to provide services to all PLWHA. In these prior studies, the most common reasons given by providers for denying services to PLWHA included lack of expertise or equipment, having no prior experience in treating an HIV-positive patient,

inadequately trained or uncooperative staff, and the referral of all HIV-positive to “specialists.”

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.⁸⁶ 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 Angeles Counties Service Provider Areas or SPAs. For another 66 calls, testers used the same script stating they had dental insurance (Delta Dental) but requested services in Spanish. For the final 66 calls, testers requested services in English but stated they had Denti-Cal (part of Medi-Cal), a federal-state public benefits people that helps provide dental services for low income people in California. 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% confidence intervals for statistical comparisons.⁸⁷

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). The DCA issues licenses in more than 100 businesses and 200 professional categories, including doctors and dentists.⁸⁸ The DCA website features a search function that allows members of the public to search for dentists using several criteria, including by county.⁸⁹ 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.⁹⁰

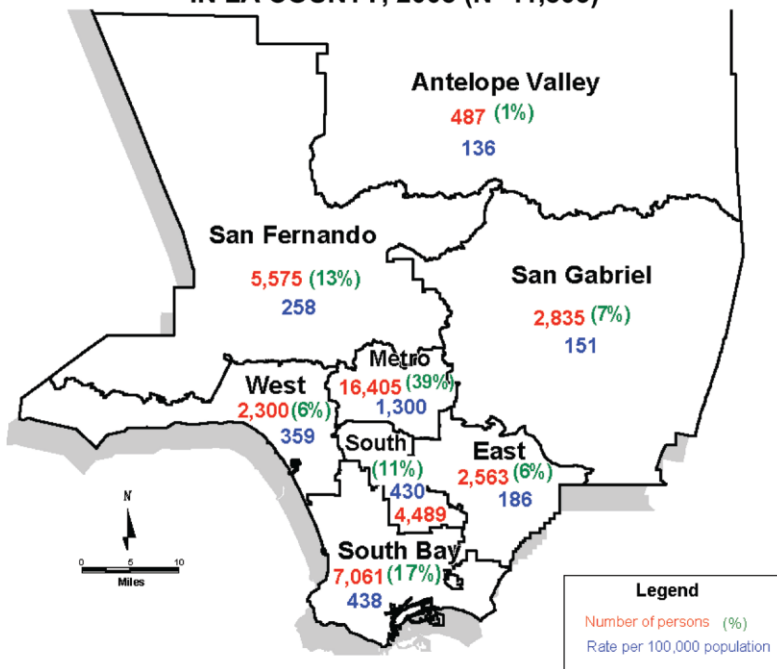
From that group, we removed 1,324 dentists whose sole listed address is a home address.⁹¹ We did this because we wanted to contact all dentists at their dental practices, to replicate what a person looking for a new dentist would do. In addition, we wanted to determine whether different parts of Los 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 12 in institutional practice, this left 6,592 dentists.

We then further organized the list based on each dentist's geographical area. Like other diseases, HIV/AIDS has not affected all areas of the county equally.⁹² The Los Angeles County Department of Public Health has divided Los Angeles into eight geographical regions, called Service Planning Areas (SPAs)⁹³ whose boundaries are determined by ZIP codes.⁹⁴ The Metro SPA has the highest concentration of PLWHA followed by the South Bay. The Antelope Valley has the lowest concentration.⁹⁵

Figure 4. Distribution of Persons Reported Living with HIV/AIDS in Los Angeles County by SPA, 2008 (source: HIV Epidemiology Program, LAC-DPH)

PERSONS REPORTED LIVING WITH HIV/AIDS AND LIVING HIV/AIDS RATE PER 100,000 POPULATION BY SERVICE PLANNING AREA (SPA) IN LA COUNTY, 2008 (N=41,803)



Source: HIV Epidemiology Program, LAC-DPH; data as of December 2008

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% margin of error, with a 90% confidence level.⁹⁶ In two cases, the indicated sample size was fewer than 50 dentists, so for each SPA we included the names of at least 50 dentists to increase accuracy.⁹⁷ 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 66 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).⁹⁸ Testing was done in Spanish because almost 40% of PLWHA in Los Angeles County are Latino.⁹⁹ In terms of people diagnosed with AIDS, Latinos have been the predominant racial and ethnic group impacted in Los Angeles County since 1997.¹⁰⁰ Overall, 45% of the Latino population in Los Angeles County is foreign born.¹⁰¹ According to 2009 CHIS Data, over 12% of residents only speak Spanish in the home and over 28% speak Spanish and English in the home.¹⁰²

Finally, because a large percentage of PLWHA have their medical and dental care covered through public benefits programs, an additional 66 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 Angeles County.¹⁰³ Testers called these dentists and stated 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, California's Medicaid program primarily

for poor and low income people.¹⁰⁴ However, due to budget cuts, routine care was eliminated from the Denti-Cal program for most adult Medi-Cal beneficiaries in 2009.¹⁰⁵ 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% of all Los Angeles County residents 18 years and

over are enrolled in the Medi-Cal program, and therefore qualified for Denti-Cal,¹⁰⁶ according to data from the Center for Disease Control Medical Monitoring Project, 47% PLWHA surveyed in 2006-2007 were covered by their state's Medicaid program at some point during the prior year.¹⁰⁷ Similarly, the Los Angeles Coordinated HIV Needs Assessment (LACHNA) conducted in 2007-2008, found that 52% of respondents had their medical care covered through public programs such as Medi-Cal.¹⁰⁸

For low income PLWHA, another source of funding is the Ryan White system. Currently, Ryan White-funded programs provide services in medical and supportive services clusters to over 23,000 clients in Los Angeles County. Funding for dental services is available under Ryan White Care Act and supports services to roughly 2,500 PLWHA every year.¹⁰⁹ However, since the Ryan White funded programs are specifically for PLWHA, 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.¹¹⁰ 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 persons not infected, in many cases in ways that would also violate anti-discrimination 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 Section I above, these policies would clearly violate local, state, and federal anti-discrimination laws.

Results

Summary of Findings

Of the dentists contacted, 90% (N=551) responded with an unqualified "yes" to accepting PLWHA. Only 5% (N=29) stated that they would not accept PLWHA. Another 5% (N=32) provide 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%

* Statistically significant at P<0.10 as compared to Delta Dental English calls.

Type of Dental Coverage. Rates of discrimination were higher when the testers stated that they had Denti-Cal, the public benefit program for low-income people, compared to Delta Dental, a private insurance program taken by most dentists in Los Angeles County. 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% of the time, compared to 8% 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% 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% of providers in the South SPA had such responses, five times the rates of such policies as providers in the Antelope Valley (4%), San Fernando Valley (3%), and West (3%) SPAs. Combined rates of unlawful and potentially unlawful policies were also high in the San Gabriel Valley SPA (17%). While the combined rates were higher in the Metro SPA (11%), this difference was not statistically significant as compared to any other SPA.

For the dentists who were called by testers who indicated that they had private dental insurance, the on-line 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

Table 2. Responses to Delta Dental Insurance Calls in English (480), by Los Angeles County Service Provider Area (SPA)

	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

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.

on-line records where it was provided. Where this information was not provided in the on-line 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, the same percentage of dentists providing those responses were male as the percentage of dentists responding that they would treat PLWHA who were male—77%.

Year of Graduation. Dentists who graduated before 1988 were more likely to provide a discriminatory or potentially discriminatory response. Overall, 68% of these 480 dentists graduated prior to 1988. However, almost 90% 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% 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.

Reasons Provided for Responses

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% 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% of these responses were accompanied with assurances such as "absolutely," "definitely," "why not," "of course," and "he sure does."

Table 3. Responses to Delta Dental Insurance Calls in English (480), by Response, and by Dentists' Sex, Year of Graduation, and Country of Dental School

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%*

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

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

patients who had not informed them they were HIV-positive. The calls made in Spanish encountered these types of responses more frequently with 6% stating they had never treated an HIV-positive patient before, and 3% stating they would use extra precautions.

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 of the other dental offices indicating that they would accept PLWHA displayed less certainty and knowledge. For 8% 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 dentist before responding to the caller. This percentage was slightly higher (11%) for those calls where the tester said they had Denti-Cal.

Two percent of providers who responded they would accept PLWHA indicated they had never treated an HIV-positive patient before, and 1% indicated they would use extra infection control precautions beyond what they would use for

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 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% of those providers stating 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%

Reasons Given for No Responses

Five percent (29) 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 was reached by 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%), 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 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 (5), USC (3), “LA County” (2), Loma Linda (1), and San Gabriel Dental Society (1).

Nearly 40% of the dentists who would not accept PLWHA said their offices were not equipped to treat PLWHA, either 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% of the “no” responses, the reason given was that the dentist was not accepting patients at this time. Since the first questions 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 like this response was merely a pretext for discrimination. Finally, 7% 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 that they 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%

Reasons Given for Different Treatment Responses

Five percent (32) 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% 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% 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 (4), USC (3), “the West Hollywood Clinic” (1), and St. Mary’s (1).

Nearly one-fifth of these responses (18%) 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% of these responses indicated that PLWHA were treated in “isolation rooms.”

Over one-fourth of these responses (26%) 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.*”).

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%

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 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.

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 their HIV-status when making their initial appointment, they 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% of PLWHA in Los Angeles County live in the Metro SPA.¹¹¹ The South SPA has the highest proportion of female AIDS cases, almost twice that of Los Angeles County overall.¹¹² It also has the highest proportion of Black

PLWHA. Among PLWHA in the South SPA, 54% are black and 41% are Latino.¹¹³ Overall, the San Gabriel Valley (24%), South (3%), and Metro (22%) SPAs all have general populations that are less than one-quarter white.¹¹⁴ This means that, to some extent, HIV discrimination by dentists is concentrated in areas with a higher proportion of PLWHA and in areas where PLWHA are “special and emerging populations” with specific vulnerabilities and care and

service needs. These include the overlapping populations of women, Blacks, Latino/as, and Women of Color.¹¹⁵

In addition, when the callers stated 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 may indicate that dentists serving poorer individuals are more likely to discriminate on the basis of HIV-status. 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% of the federal poverty level (45%) followed by the Metro SPA (34%).¹¹⁶

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. The rate of dentists who refuse treatment to all PLWHA was less than one-fifth of the lowest level of discrimination found in these prior studies. 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.

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 Americans with Disability Act. 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.¹¹⁷ The case was settled in 1993¹¹⁸ and the resulting consent decree required Western Dental to conduct training sessions on caring for PLWHA for all of its providers and to establish written policies of non-discrimination and confidentiality with respect to PLWHA in all of its offices.¹¹⁹ 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.¹²⁰

The organizations that were involved with the 1992 case against Western Dental also indicate the range of organizations in Los Angeles County that were engaged in legal enforcement activities against dentists for HIV-discrimination. These organizations included AIDS Project Los Angeles, the Los Angeles Gay and Lesbian Center, the American Civil Liberties Union, the Disability Rights Legal Center, and Lambda Legal Defense and Education Fund. 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 1997.¹²¹ Those complaints resulted in settlements ranging from \$2,500 to \$50,000.¹²² In 2008, HALSA brought a second suit against Western Dental for discrimination against PLWHA.¹²³ The two patients, on behalf of whom the suit was brought, were refused treatment at a Santa Monica office because they were HIV-positive.¹²⁴ That case was successfully settled in February 2009.¹²⁵

The enforcement efforts by non-profit 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 the 1992 Western Dental lawsuit and condemned the discrimination.¹²⁶ 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.¹²⁷

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.¹²⁸ 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 1986¹²⁹ to 2009.¹³⁰ 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 dental 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."¹³¹

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.¹³² From 2001-2007, 13 complaints against dentists for discriminating against PLWHA were filed, investigated, and resolved by the OCR, in OCR's Region IX.¹³³ Ten of these were filed against dentists in Los Angeles County.¹³⁴ All 13 complaints involved denial of treatment.¹³⁵

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 80s and early 90s.¹³⁶ Evans believes that there has been a decline in case filings against dentists since 2001 as the result of increased awareness of non-discrimination laws and policies, better information regarding risks of transmission, and new medications.¹³⁷ 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.¹³⁸

These legal enforcement efforts not only resulted in monetary settlements for individual plaintiffs, but also newspaper stories that publicized the issue more broadly,¹³⁹ coverage by publications directed at dentists,¹⁴⁰ 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 things are worth further exploration. First, why haven't similar enforcement efforts 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 non-profit 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 incorporated into their curricula. In addition, all dental students at USC and UCLA have an opportunity to provide dental care for 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.¹⁴¹ While an HIV-specific course is no longer required, courses on infection control in general are still required.¹⁴²

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.¹⁴³ 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 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.¹⁴⁴ The providers' attitudes and beliefs toward PLWHA changed most significantly of the three components studied, with 86% of dental care providers indicating more positive attitudes and beliefs after the training.¹⁴⁵ Further, 65% of the providers demonstrated increased HIV-related knowledge after the trainings, and 55% 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.¹⁴⁶ The study also found that during the period of the study, best estimates of the number of HIV/AIDS patients treated by the dentists approximately doubled for the dentists and nearly quadrupled for dental hygienists.¹⁴⁷ Most likely, this is a result of providers being more aware when they are treating PLWHA, although the study found that 9% more dentists reported treating any PLWHA than before the study.¹⁴⁸

In addition, other studies have also found that "courses in HIV and AIDS have been found to be valuable 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."¹⁴⁹ These courses also improve providers' ability to communicate with PLWHA and to counsel staff who are reluctant to treat PLWHA.¹⁵⁰

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% 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% indicated that either the office was not equipped to PLWHA or that 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%) of the dentists who refused services to all PLWHA told the tester they should seek services from another provider, a clinic, or a hospital. Of those providing potentially discriminatory responses, over 60% stated that would provide limited services, but then the PLWHA would be referred for all other services.

In addition, training may be need 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 their 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% of responses otherwise classified as "different treatment" indicated that a medical clearance or more medical information would be required, as opposed to only 3% 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.¹⁵¹ On all of these questions, 30% of more respondents provided the most desired answer after they had taken the training course.¹⁵² In addition, after the course, an additional 10% 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.¹⁵³ 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 such segregation of PLWHA is unlawful. In addition, some offices told the testers they had no available appointments after the tester disclosed they were HIV-positive, after previously stating appointments were available. Staff in these offices may benefit from learning that such pretexts would not hold up in court.

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 by the frequent inability of the person answering the phone to answer the tester's inquiry without first checking with someone else. Over a 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% 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 those 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 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*.

Those 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, a public benefit for poorer patients, as opposed to 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, perhaps this training requirement can be built into the approval process.¹⁵⁴ 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.¹⁵⁵ 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 Denti-Cal offers to providers to meet continuing education

requirements that are required of all dentists licensed to practice in California.¹⁵⁶

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 those providers in the area serving some of the most concentrated populations of women, Blacks, and Latino/as living with HIV/AIDS.

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 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 those 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.

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Acknowledgements

We would like to thank M.V. Lee Badgett, Gary J. Gates, Roseann Mulligan, and Nancy Warren for their thoughtful reviews and feedback on this study, as well as Williams Institute fellows Blanca Corea, Deborah Ho, Craig Konnoth, and Christy Mallory for contributing countless hours to conducting this study and related research. This study was made possible through the generous support of the Macy's Passport Fund, the Williams Institute, and the UCLA/Pacific AIDS Education and Training Center (PAETC) at the David Geffen School of Medicine at UCLA.

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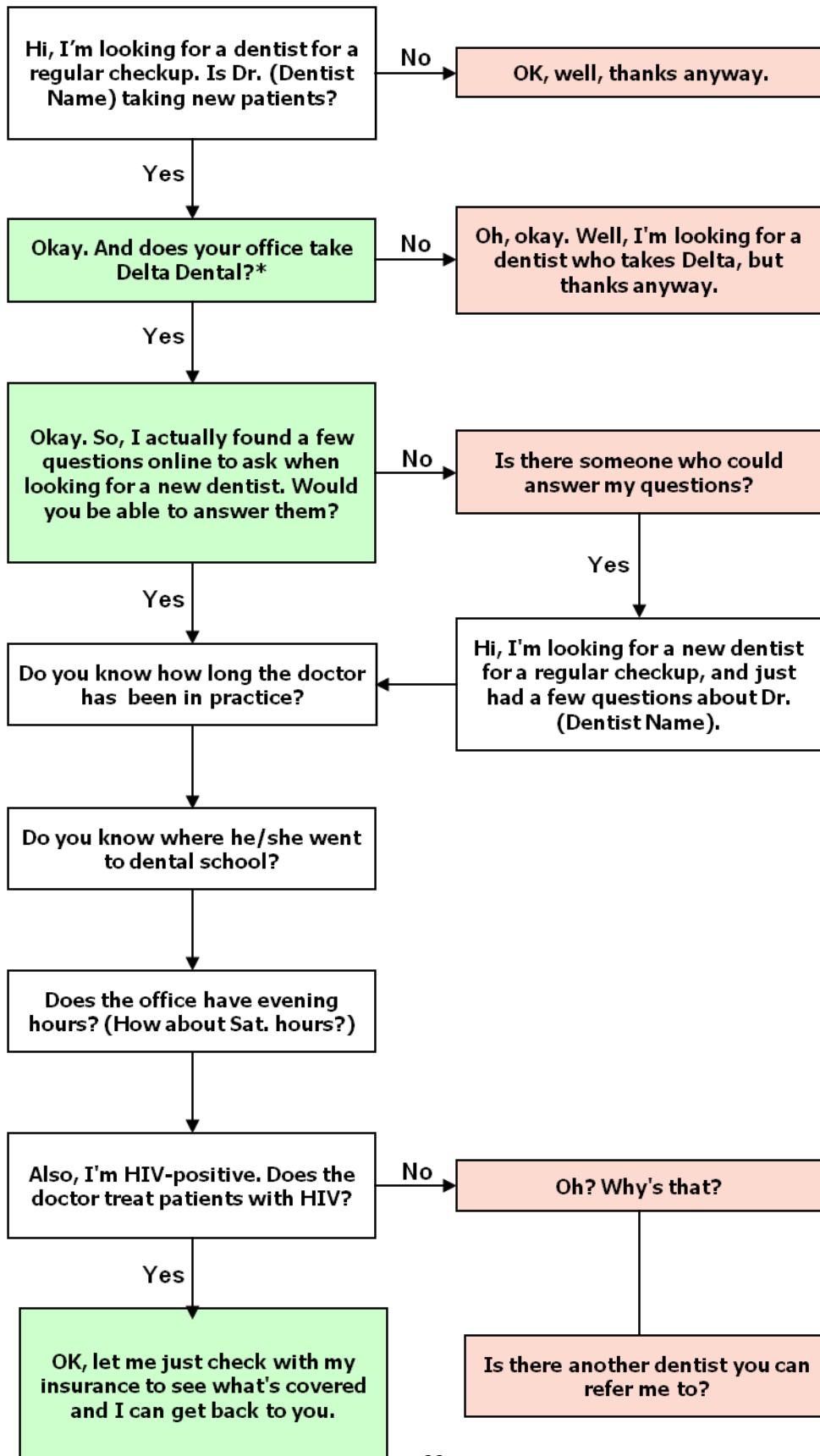
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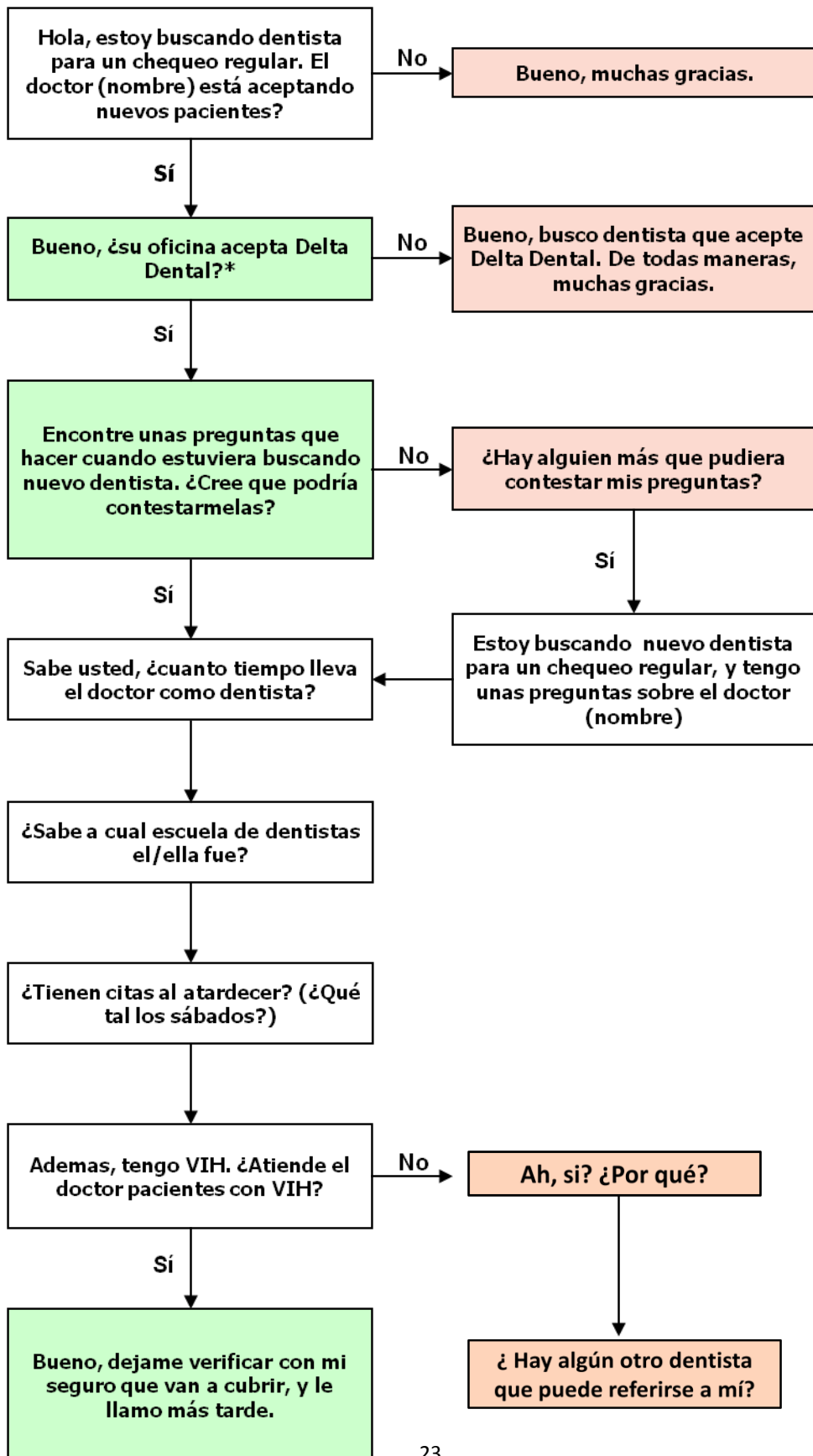
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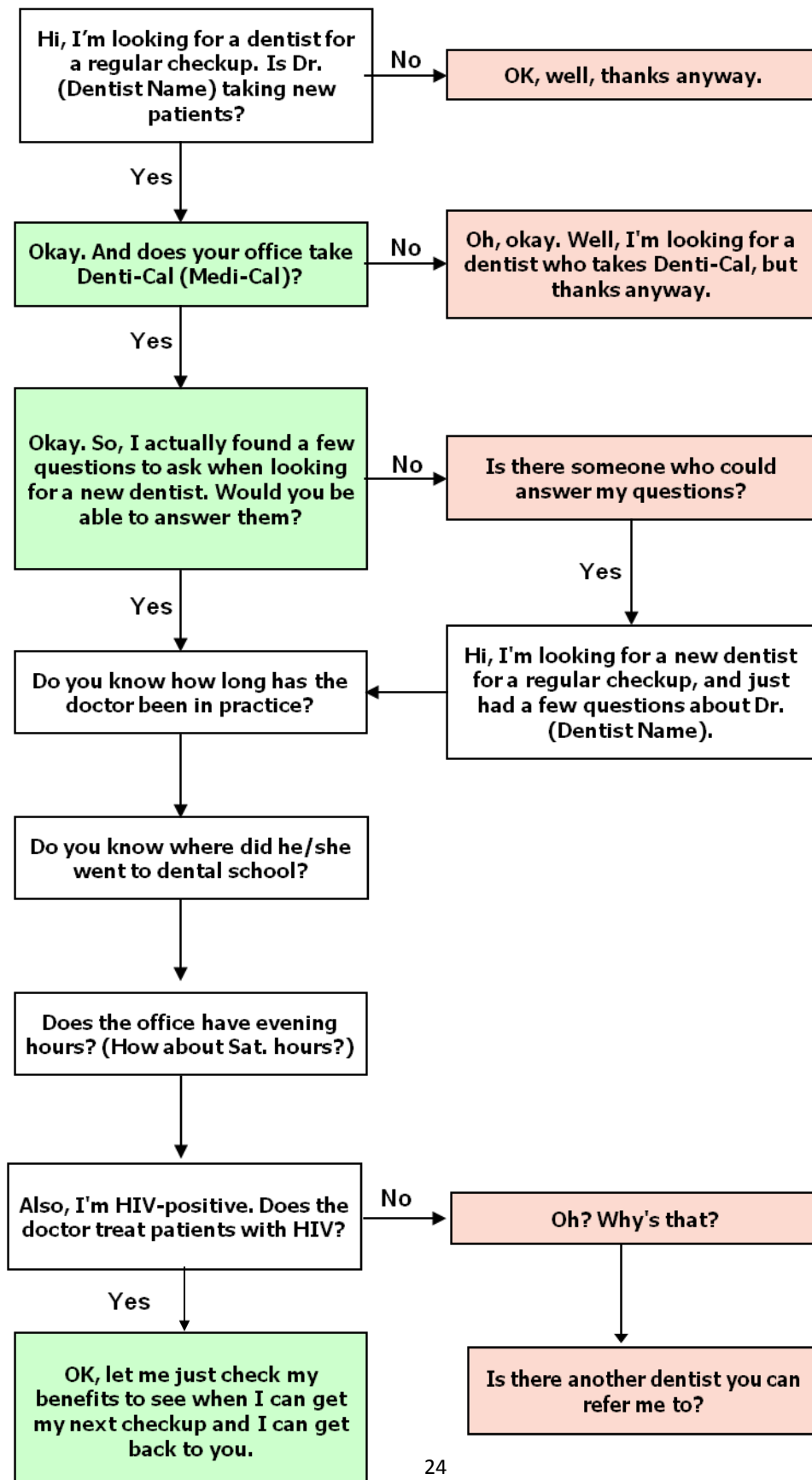
Appendix A Delta-Dental English Calls Script



Appendix B Delta Dental Spanish Calls Script



Appendix C **Flow Chart For Dental-Cal Calls Script**



Endnotes

¹ These oral manifestations include oral candidiasis or thrush, Kaposi's Sarcoma tumors, Hairy Leukoplakia, gingivitis, and periodontitis. David A. Reznick, *Oral Manifestations of HIV Disease*, 13 PERSPECTIVE- ORAL MANIFESTATIONS 143 (2005).

² Shilpa Kolhatkar et al., *Bilateral Vestibuloplasty Utilizing Palatal Soft Tissue Grafts in an HIV-Positive Patient*, 37 CDA JOURNAL 467 (2009).

³ *Id.*

⁴ *Id.*

⁵ 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 problem in the mouth, including "the risk of tooth loss due to increases in caries and periodontal disease." *Id.*

⁶ Amy Rock Wohl et al., *Barriers and Unmet Needs for Supportive Services for HIV Patients in Care in Los Angeles County, California*, 25 AIDS PATIENT CARE STDs 525 (2011).

⁷ *Id.*

⁸ Eve Cuny & William M. Carpenter, *Occupational Exposure to Blood and Body Fluids: New Postexposure Prophylaxis Recommendations*, 26 J. CALIF. DENT. ASSOC. 261, 269-71 (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").

⁹ Ann M. Lyles, *What the Dentist Should Know about a Patient with HIV/AIDS*, 29 J. CAL. DENT. ASSOC. 158 (2001).

¹⁰ WILLIAM G. KOHN ET AL., CENTER FOR DISEASE CONTROL AND PREVENTION, GUIDELINES FOR INFECTION CONTROL IN DENTAL HEALTH-CARE SETTINGS (2003), available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5217a1.htm>.

¹¹ *Id.*

¹² AMERICAN DENTAL ASSOCIATION, POLICY STATEMENT ON BLOODBORNE PATHOGENS, INFECTION CONTROL AND THE PRACTICE OF DENTISTRY (2004), available at <http://www.ada.org/prof/resources/positions/statements/blood.asp>. 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 (2010).

¹³ 524 U.S. 624 (1998).

¹⁴ *US v. Morvant*, 898 F. Supp. 1157 (E.D. La. 1995).

¹⁵ *Cahill v. State Div. of Human Rts*, 89 N.Y. 2d 14 (N.Y. 1996).

¹⁶ *Bloom v. Madison Dental Centre*, 896 F. Supp. 166 (D. N.J. 1995); *Beaulieu v. Clausen*, 491 N.W.2d 662 (Minn. Ct. App. 1992).

¹⁷ *Merchant v. Kring*, 50 F. Supp. 2d 433 (W.D. Pa 1999).

¹⁸ *Barton v. NY City Comm. on Human Rts*, 542 N.Y.S.2d 176 (N.Y. App. Div. 1989).

¹⁹ *Id.*

²⁰ U.S. Dep't of Justice, Civil Rights Division, Enforcement Highlights: Fighting Discrimination Against Persons with HIV/AIDS, available at <http://www.ada.gov/hivreprt.txt> (last visited Nov. 21, 2011).

²¹ Cheryl P. Weinstock, *Public and Private Toll of Living with AIDS*, NY TIMES, Oct. 21, 2009.

²² Gwen Ifill, *Dentist Faces Fine over AIDS Patient*, NY TIMES, Aug. 7, 1991.

²³ California state laws that prevent health care providers from discriminating against persons living with HIV/AIDS include the Unruh Act (CAL. CIV. CODE §51 *et seq.*) and California Civil Code Sections 54 and 54.1. Both laws incorporate violations of the American with Disabilities Act.

²⁴ Title III of the Americans With Disabilities Act (ADA), 42 U.S.C. §§ 12181(7)(F), 12182(a) (2010); 28 C.F.R. § 36.104(7) (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) (2010).

²⁵ *Bragdon*, 524 U.S. at 641-42 (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 T. 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) and (*EEOC v. Lee's Log Cabin Rest.*, 546 F.3d 438 (7th Cir. 2008)), the ADA Amendments Act of 2008 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." 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 ADA Amendments Act of 2008, Pub. L. No. 110-325, 122 Stat. 3553 (2008) (codified at 42 U.S.C. § 12101 et seq.). The Department of Justice and the Equal Employment Opportunity Commission have issued regulations and guidance on the 2008 Amendments clarifying that HIV (even when asymptomatic) is a disability covered by the ADA. In administrative regulations issued by the Department of Justice implementing the public accommodations provisions of the ADAAA, HIV infection (whether symptomatic or asymptomatic) is a *per se* impairment. In administrative guidance, the Department of Justice 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, 704 (2010) (citing Memorandum from Douglas W. Kmiec, Acting Assistant Attorney General, Office of Legal Counsel, Department of Justice, to Arthur B. Culvahouse, Jr., Counsel to the President (Sept. 27, 1988), reprinted in *Hearings on S. 933, the Americans with Disabilities Act, Before the Subcomm. on the Handicapped of the Senate Comm. on Labor and Human Res.*, 101st Cong., 1st Sess. 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) (2010). 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). Additionally, discrimination on the basis of HIV-status is explicitly prohibited under California Law. See CAL. HEALTH & SAFETY CODE § 129990 (2010) (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. CITY OF LOS ANGELES, CAL., CODE § 45.84 (2010).

²⁶ 42 U.S.C. §§ 12181-12189 (2010); 42 U.S.C. §§ 12101-12213 (2010); 47 U.S.C. §§ 225, 611 (2010).

²⁷ 8 C.F.R. § 36.302(b), (b)(2) and App. B § 36.302(b)(2) (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 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., *Morvant*, 898 F. Supp. 1157 (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.).

²⁸ *Lesley v. Chie*, 250 F.3d 47, 56 (1st Cir. 2001) (gynecologist lawfully referred HIV-positive patient where he made a fact-specific and individualized inquiry before making his decision to transfer her to a program specializing in prenatal care for HIV-positive patients and where his decision was confirmed by independent and knowledgeable persons at the time).

²⁹ See *Chevron v. Echazabal*, 536 U.S. 73 (2002) (upholding EEOC regulation extending direct threat defense to "threat to self"). The U.S. Department of Justice 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 Rights Sec., Civil Rights Div., U.S. Dep't of Justice, Questions and Answers: The Americans with Disabilities Act and Persons with HIV/AIDS, <http://www.ada.gov/pubs/hivqanda.txt> (last visited Nov. 22, 2011).

³⁰ 42 U.S.C.A. § 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.").

³¹ 28 C.F.R. § 36.208(c) (2002).

³² *Shultz v. Hemet Youth Pony League, Inc.*, 943 F. Supp. 1222 (C.D. Cal. 1996); *Anderson v. Little League Baseball, Inc.*, 794 F. Supp. 342 (D. Ariz. 1992); *Morvant*, 898 F. Supp. 1157 (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).

³³ Federal regulations implementing the ADA state:

In determining whether the patient poses a direct threat, the health care provider must consider current medical and scientific knowledge about (a) the nature of the risk (how the disease is transmitted), (b) the duration of the risk (how long is the carrier infectious), (c) the severity of the risk (what is the potential harm to third parties) and (d) the probabilities the disease will be transmitted and will cause varying degrees of harm.

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 Bd. of Nassau County v. Arline*, 480 U.S. 273, 288 (1987).

³⁴ *Bragdon*, 524 U.S. at 649 ("The existence, or nonexistence, of a significant risk must be determined from the standpoint of the person who refuses the treatment or accommodation").

³⁵ *Morvant*, 898 F. Supp. 1157. *See also*, *Abbott v. Bragdon*, 912 F.Supp. 580 (1st Cir. 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 patient); *Bragdon*, 524 U.S. at 648-50 (“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.”).

³⁶ *Doust v. Dornfeld et al.*, No. MID-L-6905/02, settlement announced (N.J. Super. Ct., Middlesex County May 13, 2003).

³⁷ *Morvant*, 898 F. Supp. at 1159 (dentist found to have discriminated against PLWHA in violation of the ADA for referring patients to another facility because the dentist feared he would lose staff if he had to treat PLWHA).

³⁸ 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, 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. As discussed, it is a violation of the American’s with Disabilities Act for a dentist to discriminate against a person living with HIV and a violation several provisions of California law, under which HIV/AIDS is considered a *per se* disability. As such, member dentists of the California Dental Association are ethically obligated to provide care to people living with HIV.

CAL. DENTAL ASSOC., CODE OF ETHICS § 4 (2005), available at http://www.cda.org/page/CDA_Code_of_Ethics#4.

³⁹ The FDI World Dental Federation, one of the oldest professional organizations in the world, 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.” American Dental Association, About the FDI World Dental Federation, <http://www.ada.org/ada/international/fdi.asp> (last visited Aug. 16, 2011); FDI WORLD DENTAL FEDERATION, DENTAL ETHICS MANUAL, 47-48 (2007), available at

http://www.fdiworldental.org/resources/assets/journals/FDI_Dental_Ethics_Manual_Low_Res.pdf.

⁴⁰ AMERICAN DENTAL ASSOCIATION, ADA PRINCIPLES OF ETHICS AND CODE OF PROFESSIONAL CONDUCT III § 4.A.1 (2011), available at <http://www.ada.org/1382.aspx>.

⁴¹ LOS ANGELES COUNTY COMMISSION ON HIV, STANDARDS OF CARE: ORAL HEALTH CARE (2005), available at http://hivcommission-la.info/cms1_032641.pdf.

⁴² Barbara Gerbert, *AIDS and Infection Control in Dental Practice: Dentists’ Attitudes, Knowledge, and Behavior*, 114 JADA 311 (1987); Herbert M. Hazelkorn, *The Reaction of Dentists to Members of Groups at Risk of AIDS*, 119 JADA 611 (1989); A. Carl Verrusio et al., *The Dentist and Infectious Diseases: A National Survey of Attitudes and Behavior*, 118 JADA 553 (1989); Donald Sadowsky & Carol Kunzel, *A Model Predicting Dentists’ Willingness to Treat HIV-Positive Patients*, 5 J. ACQUIRED IMMUNE DEFICIENCY SYNDROMES 701 (1992); M. Elizabeth Bennett et al., *Dentists’ Attitudes Toward the Treatment of HIV-Positive Patients*, 126 JADA 509 (1995); Carol Kunzel, *Assessing HIV-Related Attitudes and Orientations of Male and Female General Dentists*, 126 JADA 862 (1995).

⁴³ Gerbert, *supra* note 42.

⁴⁴ *Id.*

⁴⁵ *Id.*

⁴⁶ *Id.*

⁴⁷ Hazelkorn, *supra* note 42.

⁴⁸ Sadowsky & Kunzel, *supra* note 42.

⁴⁹ Bennett et al., *supra* note 42.

⁵⁰ *Id.* at 510-11, Tables 1 & 2.

⁵¹ *Id.* at 510, Table 1.

⁵² *Id.*

⁵³ Verrusio et al., *supra* note 42.

⁵⁴ Kunzel, *supra* note 42.

⁵⁵ Sadowsky & Kunzel, *supra* note 42; Kunzel, *supra* note 42.

⁵⁶ Sadowsky & Kunzel, *supra* note 42.

⁵⁷ Roseann Mulligan et al., *The Effect of an HIV/AIDS Educational Program on the Knowledge, Attitudes, and Behaviors of Dental Professionals*, 70 J. DENT. EDUC. 857, 862 (2006).

⁵⁸ *Id.* at 861.

⁵⁹ *Id.* at 862.

⁶⁰ *Id.*

⁶¹ *Id.* at 861.

⁶² *Id.* at 862.

⁶³ Leonard A. Cohen et al., *Attitudes of Dental Faculty Toward Individuals with AIDS*, 53 J. DENTAL EDUCATION 199 (1989); Robert J. Weyant et al., *Desire to Treat HIV-Infected Patients: Similarities and Differences Across Health-care Professions*, 8 AIDS 117 (1994); Jason P. Seacat et al., *Education about Treating Patients with HIV Infection/AIDS: The Student Perspective*, 67 J. DENT. EDUC. 630 (2003); Leonard A. Cohen, *Attitudes of Dental Hygiene Students Toward Individuals with AIDS*, 69 J. DENT. EDUC. 266 (2005).

⁶⁴ Cohen et al., *Attitudes of Dental Faculty Toward Individuals with AIDS*, *supra* note 63; Weyant et al., *supra* note 63; Seacat et al., *supra* note 63; Cohen et al., *Attitudes of Dental Hygiene Students Toward Individuals with AIDS*, *supra* note 63.

⁶⁵ Cohen et al., *Attitudes of Dental Faculty Toward Individuals with AIDS*, *supra* note 63; Cohen et al., *Attitudes of Dental Hygiene Students Toward Individuals with AIDS*, *supra* note 63.

⁶⁶ Cohen et al., *Attitudes of Dental Faculty Toward Individuals with AIDS*, *supra* note 63; Cohen et al., *Attitudes of Dental Hygiene Students Toward Individuals with AIDS*, *supra* note 63.

⁶⁷ Weyant et al., *supra* note 63.

⁶⁸ Jason P. Seacat et al., *supra* note 63.

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

⁷⁰ *Id.*

⁷¹ Other groups included in the survey were people who were of low income, frail elderly, homebound, medically complex, mentally compromised, homeless, drug user, other ethnic group, Title XIX, jailed, and non-English speaking. *Id.* at 1309, Table 1.

⁷² Scott Burris, *Dental Discrimination against the HIV-Infected: Empirical Data, Law and Public Policy*, 13 YALE J. ON REG. 1, 24 (1996).

⁷³ *Id.*

⁷⁴ *Id.* at 25.

⁷⁵ *Id.* at 24.

⁷⁶ *Id.*

⁷⁷ *Id.* at 29.

⁷⁸ *Id.* at 24.

⁷⁹ 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. INTERN. MED. 807 (2005).

⁸⁰ *Id.* at 807.

⁸¹ *Id.* at 809.

⁸² *Id.* at 810.

⁸³ *Id.* at 809.

⁸⁴ *Id.*

⁸⁵ 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).

⁸⁶ See *id.* at Appendix A for the script used during the interviews.

⁸⁷ Calculation of 90% 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% of the population would decline service and 5% 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 US were assumed to be the percentages of each group in the sample (77%, 68%, and 25%, 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%, 68%, and

25%, respectively). Calculations of margins of error and requisite confidence intervals were derived using the Raosoft sample size calculator (<http://www.raosoft.com/samplesize.html>).

⁸⁸ Cal. Dep't of Consumer Affairs, More About the Department of Consumer Affairs, http://www.dca.ca.gov/about_dca/morabout.shtml (last visited Nov. 21, 2011).

⁸⁹ Cal. Dep't of Consumer Affairs, License Search for Dental License, [http://www2.dca.ca.gov/pls/wllpub/wllqryna\\$icev2.startup?p_qte_code=DDS&p_qte_pgm_code=3610](http://www2.dca.ca.gov/pls/wllpub/wllqryna$icev2.startup?p_qte_code=DDS&p_qte_pgm_code=3610) (last visited Nov. 21, 2011).

⁹⁰ Only dentists with licenses that are current and renewed may legally practice dentistry in California.

⁹¹ 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.

⁹² HIV EPIDEMIOLOGY PROGRAM, LOS ANGELES COUNTY DEP'T OF PUBLIC HEALTH, AN EPIDEMIOLOGIC PROFILE OF HIV AND AIDS IN LOS ANGELES COUNTY 2009 33 (2009).

⁹³ The eight Service Planning Areas are Antelope Valley (SPA 1), San Fernando (SPA 2), San Gabriel (SPA 3), Metro (SPA 4), West (SPA 5), South (SPA 6), East (SPA 7) and South Bay (SPA 8). Dep't of Pub. Health, County of Los Angeles, Service Planning Areas – What is a SPA?, <http://lapublichealth.org/spa/spawhat.htm> (last visited Aug. 16, 2011). For an interactive map of all the SPAs, see Dep't of Pub. Health, County of Los Angeles, Service Planning Areas – Maps, <http://lapublichealth.org/spa/spamap.htm> (last visited Aug. 16, 2011).

⁹⁴ For a list of which ZIP codes correspond to which SPAs, see UNITED WAY OF GREATER LOS ANGELES, 2007 LOS ANGELES COUNTY ZIP CODE DATA BOOK (2007).

⁹⁵ HIV EPIDEMIOLOGY PROGRAM, *supra* note 92 at 33.

⁹⁶ Raosoft, Sample size calculator, <http://www.raosoft.com/samplesize.html> (last visited Nov. 22, 2011). This also assumes a 90% confidence level and 50% response distribution.

⁹⁷ For SPA 1 (Antelope Valley), the population size of 96 resulted in a sample size of 40; increasing the sample size to 50 decreases the margin of error to 8%. 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%.

⁹⁸ Delta-Dental, Provider Directory, <https://www.deltadentalins.com/PD/providerDirectory.do?action=s01> (last visited Nov. 28, 2011).

⁹⁹ HIV EPIDEMIOLOGY PROGRAM, *supra* note 92 at 17, 74.

¹⁰⁰ *Id.* at 27.

¹⁰¹ *Id.* at 5.

¹⁰² ANALYSIS BY GARY J. GATES, WILLIAMS DISTINGUISHED SCHOLAR, THE WILLIAMS INSTITUTE, USING DATA FROM THE 2009 CALIFORNIA HEALTH INTERVIEW SURVEY (CHIS) CONDUCTED BY THE UCLA CENTER FOR HEALTH POLICY RESEARCH (2011).

¹⁰³ CAL. DEP'T OF HEALTH CARE SVCS, DENTISTS ACCEPTING NEW PATIENTS BY SPECIALTY REFERRAL LIST, LOCATION: LOS ANGELES COUNTY (2008).

¹⁰⁴ 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 21, refugees, people in nursing facilities, women with breast or cervical cancer, and caretakers of children under 21 in some circumstances. CAL. DEP'T OF HEALTH CARE SERVICES, MEDI-CAL DENTAL PROGRAM PROVIDER HANDBOOK 1-1 (2011) [hereinafter MEDI-CAL DENTAL PROGRAM HANDBOOK].

¹⁰⁵ 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. 25 Denti-Cal Bull. (Cal. DHCS) No. 22 (May 2009), *available at* http://www.denti-cal.ca.gov/provsrvcs/bulletins/Volume_25_Number_22.pdf; California Dep't of Health Care Svcs, Denti-Cal FAQs: Elimination of Most Adult Dental Services Beneficiary Frequently Asked Questions, *available at* http://www.denti-cal.ca.gov/provsrvcs/FAQs/Bene_FAQs.pdf (last visited Nov. 21, 2011).

¹⁰⁶ CALIFORNIA HEALTH INTERVIEW SURVEY, CHIS 2005 ADULT PUBLIC USE FILE (2005).

¹⁰⁷ CENTER FOR DISEASE CONTROL AND PREVENTION, U.S. DEP'T OF HEALTH AND HUMAN SERV. HIV SPECIAL SURVEILLANCE REPORT 10 (2010).

¹⁰⁸ HIV EPIDEMIOLOGY PROGRAM, *supra* note 92 at 89.

¹⁰⁹ OFFICE OF AIDS PROGRAMS AND POLICY, LOS ANGELES COUNTY DEP'T OF

PUBLIC HEALTH, HIV CARE AND TREATMENT SERVICE UTILIZATION: 2009 YEAR END REPORT (2011), *available at* <http://ph.lacounty.gov/aids>.

¹¹⁰ 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.

¹¹¹ HIV EPIDEMIOLOGY PROGRAM, *supra* note 92 at 33.

¹¹² *Id.* at 45.

¹¹³ *Id.*

¹¹⁴ *Id.* at 10.

¹¹⁵ *Id.* at 73-76.

¹¹⁶ *Id.* at 9.

¹¹⁷ Scott Harris, *Suit Claims Dental Chain Turned Away 4 with AIDS Virus: Health: The Head of the Clinic Denies the Charges. Attorneys Say There May Be More Such Actions in the Bias Cases*, L.A. TIMES, Mar. 6, 1992.

¹¹⁸ United Press International, *Dental Chain Settles AIDS Discrimination Case*, June 16, 1993, *available at* <http://aidsinfobbs.org/library/cdcsums/1993/99>.

¹¹⁹ *Id.*

¹²⁰ Western Dental, About Us, <http://www.westerndental.com/about-us.aspx> (last visited Nov. 22, 2011).

¹²¹ HIV & AIDS Legal Services Alliance (HALSA), History, <http://www.halsaservices.org/history.php> (last visited Nov. 22, 2011).

¹²² 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.

¹²³ Complaint, *Goodman & Ford v. Western Dental Services, Inc.*, *available at* <http://www.hivlawandpolicy.org/resources/view/297> (last visited Nov. 22, 2011).

¹²⁴ *Id.* at 5.

¹²⁵ Email from Laurie E. Aronoff, Project Director, Los Angeles County Bar Association AIDS Legal Services Project & HALSA, to Craig Konnoth, the Williams Institute (Aug. 11, 2011 12:30:00 PST) (on file with author).

¹²⁶ Harris, *supra* note 117.

¹²⁷ Los Angeles County Bar Association, AIDS Legal Services Project, <http://www.lacba.org/showpage.cfm?pageid=419> (last visited Aug. 16, 2011).

¹²⁸ David I. Schulman, *AIDS Discrimination: Its Nature, Meaning and Function*, 12 NOVA L. REV. 1113, 1119 (1998).

¹²⁹ *Id.* at 1125.

¹³⁰ Email from David I. Schulman, Supervising Attorney, Los Angeles City Attorney's Office, to Brad Sears, Executive Director, the Williams Institute (Aug. 12, 2011 16:07:00 PST) (on file with author).

¹³¹ Schulman, *supra* note 128 at 1125.

¹³² 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, all of these cases involve dentists that accept Denti-Cal patients or receive other HHS money. Email from Brock Evans, Senior Equal Opportunity Specialist, Office for Civil Rights Region IX, Dep't of Health and Human Serv., to Christy Mallory, the Williams Institute (Feb. 11, 2010, 17:05:00 PST) (on file with author).

¹³³ *Id.*

¹³⁴ *Id.*

¹³⁵ In six of the 13 cases filed with the OCR, the OCR and the dentists reached formal Resolution Agreements, requiring 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. Email from Brock Evans, Senior Equal Opportunity Specialist, Office for Civil Rights Region IX, Dep't of Health and Human Serv., to Christy Mallory, the Williams Institute (Feb. 18, 2010, 11:17:00 PST) (on file with author).

¹³⁶ *Id.*

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- ¹³⁷ *Id.*
- ¹³⁸ *Id.*
- ¹³⁹ Harris, *supra* note 117.
- ¹⁴⁰ David I. Schulman, *The Dentist, HIV and the Law: Duty to Treat, Need to Understand*, 21 J. CAL. DENT. ASSOC. 45 (1993).
- ¹⁴¹ CAL. CODE REGS. tit. 16, §§ 1015, 1017 (2010).
- ¹⁴² CAL. CODE REGS. tit. 16, § 1016(2)(b)(1) (2010).
- ¹⁴³ Email from Thomas Donahue, Director of the Pacific AIDS Education Training Center, to Brad Sears, Executive Director, the Williams Institute (Sept. 8, 2011, 15:28:00 PST) (on file with author).
- ¹⁴⁴ Roseann Mulligan, Hazem Seirawan, Joyce Galligan & Sue Lemme, The Effect of an HIV/AIDS Educational Program on the Knowledge, Attitudes, and Behaviors of Dental Professionals, 70 J. DENT. EDUC. 857 (2006).
- ¹⁴⁵ *Id.* at 862.
- ¹⁴⁶ *Id.* at 862, 864.
- ¹⁴⁷ *Id.* at 861.
- ¹⁴⁸ *Id.*
- ¹⁴⁹ *Id.* at 867.
- ¹⁵⁰ *Id.*
- ¹⁵¹ Mulligan, *supra* note 63.
- ¹⁵² *Id.* at 864-67.
- ¹⁵³ *Id.* at 863.
- ¹⁵⁴ MEDI-CAL DENTAL PROGRAM HANDBOOK, *supra* note 104 at 3-1 – 3-45.
- ¹⁵⁵ Cal. Health & Hum. Svcs Agency, Medi-Cal Provider Agreement (Nov. 2011), *available at* http://www.dental.ca.gov/provsrvcs/forms/dhcs6208_9106.pdf.
- ¹⁵⁶ MEDI-CAL DENTAL PROGRAM HANDBOOK, *supra* note 104 at 3-1 – 3-45. The California Dental Board requires continuing education for all dentists. Dental Bd. of Cal., Dep’t of Consumer Affairs, Continuing Education Requirement, http://www.dbc.ca.gov/licensees/cont_education.shtml (last visited Nov. 22, 2011).