

A Health Care Worker's Duty to Undergo Routine Testing for HIV/AIDS and to Disclose Positive Results to Patients

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COMMENTS

A HEALTH CARE WORKER'S DUTY TO UNDERGO ROUTINE TESTING FOR HIV/AIDS AND TO DISCLOSE POSITIVE RESULTS TO PATIENTS

I. INTRODUCTION

During the last year, 44,714 new cases of Acquired Immunodeficiency Syndrome (AIDS) were reported to the Centers for Disease Control (CDC),¹ bringing the total number of reported AIDS cases to 191,601.² That total includes 6,438 health care workers (HCWs)³ with AIDS as of March 31, 1991.⁴ Significantly, however, the number of HCWs infected with the Human Immunodeficiency Virus (HIV) which causes AIDS is unknown.⁵ The above statistics reflect only those HCWs who

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1. These numbers reflect reports for the year ending August, 1991. U.S. AIDS Cases Reported Through August 1991, HIV/AIDS Surveillance Report (Division of HIV/AIDS, U.S. Dep't of Health and Human Servs., Atlanta, Ga.), Sept. 1991, at 1, 5 [hereinafter Surveillance Report]. Estimates indicate that approximately 70% to 90% of AIDS cases nationwide are reported to the CDC. Carol Ciesielski, M.D. et al., Dentists, Allied Professionals With Aids, 122 JADA 42, 43 (1991).

2. Surveillance Report, *supra* note 1.

3. Throughout this comment "health care provider," "health care worker," or "doctor" may be used to refer to persons in the same group. The CDC defines health care workers as "persons, including students and trainees, whose activities involve contact with patients or with blood or other body fluids from patients in a health care setting." Recommendations for Prevention of HIV Transmission in Health-Care Settings, Morbidity & Mortality Weekly Report (Ctrs. for Disease Control, U.S. Dep't of Health and Human Servs., Atlanta, Ga.), Aug. 21, 1987 (Supp.), at 2S, 3S [hereinafter Recommendations].

4. Ciesielski, M.D. et al., *supra* note 1, at 42.

As of March 14, 1988, a total of 55,315 adults with AIDS had been reported to CDC. Occupational information was available for 47,532 of these persons, 2,586 (5.4%) of whom were classified as health-care workers. A similar proportion (5.7%) of the U.S. labor force was employed in health services.

Update: Acquired Immunodeficiency Syndrome and Human Immunodeficiency Virus Infection Among Health-Care Workers, Morbidity and Mortality Weekly Report (Ctrs. for Disease Control, U.S. Dep't of Health and Human Servs., Atlanta, Ga.), April 22, 1988, at 229 (footnote omitted) [hereinafter Update].

5. Out of the 168,913 reported cases of U.S. adults with AIDS, occupational information was available for 135,617 (80%). Of those, 6,436 (4.8%) were HCWs, of whom 171 were dental workers. Approximately 70% of the HCWs reported to have AIDS have died. Out of the 171 dental workers included in that number, 120 have died. It is not known how many of the remaining 51 dental workers are still practicing. Ciesielski, *supra* note 1, at 42-43.

have actually developed AIDS and do not reflect the number of HCWs carrying and capable of transmitting HIV.⁶

On July 27, 1990, the CDC published news of its first reported case of possible HIV transmission from a HCW to a patient.⁷ A Florida dentist is believed to have infected Kimberly Bergalis and at least two other patients with HIV.⁸ As a result, the Kimberly Bergalis Patient and Health Provider Protection Act of 1991⁹ was introduced in Congress. Should the Act pass, it will:

- 1) prohibit a HCW infected with HIV from providing specified medical and dental procedures "on the basis that performing the procedure on an individual would pose a risk of the transmission of the disease from the [HCW] to the individual;"¹⁰
- 2) require any HCW who performs such procedures to undergo testing for HIV/AIDS as frequently as the Secretary of the Public Health Service deems necessary;¹¹ and,
- 3) prohibit any HCW, who, through testing is discovered to be infected with HIV, from performing the procedures described in section (a)(2), except where the provider:
 - (i) informs the patient involved that the provider has the disease;
 - (ii) informs the patient of the risk posed by the disease in the context of the procedure; and
 - (iii) obtains the written consent of the patient for the provider to perform the procedure notwithstanding such risk;¹²

After its proposal, the bill was submitted to the Energy and Commerce Committee where it currently remains.¹³ However, in reaction to a proposal by Senator Jesse Helms to make it a federal crime for a HCW to perform high-risk procedures without disclosing that he was HIV

6. See *infra* section 2.

7. Possible Transmission of Human Immunodeficiency Virus to a Patient During an Invasive Dental Procedure, *Morbidity and Mortality Weekly Report* (Ctrs. for Disease Control, U.S. Dep't of Health and Human Servs., Atlanta, Ga.), July 27, 1990, at 489 [hereinafter *Possible Transmission*].

8. Update, *supra* note 4.

9. H.R. 2788, 102d Cong., 1st Sess. (1991).

10. Section 2648A(a)(2) of the Public Health Service Act proposed by H.R. 2788, "To Amend Title XXVI of the Public Health Service Act to provide for the establishment of protections against certain communicable diseases for both health care providers and the patients of such providers, and to provide for certain forms of assistance for such providers and patients."

11. Sections 2648A(b)(1)(A) and (B) of the Public Health Service Act proposed by H.R. 2788.

12. Sections 2648A(b)(2)(A)(i)-(iii) of the Public Health Service Act proposed by H.R. 2788.

13. H.R. 2788, 2 Topical Law Reports (CCH) ¶ 28,318 (July 3, 1991).

positive, the House and Senate approved a compromise that requires states to adopt federal *guidelines* which provide that HCWs who perform invasive procedures should be tested for AIDS, should avoid risky procedures except when life or limb is in danger, and should inform patients if they are infected.¹⁴ Though this is a step in the right direction, guidelines do not fill the role of mandatory requirements.

If Congress decides not to require mandatory testing of HCWs, that will not do away with the issue. The Kimberly Bergalis Act brought national attention to the risk of HCW-to-patient transmission. As a result of Kimberly's infection, the risk of HCW-to-patient transmission has become a reality to the nation rather than merely a theoretical possibility,¹⁵ and there is an increased awareness of the serious consequences which can result from HIV infected HCWs performing invasive procedures.

The purpose of this comment is to analyze whether HCWs infected with HIV have a duty under tort law to disclose that information to their patients. Further, this comment will address whether such a duty to disclose encompasses a duty of HCWs to undergo routine testing for HIV in order to be able to make such a disclosure.¹⁶ After determining that the benefits involved in imposing a duty to test and to disclose far outweigh the costs of imposing such a duty, this comment will conclude by finding that a duty to disclose which encompasses the duty to test even if Congress does not require mandatory testing does in fact exist.¹⁷

First, this comment will describe the AIDS disease and its history and its pathology in Section II. Section III will focus on the health care industry's reaction to AIDS. In Section IV, this comment will analyze a tort imposed duty to test and disclose. In Sections V and VI, this comment will describe the need for the duty and will balance the costs and benefits of such a duty. Finally, Section VII will address the scope of such a duty, and Section VIII will propose ways of reducing the negative impact of such a duty on HCWs.

14. Compromise Measure Bars Spread of AIDS by Doctors, *Morning Advocate* (Baton Rouge, La.), Oct. 4, 1991, at 7A.

15. The primary risk of transmission occurs when a HCW injures himself during a procedure (usually on a sharp object, such as bone or a surgical instrument) which causes him to bleed into the operative field. See *infra* text accompanying notes 34-37.

16. A full analysis of the constitutional issues involved in mandatory testing and disclosure is beyond the scope of this article. For information on this topic, see *The Constitutional Implications of Mandatory AIDS Testing in Health Care Industry*, 17 Sw. U. L. Rev. 787 (1988).

17. For an opposing view on the subject, see Larry Gostin, *Hospitals, Health Care Professionals, and AIDS: The "Right to Know" the Health Status of Professionals and Patients*, 48 Md. L. Rev. 12 (1989).

II. THE DISEASE

A. *Description and History*

Perhaps the easiest way to focus on the various stages of the AIDS disease is to think of them as three levels of a pyramid.¹⁸ The bottom level, the largest, represents those persons infected with HIV, the retrovirus which causes AIDS.¹⁹ Individuals at this stage would be seropositive (i.e., HIV blood test results would be positive), but they would not have any symptoms generally associated with AIDS and would probably not be aware of their disease without testing.²⁰ The great majority of these persons will develop AIDS.²¹

The middle level of the pyramid would represent those persons with Aids Related Complex (ARC). ARC patients have symptoms such as "enlarged lymph nodes, shingles, weight loss, persistent fever, night sweats, persistent dry cough or diarrhea and compromised immune function."²² As with seropositive patients, all ARC patients will not necessarily develop AIDS, but the majority will.²³

The top level of the pyramid would represent patients who meet the definition of AIDS because they are suffering from one or more of the opportunistic diseases traditionally associated with AIDS. These include: opportunistic infection,²⁴ Kaposi's sarcoma,²⁵ non-Hodgkin's lymphoma of high grade pathogenicity, or, in children under age thirteen, a lymphocytic (white blood cell) infiltrative process in the lung.²⁶ One suffering from AIDS is more contagious than one only HIV infected.²⁷ AIDS has no known cure, and the great majority of individuals with AIDS will die.²⁸

18. This depiction is commonly used to describe the disease.

19. *Rossi v. Estate of Almaraz*, Nos. 90344028, CL123396 (Md. Cir. Ct. May 23, 1991) (1991 WL 166924).

20. *Id.*

21. David Bell, M.D. et al., *Surgical Practice in Hospitals: HIV and the Surgical Team*, American College of Surgeons Bulletin, July 1990, at 12.

22. Comment, *Hospitals and AIDS Discrimination: Applicability of Federal Discrimination Laws to HCW and Staff Physicians*, 6 *J. Contemp. Health L. & Pol'y* 193, 196-97 n.18 (1990) (citing Arthur Leonard, *AIDS and Employment Law Revisited*, 14 *Hofstra L. Rev.* 11, 18 n.38 (1985)).

23. *Id.*

24. Infection caused by an organism that does not usually cause disease.

25. A malignant skin lesion that is normally not found in young individuals.

26. Marc Sicklick, M.D. & Ayre Rubinstein, M.D., *A Medical Review of AIDS*, 14 *Hofstra L. Rev.* 5 (1985) (citing Selik et al., *Acquired Immune Deficiency Syndrome (AIDS) Trends in the United States, 1978-1982*, 76 *Am. J. Med.* 493, 499 (1984)).

27. *Estate of Behringer v. Medical Ctr. at Princeton*, 592 A.2d 1251, 1267 (N.J. Super. Ct. Law Div. 1991).

28. Bell, M.D. et al., *supra* note 21, at 12.

The first cases of AIDS in the United States were reported by CDC in 1981, just ten years ago.²⁹ In 1984, scientists isolated the HIV. Blood screening tests for the presence of HIV became available in 1985. This led to the realization that there are at least two latency periods involved in the progression of HIV. The first is the period of time between actual infection with HIV and the time when a person could test positively for the antibody. In ninety-five percent of cases, antibody tests will be positive within six months of the date of transmission of (i.e., infection with) the virus.³⁰ Thus, there is a "window" in which a person may be infected with HIV but have no way of knowing it. The second latency period occurs between the time when a person is HIV positive and the time he develops AIDS symptoms. This period is prolonged, the mean latency period between infection with the virus and the onset of AIDS being in excess of five years.³¹

Thus, a person infected with HIV may have a false sense of security and continue to fully function for years before realizing that he or she is capable of infecting others. In fact, *estimates show that only twelve percent of people infected with HIV know they are carrying the virus.*³² As mentioned previously, information is not available concerning the number of HCWs infected with HIV who have not yet developed AIDS.³³

B. Modes of Transmission

It is now widely known that HIV may be transmitted by: sexual intercourse; parenteral procedures (e.g., injection or other invasive procedure breaking the skin³⁴ which makes transmission prevalent among intravenous drug users who share syringes); receipt of donations of blood,³⁵ semen, breast milk, organs or other human tissue; and child birth or breast feeding.

29. *Rossi v. Estate of Almaraz*, Nos. 90344028, CL123396 (Md. Cir. Ct. May 23, 1991) (1991 WL 166924) (citing Morbidity and Mortality Weekly Report (Ctrs. for Disease Control, U.S. Dep't of Health and Human Servs., Atlanta, Ga.) June 5, 1981 and July 4, 1981).

30. *Rossi*, 1991 WL 166924 (citing Horsburgh et al., Duration of Human Immunodeficiency Virus Infection Before Detection of Antibody, *The Lancet*, September 16, 1989, at 637-40).

31. *Estate of Behringer*, 592 A.2d at 1267.

32. Panel Cites Apathy to AIDS Crisis, *State Times* (Baton Rouge, La.), September 25, 1991 at 1A, 6A (relying on the Ctrs. for Disease Control as authority).

33. See *supra* text accompanying note 6.

34. *Estate of Behringer v. Medical Ctr. at Princeton*, 592 A.2d 1251, 1267 (N.J. Super. Ct. Law Div. 1991).

35. Estimates reveal that one in 40,000 units of blood having been screened as negative for HIV antibody may nevertheless transmit HIV. Bell, M.D. et al., *supra* note 21, at 9 (relying on Cohen et al., Transmission of Retrovirus by Transfusion of Screened Blood in Patients Undergoing Cardiac Surgery, *N. Engl. J. Med.* 320:1172-6 (1989), and Busch et al., Risk Associated With Transfusion of HIV-Antibody-Negative Blood, *N. Engl. J. Med.* 322:850-1 (1990)).

The health care setting thus poses a risk of transmission between a HCW and a patient primarily through the possibility of contact between one party's skin³⁶ or mucous membrane and the other's blood, tissue, semen, vaginal secretions, or other blood contaminated body fluids when a HCW is injured by a sharp instrument during an invasive procedure.³⁷

III. THE HEALTH CARE INDUSTRY'S REACTION TO AIDS

A. *Precautions Taken*

No doubt the AIDS epidemic has greatly impacted the health care industry. A simple visit to the dentist will reveal the extensive measures which the profession has been forced to adopt in order to protect against transmission of the disease. Face shields and gloves are two of the more visible precautions that the health care industry has had to incorporate into the practice of medicine. The CDC has recommended detailed guidelines, including: that special precautions be taken prior to mouth-to-mouth resuscitation; that all HCWs wear gloves for contact with oral mucous membranes of all patients; that gloves be changed between each patient; and that HCWs take precautions to prevent injuries caused by needles, scalpels and other instruments or surgical devices during procedures.³⁸

B. *Focus on Patient-to-HCW Transmission*

Understandably, the health care industry has been primarily concerned with the transmission of HIV from a patient to a HCW.³⁹ Much of the commentary written on the subject stresses the risk of HCWs contracting HIV from their patients; the risk of transmission occurring in the opposite direction (i.e., from HCW to patient) has received little attention from the health care industry or anyone else for that matter. A quote from one doctor illustrates this:

[T]he normal practice of a physician is unlikely to expose a patient to the doctor's blood. The doctor is more likely to be

36. This is especially so "if the exposed skin is chapped, abraded, or afflicted with dermatitis, or if the contact is prolonged or involves an extensive area." Bell, M.D. et al., *supra* note 21, at 7.

37. This risk will be discussed more fully later in this article. See *infra* text accompanying notes 131-33.

38. Bell, M.D. et al., *supra* note 21, at 13-14.

39. Generally, however, precautions which will reduce the risk for the doctor will also reduce the risk for the patient. "The use of gloves to prevent blood contact with hands should reduce the risk of HIV infection, as well as protect the patient from infections that are potentially transmissible from the HCW." Bell, M.D. et al., *supra* note 21, at 14.

exposed to the patient's body fluids than vice versa. To imply that the usual practice of medicine would infect patients may be close to suggesting that AIDS can be transmitted by casual contact.⁴⁰

However, that author narrowly defines "usual practice of medicine" since he goes on to say that "[t]he situation may be somewhat different in the case of a surgeon, who may suffer a cut or puncture that could then drop blood into the operative field."⁴¹ Statistics suggest that a surgeon sustains a significant cut in one in forty cases.⁴² Only anecdotal information is available regarding the risk of transmission from physician to patient.⁴³

Another doctor confirms that little attention has been given to the problem of physician-to-patient transmission: "Since it is unknown how often patients undergoing invasive procedures are exposed to the blood of HCWs, the risk of HIV transmission from an infected HCW to a patient during an invasive procedure cannot be determined."⁴⁴ Doctors at Johns Hopkins University School of Medicine concur: "We conclude that the [HIV] epidemic has a major impact on emergency services and that strategies need to be developed for appropriate use of emergency resources and also for maximizing provider protection."⁴⁵

C. Testing of Hospitalized Patients

An additional reaction by the medical industry to the AIDS epidemic has been its desire to test patients for HIV prior to treating them.⁴⁶ In fact, the CDC has recommended in a draft report that all hospitalized patients be tested during their treatment.⁴⁷ A CDC spokesman tried to placate potential patients by assuring them that "[t]his really is directed

40. Letter from Hacib Aoun, M.D., in 322 New Engl. J. Med. 1154, 1156 (1990).

41. *Id.*

42. Estate of Behringer v. Medical Ctr. at Princeton, 592 A.2d 1251, 1279 (N.J. Super. Ct. Law Div. 1991) (citing Larry Gostin, Hospitals, Health Care Professionals, and AIDS: The "Right to Know" the Health Status of Professionals and Patients, 48 Md. L. Rev. 12 (1989)).

43. *Id.*

44. Bell, M.D. et al., *supra* note 21, at 9.

45. Gabor Kelen, M.D. et al., Human Immunodeficiency Virus Infection in Emergency Department Patients, Epidemiology, Clinical Presentations, and Risk to Health Care Workers: The Johns Hopkins Experience, 262 JAMA 516 (1989) (emphasis added).

46. Despite the apparent focus on protecting HCWs from HIV-infected patients, a recent survey did reveal that a substantial majority of physicians nevertheless feel a professional responsibility to care for HIV-infected patients if it is within their realm of competence to do so. John Rizzo et al., Physician Contact With and Attitudes Toward HIV-Seropositive Patients, 28 Med. Care 251, 259 (1990).

47. Wider AIDS Testing Plan is Proposed, State Times (Baton Rouge, La.), September 19, 1991, at 1A.

at testing patients for the patients' own benefit, rather than protecting health care workers, . . . It's so patients are better managed, and their risks are known."⁴⁸ If implemented, this testing would be added to the existing recommendations by CDC that "universal precautions," involving a presumption that all blood and certain body fluids of all patients are HIV-seropositive, be taken to control the spread of infection.⁴⁹

D. First Case of HCW-to-Patient Transmission

With the first report of HCW-to-patient transmission of HIV in the Kimberly Bergalis case, some attention has turned to the problem of HIV-infected HCWs transmitting the virus to patients. The CDC published recommendations for preventing transmission of AIDS (and Hepatitis B) from HCWs to patients during "Exposure-Prone Invasive Procedures."⁵⁰ However, the current CDC recommendations fall short of those proposed in the Kimberly Bergalis Act, and:

- 1) merely provide for after-the-fact procedures, suggesting that "[i]f an incident occurs during an invasive procedure that results in exposure of a patient to the blood of a HCW, the patient should be informed of the incident, and previous recommen-

48. *Id.* In a recent case on this topic, a Pennsylvania court held that an unauthorized AIDS test performed on a patient's blood sample which had been relinquished by the patient to the doctor was insufficient to support a claim for invasion of privacy. *Doe v. Dyer-Goode*, 566 A.2d 889 (Pa. Super. Ct. 1989).

49. Bell, M.D. et al., *supra* note 21, at 10.

50. The introduction to these guidelines reads as follows:

The recommendations outlined in this document are based on the following considerations:

- infected HCWs who adhere to universal precautions and who do not perform invasive procedures pose no risk for transmitting HIV or [Hepatitis B] to patients.
- infected HCWs who adhere to universal precautions and who perform certain exposure-prone procedures . . . pose a small risk for transmitting [Hepatitis B] to patients.
- HIV is transmitted much less readily than [Hepatitis B].

In the interim, until further data are available, additional precautions are prudent to prevent HIV and [Hepatitis B] transmission during procedures that have been linked to HCW-to-patient [Hepatitis B] transmission or that are considered exposure-prone.

Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures, Morbidity and Mortality Weekly Report (Ctrs. for Disease Control, U.S. Dep't of Health and Human Servs., Atlanta, Ga.) July 12, 1991, at 1 (citation omitted) [hereinafter Recommendations].

dations for management of such exposures should be followed,"⁵¹ and

- 2) specifically reject mandatory testing of HCWs by stating: Mandatory testing of HCWs for HIV antibody . . . is not recommended. The current assessment of the risk that infected HCWs will transmit HIV . . . to patients during exposure-prone procedures does not support the diversion of resources that would be required to implement mandatory testing programs. Compliance by HCWs with recommendations can be increased through education, training, and appropriate confidentiality safeguards.⁵²

However, the Council on Ethical and Judicial Affairs of the American Medical Association has recognized a duty on the part of HCWs to disclose their HIV-infection, and even goes so far as to suggest that patient consent following such disclosure is not enough:

[T]he Council believes that if a risk of transmission of an infectious disease from a physician to a patient exists, disclosure of that risk to patients is not enough; *patients are entitled to expect that their physicians will not increase their exposure to the risk of contracting an infectious disease, even minimally.* If no risk exists, disclosure of the physicians' medical condition to his or her patients will serve no rational purpose; if a risk does exist, the physician should not engage in the activity.⁵³

This is the strongest current recommendation by a medical authority, but it has been criticized.

Those recommendations lend themselves to arbitrary restrictions on [HCWs] and are stiffer than the policies implemented to protect against other risks (such as hepatitis) that patients face in hospitals.

Because of the public fears stirred up by [the Florida dentist] report, some will propose testing all [HCWs] for HIV. The best scientific information at hand does not warrant HIV screening

51. *Estate of Behringer v. Medical Ctr. at Princeton*, 592 A.2d 1251, 1265 (N.J. Super. Ct. Law Div. 1991) (citing Ctrs. for Disease Control, Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus during Invasive Procedures, 35 *Morbidity and Mortality Weekly Report* 221-23 (1986)).

52. The recommendations describe "exposure-prone" procedures as those which have been linked to the transmission of Hepatitis B from HCWs to patients even when the universal precautions had been taken. These include: "certain oral, cardiothoracic, colorectal . . . and obstetric/gynecologic procedures." Recommendations, *supra* note 50, at 4, 6 (citations omitted).

53. *Estate of Behringer*, 592 A.2d at 1259 (emphasis added).

of [HCWs], however, and *such screening could be justified only if the risk of transmission from [HCW] to patient were found to be meaningful.* . . .

. . . [T]here is reason to recommend preventive and protective measures to be followed by a worker with a transmissible illness, but there is no reason for the removal of infected workers from patient care, unless they fail to comply with the preventive guidelines and barrier precautions.⁵⁴

Thus, no medical authority has mandated routine HIV testing for HCWs, and it does not appear likely that any will. HCWs would be faced with the inconvenience of routine testing, and those who were HIV-positive would have to disclose that information to patients. As a result, many HCWs may lose their livelihood. Additionally, the first death caused by HCW-to-patient transmission has apparently not even elevated the risk to the level of "meaningful." Therefore, waiting for the medical profession to decide that HCWs need to be tested is similar to relying on the fox to guard the henhouse.

Although the medical profession itself is not eager to require testing of its members, perhaps HCWs nevertheless have a duty in tort law to disclose their HIV-infection to patients and to undergo routine testing in order to facilitate that disclosure.

IV. ANALYSIS OF A TORT LAW IMPOSED DUTY TO TEST AND DISCLOSE

Potential tort liability exists for an HCW infected with HIV who performs invasive procedures on a patient without disclosing his infection. This liability could arise from a patient's claims of battery, general negligence, or negligence based on a lack of informed consent.

A. Battery

The Louisiana Supreme Court in *Caudle v. Betts* defined battery as "[a] harmful or offensive contact with a person, resulting from an act intended to cause him to suffer such a contact . . ."⁵⁵ Thus, one does not have to intend, or be substantially certain, that the offensive contact will cause harm in order to have committed a battery. He need only intend to make the offensive contact in order to be liable for all consequences of that contact whether or not those consequences are reasonably foreseeable.⁵⁶

54. Letter from Hacib Aoun and Patricia Aoun, M.D., in 324 *New Engl. J. Med.* 265, 266 (1991).

55. *Caudle v. Betts*, 512 So. 2d 389 (La. 1987).

56. *Id.* at 392.

Thus, when an HIV-infected HCW performs an invasive procedure on a patient without disclosing his condition, he is no doubt offensively contacting the patient without the patient's consent and is therefore committing a battery.⁵⁷ A HCW who was not aware of his HIV-infection at the time he made the contact, however, would lack the requisite intent to inflict an offensive contact and could probably not be found to have committed a battery. Some dispute may arise as to whether the contact would be offensive if no accident occurs during the procedure which would expose the patient to the blood of the HCW. However, given the burdensome consequences which follow such an accident even if the patient does not subsequently contract HIV,⁵⁸ a reasonable person would likely find the contact offensive for the simple fact that it exposes him to a risk of such a dreadful outcome.

Based on this analysis, it appears that a patient would have a strong claim against an HIV-infected HCW for battery. The fact that battery is an intentional tort raises important issues which are usually not present in other medical malpractice claims. "Universally, harmful conduct is considered more reprehensible if intentional."⁵⁹ For example, it is against public policy for liability insurance to cover the intentional acts of the insured. Thus, a HCW found liable for battery would have no assistance in carrying the burden of the judgment.

B. General Negligence

The same patient may be able to establish a cause of action in negligence by proving that: 1) the performance of an invasive procedure by an HIV-infected HCW was the cause-in-fact of the patient subsequently contracting the virus; 2) the HCW owed a duty to the patient to act reasonably to avoid transmitting the virus to the patient; and 3) the HCW breached that duty. In order to establish the cause-in-fact element, one would need to determine whether any accidents occurred during the procedure which could have resulted in the HCW's blood coming into contact with the patient's body fluids. In addition, experts could compare DNA taken from blood samples to determine whether the patient and the HCW are infected with the same strain of the virus. That, along with studies of the patient's sexual history and the HIV status of his partners, can lead to highly reliable conclusions as to whether the HCW did in fact transmit the virus to the patient.⁶⁰

57. Cf. *Ashcraft v. King*, 278 Cal. Rptr. 900, 903-04 (Cal. Ct. App. 1991) where an appellate court held that a surgeon committed battery if the patient's consent to surgery was conditioned on use of only family-donated blood, and patient was harmed by the surgeon intentionally violating that condition.

58. See *infra* text accompanying notes 144-48.

59. *Bazley v. Tortorich*, 397 So. 2d 475, 477 (La. 1981).

60. See *supra* note 7.

Once causation is established, the question arises whether the HCW owed a duty to the patient to act reasonably to avoid transmitting the virus to the patient. Surely such a duty exists. Arguably two individuals not in the HCW-patient relationship owe this duty to one another. An HCW owes a fiduciary duty to his patient because the relationship is one of trust. In addition, the medical industry is responsible for the spread of disease, and its members have voluntarily assumed the duty to guard the health care of their patients.⁶¹

Once a duty is established, the next inquiry is whether the HCW breached his or her duty to act reasonably to avoid transmitting HIV to his or her patient by performing the invasive procedure. Whether the HCW acted reasonably must be considered objectively in light of the scientific knowledge and relevant circumstances at the time the alleged breach occurred.⁶² Therefore, perhaps prior to the Kimberly Bergalis case, following the CDC recommendations concerning "universal precautions" would have been sufficient to fulfill the duty of acting reasonably. However, the risk of HCW-to-patient transmission of HIV is now a real risk—it has happened at least once. In addition, the medical industry is acutely aware that HCWs are at risk of being infected by their patients.⁶³ The logical conclusion to draw from these facts is that HIV was first transmitted from patients to HCWs and will next be increasingly transmitted from HCWs back to patients. Thus, the risk of HCW-to-patient transmission of HIV is now *foreseeable*. Such foreseeability should, therefore, give rise to more caution being taken by HIV-infected HCWs before their actions reach the level of "reasonable."

Application of the Learned Hand Formula provides one method of determining whether performing invasive procedures would be reasonable action. The likelihood of an HIV-infected HCW transmitting HIV to a particular patient during an invasive procedure is at least .0025% based on current available data.⁶⁴ However, the number of HCWs infected with HIV is unknown, making it impossible to determine the likelihood that a patient would be exposed to the blood of an HIV-infected HCW. The severity of the harm which would result is extremely high since the majority of those infected with HIV will contract AIDS, and the majority of those will die. Further, those who do not contract HIV, but who are exposed to the blood of a HCW during surgery, will have to undergo

61. *Rajnowski v. St. Patrick's Hosp.*, 1990 La. Lexis 2973 (La. 1990) (Dennis, J., concurring in denial of reh'g).

62. *Estate of Behringer v. Medical Ctr. at Princeton*, 592 A.2d 1251, 1267 n.9 (N.J. Super. Ct. Law Div. 1991).

63. Surveillance Report, *supra* note 1, at 16.

64. See *infra* text accompanying note 81. Note that this probability is based on current available data which includes only the number of HCWs suffering from AIDS and does not include the number of HCWs infected with HIV.

extensive testing for years and make serious lifestyle adjustments.⁶⁵ Finally, the cost of avoidance is not insignificant. Even though the cost of having a healthy HCW perform the invasive procedure is low, the cumulative cost of such avoidance would be higher since HIV-infected HCWs would basically have to give up their careers.⁶⁶ Since the likelihood of harm is unknown, the risk is extremely high, and the cost of avoidance is moderate, a HCW may be required to err on the side of caution. Thus, an HIV-infected HCW who performs invasive procedures may be negligent for failing to have a HCW who does not pose a risk to the patient's health perform the procedure.

Courts outside of Louisiana have addressed negligence with respect to the transmission of AIDS. In *Rossi v. Estate of Almaraz*,⁶⁷ the issue was whether a woman who had a benign mass removed from her breast by a physician who died of AIDS just over a year after performing the surgery had an action against the physician's estate and the hospital who employed him for fear of contracting AIDS. The plaintiff's original complaint included an allegation of lack of informed consent, but that allegation was amended to one of straight negligence, alleging that the physician operated on the plaintiff while knowing that he had AIDS.⁶⁸ The defendants moved for dismissal, so the issue before the court was whether the plaintiff had alleged a compensable injury, assuming all of the allegations were true. The plaintiff alleged that her damages included her "daily fear of having been exposed to the risk of the disease" and that she "has been required to undergo invasive AIDS testing."⁶⁹ The *Rossi* court cited *Burk v. Sage Products*⁷⁰ which had previously addressed the issue.

In *Burk*, a needle protruding from a disposal container stuck a paramedic. While he alleged that there were several patients with AIDS on the hospital floor where the accident occurred, he was unable to show that the needle which pricked him had actually been used on an AIDS patient. The patient tested HIV seronegative five times in just over a one year period, but alleged the fear of contracting AIDS as an injury. The *Burk* court acknowledged that fear of contracting a disease was a compensable injury in earlier cases, but denied plaintiff's action using the following reasoning. In those cases which allowed recovery

65. They are forced to undergo periodic testing for at least one year and suffer extreme anxiety and mental anguish awaiting the test results; they are counselled concerning major lifestyle changes regarding sexual practices and conceiving children.

66. See *infra* text accompanying note 149.

67. Nos. 90344028, CL123396 (Md. Cir. Ct. May 23, 1991) (1991 WL 166924).

68. The other three allegations included intentional infliction of emotional distress, breach of fiduciary duty, and battery. *Id.*

69. *Id.*

70. 747 F. Supp. 285 (E.D. Pa. 1990).

for fear of disease, the plaintiffs were faced only with the question of whether they would contract the disease in the future; they already knew they had been exposed to the disease. On the other hand, the plaintiff in the *Burk* case did face the additional question of whether he had, in fact, been exposed to the AIDS virus in the first place.⁷¹ Thus, the plaintiff's injury in *Burk* was really fear of initial exposure to AIDS which is not compensable, rather than fear of contracting AIDS due to exposure, which is compensable.⁷²

The *Rossi* court analogized to *Burk* and found that Mrs. Rossi was unable to allege sufficient facts to prove that she was in fact exposed to AIDS in the first place and dismissed her complaint. The *Rossi* court reasoned: "Because there are no reported cases of transmission of AIDS from a surgeon to a patient, such transmission is only a theoretical possibility when proper barrier techniques are employed."⁷³ The court noted that the plaintiff had not alleged that the doctor failed to use protective barriers nor that any incident occurred which would have allowed Dr. Almaraz's blood to enter her body. The court concluded: "Under the principles of *Burk*, without proof of exposure, that is, without a positive HIV test, the plaintiff cannot present compensable damages."⁷⁴

Thus, the *Rossi* court appears to require a plaintiff to test positively for HIV prior to having a claim for fear of contracting AIDS. That is absurd. A plaintiff who tests positively for HIV would not need to rely on fear of contracting AIDS in order to establish a compensable injury. Such a patient would have extensive damages, such as loss of consortium and affliction with an incurable disease to name only a few. In addition, the court placed the burden on the plaintiff to prove accidents during surgery which could have resulted in exposure. Surely that burden cannot be carried by a layperson who is usually unconscious during the time when any such accident might occur. Finally, the court in *Rossi* placed great emphasis on the fact that there had been no case of transmission of AIDS from HCW-to-patient. Thus, had the case been decided two months later, after the first such case was discovered, would the outcome have been different?

C. Medical Informed Consent

Perhaps a patient's strongest claim in virtually any jurisdiction would be one based on lack of informed consent. A patient has a cause of

71. *Id.* at 287. In addition, the negative test results appeared to establish a medical fact that he would not develop AIDS. *Id.* at 288.

72. *Id.* at 288.

73. *Rossi*, 1991 WL 166924.

74. *Id.*

action in negligence for lack of informed consent against a physician who has performed a procedure to which the patient has consented but who has failed to disclose to the patient certain risks involved in the procedure.⁷⁵ Therefore, a physician infected with HIV who performs an invasive procedure on a patient without informing the patient of his condition probably has not obtained the patient's informed consent and may be liable for any damages caused the patient as a result of this negligence.⁷⁶

I. Louisiana Law

Louisiana has both a legislative and jurisprudential basis for a cause of action arising from lack of medical informed consent.

a. Louisiana Legislation

The Louisiana Legislature passed the Uniform Consent Law in 1975 to define consent to medical treatment. The statute provides in pertinent part:

A. Notwithstanding any other law to the contrary, written consent to medical treatment means a consent in writing to any medical or surgical procedure or course of procedures which (a) sets forth in general terms the nature and purpose of the procedure or procedures, together with the known risks, if any, of death, brain damage, quadriplegia, paraplegia, the loss or loss of function of any organ or limb, or disfiguring scars associated with such procedure or procedures⁷⁷

According to the requirements of this statute, must a doctor's HIV infection be disclosed to a patient prior to performing an invasive procedure in order for the doctor to obtain informed consent? Arguably it *does*, based on the following analysis. First of all, the HCW who performs an invasive procedure on a patient is within the purview of the statutory requirements because the statute pertains to consent for "any medical or surgical procedure or course of procedures." The statute requires that, for informed consent to be obtained, "the known risks, *if any*, of death . . . associated with such procedure" must be set forth for the patient in general terms. This means that *any* known risk must be disclosed to the patient. The legislature could have qualified the word "any" with words like material, substantial or significant. Instead, the

75. Neil C. Abramson, Comment, A Right to Privacy Tour de Force into Louisiana Medical Informed Consent, 51 La. L. Rev. 755, 756 (1991).

76. See Estate of Behringer v. Medical Ctr. at Princeton, 592 A.2d 1251 (N.J. Super. Ct. Law Div. 1991) and *infra* text accompanying notes 104-13.

77. La. R.S. 40:1299.40 (1977 and Supp. 1991).

legislature has arguably concluded that any risk of death is material because of the gravity of the potential consequences at stake.⁷⁸ It is not uncommon for a doctor to nick or cut himself during an invasive procedure which may cause him to bleed into the operative field,⁷⁹ and, as was discussed earlier, infection with HIV brings with it a great risk of death.⁸⁰ The chance of occurrence of such an injury *and* transmission of the infection to the patient is believed to be .0025% (less than one half of one percent).⁸¹ Though this chance may be small when considering each individual patient, it falls within "the known risks, if any, of death . . . associated with such procedure." Therefore, under this statute, a doctor would have to disclose his HIV-infection to his patient prior to performing an invasive procedure in order to obtain informed consent.

b. Louisiana Jurisprudence

There is also a jurisprudential basis for a cause of action arising from lack of medical informed consent in Louisiana. The Louisiana Supreme Court decisions in *LaCaze v. Collier*⁸² and *Hondroulis v. Schuhmacher*⁸³ set forth the medical informed consent doctrine as it exists in Louisiana. These cases interpret the Uniform Consent Law⁸⁴ passed by the Louisiana Legislature in 1975. The Louisiana Supreme Court in *Hondroulis* decided that the Uniform Consent Law provided only the "legislative limits of medical consent" and *not* the *exclusive* means for bringing a cause of action for lack of informed consent in Louisiana.⁸⁵ Therefore, a cause of action may be brought under the

78. See *infra* text accompanying notes 86-88 for a discussion of the "materiality" of the risk which the jurisprudence explains must be present in order for disclosure of the risk to be required.

79. See *supra* note 7.

80. See *supra* text accompanying notes 21-28.

81. This was agreed upon by two experts in *Estate of Behringer*, and one of the experts explained:

Whether an injury occurs, whether it occurs within range of the patient's blood, whether the surgeon's blood makes its way out from beneath two layers of gloves, and whether there is then a transmission of the surgeon's blood into the patient's blood, are all independent events that geometrically reduce the chance of blood-to-blood contact. . . . [The expert] added that the risk factor was affected by the nature of the surgery performed, e.g., orthopedic surgeons or gynecological surgeons operating in some areas by "feel" bear a higher risk of accident than do surgeons such as ENT specialists.

Estate of Behringer v. Medical Ctr. at Princeton, 592 A.2d 1251, 1264 (N.J. Super. Ct. Law Div. 1991).

82. 434 So. 2d 1039 (La. 1983).

83. 553 So. 2d 398 (La. 1988).

84. La. R.S. 40:1299.40 (1977 and Supp. 1991).

85. Neil C. Abramson, Comment, A Right to Privacy Tour de Force into Louisiana Medical Informed Consent, 51 La. L. Rev. 755 (1991).

jurisprudence even if the requirements of the Uniform Consent Law are not met.

The jurisprudential foundation begins with *LaCaze* which held that the duty of a physician in obtaining informed consent included the duty to inform the patient of: 1) the patient's particular condition, 2) the general nature of the proposed treatment, 3) all "material" risks associated with the treatment, 4) the likelihood of success, 5) the risks of refusing the treatment, and 6) the risks and availability of alternative treatment. "Material risks" were defined as those risks "to which a reasonable person . . . would attach significance in deciding whether or not to undergo or forego the proposed treatment."⁸⁶ The *LaCaze* court also applied an objective test to determine causation: "whether a reasonable patient in this plaintiff's position would have consented to the treatment had the material information and risks been disclosed."⁸⁷ Finally, as with any other negligence suit, the plaintiff was required to prove damages.⁸⁸ In 1988, the Louisiana Supreme Court in *Hondroulis* explained that the "informed consent doctrine is based on the principle that every human being of adult years and sound mind has a right to determine what shall be done to his or her own body."⁸⁹

The Louisiana Fifth Circuit Court of Appeal recently applied this existing law and rendered a pivotal decision involving the lack of informed consent in *Hidding v. Williams*.⁹⁰ In that case, an orthopaedic surgeon performed a decompressive central laminectomy on a fifty-nine year old man. As a result of the surgery, the patient's excretory systems did not function properly; he suffered loss of bowel and bladder control.⁹¹ Affirming the trial court, the appellate court held that the doctor did not obtain the patient's informed consent because he failed to disclose to the patient: 1) that nerve damage was a known risk of the surgery involved, and 2) that the doctor was suffering from alcohol abuse at the time of the surgery.

The court applied a two-step analysis in determining whether the procedure involved a material risk. The first step requires "examination of the 'incidence of injury/degree of harm' ratio."⁹² The court noted that this step requires expert testimony to ascertain what risks exist and how likely they are to occur. The second step, taken once this probability

86. *Id.* at 757 n.12.

87. *Id.*

88. *Id.*

89. *Hondroulis v. Schuhmacher*, 553 So. 2d 398, 411 (La. 1988).

90. 578 So. 2d 1192 (La. App. 5th Cir. 1991).

91. Until his death from an unrelated cause in January, 1990.

92. *Hidding v. Williams*, 578 So. 2d 1192, 1194 (La. App. 5th Cir. 1991) (citing *Canterbury v. Spence*, 464 F.2d 772, 788 (D.C. Cir. 1972)).

of harm is defined and the parameters of the risk are established, becomes one for the trier of fact who must determine whether a reasonable person in the patient's position would attach significance to the specific risk.⁹³

The court held that the doctor was negligent in not adequately informing the patient of the risk of losing bladder and bowel control since such a loss occurred in 1 out of 200,000 cases.⁹⁴ More importantly, the court also held that the doctor's failure to disclose his chronic alcohol abuse to the patient and the patient's wife constituted a failure to obtain informed consent to the surgery. The court reasoned: "Because this condition creates a material risk associated with the surgeon's ability to perform, which if disclosed would have obliged the patient to have elected another course of treatment, the fact-finder's conclusion that non-disclosure is a violation of the informed consent doctrine is entirely correct."⁹⁵ "[T]his condition presented a material risk to the patient, *the increased potential for injury during surgery*, that was not disclosed."⁹⁶ A concurring opinion alleged that the question of injury, i.e. a cause-in-fact relationship, had been left out of the analysis, making the majority opinion an automatic imposition of liability when a professed and practicing alcoholic operates on any patient.⁹⁷

This is the jurisprudential backdrop against which one would analyze a patient's lack of informed consent cause of action in Louisiana based on an HCW's performing invasive procedures without disclosing his HIV infection. No doubt, *Hidding* takes a step toward requiring that disclosure. In both situations, the undisclosed risk is the doctor's *disease*.

In *Hidding*, the court held that the doctor's alcoholism was a material risk because it presented an "increased potential for injury during sur-

93. *Hidding*, 578 So. 2d at 1194 (citing *Hondroulis*, 553 So. 2d at 412).

94. The court noted that the patient had minimal reading skills and the only indication made to him of this risk was a clause in the medical consent form he signed which listed one of the risks associated with the procedure as "the loss of or loss of function of body organs." *Hidding*, 578 So. 2d at 1195-96.

95. *Id.* at 1196.

96. *Id.* at 1198 (emphasis added).

97. *Id.* at 1198. Two years following the patient's surgery:

[T]he Louisiana State Board of Medical Examiners suspended Dr. Williams' medical license on charges of "[h]abitual or recurring drunkenness," LSA-R.S. 37:1285(4); "[p]rofessional or medical incompetency," 37:1285(12); "[u]nprofessional conduct," 37:1285(13); "[c]ontinuing or recurring medical practice which fails to satisfy the prevailing and usually accepted standards of medical practice in this state," 37:1285(14); and "[i]nability to practice medicine . . . with reasonable skill or safety to patients because of mental illness or deficiency; physical illness, including but not limited to deterioration through the aging process or loss of motor skills; and/or, excessive use or abuse of drugs, including alcohol." 37:1285(25).

Id. at 1196-97.

gery."⁹⁸ Though no damages were expressly linked to the failure to disclose alcoholism, the court seems to be implying that, had the doctor not been handicapped by chronic alcoholism, this surgery probably would not have been the one in 200,000 to result in the patient's loss of bladder and bowel control. In other words, the *type* of potential injury would have been the same with or without the alcoholism, but the *probability* for the patient to be the one in 200,000 was increased by the doctor's chronic alcoholism. Thus, it appears that the effect on the doctor's ability to avoid an already existing risk is what made the chronic alcoholism in *Hidding* a material risk warranting disclosure.

In the case of a doctor with HIV, there is also an "increased potential for injury during surgery." However, unlike the doctor in *Hidding*, the doctor with HIV has added a "new" injury to the repository of possible injuries the patient could sustain during the surgery. By doing so, the doctor has increased the potential for that injury to occur (i.e., from near zero to .0025%).⁹⁹ Instead of the injury being the increased chance of an already existing risk occurring—i.e., the alcoholism causing the surgery in *Hidding* to be the one in 200,000 to result in malfunction of excretory systems—the injury here is: 1) the risk of contracting a contagious disease which causes AIDS and often results in death, and 2) the risk of having to undergo frequent and traumatic testing and major life-style changes should the doctor puncture himself and expose blood into the operative field even if infection does not occur.¹⁰⁰ Therefore, the HIV infection increases the patient's potential for injury during surgery because it creates a risk of an entirely separate injury otherwise not present.

Even though the doctor's HIV infection arguably does not interfere with the doctor's ability as it did in *Hidding*, it presents a material risk because it introduces a risk of a distinct injury—the risk that the patient will contract the disease from the doctor. Thus, "the increased potential for injury during surgery" as a result of the doctor's disease arises, in the case of alcoholism from the effect on ability, and, in the case of HIV, from the possibility of transmission.

As a result of this analysis, it appears that if a HCW fails to disclose his HIV infection to his patients prior to performing invasive procedures, he would be negligent in Louisiana whether one applied Louisiana Revised Statutes 40:1299.40 or *Hidding* and its supporting line of cases.

2. Other Jurisdictions

Jurisdictions outside of Louisiana have faced the issue of lack of informed consent with regard to AIDS. In *Doe v. Johnston*,¹⁰¹ the Iowa

98. See supra text accompanying note 96.

99. See supra text accompanying note 64.

100. See infra text accompanying notes 144-48.

101. 476 N.W.2d 28 (Iowa 1991).

Supreme Court addressed the issue of whether a doctor's failure to warn a patient of the risk of contracting AIDS from a blood transfusion, or, in the alternative, whether failing to advise him that he could self-donate the necessary blood, was a breach of the standard of medical care. The court explained the "patient rule" which gives the patient a right to make an informed decision regarding whether to submit to a particular medical procedure and places a duty on the doctor to disclose all material risks involved in the procedure.¹⁰² The court held that the doctor was not negligent, noting that in 1985, there was conflicting evidence as to materiality of the risk, as well as to the availability of autologous transfusions (self-donating). Prior to arriving at this conclusion, the court narrowly articulated the issue as follows: "whether, in February 1985, the risk of contracting AIDS from blood products was so material, and the use of autologous transfusion so reasonable, that the doctor was negligent as a matter of law in failing to so advise his patient."¹⁰³ Thus, it appears from the qualified wording of the issue and the dispute over the information regarding AIDS and blood transfusions available in 1985, that the doctor probably would have been found negligent had the same facts arisen today.

In *Estate of Behringer v. Medical Center at Princeton*, a Superior Court of New Jersey recognized a physician's duty to disclose his HIV seropositive status to patients prior to performing surgery and to inform them of the risk of a surgical accident in order to obtain informed consent.¹⁰⁴ The plaintiff in this case was an ENT surgeon¹⁰⁵ previously allowed to operate at the defendant-hospital. The surgeon was also admitted as a patient at the defendant-hospital. While in the hospital as a patient, the surgeon tested positively for HIV and was diagnosed with Pneumocystis Carinii Pneumonia (PCP), a combination leading to the conclusion that he had AIDS. Thereafter, the hospital revoked plaintiff's surgical privileges. Following his discharge from the hospital, numerous friends and co-workers called to wish him well. This apparent breach of confidentiality on the part of the hospital, as well as the hospital's suspension of his surgical privileges, prompted the plaintiff to bring an action against the hospital for: 1) breach of the hospital's and certain employees' duty to maintain confidentiality of his diagnosis and test results, and 2) a violation of the New Jersey Law Against Discrimination as a result of defendants' placing conditions on plaintiff's continued performance of surgical procedures at the medical center.

102. *Id.* at 31.

103. *Id.* at 30.

104. 592 A.2d 1251 (N.J. Super. Ct. Law Div. 1991).

105. In addition to performing ear, nose and throat surgery, he also performed facial plastic surgery.

After recognizing its responsibility to "explore[] the competing interests of a surgeon with AIDS, his patients, the hospital at which he practices and the hospital's medical and dental staff,"¹⁰⁶ the court summarized its holding in pertinent part as follows:

[1] The Medical Center met its burden of establishing that its policy of *temporarily suspending and, thereafter, restricting plaintiff's surgical privileges was substantially justified by a reasonable probability of harm to [a] patient.*

[2] The "*risk of harm*" to [a] patient *includes* not only the actual transmission of HIV from surgeon to patient but the risk of a surgical accident, i.e., a scalpel cut or needle stick, which may subject the patient to *post-surgery HIV testing.*

[3] . . . [*M*edical center, as a condition of vacating the temporary suspension of plaintiff's surgical privileges, *properly required plaintiff, as a physician with a positive diagnosis of AIDS, to secure informed consent* from any surgical patients.

[4] The medical center's policy of restricting surgical privileges of [HCWs] who pose "any risk of HIV transmission to the patient" was a reasonable exercise of . . . authority . . . where plaintiff was an AIDS-positive surgeon.¹⁰⁷

Thus, there is at least one court which has recognized a surgeon's duty to disclose the fact that he has AIDS to his patients prior to operating in order to obtain informed consent. It should be noted, however, that the *hospital* imposed the duty in this case, not the law, and the court merely approved of that decision because the hospital established that its actions were "substantially justified by a reasonable probability of harm to [a] patient." In fact, the court articulated its "growing awareness that courts should allow hospitals, as long as they proceed fairly, to run their own business."¹⁰⁸ Thus, we are left with the question of whether a court would impose a duty to disclose if disclosure was not required by the hospital.

106. Estate of Behringer v. Medical Ctr. at Princeton, 592 A.2d 1251, 1254 (N.J. Super. Ct. Law Div. 1991).

107. Id. at 1255 (all emphasis in original omitted) (emphasis added). The court also held that:

[5] The medical center breached its duty of confidentiality to plaintiff, as a patient, when it failed to take reasonable precautions regarding plaintiff's medical records to prevent plaintiff's AIDS diagnosis from becoming a matter of public knowledge.

[6] Plaintiff, as an AIDS-afflicted surgeon with surgical privileges at the medical center, was protected by the Law Against Discrimination.

N.J.S.A. 10:5-1 et seq.

108. Id. at 1276 (quoting Nanavati v. Burdette Tomlin Mem. Hosp., 107 N.J. 240, 249-50, 526 A.2d 697 (1987)).

The opinion includes a review of the hospital's lengthy decision process. Initially, only the president of the medical center thought that the plaintiff's surgical privileges should be suspended, and he had no data to back him up.¹⁰⁹ It was this lack of available information about the possible transmission from a HCW to a patient which kept the other members of the executive committee of the hospital from initially agreeing with him.¹¹⁰ After a series of meetings where the president and the hospital's legal counsel expressed concerns about the hospital's reputation and potential exposure to litigation, the board of trustees of the hospital voted to require that a special "informed consent form" be presented to patients about to undergo surgery by HIV-positive surgeons.¹¹¹ In determining that the hospital's procedure was fair,¹¹² the court noted that "[i]f there is to be an ultimate arbiter of whether the patient is to be treated invasively by an AIDS-positive surgeon, the arbiter will be the fully-informed patient."¹¹³ Thus, the *Behringer* court has recognized that the risk of a physician transmitting AIDS to a patient is a risk which, if not disclosed to a patient, could result in liability on the part of the hospital, and, therefore, the hospital was reasonable in taking the measures it did in order to prevent that exposure. This appears

109. Note: The CDC merely recommends that the decision be made on a case-by-case basis. Recommendations, *supra* note 3, at 16S.

110. *Estate of Behringer*, 592 A.2d at 1257. Note, the date of this decision was about two months prior to the Kimberly Bergalis case. The court recognized that it was bound "by the state of medical science at the time of the relevant fact circumstances, not on future speculation" and that subsequent to trial a case of HCW-to-patient transmission had been reported. *Id.* at 1267 n.9.

111. The consent form read as follows:

THE MEDICAL CENTER AT PRINCETON, NEW JERSEY SUPPLEMENTAL CONSENT FOR OPERATIVE AND/OR INVASIVE PROCEDURE

I have on this date executed a consent, which is attached hereto, for (Procedure) _____ to be performed by Dr. _____. In addition, I have also been informed by Dr. _____, that he has a positive blood test indicative of infection with HIV (Human Immunodeficiency Virus) which is the cause of AIDS. I have also been informed of the potential risk of transmission of the virus.

(witness)

(signature of patient)

Id. at 1258.

112. The court applied the following test to determine whether the hospital wrongfully discriminated against the plaintiff:

whether the continuation of surgical privileges, which necessarily encompasses invasive procedures, poses a "reasonable probability of substantial harm" to others, including co-employees and, more importantly, patients.

In the present case both parties agree that the risk of incident, i.e., transmission of the HIV virus from physician to patient, is small, but that the risk of injury from such transmission is high, i.e., death.

Id. at 1276.

113. *Id.* at 1283 (emphasis added).

to be a step towards a positive answer to the question of whether a duty to disclose would be imposed by a court and found to have been breached if disclosure was not required by the hospital. If no such duty existed, the court could hardly have been justified in finding reasonable the hospital's suspension of the doctor's surgical privileges.

3. *The Irrational Patient*

When considering the requirement that HCWs disclose their HIV infection to patients in order to obtain informed consent, one cannot help but wonder whether, given the hysteria which often surrounds AIDS, a patient could rationally act on such information. Several cases have addressed this issue in analogous situations and found that the doctor, nevertheless, has a duty to make the disclosure. In *Cowman v. Hornaday*, the Supreme Court of Iowa held that a physician has a duty to disclose to a patient considering a vasectomy all known material risks of complication inherent in the proposed surgery and that he could not withhold information on the basis that to disclose it might alarm the patient.¹¹⁴ In *Kinikin v. Heupel*, the Supreme Court of Minnesota held that a patient's cancer phobia did not relieve the physician of his duty to warn her of the risk of skin cancer presented by prophylactic breast surgery.¹¹⁵

On the other hand, a Louisiana court recognized in *Hondroulis v. Schuhmacher* that:

[a] doctor has a "therapeutic privilege" to withhold disclosure of a material risk when the physician reasonably foresees that disclosure will cause the patient to become ill or emotionally distraught so as to foreclose a rational decision, complicate or hinder treatment, or pose psychological damage to the patient. This privilege must be carefully circumscribed, however, for otherwise it might devour the disclosure rule itself.¹¹⁶

Whether to apply such a privilege with respect to the disclosure of a doctor's HIV infection, however, simply begs the question. If the patient gets upset and irrational at the prospect of being operated on by a doctor with HIV, the patient has a simple alternative—have another doctor without HIV perform the procedure. This is quite different from cases such as *Cowman* and *Kiniken* where the patient would have to forego the treatment entirely. Therefore, going through the exercise of determining how a certain patient will react to the information would be harder in most instances than simply having someone else perform

114. 329 N.W.2d 422, 427 (Iowa 1983).

115. 305 N.W.2d 589, 595 (Minn. 1981).

116. *Hondroulis v. Schuhmacher*, 553 So. 2d 398, 413 (La. 1988) (citing *Canterbury v. Spence*, 464 F.2d 772, 789 (D.C. Cir. 1972)).

the procedure. Of course, the easiest route from the medical industry's perspective would be not to deal with the irrational patient at all by not requiring disclosure. Should the "therapeutic privilege" be conclusively invoked by the medical industry for the "benefit" of us all?

Based on the above analysis of current law in both Louisiana and other jurisdictions, a HCW has a legal duty in tort law to disclose his HIV infection to patients prior to performing invasive procedures. In Louisiana, this duty derives from both legislation (i.e., the Uniform Consent Law) and jurisprudence, especially *Hidding*, where a doctor suffering from chronic alcoholism lacked informed consent because he did not disclose his condition to the patient prior to performing surgery. Outside of Louisiana, the *Estate of Behringer* court has recognized such a duty by finding that a hospital acted reasonably *in order to avoid liability* when it suspended an HIV-infected doctor's surgical privileges and conditioned future privileges on patients' completing a special consent form which disclosed that the doctor performing the procedure was HIV positive.

V. NEED FOR THE DUTY TO TEST AND DISCLOSE

There are many compelling reasons to require that a HCW disclose his or her HIV infection, most of which were addressed by the *Estate of Behringer* court in reaching its conclusion. These will be discussed below along with the need for a corollary duty of HCWs to routinely test for HIV infection in order to be able to disclose positive results to their patients.

A. *Relative Position of Doctor and Patient*

The relative position of a doctor and patient places the patient at the mercy of the doctor. A doctor owes a fiduciary duty to his patient because the relationship is one of utmost trust.¹¹⁷ No doubt, the eminence of the medical profession comes in part from society's total dependence upon members of the health care profession for its health and well-being. The eminence also finds roots in the power of the profession, spawned by its knowledge of and control over illnesses and ailments and often life and death.

Acting for the good of the patient is the most ancient and universally acknowledged principle in medical ethics. . . . Every participant in clinical ethical decisions invokes the good of the patient to justify his or her moral choice. . . . The two major ethical theories vying for dominance in promoting the good of

117. *Rajnowski v. St. Patrick's Hosp.*, 1990 La. Lexis 2973 (1990) (Dennis, J., concurring in denial of reh'g).

the patient are the autonomy of the individual patient and the social utility and accountability of the physician.¹¹⁸

Consequently, the power which the medical profession has over society should be wielded with care and concern for the patient.

This disparity between the respective positions of patient and physician and the almost total control the doctor has over that relationship imposes a duty upon physicians to take every precaution available to them in order to protect their patients. Today these precautions should include routine testing for HIV infection and disclosure of positive results to patients. Why? Because the doctor is in control. The patient has no ability to employ "universal precautions" when dealing with doctors. The patient cannot establish or enforce guidelines which doctors are to follow during invasive procedures. The patient will probably not even know when a violation of such guidelines has occurred.

On the other hand, "[t]he doctor is trained to recognize, diagnose, and avoid contracting the patient's disease. . . . While secretive patients may transmit their diseases to unwary doctors, *doctors are responsible for both their own health and the health of their patients.*"¹¹⁹ In addition to this responsibility for the health of their patients, the medical industry is responsible for the spread of disease and engages in "lookback" programs in order to warn third parties associated with the AIDS victims of the possibility of contracting the disease from the patient. The *Estate of Behringer* court recognized: "If a physician has a duty to warn third parties of the HIV status of patients who may be, for example, sexual partners of the patient, it could legitimately be argued that the risk of transmission would similarly require the surgeon to warn his own patients."¹²⁰

B. The Epidemic Coming "Full Circle"

Among the most troubling reasons that the duty is necessary is the realization that, as will be explained below, the AIDS epidemic has come "full circle." There has been great concern and attention given to the problem of patient-to-HCW transmission of HIV in the medical industry.¹²¹ Unfortunately, this focus was justified.¹²² However, the tragedy of HCWs being stricken with a deadly disease in the pursuit of helping others has left us with an even bigger and more frightening concern: HCWs themselves are in a high risk group for contracting

118. *Id.*

119. *Estate of Behringer v. Medical Ctr. at Princeton*, 592 A.2d 1251, 1282 (N.J. Super. Ct. Law Div. 1991) (citation omitted) (emphasis added).

120. *Estate of Behringer*, 592 A.2d at 1281 n.19.

121. See *supra* text accompanying notes 39-45.

122. Surveillance Report, *supra* note 1, at 16.

HIV. HCWs contracting HIV from their patients is only one phase in the spread of this indiscriminating virus. The logical consequence of that phase is the beginning of another phase in the epidemic as the virus spreads from HCWs back to patients.

The first discovery of a HCW-to-patient transmission in the Kimberly Bergalis case makes this second phase seem, in hindsight, almost obvious. Of course, epidemics do not come with written strategies to inform their victims of the paths they will take. Instead, society and its experts are left to struggle, using knowledge and resources, to combat the epidemic. They can do this by placing obstacles in the paths they can *foresee* that the disease will take and/or obstacles in the paths they cannot *afford* for the disease to take (no matter how unlikely it seems at the time that the disease would in fact take those paths).

Prior to the Kimberly Bergalis case, transmission of HIV from HCWs to patients was a path society could not *afford* for the disease to take. For if it did, the source of health care would then be paradoxically transformed into a source of infection, disease and death. Unfortunately, that risk was not taken seriously, and the HCW-to-patient path was left unprotected. Now, however, given what we know about the Kimberly Bergalis case, HCW-to-patient transmission is also a path society can *foresee* the disease will take. According to basic negligence principles, once such a tragedy is foreseeable, duties to prevent the tragedy emerge. One such duty is that of HCWs to undergo routine testing and disclose positive results to their patients.

C. *Lack of Incentive for Voluntary Disclosure*

Still another need for the duty arises from the lack of incentive for HCWs to *voluntarily* disclose their diseases. For example, in *Estate of Behringer*, the plaintiff's companion indicated that once the surgeon was diagnosed with AIDS, his relationships with neighbors and friends changed. "There was less social contact and communication and what she perceived as a significant diminution in the popularity of plaintiff."¹²³ His practice was even more significantly impacted than his social relationships.

During his short absence from the office (approximately one month), many of his patients requested transfer of their files or indicated that they no longer wanted to be treated by the plaintiff. In fact, plaintiff's companion, at one point instructed the plaintiff's receptionist not to confirm any information regarding plaintiff's disease and to "instruct patients that plaintiff did not have AIDS." In addition, within two months of plaintiff's return to work, three employees left and a re-

123. 592 A.2d at 1256.

placement employee left the day after she learned that plaintiff had AIDS.¹²⁴

This sad series of events represents two related phenomena: 1) society is fearful of AIDS, and this fear, combined with ignorance about the disease and modes of transmission, generates bigotry and prejudice toward victims of the disease, and 2) this prevalent, though regrettable, response by society to AIDS and its victims strips all incentive to disclose from an HIV-infected HCW who might otherwise have disclosed his disease.¹²⁵ "AIDS brings with it a special stigma."¹²⁶ Why would anyone voluntarily subject themselves to this stigma? The answer is they understandably will not.¹²⁷ This lack of incentive was acknowledged in *Estate of Behringer*:

[T]here must be a way to free physicians, in the pursuit of their healing vocation, from possible contamination by self-interest or self-protection concerns which would inhibit their independent medical judgments for the well-being of their . . . patients. There are principles of law that guard against the concern for self-interest, by including in the decision-making process the most critical participant—the patient.¹²⁸

124. *Id.* at 1256-57.

125. Ironically, it was public fear which prompted the hospital in the *Estate of Behringer* case to adopt a special informed consent form which required disclosure of a physician's HIV prior to surgery because of the potential damage to the hospital's reputation and potential litigation. *Id.* at 1257.

126. *Id.* at 1269. A few examples of the hysterical public reaction to AIDS were provided by the court:

removal of a teacher with AIDS from teaching duties; refusal to rent an apartment to male homosexuals for fear of AIDS; firebombing of the home of hemophiliac children who tested positive for AIDS; refusal by doctors and [HCWs] to treat people with or suspected of having AIDS; refusal of co-workers of an AIDS victim to use a truck used by the victim; filing of a charge of attempted murder against an AIDS victim who spat at police; requiring an AIDS victim to wear a mask in a courtroom; denial to children with AIDS of access to schools; threatening to evict a physician who treated homosexuals; boycotting of a public school after a child with AIDS was allowed to attend; firing of homosexuals who displayed cold symptoms or rashes; refusal of paramedics to treat a heart attack victim for fear he had AIDS; refusal by police to drive an AIDS victim to the hospital; police demands for rubber masks and gloves when dealing with gays; refusal to hire Haitians; and urging of funeral directors not to embalm the bodies of AIDS victims.

Id. at 1272 (citing *Doe v. Barrington*, 729 F.Supp. 376, 384 n.8 (D.N.J. 1990)).

127. This was acknowledged in explanation for the lack of information regarding the number of dental workers with AIDS: "persons who know that they are HIV-infected or who have non-occupational risks may not volunteer to be tested." Ciesielski, M.D. et al., *supra* note 1, at 44.

128. *Estate of Behringer v. Medical Ctr. at Princeton*, 592 A.2d 1251, 1278 (N.J. Super. Ct. Law Div. 1991).

This lack of any incentive for voluntary disclosure makes it absolutely imperative that courts, if not Congress, recognize a legal duty on the part of HCWs to disclose their HIV infection.

VI. THE NEED FOR ROUTINE TESTING OF HCWS

Since the duty and the need for disclosure have been established, this author believes that HCWs should undergo routine testing in order to be capable of disclosing. Full disclosure of the risks involved in a given procedure is impossible unless a HCW knows, with as much certainty as possible, whether he is capable of transmitting HIV to the patient. The court in *Estate of Behringer* specifically refused to address this issue,¹²⁹ implying that it is indeed an issue raised as soon as one finds there is a duty to disclose. It is true that one cannot disclose what he does not know; however, because one does not have to know he is infected with HIV in order to transmit it, and because one is probably more likely to transmit HIV if he is unaware of his infection (due to his engaging in activities that he would not otherwise engage in), the duty to disclose should include the duty to be tested.

Serious consequences would result if the duty imposed upon HCWs to disclose their HIV infection did not require them to routinely test for its presence. This in effect would be rewarding ignorance. HCWs would be encouraged not to test even if they thought they might be infected. The impediments to voluntary disclosure discussed earlier are magnified with regard to testing. Those who might have voluntarily tested for their own benefit when not required to disclose the information to patients would be deterred from doing so for fear of receiving positive test results which would have to be disclosed and which would likely destroy their careers. Therefore, the imposition of a duty to disclose without the correlative duty to undergo routine testing would, in all likelihood, do more harm than good.

A. *Balancing the Costs and Benefits*

Perhaps the most rational way to make any decision is to balance the costs and benefits. What are the benefits of requiring HCWs to routinely test for HIV and to disclose positive results to their patients? The most obvious benefit would be to help prevent the spread of AIDS. Additionally, as was suggested by the CDC with regard to testing hospitalized patients,¹³⁰ the HCW would become aware of the existence of HIV much earlier through routine testing. Rather than only discovering

129. "This case does not involve nor will this court decide the issue of mandatory screening of physicians for HIV." *Id.* at 1279 n.18.

130. See *supra* text accompanying notes 46-48.

HIV once opportunistic diseases indicating AIDS have forced the HCW to seek treatment, as was the case with the surgeon in *Estate of Behringer*, the HCW would be able to seek immediate treatment at the earliest stages of the disease. Besides these personal benefits (which were supposed to sell the idea to hospitalized patients without more), incredible benefits would be gained by patients treated by the HCW. Since the mean latency period for the development of AIDS after HIV infection is five years, far fewer patients would be exposed to the risk of contracting the disease if the HCW discovered his disease through routine testing immediately after infection.¹³¹

Further, as noted by the court in *Estate of Behringer*, the cumulative risk of exposure in the health care setting is far higher when a HCW is infected with HIV than when a patient is infected with HIV. The patient will have relatively few invasive procedures performed while the infected HCW is likely to perform numerous invasive procedures even if his career is cut short by the virus.¹³² Calculations suggest that the risk of a HCW contracting HIV in a single surgery from an HIV-infected patient is remote—from 1/130,000 to 1/4500. Assuming that the risk of any one of an HIV-infected HCW's patients contracting the virus from the surgeon is exceedingly low—1/130,000, the risk that *one of his patients* will become infected becomes higher the more operations he performs—1/1,300 with 100 operations or 1/126 with 500 operations.¹³³ Finally, without routine testing, the HCW is not likely to discover his disease until he suffers from AIDS which is more easily transmissible than HIV.¹³⁴

Another benefit to be derived from testing and disclosure is a reduction in the injuries suffered by patients who undergo invasive procedures by a HCW infected with HIV. As the court in *Estate of Behringer* recognized (while the court in *Rossi* did not), the risk to patients in such a situation goes beyond the possibility of dying as a result of contracting AIDS. It also includes the extensive testing which patients must undergo after exposure to the blood of a HCW.

Apparently, the medical industry has balanced the risk of the patient having to undergo extensive testing and lifestyle changes, contracting HIV and dying, with the cost of a HCW having to undergo routine testing, disclose positive results to patients and possibly lose his career.

131. See *supra* text accompanying notes 30-31, describing the two latency periods involved between HIV infection and the development of AIDS.

132. *Estate of Behringer*, 592 A.2d at 1280 (citing Larry Gostin, Hospitals, Health Care Professionals, and AIDS: The "Right to Know" the Health Status of Professionals and Patients, 48 Md. L. Rev. 12 (1989)).

133. *Estate of Behringer v. Medical Ctr. at Princeton*, 592 A.2d 1251, 1280 (N.J. Super. Ct. Law Div. 1991) (citing Gostin, *supra* note 132).

134. *Id.* at 1267.

Not surprisingly, the medical industry has determined that "[t]he current assessment of the risk that infected HCWs will transmit HIV . . . to patients during exposure-prone procedures does not support the diversion of resources that would be required to implement mandatory testing programs."¹³⁵ Thus, the current CDC recommendations suggest that "if an incident occurs during an invasive procedure that results in exposure of a patient to the blood of an HCW, the patient should be informed of the incident, and previous recommendations for management of such exposures should be followed."¹³⁶ One cannot help but empathize with the patient who responds with a resounding, "Now you tell me!!" What could be more frustrating than learning after the fact that you have been exposed to HIV when, if only you had been informed in advance, you could have made a decision to avoid the risk? Yet, this is the current recommended practice.

Shouldn't courts, if not Congress, be striking the balance between the risks to patients and the costs to the medical industry rather than the medical industry itself? It seems courts may be beginning to reclaim that responsibility. In *In Re: Milton S. Hershey Medical Center of the Pennsylvania State University*,¹³⁷ a case following *Estate of Behringer* and citing it with approval, Dr. Doe was accidentally cut by the attending physician during an invasive procedure. *The following day*, Dr. Doe voluntarily submitted to a blood test for HIV, and the results were positive. Dr. Doe took a voluntary leave of absence. Hershey Medical Center conducted an investigation and identified 279 patients who had been involved to some degree with Dr. Doe during their medical treatment. Harrisburg Hospital, also a party to the litigation, did the same and found 168 patients who had been in contact with Dr. Doe during his joint residency.¹³⁸

The trial court issued an order allowing limited disclosure of Dr. Doe's HIV status, and the hospitals proceeded to inform the patients of the doctor's status without revealing his name. The doctor appealed. The appellate court was faced with the issue of whether the hospitals sustained their burden of proving a "compelling need" for disclosing Dr. Doe's HIV status considering the strong proscriptions against disclosure contained in *The Confidentiality of HIV-Related Information*

135. See *supra* text accompanying note 52.

136. *Estate of Behringer*, 592 A.2d at 1265 (citing Ctrs. for Disease Control, Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus during Invasive Procedures, 35 *Morbidity and Mortality Weekly Report* 221-23 (1986)).

137. 595 A.2d 1290 (Pa. Super. Ct. 1991).

138. The extent of the contact Dr. Doe had with the patients was not made part of the record. *Id.* at 1291.

Act adopted by the Pennsylvania Legislature.¹³⁹ That act provides in part: "[T]he court shall weigh the need for disclosure against the privacy interest of the individual and the public interests which may be harmed by disclosure."¹⁴⁰

The court noted that although the chance of transmitting the HIV virus during surgical procedures was slim—1/48,000 according to one commentator—the potential was nevertheless present.¹⁴¹ However, the court recognized:

When one begins to calculate how many individuals may be subjected to the same risk by the same medical worker, multiplied by the aggregate of infected health care professionals, the numbers become staggering. . . . Surely, it is no consolation to the one or two individuals who become infected after innocently consenting to medical care by an unhealthy doctor that they were part of a rare statistic.¹⁴²

Despite Dr. Doe's argument that disclosure would discourage HCWs from voluntarily seeking HIV testing, the court found that a compelling need did exist and that disclosure had been proper. The court acknowledged Dr. Doe's right to privacy but stated: "*Dr. Doe's medical problem was not merely his. It became a public concern the moment he picked up a surgical instrument and became a part of a team involved in invasive procedures.*"¹⁴³

The court addressed the necessity of informing patients so that they might obtain testing and treatment and not inadvertently pass on the virus to others, but the opinion does not address the impact this process must have had on the 447 patients who were told after exposure that they should undergo testing to see if they had been infected with a deadly virus.

In the Kimberly Bergalis case,¹⁴⁴ a Florida dentist had been diagnosed with AIDS three months prior to the date he extracted two molars from Kimberly.¹⁴⁵ After the discovery of Kimberly's infection and its subsequent link to the dentist,¹⁴⁶ 591 of the dentist's other patients were

139. *Id.* at 1294. The appellate court determined that the issue was not moot even though the disclosure had already occurred because the scenario would undoubtedly be repeated.

140. *Id.* at 1295 (citing 35 P.S. § 7608(c)).

141. *Id.* at 1296.

142. *Id.* (emphasis added) (citations omitted).

143. *Id.* at 1298.

144. See *supra* text accompanying notes 7-8.

145. Possible Transmission, *supra* note 7.

146. Four weeks after Kimberly's dental procedure, she sought treatment for a sore throat. Twenty-four months after the procedure, she was diagnosed with PCP, an op-

tested for HIV. Another 1,100 people who were identified as possible patients and could be located were notified, and 141 of them were tested.¹⁴⁷

This in itself is a cost, regardless of whether the patients ultimately test positively for HIV. Their lives are disrupted. They are forced to undergo periodic testing for at least one year and suffer extreme anxiety and mental anguish awaiting the test results; they are counselled concerning major lifestyle changes regarding sexual practices and conceiving children. Just because this cost is paid by people with random identities from all walks of life rather than by members of one profession capable of uniting in a single voice does not mean that the cost is insignificant.

Why should all of these individuals be tested under such traumatic conditions rather than requiring HCWs to be tested under routine conditions? The HCWs certainly have better access to testing facilities than the public at large and probably work in or near them on a daily basis. That would be a factor indicating that on a per test basis, it would be more efficient to test HCWs than members of the public at large. In any event, something routine is obviously more palatable than something unexpected, traumatic and life altering. Upon entering the profession and deciding to perform invasive procedures, the HCW would be made aware of the requirement of future routine testing. Otherwise, countless¹⁴⁸ numbers of patients will be caught completely off guard and will have to await test results that could mean the difference between life and death.

portunistic disease, and tested positively for HIV. Kimberly fell into no risk group for HIV infection, and both of her previous boyfriends tested seronegative. Sophisticated comparisons were made of DNA extracted from blood samples of the dentist and Kimberly. The "multifaceted analysis showed a similarity between the sequences from the patient and the dentist that was comparable to what has been observed for cases that have been epidemiologically linked (Los Alamos National Laboratory, unpublished data)." *Id.* at 489-90.

147. Update, *supra* note 4.

148. Approximately 27 million operations are performed each year in United States hospitals. Adalisa Panlilio, M.D., M.P.H. et al., Blood Contacts During Surgical Procedures, 265 JAMA 1533 (1991).

Defendant's expert in *Estate of Behringer* stated that "[a]s a practical matter, . . . surgeons incur needle sticks and other cuts in the operating room on a regular basis, and the wearing of surgical gloves does not protect a surgeon from needle sticks or bleeding into the patient's surgical wound or oral cavity." *Estate of Behringer v. Medical Ctr. at Princeton*, 592 A.2d 1251, 1265 (N.J. Super. Ct. Law Div. 1991). "Studies indicate that a surgeon will cut a glove in approximately one out of every four cases, and probably sustain a significant skin cut in one out of every forty cases." *Id.* at 1279.

Of course, the number of HCWs performing these operations who are infected with HIV is not known. Therefore, according to current practice, the number of patients who are exposed to an HIV infected HCW's blood during an invasive procedure will not be known until after the accident.

What are the costs associated with requiring testing and disclosure? Realistically, in most cases, the practice of the doctor who discloses that he is HIV-positive will be destroyed. That is the real cost involved in requiring an HIV-infected HCW to disclose his condition to patients. In fact, the *Estate of Behringer* court recognized that this cost should be weighed against the value derived from the HIV-infected HCW performing invasive procedures. The court noted that “[w]hile society must protect the availability of vital services, there is no need to protect the services of any one provider.”¹⁴⁹

However, a separate analysis is required in order to justify the costs involved in mandatory testing of HCWs. Taking the court’s analysis¹⁵⁰ a step further to mandatory testing of HCWs requires consideration of three elements:

- (a) The social value which the law attaches to the interest which is to be advanced or protected by the conduct.

As determined in *Estate of Behringer*, “[t]he law places a very high value on a patient’s safety and well-being.”¹⁵¹ The safety and well-being of patients (including the HCWs who become patients as a result of positive HIV test results) would be promoted by mandatory testing because HIV infection in HCWs would be discovered much earlier through routine testing, and, therefore, less patients would be at risk of exposure. In addition, routine testing would drastically reduce the risk of HIV being spread from HCW-to-patient and would, therefore, be a valuable weapon against a disease of epidemic proportions. Perhaps most importantly, routine testing would make it possible to assess the risk of HCW-to-patient transmission which is certainly more prudent than just assuming the risk is low. As a result, routine testing would maintain and perhaps bolster society’s confidence in the medical profession.

- (b) The extent of the chance that this interest will be advanced or protected by the particular course of conduct.

The extent of the chance that these interests would be advanced by routine testing is very high, though as yet undeterminable. Recall that with routine testing, HIV infection would be discovered in ninety-five percent of cases within six months’ of the HCW’s infection.¹⁵² Once HIV is discovered in a HCW, patients would be informed of the HCW’s

149. *Estate of Behringer*, 592 A.2d at 1281 (citing Gordon Keyes, Health-Care Professionals with AIDS: The Risk of Transmission Balanced Against the Interests of Professionals and Institutions, 16 J.C. & U.L. 589, 603-04 n.114 (1990)).

150. The court followed Keyes’ suggestion which utilizes the risk-benefit analysis found in Restatement (Second) of Torts, § 293 (a)-(c) (1965). *Estate of Behringer*, 592 A.2d at 1281.

151. 592 A.2d at 1281.

152. See *supra* text accompanying note 30.

condition before that HCW performed invasive procedures and potentially exposed the patient to the virus. Because a patient would obviously opt against surgery by an HIV-infected HCW, patients would no longer be exposed to HCWs' HIV during the prolonged latency period between the time a HCW is seropositive and the time he develops opportunistic diseases which would otherwise alert the HCW to seek treatment and discover his condition. Thus, routine testing would greatly advance and protect the interests described in paragraph (a).

(c) The extent of the chance that such interest can be adequately advanced or protected by another and less dangerous course of conduct.¹⁵³

The only other possible course of conduct that might be less costly than routine testing that this author can suggest would be to impose a reasonable man based standard for HIV testing. Instead of requiring mandatory testing for all HCWs who perform invasive procedures, the duty would require a HCW to be tested who reasonably believed himself to be at risk of carrying HIV based on factors such as lifestyle, behavior and perhaps exposure to HIV-infected patients.

There are, however, several problems with this alternative. Such a duty would not be that different from the "case-by-case" policy currently in effect. As was previously discussed, all members of the health care industry could be considered at high risk for contracting HIV. This is illustrated in the fact that one of the factors considered in narrowing the source of Kimberly Bergalis' infection was that she had never "been employed in a health-care or other setting where she could have been exposed to HIV-infected blood or other body fluids."¹⁵⁴ Another problem with this alternative is that the "unreasonable person" might be infected with HIV and find that potential liability is not enough incentive to test for and disclose the positive results. Therefore, to select individuals from the group of HCWs based on factors personal to them, would probably not advance the interest of blocking the spread of the virus from HCWs-to-patients.

Additionally, it would not promote confidence in the medical profession because the profession would not be taking every precaution available to it in order to protect its patients. Further, the circle of transmission would not have been severed as cleanly as possible, and therefore, the medical profession would be placing the livelihood of its members above the need to stop the spread of AIDS. Thus, it appears that there is no less dangerous alternative course of conduct which would adequately advance the interests and protections afforded by routine, mandatory testing.

153. *Id.*

154. Possible Transmission, *supra* note 7.

Therefore, since the interests are high, the chance of advancing and protecting them are high, and no adequate alternatives which are less dangerous exist, one can conclude that the benefits of mandatory testing of HCWs outweigh the costs.

VII. SCOPE OF THE DUTY

If a duty to test and disclose is imposed on HCWs, what are its parameters?

A. *Who Owes the Duty?*

As has been implicit throughout this article, only those HCWs who perform *invasive procedures* would be subject to the duty to test and disclose. The duty to test and disclose derives from the duty to obtain informed consent; however, there may be HCWs who have the duty to obtain informed consent but who do not perform invasive procedures. Those HCWs would not be required to test and disclose. There are also those in the medical profession who do not owe the duty to obtain informed consent, such as a radiologist whose duty is to read X-ray film and write a report to the treating physician.¹⁵⁵ Such a person would not owe the duty to test and disclose.

The degree of invasiveness of the procedures performed by a particular HCW, however, should not determine whether or not the HCW must undergo routine HIV testing and disclose positive results; rather, *the degree of invasiveness should be used to set the frequency with which those routine tests must be performed.* For example, an oral surgeon, who performs highly invasive procedures in the mucous membrane area which is highly susceptible to transmission of HIV, or an obstetrician, who performs many procedures "by feel" which increases the likelihood of nicks or cuts, should probably be tested more frequently than a general practitioner who occasionally administers injections.

Several cases have addressed the scope of the duty to obtain informed consent and thus provide parameters for the duty to test and disclose. In *Nisenholtz v. Mount Sinai Hospital*,¹⁵⁶ the New York Supreme Court held that a physician who merely refers a patient to another doctor does not become liable if the second doctor performs surgery without obtaining informed consent.

In *Lincoln v. Gupta*,¹⁵⁷ a Michigan appellate court held that a hospital did not owe a duty to obtain informed consent of a patient. Rather, it was the doctor's duty to inform the patient of risks associated

155. Cf. *Townsend v. Turk*, 266 Cal. Rptr. 821 (Cal. Ct. App. 1990).

156. 483 N.Y.S.2d 568 (N.Y. Sup. Ct. 1984).

157. 370 N.W.2d 312 (Mich. Ct. App. 1985).

with the procedure and any breach of that duty was committed by the doctor rather than the hospital. Perhaps in the context of transmission of HIV, however, the hospital would be liable if it did not have procedures established for the testing of HCWs and for facilitating the disclosure of positive results (such as a special informed consent form used by the hospital in *Estate of Behringer*).

B. To Whom is the Duty Owed?

To whom the duty is owed may be less easily determined. At what point must the HIV-infected HCW disclose his infection to a patient—prior to establishing the HCW-patient relationship or simply prior to performing any invasive procedures? The duty to test comes into existence when the HCW undertakes to perform invasive procedures; that duty is not patient specific. However, the duty to disclose HIV infection in order to obtain informed consent is patient specific. Thus, there would probably be situations where the HCW has tested positively for HIV but does not need to disclose the results to a particular patient because the HCW is not performing an invasive procedure on that patient.

What about co-workers and employers? As a practical matter, the employer may be the one conducting the testing and monitoring the results in which case it would know without disclosure by the HCW. As for co-workers, the duty owed them is beyond the scope of this article but is an issue which must be considered.¹⁵⁸

What about professional liability insurance carriers? Perhaps premiums would be reduced for those who are not HIV-positive rather than having the cost of possible HCW-to-patient transmission spread across all HCWs.

VIII. POSSIBLE METHODS FOR REDUCING THE BURDEN

In balancing the costs and benefits of imposing a duty to test and disclose, one must recognize significant costs. The administrative costs of routinely testing HCWs will be offset long term, to some extent, by the reduction in the number of patients who would have to be tested after an accident occurs. Those costs are also justified by the extreme anguish of those patients who are called to be tested after the fact.

Another cost generated by the imposition of such a duty is the destruction of the career of a valued member of the medical profession. Once a HCW tests positively for HIV and has to disclose those results

158. For a full discussion of hospital liability for the transmission of AIDS to patients or among co-workers, see Comment, *Hospitals and AIDS Discrimination: Applicability of Federal Discrimination Laws to HCWs and Staff Physicians*, 6 J. Contemp. Health L. & Pol'y 193 (1990).

to patients, his career virtually comes to a halt.¹⁵⁹ Perhaps a way of reducing the impact of this inevitable consequence would be to pay HIV-infected HCWs a higher salary to work with AIDS patients. Free enterprise has already required that HCWs (HIV infected or not) who treat AIDS patients be paid a premium.

Several benefits would be derived from giving employment opportunities in AIDS treatment and research facilities to HIV-infected HCWs first. The HCWs would benefit because they would be able to enjoy an increased salary without assuming an additional risk of contracting HIV as do HCWs who are not infected with HIV. That would help them with the increased medical costs associated with HIV. They would also realize a sense of reward and vitality from being part of the battle against the progression of AIDS. The patients suffering from AIDS would benefit because an HIV-infected HCW would undoubtedly be more understanding and create a warmer environment than would a HCW who is understandably fearful of contracting the patients' disease.

IX. CONCLUSION—RESOLVING UNCERTAINTY IN FAVOR OF DISCLOSURE

"AIDS is not a disease that is, or that should be taken lightly by our society. Rather, many view it as a problem of epidemic proportion that knows no bounds and discriminates against no one."¹⁶⁰ If this is true, which it certainly seems to be, what is the role of the medical profession in light of this epidemic? Is it just another business enterprise which provides employment opportunities for the highly skilled and specially trained? Or is its role to promote, preserve, protect, and restore public health? One must hope it is the latter, and if it is, an HCW's infection with HIV becomes a public concern the moment he picks up a medical instrument and becomes part of a team involved in invasive procedures.¹⁶¹

Just as a football star who irreparably injures his knee can no longer lead his team to victory, a HCW who contracts a deadly disease can no longer protect the health of a patient (who is not HIV positive) by performing invasive procedures. Patients are entitled to expect that their HCWs will not increase their exposure to the risk of contracting an infectious disease.¹⁶² The guardian of this expectation is the doctrine of medical informed consent which "is based on the principle that every human being of adult years and sound mind has a right to determine what shall be done to his or her own body."¹⁶³

159. See *supra* text accompanying notes 123-24.

160. In Re: Milton S. Hershey Medical Ctr. of the Pa. State Univ., 595 A.2d 1290, 1301 (Pa. Super. Ct. 1991).

161. See *supra* text accompanying note 143.

162. See *supra* text accompanying note 53.

163. See *supra* note 89.

Even though the risk of HCW-to-patient transmission is arguably small, the stakes are extremely high and the risk, after all, is the *patient's*. Assessment of the importance of the risk cannot belong to anyone but the patient, and that assessment cannot be made without routine testing of HCWs and disclosure of positive results to patients. Though the risk is arguably small, its degree is terribly uncertain.¹⁶⁴ Simply because we cannot calculate the risk with accuracy should not provide grounds to assume it away. *Perhaps if we instituted mandatory testing we would find that the risk is much greater than we once thought.* There is no way to know until we know how many HCWs in fact are infected with HIV. With the rate that this disease has spread and the recent first *known* death caused by HCW-to-patient transmission of HIV, shouldn't we resolve the uncertainty in favor of protecting health and preventing further spread of the disease?

Ten years ago, we were shocked by the discovery of this incredible disease. Years later, we were shocked to learn that not only homosexual men and intravenous drug users fell victims to the disease but so did heterosexual "mainstream" Americans. In 1990, we were shocked by the announcement that Kimberly Bergalis had contracted HIV from her dentist. Is it logical for the medical profession to sit back on its knowledge, comfortable with the notion that "there [is] little evidence of transmission of the virus by HCWs, other than the case of a Florida dentist"?¹⁶⁵

This author suggests that this disease has permeated our society with alarming speed and devastation and will shock us again. Perhaps it is time to place obstacles in its path to prevent its only skilled combatant—the medical profession—from becoming its unwitting co-conspirator.

Jane H. Barney

164. See *supra* text accompanying notes 43-44.

165. "'The Florida case is too bizarre [sic] to be helpful' in making public health policy" said the Director of the CDC. William Welch, CDC Wants Voluntary AIDS Tests, *The Daily Reveille* (Louisiana State University), Sept. 20, 1991, at 1, 10.