

Hospitals, Health Care Professionals, and Aids: the "Right to Know" the Health Status of Professionals and Patients

Larry Gostin

Follow this and additional works at: <http://digitalcommons.law.umaryland.edu/mlr>



Part of the [Health Law Commons](#)

Recommended Citation

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)

Available at: <http://digitalcommons.law.umaryland.edu/mlr/vol48/iss1/5>

This Article is brought to you for free and open access by the Academic Journals at DigitalCommons@UM Carey Law. It has been accepted for inclusion in Maryland Law Review by an authorized administrator of DigitalCommons@UM Carey Law. For more information, please contact smccarty@law.umaryland.edu.

Articles

HOSPITALS, HEALTH CARE PROFESSIONALS, AND AIDS: THE "RIGHT TO KNOW" THE HEALTH STATUS OF PROFESSIONALS AND PATIENTS

LARRY GOSTIN*

The acquired immune deficiency syndrome (AIDS) epidemic has transformed perceptions about the hazards involved in the practice of medicine, nursing, and associated fields. Documented cases of transmission of the human immunodeficiency virus (HIV) have demonstrated that health care professionals (HCPs)¹ can contract their patient's lethal infections.²

AIDS, therefore, is increasingly being viewed as an occupational disease for HCPs,³ despite the evidence that HIV is exceedingly hard to transmit in health care settings.⁴ For most HCPs this has not meant, as has often been suggested, an abandonment of their legal and ethical duties to treat persons with HIV.⁵ But HCPs, particularly those who carry out seriously invasive procedures,⁶

* Executive Director, American Society of Law and Medicine; Adjunct Associate Professor of Health Law, Harvard School of Public Health; Associate Director, World Health Organization/Harvard University International Collaborating Center on Health Legislation. B.A., State University of New York at Brockport, 1971 (summa cum laude); J.D., Duke University, 1974. The author is the editor of a volume of essays entitled "Hospitals, Health Care Professionals, and AIDS" to be published by Yale University Press.

1. Health care professionals (HCPs) are broadly defined 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." Centers for Disease Control, *Recommendations for Preventing Transmission of HIV in Health-Care Settings*, 36 MORBIDITY & MORTALITY WEEKLY REP. 305, 305 (1987) [hereinafter *CDC Recommendations: No. 2S*].

2. See Bayer, *AIDS and the Duty to Treat: Risk, Responsibility, and Health Care Workers*, 64 BULL. N.Y. ACAD. MED. 498, 499 (1988) (citing Friedland & Klein, *Transmissions of the Human Immunodeficiency Virus*, 317 NEW ENG. J. MED. 1125, 1127 (1987)).

3. See, e.g., Brennan, *Ensuring Adequate Health Care for the Sick: The Challenge of the Acquired Immunodeficiency Syndrome as an Occupational Disease*, 1988 DUKE L.J. 29, 33; Gerbert, Maguire, Badner, Altman & Stone, *Why Fear Persists: Health Care Professionals and AIDS*, 260 J. A.M.A. 3481, 3481 (1988).

4. See, e.g., *CDC Recommendations: No. 2S, supra* note 1, at 306-07.

5. See *infra* notes 58-59 and accompanying text.

6. Seriously invasive procedures are distinguished from other medical procedures. "Seriously invasive procedure" is narrowly defined as "surgical entry into tissues, cavities or organs or repair of major traumatic injuries," where there is likely to be exposure to substantial amounts of blood. *CDC Recommendations: No. 2S, supra* note 1, at 308-09.

claim the right to know whether their patients are infected with HIV.⁷ Their claim is not only to have access to HIV-positive test results available in the medical records, but to have the right to screen patients for HIV without their consent.

The Surgeon General has advocated HIV screening of all pre-operative patients.⁸ Some hospitals, irrespective of what the law may allow, already screen their patients without specific informed consent.⁹ There is even a strand of professional opinion that says specific consent to an HIV test is not required by law, provided there is consent to the "routine" taking of blood samples.¹⁰ Other HCPs concede that it is currently unlawful to test without consent, but have called for new legislation which would authorize compulsory testing and screening of patients.¹¹ This legal and policy debate has taken place without any analysis of whether the doctrine of informed consent applies to an HIV test and, more importantly, whether compulsory testing would be an efficacious policy in impeding the spread of HIV to HCPs.

Patients undergoing seriously invasive procedures also claim the right to know if their physician is infected with HIV. In a 1987 Gallup Poll, eighty-six percent of those polled said patients should be told if their physician has AIDS.¹² The same poll revealed that

The hepatitis B virus (HBV) experience indicates that only health care workers (HCWs) who perform seriously invasive procedures have transmitted the HBV to patients. *Id.* at 317. As the human immunodeficiency virus (HIV) is significantly more difficult to transmit than HBV, it is reasonable to conclude that any limitation on the right to practice medicine that may be warranted should be applicable only to seriously invasive procedures.

7. See, e.g., Foreman, *Ethics, Risks Collide in Treatment of AIDS Patients*, Boston Globe, Jan. 31, 1988, at 1; Judis, *An AIDS Nightmare*, N.Y. Times, Jan. 17, 1988, § 6 (Magazine), at 32; Gordon, *HIV Status of Patients of Routine Testing Advocated*, AIDS PATIENT CARE, Dec. 1987, at 34; Staver, *Orthopod Urges HIV Testing*, Am. Med. News, Dec. 4, 1987, at 36-37.

8. Breo, *Dr. Koop Calls for AIDS Tests Before Surgery*, Am. Med. News, June 26, 1987, at 1.

9. See Henry, Willenbring & Crossley, *Human Immunodeficiency Virus Antibody Testing: A Description of Practices and Policies at U.S. Infectious Disease-Teaching Hospitals and Minnesota Hospitals*, 259 J. A.M.A. 1819, 1821 (1988) (34% of the United States infectious disease hospitals and 57% of the Minnesota hospitals estimated that the consent of the patient was rarely obtained when an HIV test was ordered).

10. See *infra* notes 131-135 and accompanying text.

11. See, e.g., AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, AIDS: STATEMENT OF PRINCIPALS AND INTERMEDIATE RECOMMENDATIONS FOR EMERGENCY DEPARTMENT PERSONNEL AND PREHOSPITAL CARE PROVIDERS, reprinted in 17 ANNALS EMERGENCY MED. 1249 (Nov. 1988).

12. See *New AHA Guidelines Urge Universal AIDS Precautions*, 16 MED. STAFF NEWS 2, 2 (Aug. 1987) ("In a recent poll of 1,000 adults nationwide, conducted [] by SRI Gallup, 80 percent of the respondents said health care workers should be screened for AIDS, . . .

most patients would choose not to receive treatment from an infected physician.¹³ The patients' case has been buttressed by a policy statement from the American Medical Association (AMA) that a "physician who knows that he or she is seropositive should not engage in any activity that creates a risk of transmission of the disease to others."¹⁴ Presumably this policy would extend to other health care workers (HCWs), for example, those on a surgical team who perform seriously invasive procedures. If it is wrong for infected physicians to invasively treat patients, does this create a correlative duty on the part of hospitals to screen physicians before they carry out such treatment?

The prospect of a right to know the health status of both doctor and patient, with calls for screening on both sides, together with the potential of litigation for avoidable transmission of HIV, undermines trust within the health care system. This article will address why patients and HCPs with HIV should have autonomy and privacy rights to choose whether to consent to an HIV test and to disclose their serologic status. The article will demonstrate that the risk of HIV transmission in health care settings is exceedingly low, that it is probably lower than other well-accepted risks taken by patients and professionals, and that there are other less intrusive ways to further reduce the risk. The article concludes that knowledge of a patient's serologic status is unlikely to reduce risk, since no effective action could be taken with the information. Balanced against the negligible public health benefit of a right to know are significant personal, financial, and social costs of screening programs.

HIV status certainly is relevant clinical information and infected patients should be encouraged to inform their physicians voluntarily. Similarly, infected physicians should be encouraged to disclose the information to their employers who, in turn, should ensure that the physician poses no meaningful risk to patients.¹⁵ But to exchange this policy of voluntary disclosure for one involving the sys-

and 86 percent said patients should be told if the health care worker caring for them has AIDS.").

13. See *id.* (57% of respondents in a nationwide poll said HCWs who have AIDS should be denied the right to treat patients).

14. Council on Ethical and Judicial Affairs, *Ethical Issues Involved in the Growing AIDS Crisis*, 259 J. A.M.A. 1360, 1361 (1988) [hereinafter *Ethical Issues*]. A seropositive test denotes a showing of the antibody for which the test is administered to detect. See DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 1192 (26th ed. 1985).

15. For a complete discussion of the rights and responsibilities of an HIV-infected physician, see generally Gostin, *HIV-Infected Physicians and the Practice of Seriously Invasive Procedures*, 19 HASTINGS CENTER REP. 32 (1989).

tematic and mandatory collection of highly intimate data would trample individual autonomy and privacy rights.¹⁶ It also would significantly burden health care providers with financial costs and potential legal liability.

I. OCCUPATIONAL RISKS OF HIV

Numerous studies, all pointing in the same direction, show that the occupational risk of acquiring HIV in health care settings is extremely low.¹⁷ The risk is most often associated with accidental percutaneous¹⁸ inoculation of contaminated blood.¹⁹ For those who do not sustain needle-stick injuries the risk is negligible.²⁰

A. Population Studies

The percentage of HCPs with AIDS (5.4 percent)²¹ is comparable to, indeed lower than, the percentage in the work force at large (5.7 percent).²² Seroprevalence rates for HIV among HCPs without

16. Compare Comment, *Prohibiting the Use of the Human Immunodeficiency Virus Antibody Test by Employers and Insurers*, 25 HARV. J. ON LEGIS. 275, 306-08 (1988) (recommending prohibition of the use of tests for employment purposes) with Comment, *The Constitutional Implications of Mandatory AIDS Testing in Health Care Industry*, 17 SW. U.L. REV. 787, 821-22 (1988) (U.S. Constitution does not bar mandatory testing and exclusion of AIDS carriers from certain positions).

17. See, e.g., Allen, *Health Care Workers and the Risk of HIV Transmission*, 18 HASTINGS CENTER REP. 2, 2 (Apr./May 1988); CDC Recommendations: No. 2S, *supra* note 1, at 306-07; Centers for Disease Control, *Update: Acquired Immunodeficiency Syndrome and Human Immunodeficiency Virus Infection Among Health-Care Workers*, 37 MORBIDITY & MORTALITY WEEKLY REP. 229, 232 (1988) [hereinafter *CDC Update*]; Friedland & Klein, *Transmission of the Human Immunodeficiency Virus*, 317 NEW ENG. J. MED. 1125, 1131 (1987); Hughes, Garner, Marcus & Jaffee, *AIDS: Epidemiological Lessons from the Health-Care Setting*, 11 J. HOSP. INFECTION 209, 215 (1988); Kuhls, Viker, Parris, Garakian, Sullivan-Bolyai & Cherry, *Occupational Risk of HIV, HBV and HSV-2 Infections in Health Care Personnel Caring for AIDS Patients*, 77 AM. J. PUB. HEALTH 1306, 1307 (1987). The first case of an HCP dying of AIDS was recently reported. It is also the first case of its kind reported from Latin America, despite the fact that Brazil, Haiti, Mexico, and other countries have reported thousands of cases of AIDS. See deLeon, Sanchez-Mejorada & Zaidi-Jacobson, *AIDS in a Blood Bank Technician in Mexico City*, 9 INFECTION CONTROL & HOSP. EPIDEMIOLOGY 101, 101-02 (1988) (letter to the editor).

18. "Percutaneous" means passing through unbroken skin. STEDMAN'S MEDICAL DICTIONARY: LAWYERS' EDITION 1052 (5th ed. 1982).

19. *CDC Update*, *supra* note 17, at 232.

20. See Centers for Disease Control, *Update: Human Immunodeficiency Virus Infections in Health-Care Workers Exposed to Blood of Infected Patients*, 36 MORBIDITY & MORTALITY WEEKLY REP. 285, 287 (1987) [hereinafter *CDC: HIV in HCWs*].

21. *CDC Update*, *supra* note 17, at 229.

22. Bureau of Labor Statistics, *Employment and Earnings*, 35 U.S. Dept. of Labor, Bureau of Labor Statistics 13, 93, 194 (1988).

parenteral²³ exposure are comparable to those of American blood donors.²⁴ HCPs, then, do not make up a disproportionate percentage of cases of AIDS or HIV.²⁵ Further, intensive follow-up investigations by the Centers for Disease Control (CDC) reveal that approximately ninety-five percent of all cases of AIDS among HCPs have an identifiable risk.²⁶ These macro-data suggest that occupational exposure for HCPs is a very insignificant mode of transmission of HIV.

B. Percutaneous, Surface, and Mucous Membrane Exposure

There have been twenty-five reported cases where HCPs have been thought to contract HIV in the workplace.²⁷ In most of these cases HCPs accidentally stuck themselves with contaminated needles.²⁸ In a few cases, the HCP had direct contact with infected blood.²⁹ The third group of HCPs were providing care to infected patients, but had no known accident or blood exposure.³⁰

23. "Parenteral" refers to the introduction of substances into an organism. *STEDMAN'S MEDICAL DICTIONARY: LAWYERS' EDITION* 1031 (5th ed. 1982).

24. Wormser, Joline, Sivak & Arlin, *Human Immunodeficiency Virus Infections: Considerations for Health Care Workers*, 64 *BULL. N.Y. ACAD. MED.* 203, 204 (1988) (citing Shott, Berkowitz & Cumming, *Prevalence of HTLV-III Antibody in American Blood Donors*, 313 *NEW ENG. J. MED.* 384, 385 (1985)).

25. Friedland & Klein, *supra* note 17, at 1131 (as of May 1986, 5.5% of all patients with AIDS in the United States reported that they were HCPs, and HCPs represented 5.4% of the workforce).

26. Overall, 5.3% of HCPs with AIDS had an undetermined risk. The proportion, however, appears to be increasing from 1.5% in 1982 to 6.2% in 1987. The proportion of other AIDS patients with an undetermined risk also has increased over time. *CDC Update*, *supra* note 17, at 230.

27. Telephone interview with Jacqueline Polder, Epidemiologist, Hospital Infections Program, Centers for Disease Control (Feb. 15, 1989).

28. *Needlestick Transmission of HTLV-III from a Patient Infected in Africa*, 2 *LANCET* 1376, 1377 (1984); Neisson-Vernant, Arfi, Mathez, Leibowitch & Monplaisir, *Needlestick HIV Seroconversion in a Nurse*, 2 *LANCET* 814, 814 (1986); Oksenhendler, Harzic, Le Roux, Rabian & Clauvee, *HIV Infection with Seroconversion After a Superficial Needlestick Injury to the Finger*, 435 *NEW ENG. J. MED.* 582, 582 (1986); Stricof & Morse, *HTLV-III/LAV Seroconversion Following a Deep Intramuscular Needlestick Injury*, 314 *NEW ENG. J. MED.* 1115, 1115 (1986); Weiss, Saxinger, Rechtman, Grieco, Nadler, Holman, Ginzburg, Groopman, Goedert, Markham, Gallo, Blattner & Landesman, *HTLV-III Infection Among Health Care Workers: Association with Needle-stick Injuries*, 254 *J. A.M.A.* 2089, 2090-92 (1985) (hereinafter Weiss).

29. See *CDC: HIV in HCWs*, *supra* note 20, at 285-86 (HCW got blood on her index finger attempting to insert an arterial catheter into a patient; phlebotomist filling a vacuum blood-collection tube was spattered on her face and in her mouth when the top of the tube flew off; and medical technologist manipulating a blood-separating machine spilled blood on her hands and forearms).

30. See Centers for Disease Control, *Apparent Transmission of Human T-Lymphotropic Virus Type III/Lymphadenopathy Associated Virus from a Child to a Mother Providing Health Care*,

While the twenty-five reported cases of occupational exposure to HIV are cause for concern, they nonetheless appear relatively insignificant given the frequency of contacts between HCPs and HIV-infected patients.³¹ Several prospective studies show that even with a percutaneous exposure to HIV the risk of infection is fairly low. There is a range of 0.03 to 0.9 percent probability that an HCP will contract HIV following a documented case of percutaneous (*e.g.*, a needle-stick or cut) or mucous membrane (*e.g.*, a splash to the eye or mouth) exposure to HIV-infected blood.³² This rate of seroconversion compares favorably with the risk of twelve to seventeen percent after accidental percutaneous injection from patients with hepatitis B virus (HBV), even after passive immunization of recipients by immune serum globulin.³³

The spillage of blood on skin surfaces also is not thought to pose a significant risk. Three cases of seroconversion of HCPs from mucous membrane exposures to infected blood, however, demon-

35 MORBIDITY & MORTALITY WEEKLY REP. 76, 76-77 (1986) (mother apparently infected with the virus while providing her son with nursing care that involved extensive unprotected exposure to the child's infected blood and bodily secretions and excretions).

31. As of December 5, 1988, there were a cumulative total of 79,823 cases of AIDS reported to the Centers for Disease Control. Centers for Disease Control, United States Cases Reported to CDC, WEEKLY SURVEILLANCE REP., Dec. 5, 1988, at 1. There are estimated to be between 945,000 and 1.4 million persons infected with HIV. INST. OF MED., NAT'L ACAD. OF SCI., CONFRONTING AIDS—UPDATE 1988, 49-50 (1988) [hereinafter CONFRONTING AIDS UPDATE]. Many of those who have serious symptoms of infection or disease, because they need frequent treatment and care, have had repeated contact with HCPs.

32. See, *e.g.*, CDC Recommendations: No. 2S, *supra* note 1, at 306-07; Friedland & Klein, *supra* note 17, at 1127 (placing the average level of risk of HIV transmission at 0.76%); Gerberding, Bryant-LeBlanc, Nelson, Moss, Osmond, Chambers, Carlson, Drew, Levy & Sande, *Risk of Transmitting the Human Immunodeficiency Virus, Cytomegalovirus, and Hepatitis B Virus to Health Care Workers Exposed to Patients with AIDS and AIDS-Related Conditions*, 156 J. INFECTIOUS DISEASES 1, 6 (1987) [hereinafter Gerberding] (less than 1%); Henderson, Saah, Zak, Kaslow, Lane, Folks, Blackwelder, Schmitt, LaCamera, Masur & Fauci, *Risk of Nosocomial Infection with Human T-Cell Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus in a Large Cohort of Intensively Exposed Health Care Workers*, 104 ANNALS INTERNAL MED. 644, 644 (1986) [hereinafter Henderson] (study found 0.56%); Marcus & CDC Cooperative Needlestick Surveillance Group, *Surveillance of Health Care Workers Exposed to Blood from Patients Infected with the Human Immunodeficiency Virus*, 319 NEW ENG. J. MED. 1118, 1119-20 (1988) [hereinafter Marcus] (placing the average level of risk of HIV transmission at 0.42%); McCray, *Occupational Risk of the Acquired Immunodeficiency Syndrome Among Health Care Workers*, 314 NEW ENG. J. MED. 1127, 1131 (1986) (special report of the Cooperative Needlestick Surveillance Group found 0.72%). *But see* McEvoy, Porter, Mortimer, Simmons & Shanson, *Prospective Study of Clinical, Laboratory, and Ancillary Staff with Accidental Exposures to Blood or Other Body Fluids from Patients Infected with HIV*, 294 BRIT. MED. J. 1595, 1596 (1987) (no seroconversions observed in HCWs who had been exposed to HIV).

33. See Friedland & Klein, *supra* note 17, at 1127.

strated that HIV can be transmitted through a nonparenteral exposure to blood.³⁴ While these cases raised the level of public anxiety, they all involved substantial exposure to blood where adequate precautions were not taken.³⁵ In each case blood also soaked through mucous membranes and the HCP had significant breaks in the skin allowing the virus access.³⁶ There is no data quantifying the risk of surface skin exposure to blood. It is reasonable to assume, however, that the risk is far less than that caused by an injection of blood from a contaminated needle.³⁷ This would place the risk of surface skin exposure, even to a large amount of blood, well below one percent.³⁸

C. *Biting and Aggressive Behavior*

A final possible occupational risk of HIV contraction is from aggressive behavior of some patients, such as those in emergency rooms and departments of psychiatry. Here, too, the risk is negligible. Several follow-up studies of biting revealed no evidence of HIV transmission.³⁹

D. *Intimate Caring*

The risks to HCPs, then, are almost exclusively through excessive contact with blood and bodily fluids and needle-stick injuries. If HCPs follow recommended precautions⁴⁰ when handling bodily fluids and sharp instruments they will assure a virtually safe work environment.

The high degree of safety of ordinary contact, or even intimate caring activities, has been repeatedly demonstrated by major population studies of households, dentists, and HCWs in intimate contact with HIV-infected persons.⁴¹ Households with an HIV-infected

34. See CDC: *HIV in HCWs*, *supra* note 20, at 284-85.

35. *Id.*

36. *Id.* at 286-87.

37. *Id.* at 287.

38. See Friedland & Klein, *supra* note 17, at 1131.

39. Drummond, *Seronegative 18 Months After Being Bitten by a Patient with AIDS*, 256 J. A.M.A. 2342, 2342 (1986) (letter to the editor). See also Wahn, Dramer, Voit, Bruster, Scrampl & Scheid, *Horizontal Transmission of HIV Infection Between Two Siblings*, 2 LANCET 694, 694 (1986) (mother noticed teeth marks on child's arm allegedly caused by infected sibling, but found no evidence of bleeding).

40. See *infra* notes 67-78 and accompanying text.

41. These studies are reviewed in Friedland & Klein, *supra* note 17, at 1131-33; Gostin, Curran & Clark, *The Case Against Compulsory Casefinding in Controlling AIDS—Testing, Screening and Reporting*, 12 AM. J. L. & MED. 7, 22-23 (1986).

member have been studied over a period of years. In these families there was repeated exposure to saliva: they shared eating utensils, plates, drinking glasses, and toothbrushes; towels, linens, and clothes were sometimes soiled with saliva; family members helped patients to eat and drink; and they kissed on the cheeks and lips. Involving nearly 500 family members, these studies failed to find a single case of a family member contracting HIV without some additional exposure through a blood transfusion, sexual relations, or perinatal transmission.⁴²

The risk of transmission also has been studied among dental workers who have had repeated exposures to saliva and blood. In one study of 1309 dental professionals (72 percent of whom treated high risk patients and 94 percent of whom reported accidental puncture wounds), only one without a history of behavioral risk factors for AIDS had HIV.⁴³ That dentist is thought to have contracted HIV from blood exposure.⁴⁴ Other studies have not found a single additional case of transmission to a dentist.⁴⁵

42. See generally Brettler, Forsberg, Levine, Andrews, Baker & Sullivan, *Human Immunodeficiency Virus Isolation Studies and Antibody Testing: Household Contacts and Sexual Partners of Persons with Hemophilia*, 148 ARCHIVES INTERNAL MED. 1299 (1988) (study of 87 household contacts of 68 HIV antibody-positive hemophilic patients); Fischl, Dickinson, Scott, Klimas, Fletcher & Parks, *Evaluation of Heterosexual Partners, Children, and Household Contacts of Adults with AIDS*, 257 J. A.M.A. 640 (1987) (addressing the spread of the virus in 45 patients with AIDS and their families); Friedland, Saltzman, Rogers, Kahl, Lesser, Mayers & Klein, *Lack of Transmission of HTLV-III/LAV Infection to Household Contacts of Patients with AIDS or AIDS-Related Complex with Oral Candidiasis*, 314 NEW ENG. J. MED. 344 (1986) (determining the risk of transmission to close but nonsexual contacts of 39 AIDS patients); Jason, McDougal, Dixon, Lawrence, Kennedy, Hilgartner, Aledort & Evatt, *HTLV-III/LAV Antibody and Immune Status of Household Contacts and Sexual Partners of Persons with Hemophilia*, 255 J. A.M.A. 212 (1986) (evaluating the HTLV-III/LAV antibody and immune status of 88 persons living with or engaged in sexual relations with 43 hemophiliacs); Lawrence, Jason, Bouhasin, McDougal, Knutsen, Evatt & Joist, *HTLV-III/LAV Antibody Status of Spouses and Household Contacts Assisting in Home Infusion of Hemophilia Patients*, 66 BLOOD 703 (1985) (assessing the prevalences of the virus in a group of hemophiliacs, their household contacts, and those who assist in home infusions); Mann, Qujinn, Francis, Nzilambi, Bosenge, Bila, McCormick, Ruti, Asila & Curran, *Prevalence of HTLV-III/LAV in Household Contacts of Patients with Confirmed AIDS and Controls in Kinshasa, Zaire*, 256 J. A.M.A. 721 (1986); Redfield, Markham, Salahuddin, Sarngadharan, Bodner, Folks, Bollou, Wright & Gallo, *Frequent Transmission of HTLV-III Among Spouses of Patients with AIDS-Related Complex and AIDS*, 253 J. A.M.A. 1571 (1985).

43. Klein, Phelan, Freeman, Schable, Friedland, Treiger & Steigbügel, *Low Occupational Risk of Human Immunodeficiency Virus Infection Among Dental Professionals*, 318 NEW ENG. J. MED. 86, 88 (1988) [hereinafter Klein]. For several letters to the editor in response to this article, see 319 NEW ENG. J. MED. 112, 112-14 (1988).

44. Klein, *supra* note 43, at 88-89.

45. See generally Gerberding, *supra* note 32, at 8 (no evidence of HIV transmission from occupational exposure in HCWs, including dentists, at a San Francisco hospital); Siew, Gruninger & Hojvat, *Screening Dentists for HIV and Hepatitis B*, 318 NEW ENG. J. MED.

Similar studies have been done with HCPs who care for HIV-infected patients.⁴⁶ These studies also have found no cases of HIV transmission that were not attributed to accidental needle-stick injuries or mucous membrane exposures to large amounts of blood. The studies, for example, found no transmission from the exposure of open wounds to saliva,⁴⁷ from cardiopulmonary resuscitation,⁴⁸ or from the performance of invasive procedures with direct exposure to saliva.⁴⁹

E. Seriously Invasive Procedures

HCPs who carry out seriously invasive procedures, such as surgeons, have been in the forefront in calling for a right to know the serologic status of their patients.⁵⁰ As the analysis of research above indicates, surgeons face a relatively low risk of HIV transmission. There have been no documented cases of seroconversion as the result of a surgical operation. Yet, HCPs who carry out seriously invasive procedures can potentially cut or puncture their skin with sharp surgical instruments, needles, or bone fragments. Studies indicate that surgeons will cut or puncture a glove in approximately one out of every four cases⁵¹ and will sustain a significant skin cut in one out of every forty cases.⁵²

Despite the high incidence of cut gloves and skin during surgery, the overall risk in operating on an HIV-positive patient remains remote. The prevalence of HIV infection among surgical patients can be assumed to be the same as for blood donors and military recruits and personnel, which is between 1 in 10,000 and 15

1400, 1400 (1988) (letter to the editor relating study of 1195 dentists, 84% of whom reported having received accidental skin punctures, that found no evidence of HIV infection despite exposure to high risk patients).

46. See generally Gerberding, *supra* note 32; Henderson, *supra* note 32; Hirsch, Wormser, Schooley, Ho, Felsenstein, Hopkins, Joline, Duncanson, Sarnagadharan, Saxinger & Gallo, *Risk of Nosocomial Infection with Human T-Cell Lymphotropic Virus III (HTLV-III)*, 312 NEW ENG. J. MED. 1 (1985); McCray, *supra* note 32; Weiss, *supra* note 28.

47. McCray, *supra* note 32, at 1127, 1129.

48. Saviteer, White, Cohen & Jason, *HTLV-III Exposure During Cardiopulmonary Resuscitation*, 313 NEW ENG. J. MED. 1606, 1606 (1985) (letter to the editor).

49. Gerberding, *supra* note 32, at 3.

50. See, e.g., Breo, *supra* note 8, at 1.

51. Hagen, Meyer & Pauker, *Routine Preoperative Screening for HIV: Does the Risk to the Surgeon Outweigh the Risk to the Patient?*, 259 J. A.M.A. 1357, 1357 (1988) [hereinafter Hagen] (citing Cruse & Foord, *The Epidemiology of Wound Infection: A 10-Year Prospective Study of 62,939 Wounds*, 60 SURGICAL CLINICS N. AM. 27 (1980); Furuhashi & Miyamae, *Effect of Pre-Operative Hand Scrubbing and Influence of Pinholes Appearing in Surgical Rubber Gloves During Operation*, 26 BULL. TOKYO MED. DENTAL UNIV. 73 (1979)).

52. *Id.* at 1357.

in 10,000.⁵³ The risk of infection after a skin puncture with infective materials is between 3 in 10,000 and 90 in 10,000.⁵⁴ Given these data, the risk of contracting HIV in a single surgical operation of an HIV-infected patient is only in the range of 1 in 130,000 to 1 in 4,500.⁵⁵

F. Comparing the Risks of HCPs and Patients

The foregoing analysis shows that HCPs, even those engaged in seriously invasive procedures, have a very low risk of occupational exposure to HIV. There has been no scrutiny of transmission of HIV in the other direction—from HCPs to patients. No such cases have been recorded,⁵⁶ which is not surprising since no systematic attempt has been made to discover which physicians are HIV-positive and whether their patients contract HIV.⁵⁷

This article assumes that the justifications for, and against, screening patients and HCPs are symmetrical. It is reasonable to assume that both the HCP and patient run a very small risk of transmission of HIV in health care settings. While this article contends that neither patient nor HCP has a valid claim for a right to know, it is important to stress that both groups possess strong arguments in favor of screening.

HCPs can argue that they run a relatively greater risk of contracting HIV than do their patients. They can point to the absence of any recorded case of HIV transmission from an HCP to a patient. An HCP clearly is more likely to sustain parenteral or mucous membrane exposures to HIV, which are the chief occupational causes of transmission. Surgeons or other HCPs performing seriously invasive procedures are likely to be exposed to a large quantity of contaminated tissue in the operative field. Patients, on the other hand, will be exposed to little, if any, blood from surgeons who cut or puncture themselves.

The patient has an equally compelling claim that his or her right to know takes precedence over the physician's. The surgeon's significant contact with the patient's blood and organs, together

53. *Id.* at 1358 (footnotes omitted).

54. *Id.*

55. Hagen, *supra* note 51, at 1358.

56. *CDC Recommendations: No. 2S, supra* note 1, at 317.

57. *But see* Sacks, *AIDS in a Surgeon*, 313 *NEW ENG. J. MED.* 1017, 1017 (1985) (letter to the editor relating case of HIV-infected surgeon who operated on 400 patients between 1978 and 1983 without a report of HIV transmission).

with the high rate of torn gloves, makes it reasonable to assume that the risk runs in both directions.

Even if the patient's risk during a single operation is lower than that of the surgeon, the cumulative risk to surgical patients arguably is higher. While an HIV-infected patient is likely to have few seriously invasive procedures, the infected surgeon, even if the virus drastically shortens his or her surgical career, can be expected to perform between 100 and 500 operations. Even if one assumes that the risk of contracting HIV from an infected surgeon were at the low end of the range of risk discussed previously (1 in 130,000), then the cumulative risk that one of the surgeon's patients will contract HIV would still be much more realistic—1 in 1,300 (assuming 100 operations) to 1 in 260 (assuming 500 operations).

Information about a person's serologic status is necessary only if some action would be taken to reduce the risk of transmission that would not be taken if the information were unavailable. Information that a patient is HIV-positive is of very limited use to the physician since physicians have a professional,⁵⁸ if not a legal,⁵⁹ responsibility to treat infected patients. Usually it is not possible to utilize *different* methods for treating HIV-positive patients to reduce the risk of contracting the infection; and in some cases different methods could result in prolongation of operative time, potentially having an adverse effect on the patient.⁶⁰ Further, the CDC⁶¹ and the Occupational Safety and Health Administration (OSHA)⁶² recommend the universal application of barrier protection in all cases of exposure to blood. Information that a patient is HIV-positive should not significantly affect the precautions taken in most cases.⁶³

58. See *Ethical Issues*, *supra* note 14, at 1360 ("a physician may not ethically refuse to treat a patient whose condition is within the physician's current realm of competence solely because the patient is seropositive").

59. See Annas, *Not Saints, But Healers: The Legal Duties of Health Care Professionals in the AIDS Epidemic*, 78 AM. J. PUB. HEALTH 844, 848 (1988) (suggesting that health care providers in private practice have no legal duty to treat, except in specific situations dictated by statutory, common law, or contractual obligations).

60. *CDC Recommendations: No. 2S*, *supra* note 1, at 317.

61. *Id.* at 308. The CDC recommends that gloves, masks, protective eyewear, and gowns be worn depending on the procedure to be performed and the likelihood that such procedure will generate contact with blood or other bodily fluid. *Id.*

62. 52 Fed. Reg. 41,818, 41,821 (1987) (joint advisory notice of the Department of Labor and the Department of Health and Human Services (DHHS) concerning protection against occupational exposures to HBV and HIV). Barriers in the form of engineering controls, work practices, and protective equipment are required. *Id.* at 41,820.

63. Gerberding, *Recommended Infection-Control Policies for Patients with Human Immunodeficiency Virus Infection: An Update*, 315 NEW ENG. J. MED. 1562, 1563 (1987) (special report of the University of California, San Francisco task force on AIDS). After review-

Patients, on the other hand, clearly would act upon the knowledge that their physicians were infected with HIV. "Information that their physician is seropositive, at least in the subjective view of most patients, is highly relevant to the treatment decisions patients must make. A patient usually has a choice of physicians, and many would not choose a physician who is infected with HIV."⁶⁴

The purpose of this article is not to compare the respective claims of patients and HCPs to a right to know the serologic status of the other. Pitting the HCP and patient against one another in this way is singularly unhelpful. Rather, this article dwells on the comparison between risks, rights, and responsibilities of patients and HCPs for one reason: It is inherently likely that public policy would favor compulsory screening of patients, particularly those undergoing seriously invasive procedures, over compulsory screening of HCPs. This is likely both because HCPs often have more influence over the political process and because it is administratively more likely that patients will be tested for HIV during the course of performing routine blood tests. If HCPs assert a justification for testing patients for HIV without consent, it is reasonable to ask why that same justification does not apply equally, or at least substantially, to HCPs. Rather than pit the patient and HCP against one another, this article argues that HIV transmission for either patient or HCP is far too low to justify the personal and financial costs of systematic screening.

G. *Relative Risk and the Perception of Risk*

HCPs, by the nature of their profession, incur some risk of contracting infections from their patients. But the risks they incur from HIV are no greater, and probably less, than the risks from other contagious conditions or occupational hazards. HBV, not HIV, is the major occupational health hazard in the health care industry. The CDC estimates that 500 to 600 HCPs whose jobs entail expo-

ing the principles of infection control for the prevention of HIV transmission, the task force concluded that these principles did not differ from those underlying the standard procedures recommended for any patient. *Id.* The task force concluded, therefore, that the special infection-control precautions for patients known to be infected with HIV are unnecessary in most health care settings. *Id.* *But cf.* Gerberding, *Infection-Control Policies and AIDS*, 316 *NEW ENG. J. MED.* 1480, 1480 (1987) (letter to the editor advocating universal compliance with CDC infection-control guidelines, while recognizing the difficulties of enforcement).

64. See *supra* notes 12-13 and accompanying text. For an in-depth analysis of the issue of a patient's right to know the serologic status of the physician, see generally Gostin, *supra* note 15.

sure to blood are hospitalized annually with HBV infections, and over 200 of those hospitalized die from the virus.⁶⁵ Studies indicate that ten to forty percent of all health care or dental professionals show serologic evidence of past or current HBV infection.⁶⁶

The risks of HIV perceived by HCPs are distorted because of the high mortality of AIDS: the odds of contracting HIV are decidedly low but the consequences are severe. The risks also are distorted by societal perceptions of AIDS and its victims. It is not only that AIDS is a lethal disease; it also engenders social prejudice and irrational fear.

We like to believe that HCPs can view the disease with scientific detachment, immune from the prevailing fear and prejudice in society. As scientists, HCPs should recognize that they cannot expect to eliminate all risk. Provided the level of risk is within acceptable limits, it has to be accepted as a part of the ethical responsibilities of treating and caring for patients.

The goals then for HCPs, as for the public at large, are twofold: to educate HCPs about the fact that the risks of contracting HIV, while real, are well within the boundaries of other acceptable risks; and to train HCPs to take every precaution in handling the blood and bodily fluids of any patient to truly minimize the risk. These precautions are discussed next.

II. REDUCING THE OCCUPATIONAL RISKS OF HIV

The argument developed in this article against a right to know the patient's serologic status is not simply that the risk of HIV transmission is exceedingly low, but that it can be reduced even further without the need for testing. As early as 1985 the CDC recommended that blood and bodily fluid precautions be used consistently for all patients.⁶⁷ This approach, referred to as universal blood and body fluid precautions or universal precautions, should be used in the care of all patients, including those in emergency settings in which the risk of blood exposure is increased and the infection sta-

65. 52 Fed. Reg. 41,818, 41,818 (1987).

66. Palmer, Barash, King & Neil, *Hepatitis Among Hospital Employees*, 138 W. J. MED. 519, 520 (1983).

67. Centers for Disease Control, *Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus in the Workplace*, 34 MORBIDITY & MORTALITY WEEKLY REP. 681, 682-83 (1985) [hereinafter CDC: *Preventing Transmission in the Workplace*]. See also Centers for Disease Control, *Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus During Invasive Procedures*, 35 MORBIDITY & MORTALITY WEEKLY REP. 221, 221-23 (1986).

tus of the patient usually is unknown.⁶⁸

The universal precautions recommended by the CDC have a number of specifications.⁶⁹ First, all HCPs should routinely use appropriate barrier protection to prevent skin and mucous membrane exposure when contact with blood or other bodily fluids is anticipated. Gloves should be worn for touching blood and bodily fluids and for performing venipuncture; masks and protective eyewear should be worn during procedures that are likely to generate droplets of blood; gowns or aprons should be worn during procedures that are likely to generate splashes of blood.⁷⁰ Second, hands and other skin surfaces should be washed immediately and thoroughly.⁷¹ Third, all HCPs should take precautions to prevent injury caused by needles, scalpels, or other sharp instruments. Detailed advice is given on avoiding manipulation of sharp implements by hand and for disposal in puncture-resistant containers.⁷² Fourth, HCPs with exudative lesions or weeping dermatitis should refrain from all direct patient care.⁷³

In addition to these universal precautions the CDC recommends special precautions for invasive procedures, dentists, autopsies or morticians' services, and laboratories.⁷⁴ Guidelines for environmental hazards also are given.⁷⁵ The CDC updated its recommendations in June 1988 by detailing the bodily fluids to which universal precautions do⁷⁶ and do not⁷⁷ apply.⁷⁸

68. See Baker, Kelen, Sivertson & Quinn, *Unsuspected Human Immunodeficiency Virus in Critically Ill Emergency Patients*, 257 J. A.M.A. 2609, 2609 (1987). The FDA recently approved a test for HIV antibodies that can be performed in only five minutes and does not require sophisticated equipment. The new test, Recombigen HIV-1 Latex Agglutination, uses an engineered protein and microscopic beads to detect antibodies to HIV. *Five-Minute AIDS Test Is Approved by FDA*, N.Y. Times, Dec. 14, 1988, at 21, col. 1.

69. *CDC Recommendations: No. 2S*, *supra* note 1, at 308.

70. *Id.*

71. *Id.*

72. *Id.*

73. *CDC Recommendations: No. 2S*, *supra* note 1, at 308.

74. See Neslund, Matthews & Curran, *The Role of CDC in the Development of AIDS Recommendations*, 15 LAW, MED. & HEALTH CARE 73, 73-74, 76-77 (1987).

75. *Id.* at 77; Centers for Disease Control, *CDC Guidelines for the Prevention and Control of Nosocomial Infections: Guideline for Prevention of Surgical Wound Infections, 1985*, 14 AM. J. INFECTION CONTROL 71, 78 (1986).

76. Blood is the single most important source of HIV, HBV, and other blood-borne pathogens in occupational settings. Centers for Disease Control, *Update: Universal Precautions for Prevention of Transmission of the Human Immunodeficiency Virus, Hepatitis B Virus and Other Bloodborn Pathogens in Health-Care Settings*, 37 MORBIDITY & MORTALITY WEEKLY REP. 377, 378 (1988). Universal precautions, therefore, apply to blood and other bodily fluids containing visible blood. *Id.* They also apply to semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pluvial fluid, peritoneal fluid, and amniotic fluid. *Id.*

Although they could be used to set a professional standard of care in any future actions for negligence against hospitals or HCPs, the CDC guidelines have no actual regulatory effect.⁷⁹ The Department of Labor and the Department of Health and Human Services (DHHS), however, issued a joint advisory notice on occupational exposure to HIV and HBV.⁸⁰ The notice is applicable to any worker who has a "predictable job-related requirement" that may involve exposure to blood or bodily fluids—primarily HCPs and "first response" emergency workers.⁸¹ OSHA has given advance notice of proposed rulemaking in order to protect workers from the risk of blood-borne diseases.⁸² OSHA has already begun inspections to examine actual workplace compliance with the joint advisory notice.⁸³

Recently, the Department of Labor issued the draft version of proposed regulations. Although not yet finalized, these draft proposed rules would closely follow CDC guidelines. Under the draft proposed regulations, workers would be required to handle all blood and bodily fluids as if the fluids were infected. Hospitals and health care employers would be required to identify workers who could be exposed to infectious materials and provide them with gloves, gowns, masks, and other protective clothing. Health care employers also would have to ensure that protective items were used appropriately. Employers would be responsible for compulsory employee training concerning the ways blood-borne diseases are transmitted and the safe handling of infectious material. Under the draft proposed regulations, hospital and other employers who fail to comply with the standards would be subject to penalties.⁸⁴

Public health,⁸⁵ professional,⁸⁶ and regulatory⁸⁷ bodies have

77. Universal precautions do not apply to feces, nasal secretions, sputum, sweat, tears, urine, and vomitus unless they contain visible blood. *Id.*

78. *Id.* at 378-79.

79. See generally Hermann, *Liability Related to Diagnosis and Transmission of AIDS*, 15 LAW, MED. & HEALTH CARE 36, 38 (1987) (blood supplier that complied with CDC recommendations for testing should be found to have met reasonable standard of care).

80. 52 Fed. Reg. 41,818 (1987).

81. *Id.* at 41,820.

82. 52 Fed. Reg. 45,438 (1987).

83. A Connecticut hospital was cited by OSHA for failing to adequately protect employees against the spread of blood-borne diseases. 73 Daily Lab. Rep. A-1, at 1 (Apr. 15, 1988) (WESTLAW, BNA-DLR database).

84. Occupational Safety & Health Admin, Draft of OSHA Proposed Standard for Bloodborne Pathogens (Jan. 9, 1989). See also 52 Fed. Reg. 41,818 (1987).

85. See, e.g., *CDC Recommendations: No. 2S*, *supra* note 1, at 307-09; PRESIDENTIAL COMM'N ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC, REPORT OF THE PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC 34 (June 1988) [hereinafter PRESIDENT'S COMM'N] (Recommendation 3-42 states that "[a]ll institutions

supported universal precautions as the preferred policy response to impede the spread of HIV in health care settings. Documented seroconversion has occurred almost exclusively after direct contact with blood or bloody bodily fluids, either through needle-stick injury or by exposure of a mucous membrane or non-intact skin.⁸⁸ Barrier protection against spillage or splattering of blood would virtually eliminate nonpercutaneous exposure.

Needle-stick injury is likely to remain the most important risk event for HCPs. Yet, these preventable accidents remain common.⁸⁹ The rate of needle-stick injuries is gradually being lowered with the use of precautions, but still there are far too many.⁹⁰

A. *Proposals for the Enforcement of Universal Precautions*

The fact is that there continues to be significant noncompliance with CDC guidelines and other infection-control measures.⁹¹ One major reason for noncompliance is that it is difficult to convince HCPs in low prevalence areas to regard everyone as seropositive when few are.⁹² Even when HCPs do comply with the guidelines, they often must use essential equipment such as gowns, goggles,

and agencies employing health care workers should require adherence to Universal Precautions or other infection control procedures in performance standards and in workers' evaluations.").

86. See, e.g., Health & Pub. Pol'y Comm. of the Am. Co. of Physicians & Infectious Diseases Soc. of Am., *The Acquired Immunodeficiency Syndrome (AIDS) and Infection with the Human Immunodeficiency Virus (HIV)*, 108 ANNALS INTERNAL MED. 460, 462 (1988) [hereinafter Am. Co. of Physicians] ("substantial data indicate the effectiveness of such barrier techniques in preventing transmission of hepatitis B"); Letter from the AM. HOSP. ASS'N, AIDS/HIV INFECTION POLICY: ENSURING A SAFE HOSPITAL ENVIRONMENT ii (Nov. 1987) [hereinafter AHA REP.] ("Because it is often not possible to know when an individual may be infected with the HIV, consistent use of a barrier to reduce the chances of direct contact with potentially infected blood and body substances is the best way to avoid accidental exposure to HIV infection.").

87. See *supra* notes 80-84 and accompanying text.

88. Wormser, Rabkin & Joline, *Frequency of Nosocomial Transmission of HIV Infection Among Health Care Workers*, 319 NEW ENG. J. MED. 307, 307 (1988) [hereinafter Wormser] (footnotes omitted).

89. Jagger, Hunt, Brand-Elnaggar & Pearsoh, *Rates of Needlestick Injury Caused by Various Devices in a University Hospital*, 319 NEW ENG. J. MED. 284, 285-86 (1988) [hereinafter Jagger]; Oksenhender, Harzic, LeRoux & Claurel, *HIV Infection with Seroconversion after a Superficial Needlestick Injury to the Finger*, 315 NEW ENG. J. MED. 582, 582 (1986) (letter to the editor); Wormser, *supra* note 88, at 307.

90. See Wormser, *supra* note 88, at 307-08. See also Neuberger, Harris, Kundin, Bichone & Chin, *Incidence of Needlestick Injuries in Hospital Personnel: Implications for Prevention*, 12 AM. J. INFECTION CONTROL 171, 174-76 (1984).

91. Greene, *Infection Control Policies and AIDS*, 316 NEW ENG. J. MED. 1479, 1479 (1987) (letter to the editor).

92. *Id.*

and shoe covers that have not been inspected, and deal with procurement procedures designed to purchase the least expensive equipment without consideration for quality or effectiveness.⁹³ Moreover, much of the equipment is simply poorly designed: gloves do not resist punctures and disposable needles cannot be disposed of safely.⁹⁴

A number of methods could be used to encourage, or require, HCPs to adopt universal precautions; other methods could be used to ensure HCPs of high quality equipment. First, states could require, perhaps through their professional accreditation bodies, participation in appropriate education programs and certification in infection-control knowledge.⁹⁵ Second, OSHA or the Joint Commission on Accreditation of Hospitals (JCAHO) could require all health care facilities to make high quality infection-control devices and supplies available in all patient areas.⁹⁶ Third, new designs for equipment could provide a safer environment for HCPs. Needle-stick injuries, for example, could be significantly reduced by designs that allow the HCP's hands to remain behind the needle as it is covered, the needle to be covered before disassembly of the device, and the needle to remain covered after disposal.⁹⁷ Other design improvements would include puncture-resistant gloves and more flexible and impervious barrier protection for the feet, hands, and face.⁹⁸

Finally, the Department of Labor and Health and the DHHS could systematically enforce the requirements for universal precautions through periodic inspections of all hospitals across the country. These proposals would undoubtedly be difficult and expensive to implement. But they hold out the best prospect for lowering occupational risks of HIV as well as all other major blood-borne diseases.

The primary alternative to universal precautions, often vehemently proposed, is routine HIV screening of patients, with precau-

93. See PRESIDENT'S COMM'N, *supra* note 85, at 31.

94. Address by James Luck, 55th Annual Meeting of the American Academy of Orthopaedic Surgeons, in 36 BULL. AM. ACAD. ORTHOPAEDIC SURGERY (Supp. July 1988) (discussing methods of minimizing risks of HIV transmission in orthopaedics).

95. See PRESIDENT'S COMM'N, *supra* note 85, at 34 (recommendation 3-41). Florida already has passed a law requiring physicians to receive special training in infection control. See Gostin, *Public Health Strategies for Confronting AIDS: Legislative and Regulatory Policy in the United States*, 261 J. A.M.A. no. 11 (forthcoming March 17, 1989).

96. See PRESIDENT'S COMM'N, *supra* note 85, at 34 (recommendation 3-43).

97. Jagger, *supra* note 89, at 284; see Kempen, *Equipment Modifications to Reduce Needle Sticks*, 319 NEW ENG. J. MED. 308, 308 (1988) (letter to the editor).

98. Address by James Luck, *supra* note 94.

tions used only for those who test positive. This article now will address the reasons why such a policy would be inefficacious.

B. Selective Precautions for Patients Who Test HIV-Positive

Despite the consensus on the need for universal precautions, many at least implicitly argue that the precautions are unnecessarily expensive and impractical.⁹⁹ If HCPs were able to test routinely for HIV, the argument goes, precautions could be limited to those cases where the patient tested HIV-positive.

Implicit in this argument is a presumption that if a patient tests positive HCPs can take special precautions which they otherwise would not have taken, and that those special precautions will reduce the occupational risks of HIV. The evidence, however, does not support such a presumption: in the overwhelming majority of occupational transmission cases, the HCP already knew the patient was HIV-positive.¹⁰⁰ Indeed, knowledge that a patient is HIV-positive may well increase the occupational risk to HCPs, perhaps because the HCP is overly conscious of the threat of HIV and thus becomes hesitant and awkward.¹⁰¹

Rather than using special precautions only when a patient tests HIV-positive, HCPs should employ appropriate precautions whenever they anticipate contact with blood or bodily fluids, irrespective of the patient's serologic status. Failure to do so may result in a false sense of security if the patient tests negative. If HCPs, relying upon negative test results, do not take appropriate precautions, they greatly increase their chances of infection. Current HIV tests are imperfect.¹⁰² They detect antibodies to the virus, not the virus itself. Characteristically, the body will not produce antibodies for weeks after infection.¹⁰³ In some cases there will be no detectable antibodies for up to fourteen months.¹⁰⁴ Although these infected

99. See, e.g., Carey, Guido & Wiener, *Routine Preoperative Screening for HIV*, 260 J. A.M.A. 179-81 (1988) (letters to the editor).

100. See *supra* notes 27-38 and accompanying text.

101. In one medical center in New York City, 1 out of every 10 reported needle-stick accidents occurred in the course of caring for an HIV-infected patient. Krasinski, LaCouture & Holzman, *Effect of Changing Needle Disposal Systems on Needle Puncture Injuries*, 8 INFECTION CONTROL 59, 61 (1987). In a different New York City medical center, at least 7% of 440 house officers had percutaneous exposures when caring for patients with AIDS. Weiss, *supra* note 28, at 2090.

102. HIV tests produce a small number of false negative results—usually under 1%. For an examination of the technical aspects of these tests, see *infra* note 109.

103. Mueller, *The Epidemiology of Human Immunodeficiency Virus Infection*, 14 LAW, MED. & HEALTH CARE 250, 253-54 (1986).

104. *Id.*

patients produce no antibodies and test negative, they still will be infectious and capable of transmitting the virus.¹⁰⁵ Thus, reliance on an antibody test result for the purpose of using selective precautions is a dangerous practice that probably increases the risk of HIV transmission.

Reliance on HIV antibody screening also increases the risk of transmission of other blood-borne diseases. A different strain of HIV already exists in Africa and, in rare cases, in the United States.¹⁰⁶ As discussed above, HBV is very prevalent in health care settings.¹⁰⁷ Other blood-borne diseases, including those now known to cause certain human cancers, also are transmissible in hospitals.¹⁰⁸ Health care environments cannot be made safer by relying on imperfect technology designed to screen out infectious from noninfectious patients. In the long run, HCPs can protect themselves only by assuming that all blood and bodily fluids may be contaminated with some infectious agent, and by taking appropriate precautions.

Even if screening in health care settings were shown to be efficacious in impeding the spread of HIV, the personal, social, and financial costs of screening would be prohibitive.

III. INFORMED CONSENT TO HIV TESTING: DEFENDING THE PATIENT'S AUTONOMY AND PRIVACY

The HIV antibody test, the Enzyme Linked Immunosorbent Assay (ELISA), perhaps greater than any other procedure in modern medical history, has stirred controversy: while it is a relatively accurate test, it does generate a significant number of false positive results when administered to a low prevalence population.¹⁰⁹ In

105. *Id.*

106. Address by David Bell, 55th Annual Meeting of the American Academy of Orthopaedic Surgeons, in 36 BULL. AM. ACAD. ORTHOPAEDIC SURGERY (Supp. July 1988) (discussing the risks of HIV transmission in the health care setting and methods of prevention).

107. See *supra* notes 65-66 and accompanying text.

108. Address by David Bell, *supra* note 106.

109. The current test to detect HIV antibodies is the Enzyme Linked Immunosorbent Assay (ELISA). A person is identified as HIV-positive when a sequence of tests, starting with repeated ELISAs and including a confirmatory test such as the Western Blot, are repeatedly reactive. The ELISA, in fact, is one of the most accurate of all medical tests, with a sensitivity and specificity of at least 99%, when performed under optimal laboratory conditions. *CDC Recommendations: No. 2S, supra* note 1, at 315. See Burke, Brundage, Redfield, Damato, Schoble, Putman, Visintire & Kim, *Measurement of the False Positive Rate in a Screening Program for Human Immunodeficiency Virus Infections*, 319 N. ENG. J. MED. 961, 962 (1988). ELISA's bad reputation came from earlier versions where its

addition, a positive test result itself engenders irrational fear and prejudice¹¹⁰ and is perceived to have no potential benefit for the patient because no curative treatment exists.¹¹¹ This anti-testing bias is seen repeatedly in the opposition by high risk group members to widespread testing.¹¹²

HIV testing, however, takes many different forms and is done for many different reasons. The patient and others can benefit from HIV testing. But since that benefit is often equivocal, and since there are many potentially adverse personal and social effects, the decision must rest with the patient. The chief purpose of this section is to show why, as a matter of law and ethics, informed consent should always be obtained prior to an HIV test.¹¹³ The one excep-

predictive value was lower. It also came from the application of the ELISA to low prevalence populations, such as blood donors. See Cleary, Barry, Mayer, Brandt, Gostin & Fineberg, *Compulsory Premarital Screening for the Human Immunodeficiency Virus—Technical and Public Health Considerations*, 258 J. A.M.A. 1757, 1758-59 (1987); Meyer & Pauker, *Screening for HIV: Can We Afford the False Positive Rate?*, 317 NEW ENG. J. MED. 238, 239-40 (1987). Even the best scientific tests have a significant false positive rate in low prevalence populations. See Barry, Cleary & Fineberg, *Screening for HIV Infection: Risks, Benefits and the Burden of Proof*, 14 LAW, MED. & HEALTH CARE 259, 262-63 (1986). Tests to detect the virus directly are now being developed which would overcome most of the technological problems with the test. For a more complete explanation of the technical aspects of screening, see Gostin, Curran & Clark, *supra* note 41, at 10-13. See generally Centers for Disease Control, *Update: Serologic Testing for Antibody to Human Immunodeficiency Virus*, 36 MORBIDITY & MORTALITY WEEKLY REP. 833 (1988); Schwartz, Dans & Kinosian, *Human Immunodeficiency Virus Test Evaluation, Performance and Use*, 259 J. A.M.A. 2574 (1988).

110. Public opinion polls have consistently shown that a significant minority of people believe that HIV-positive persons should not be permitted in ordinary schools, jobs, and public housing. Others believe they deserve the "punishment" they are receiving. See Blendon & Donelan, *Discrimination Against People with AIDS: The Public's Perspective*, 319 NEW ENG. J. MED. 1022, 1023-25 (1988).

111. For a review of prospects for antiviral drugs for HIV, see Macklin & Friedland, *AIDS Research: The Ethics of Clinical Trials*, 14 LAW, MED. & HEALTH CARE 273, 274-75 (1986). See generally Glatt, Chirgwin & Landesman, *Treatment of Infections Associated with Human Immunodeficiency Virus*, 318 NEW ENG. J. MED. 1439 (1988); Young, *Promoting Drug Development Against AIDS and the HIV Infection*, 43 FOOD DRUG COSM. L.J. 215 (1988).

112. See R. BAYER, *PRIVATE ACTS, SOCIAL CONSEQUENCES: AIDS AND THE POLITICS OF PUBLIC HEALTH* (1989).

113. See generally Closen, Connor, Kaufman & Wojcik, *AIDS: Testing Democracy—Irrational Responses to the Public Health Crisis and the Need for Privacy in Serologic Testing*, 19 J. MARSHALL L. REV. 835 (1986); Gostin, Curran & Clark, *supra* note 41; Swartz, *AIDS Testing and Informed Consent*, 13 J. HEALTH POLITICS POLICY & LAW 607 (1988). Comment, *The Constitutional Implications of AIDS Testing in the Health Care Industry*, 17 SW. U.L. REV. 787 (1988). This section will discuss the general common-law requirements to obtain informed consent to HIV testing. In addition, several states have enacted statutes that specifically require informed consent for an HIV test, among them California, Colorado, Hawaii, Illinois, Indiana, Kentucky, Maine, Massachusetts, Oregon, Washington, and Wisconsin. See, e.g., CAL. HEALTH & SAFETY CODE § 199.22(a) (West 1988). See also Gos-

tion is blind epidemiologic screening where the patient's identity cannot be ascertained.¹¹⁴

A. Voluntary Testing

Testing for HIV in health care settings after obtaining the informed consent of the patient poses no significant legal or ethical difficulties because the decision rests ultimately with the subject of the test. The CDC recommends testing with the informed consent of patients for: (1) patient diagnosis and management, (2) management of parenteral or mucous membrane exposures of HCPs, and (3) counseling and serologic testing to prevent and control HIV transmission in the community.¹¹⁵ Clearly, the testing objectives for each of these categories are very different: the rationales for the test may be to benefit the patient, the HCP, or the welfare of others in the community.

Most patients would consent to an HIV test if they knew it

tin, *supra* note 95. Typically these statutes prohibit HIV tests without a document signed by the one to be tested giving consent, after that person has been informed and counseled about the motive and purpose of the test, as well as the personal and social ramifications. *Id.* In some states, such as Alabama, California, Colorado, and Washington, mature minors can give informed consent without parental agreement. *Id.*

114. The CDC has recommended that hospitals, in conjunction with state and local health departments, should periodically determine the prevalence of HIV infection among patients from age groups at the highest risk of infection. Centers for Disease Control, *Public Health Service Guidelines for Counseling and Antibody Testing to Prevent HIV Infection and AIDS*, 36 MORBIDITY & MORTALITY WEEKLY REP. 509, 513 (1987) [hereinafter *CDC Recommendations: Testing*]. The Public Health Service does not seek informed consent from patients prior to blind epidemiologic screening. Patients' blood is tested, however, without any means to identify the name of the patient. Such blind epidemiologic screening has been supported by the World Health Organization. World Health Organization, Report of the Meeting on Criteria for HIV Screening Programmes, WHO/SPA/GLO/87.2 (May 20-21, 1987) [hereinafter *WHO Criteria for HIV Screening*]. The rationale for screening without consent is that the epidemiologic studies provide essential data on prevalence and trends of HIV in various populations. Since patients are not identified, there are few, if any, infringements on their rights to privacy or autonomy.

Great Britain is one of the few countries in the world that explicitly reject anonymous screening as ethically unjustifiable. The view of the British government is that such screening is an abandonment of care by the physician if there are no means to inform a patient that he or she is HIV-positive. Legal commentators in Britain also have suggested that patients have a right to know, and to consent to use of their blood for specific purposes.

One way to improve the situation in the United States would be to inform patients that the hospital will conduct blind epidemiologic research with their blood. This forewarns patients not to enter the hospital if they disapprove of screening. Scientists performing blind epidemiologic screening, however, could not seek consent from each patient because the knowledge would bias the study.

115. *CDC Recommendations: No. 2S, supra* note 1, at 316.

would benefit others. These patients, however, must receive full information that accurately states the reasons for the test. The informed consent form that patients sign also should explain the performance, the meaning, and the benefits of the test, as well as the physical, personal, financial, and social risks of being tested. Accurately informing patients of the true reasons for the test is ethically important. Patients may reasonably assume that all tests are performed in their interests unless otherwise specified.¹¹⁶ HCPs would be obtaining consent by misrepresentation if they did not fairly and accurately disclose to patients that they actually were being tested to safeguard the health of HCPs or others.

1. *Patient Diagnosis and Management.*—The CDC recommends HIV testing as “a useful diagnostic tool for evaluating patients with selected clinical signs and symptoms” associated with HIV disease.¹¹⁷ Use of an HIV test for diagnostic purposes has potential benefits for the patient. A positive test result, for example, may allow early treatment and diet control to prolong life. A negative result could rule out HIV, leading the physician to explore other causes and treatments. But the benefits are finely balanced against the potential drawbacks. The most promising treatment, zidovudine (also known as AZT), currently is not indicated for early nonsymptomatic HIV, and its cumulative effects are highly toxic.¹¹⁸ The value of an HIV test, therefore, is a matter of personal judgment for the patient.

2. *Management of Parenteral or Mucous Membrane Exposures.*—As discussed above, if HCPs sustain parenteral or mucous membrane exposures to blood or bodily fluids, they run only a small risk of HIV transmission. The CDC recommends that the source patient

116. Gillon, *Testing for HIV Without Permission*, 294 BRIT. MED. J. 821, 822-23 (1987).

117. *CDC Recommendations: Testing*, *supra* note 114, at 513. It is clinically appropriate to test for HIV if the patient has “symptoms such as generalized lymphadenopathy; unexplained dementia; chronic, unexplained fever or diarrhea; unexplained weight loss; or diseases such as tuberculosis as well as sexually transmitted diseases, generalized herpes, and chronic candidiasis.” *Id.*

118. Carpenter & Mayer, *Advances in AIDS and HIV Infections*, 33 ADVANCES IN INTERNAL MED. 45, 65-68 (G. Stollerman ed. 1988) (The most common toxicity is a suppression of hematopoiesis, resulting in the need for one or more transfusions in more than a third of patients.). Zidovudine is thought by some to be potentially effective in new cases of HIV infection. See La Fon, Lehrman & Barry, *Prophylactically Administered Retrovir in Health Care Workers Potentially Exposed to the Human Immunodeficiency Virus*, 158 J. INFECTIOUS DISEASES 503, 503 (1988). Clinical trials to assess the efficacy of Zidovudine in asymptomatic patients are currently proceeding.

be informed of the incident and tested for HIV after consent is obtained.¹¹⁹ Knowing the serologic status of the source patient, however, is of no clinical benefit to the HCP. Any transmission of HIV already has occurred and knowledge of a patient's HIV status will not alter that fact. Yet, HCPs who are exposed to bodily fluids claim the right to know in order to ease the burden of uncertainty. There may be some psychological benefit of discovering the patient's serologic status, but even that benefit is uncertain. If the patient tests positive, the HCP's anxiety will, if anything, be increased even though the risk of transmission is less than one percent.¹²⁰ If the patient tests negative, the HCP still is advised to seek medical evaluation and testing if the patient is in a high risk group for HIV. Because of the "window" period (the time between infection and the development of a detectable antibody),¹²¹ source patients who test negative still may be infectious.¹²² Thus, reliance on a negative test result may lead to false assurances.

Many state legislatures, recognizing the concern of HCPs, specifically require notification of an HIV-positive test following a parenteral or mucous membrane exposure.¹²³ The CDC,¹²⁴ and most states that have legislated in the area of HIV testing,¹²⁵ have not recommended or authorized testing without consent.¹²⁶ Given the absence of any clear health benefit to the HCP, the value of compelling the patient to be tested would be difficult to establish.

3. *Prevention and Control of HIV Transmission in the Community.*—The CDC does not recommend "routine" screening of general hospital patients. It does recommend, however, counseling and routine

119. CDC: *Preventing Transmission in the Workplace*, *supra* note 67, at 685.

120. As to the risks of seroconversion following a parenteral exposure to HIV-contaminated blood or bodily fluids, see Marcus, *supra* note 32, at 1119-20, 1122 (concluding that the risk of infection after exposure to blood of seropositive patient is low).

121. See *supra* notes 103-105 and accompanying text.

122. See CDC *Recommendations: No. 2S*, *supra* note 1, at 316.

123. Several state legislatures authorize or require disclosure of a patient's HIV-positive status following a parenteral or mucous membrane exposure of an emergency worker (California, Delaware, Florida, Idaho, Illinois, Kentucky, New Hampshire, Texas, Washington, and Wisconsin) or an HCP (Colorado, Delaware, Florida, Idaho, Illinois, Kentucky, New Hampshire, Texas, Washington, and Wisconsin). See Gostin, *supra* note 95.

124. See CDC *Recommendations: No. 2S*, *supra* note 1, at 317.

125. See Gostin, *supra* note 95.

126. Two exceptions are Colorado and Maine, which allow for testing of patients without consent after a needle-stick accident. *Id.* In Maine this can occur only after a court order. ME. REV. STAT. ANN. tit. 5, § 19203-A(4) (1988). See also Holthaus, *Consent Advised Before AIDS-Antibody Tests*, HOSPITALS, July 20, 1988, at 40-41.

HIV testing for a number of categories of persons who engage in high risk behaviors.¹²⁷ But even here the CDC recommends testing only with the person's informed consent.¹²⁸

There is, therefore, little support for compulsory screening even for prevention and control of HIV transmission. The reason for the lack of support is the paucity of evidence that compulsory testing would protect the public from viral transmission. It is assumed sometimes that people will make more rational decisions about behavior changes if they are informed of their serological status. This is an assumption that has yet to be substantiated. There is still insufficient behavioral research to prove that knowledge of seropositivity influences behavior at all. Even if such knowledge did influence behavior, it is difficult to predict in which direction the behavior would move. Will those informed that they are seropositive altruistically refrain from high risk behavior, or will they act more dangerously because there is little left to lose? The available evidence thus far indicates that counseling, not necessarily testing, is helpful in reducing unsafe behavior.¹²⁹

Counseling for behavior change is a highly personal matter. The patient must be the one to decide voluntarily whether to combine testing with counseling.¹³⁰

B. Involuntary Testing

Those who call for routine testing of hospital patients seldom define what is intended by the term.¹³¹ Some have used the term "routine testing" to mean that all patients, or a certain category of patient, should be tested as a matter of course, unless they state a

127. The CDC recommends "routine" testing of the following groups: persons who may have a sexually transmitted disease, intravenous (IV) drug users, persons who consider themselves at risk, women of childbearing age with identifiable risks, prisoners, and prostitutes. *CDC Recommendations: Testing*, *supra* note 114, at 511-13.

128. *Id.* at 511.

129. See generally Becker & Joseph, *AIDS and Behavioral Change to Reduce Risk: A Review*, 78 AM. J. PUB. HEALTH 394 (1988); Fineberg, *Education to Prevent AIDS: Prospects and Obstacles*, 239 SCI. 592, 594-96 (1988); McCusker, Stoddard, Mayer, Zapka, Morrison & Saltzman, *Effects of HIV Antibody Test Knowledge on Subsequent Sexual Behaviors in a Cohort of Homosexually Active Men*, 78 AM. J. PUB. HEALTH 462 (1988).

130. For arguments against compulsory testing to protect the public health, see generally Gostin, *Screening for AIDS: Efficacy, Cost, and Consequences*, 2 AIDS & PUB. POL'Y J. 14 (1987); Gostin & Curran, *AIDS Screening, Confidentiality and the Duty to Warn*, 77 AM. J. PUB. HEALTH 361 (1987); Gostin, Curran & Clark, *supra* note 41.

131. The CDC does recommend consent prior to "routine" testing. *CDC Recommendations: No. 2S*, *supra* note 1, at 317.

particular objection.¹³² Such routine testing that did not inform each person in advance that an HIV test would be performed and did not require prior consent, however, clearly would be an involuntary procedure. Where patients are unaware that an HIV test will be given, their consent is fraudulently obtained.¹³³

Some HCPs argue that obtaining consent to draw blood and to do routine serologic tests is sufficient in law, without any need to obtain specific consent for an HIV test.¹³⁴ HCPs already feel overburdened by informed consent requirements and see no need for an additional consent. After all, the practice in medicine for many years has been to perform a whole battery of blood tests without obtaining consent for each particular test. Moreover, the HCPs contend that HIV testing has no possible adverse physical effects for patients. The drawing of blood is a procedure with minimal risk,¹³⁵ and once the blood is drawn, performance of another test on the blood cannot harm the patient physically. These HCPs argue that the law of informed consent does not apply to a test that poses no physical risk and has as its sole adverse effect the negative societal reactions to the test and the disease. Others go further and say that the only reason we do not mandatorily test is that AIDS has become a "politically protected" disease.¹³⁶

The law of informed consent in many jurisdictions lays down a patient-oriented standard for the information that must be disclosed by the physician.¹³⁷ The doctrine of informed consent is based

132. This appeared to be the position of the Reagan Administration as enunciated by the President's Assistant for Policy Development. Bauer, *AIDS Testing*, 2 *AIDS & PUB. POL'Y* J. 1, 2 (1987):

133. See Gillon, *supra* note 116, at 823.

134. Testing without the patient's knowledge or consent is not often discussed in the professional literature in this country, but a recent study did show that there is a considerable amount of surreptitious HIV-testing in hospitals. See Henry, Willenbring & Crossley, *supra* note 9, at 1821. In Great Britain, however, the professional AIDS literature has been dominated by a debate on whether specific consent to an HIV test is required or desirable in law. See generally Dyer, *Testing for HIV, the Medicolegal View*, 295 *BRIT. MED. J.* 871 (1987); Morris, *AIDS Counselling and Informed Consent*, 294 *BRIT. MED. J.* 839 (1987); Sherrard & Gatt, *Human Immunodeficiency Virus (HIV) Antibody Testing*, 295 *BRIT. MED. J.* 911 (1987). A similar debate has taken place in Canada. See generally Frank, Goel, Coates, Harvey & Schiralli, *Testing for HIV Infection: Ethical Considerations Revisited*, 139 *CANADIAN MED. A. J.* 287 (1988) (the authors believe the risk to the patient is the most significant factor in deciding when to test for HIV).

135. The only physical risk of drawing blood involves minor bruising or, rarely, infection.

136. See Bauer, *supra* note 132, at 2.

137. See, e.g., *Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir. 1972), cert. denied, 409 U.S. 1064 (1973) (adopting *Schloendorff*); *Harnish v. Children's Hosp. Medical Center*, 387 Mass. 152, 154-55, 439 N.E.2d 240, 242 (1982) (physician's failure to pro-

upon the principle of autonomy, not paternalism.¹³⁸ It is for patients to assess the value of a medical procedure and to determine where their interests lie. If the adverse consequences would be intolerable for the reasonable, prudent patient, that patient is entitled to make the decision, however unwise the assessment appears in the HCP's eyes.¹³⁹ "Although the probability of an adverse result may seem slight to the physician . . . he cannot withhold information if it is relevant to a patient's ability to make an informed consent."¹⁴⁰ Thus, courts require physicians to provide all information that a reasonable patient would find relevant in making an informed decision to undergo a medical procedure.¹⁴¹

Risks relevant or "material" to a patient's decision usually have been confined to physical risks, rather than potential social harms. If the purpose of the doctrine of informed consent is to place the health care decision with the patient, however, then serious social consequences are just as relevant for the patient as physical harms. Reasonably prudent patients would regard the potential social consequences of a positive HIV test as highly relevant to the decision to undergo the test. An HIV test is a powerful indicator of a patient's future health: scientists now believe that virtually all of those infected with HIV will go on to have serious symptomatology, ranging from severe immune deficiency and neurological dysfunction, to death.¹⁴² As with many medical tests that predict grave or fatal dis-

vide sufficient information to enable patient to give informed consent to procedure constitutes professional misconduct); *Schloendorff v. Society of New York Hosp.*, 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914) ("Every human being of adult years and sound mind has a right to determine what shall be done with his own body . . ."). *But see Dessi v. United States*, 489 F. Supp. 722, 730 (E.D. Va. 1980) (plaintiff failed to state a claim where plaintiff did not establish sufficient causal link between lack of informed consent and the injury); *Watkins v. United States*, 482 F. Supp. 1006, 1013 (M.D. Tenn. 1980) (where no test for sensitivity existed, physician not negligent for failure to warn patient sensitive to the drug concerning the drug's side effects).

138. *Canterbury*, 464 F.2d at 786 ("[T]he patient's right of self decision shapes the boundaries of the [physician's] duty to reveal.").

139. *Wilkinson v. Vesey*, 110 R.I. 606, 624, 295 A.2d 676, 687-88 (1972) (patient's right to make decision in light of own value judgment is very essence of freedom of choice).

140. *Hales v. Pittman*, 118 Ariz. 305, 309, 576 P.2d 493, 497 (1987).

141. *Canterbury*, 464 F.2d at 781-82; *Cobbs v. Grant*, 8 Cal. 3d 229, 243, 502 P.2d 1, 10, 104 Cal. Rptr. 505, 514 (1972) (integral part of physician's overall obligation to the patient is duty to reasonably disclose available choices with respect to proposed therapy, as well as all dangers inherently and potentially involved in each choice); *Harnish*, 387 Mass. at 156-57, 439 N.E.2d at 243-44.

142. After 8-1/2 years more than 40% of infected individuals in studies have developed AIDS; a similar percentage has developed symptoms of HIV and is expected to progress to AIDS. Statistics predict the possibility that virtually all will develop AIDS

eases, some patients prefer to know the information, while others do not.

Some patients bear an intolerable psychological burden when informed that they are HIV-positive, particularly if they did not even know they were being tested. A diagnosis of HIV-positivity clearly involves the extremes of human emotion—panic, hatred, guilt, and hopelessness. The intensity of these emotional responses to HIV may be due at least partially to the virus's linkage with two of life's most powerful experiences—sex and death.¹⁴³

A major study has indicated that men aged twenty to fifty-nine with HIV in New York City are at least sixty-six times more likely to commit suicide than the general population of that city.¹⁴⁴ Due to the devastating impact of the information that someone is HIV-positive, one of the highest risk periods for suicide during the course of HIV infection is shortly after the patient learns of the diagnosis. A number of anecdotal reports and psychiatric observations¹⁴⁵ suggest that suicide can result from news of a positive test result. As one commentator concluded, "Thus, the potential for severe, even fatal, emotional consequences should heighten concerns about inappropriate HIV antibody testing without proper indications, informed consent, or counseling. The risk of suicide is one more reason that such tests should never be considered as 'routine.'"¹⁴⁶

Evidence of a condition that may lead to a grave or fatal illness would be of great importance to anyone. Thrusting such unwanted health information on a patient is unconscionable. Unless HCPs tell their patients about the powerful emotional and psychological impact of HIV-positive test results, the HCPs have not provided them with all the information a reasonable patient would find relevant in making an informed decision.

HCPs also should inform patients of the potentially serious social consequences of HIV-positive test results. Hospitals and other

within 13 years after initial infection. CONFRONTING AIDS UPDATE, *supra* note 31, at 35-36.

143. Glass, *AIDS and Suicide*, 259 J. A.M.A. 1369, 1369 (1988).

144. Marzuk, Tierney, Tardiff, Gross, Morgan, Hsu & Mann, *Increased Risk of Suicide in Persons with AIDS*, 259 J. A.M.A. 1333, 1335 (1988). These results are thought to be an underestimate, given the difficulties of establishing both AIDS and suicide in official death statistics. *Id.* at 1336-37. It is interesting to note that about 5 out of the 12 suicides studied occurred in black or hispanic patients; that 5 of them expressed suicidal intent to others; and that 25% of the suicides were committed by jumping from windows in medical units of general hospitals. *Id.* at 1335.

145. Faulstich, *Psychiatric Aspects of AIDS*, 144 AM. J. PSYCHIATRY 551, 552-53 (1987).

146. Glass, *supra* note 143, at 1370.

health providers cannot guarantee the confidentiality of HIV test results. Unauthorized disclosure of the results can cause ostracism among family and friends, and can result in the loss of a job, a home, a place in school, insurance, or other benefits.¹⁴⁷ Once a person's HIV status is in the medical record, it is often made available to third-party payors. It also may be disclosed to employers, landlords, or insurers. In addition, numerous HCPs and auxiliary staff may have access to the medical records, making it very difficult to maintain the confidentiality of the record. These powerful social and emotional consequences of an HIV test would be weighed carefully by any reasonably prudent patient.

Those in favor of "routine" HIV tests contend that the tests are akin to the blood tests done for blood counts and chemistries. This argument is fundamentally wrong. Such routine tests have no equivalent personal and social consequences, and if they did have such consequences, courts likely would require HCPs to obtain specific consent.¹⁴⁸ Those in favor of "routine" HIV testing also mistakenly presume that routine testing for HIV is the standard of care in the medical profession. In fact, the CDC recommends against screening low risk groups such as general hospital patients as a matter of course.¹⁴⁹

HCPs and hospitals can be found liable precisely because the overwhelming consensus of professional opinion is that informed consent is required before an HIV test. Policy statements from the World Health Organization (WHO),¹⁵⁰ the CDC,¹⁵¹ the Presidential Commission on the Human Immunodeficiency Virus Epidemic (President's Commission),¹⁵² the AMA,¹⁵³ the American Hospital Association (AHA),¹⁵⁴ the Institute of Medicine,¹⁵⁵ and many other leading professional organizations¹⁵⁶ have recommended that HIV testing be performed only with fully informed consent and counseling. A standard of practice favoring informed consent and counsel-

147. Blendon & Donelan, *supra* note 110, at 1023-25.

148. See *supra* notes 137-141 and accompanying text.

149. CDC Recommendations: Testing, *supra* note 114, at 513.

150. See WHO Criteria for HIV Screening, *supra* note 114.

151. CDC Recommendations: No. 2S, *supra* note 1, at 317.

152. PRESIDENT'S COMM'N, *supra* note 85, at 73-81.

153. AMA Board of Trustees, *Prevention and Control of Acquired Immunodeficiency Syndrome: An Interim Report*, 258 J. A.M.A. 2097, 2101 (1987).

154. AHA REP., *supra* note 86, at iv-v.

155. INST. OF MED., NAT'L ACAD. OF SCI., CONFRONTING AIDS: DIRECTIONS FOR PUBLIC HEALTH, HEALTH CARE, AND RESEARCH 120-26 (1987); CONFRONTING AIDS UPDATE, *supra* note 31, at 71-75.

156. See, e.g., Am. Co. of Physicians, *supra* note 86, at 465.

ing has evolved through this large body of professional opinion. A physician who fails adequately to inform and counsel a patient prior to performing an HIV test is likely to be found negligent for failing to conform with the professional standard of care.

In any event, in most American jurisdictions, the information an HCP must give to a patient is not what is generally accepted in the medical profession. Rather, HCPs must provide any information that reasonably prudent patients would regard as material to the health care decision they must make. Patients have a right of self-determination in what is done with their blood, particularly when the personal and social consequences are as severe as they are after an HIV-positive test.

Courts have been highly consistent in clarifying when disclosure is unnecessary. HCPs may dispense with disclosure when the treatment is necessary in an emergency or is nonelective,¹⁵⁷ when the patient is incompetent,¹⁵⁸ or when disclosure would be harmful to the patient's psychological state.¹⁵⁹ Thus, the only valid reasons for withholding relevant information are ostensibly for the patient's therapeutic benefit.

It is impossible to conceive that an HIV test would fit into any of the recognized categories where consent can be dispensed with; it is not an emergency procedure, and it is not medically necessary or life threatening. Further, asking patients if they want an HIV test is hardly likely to be harmful to their psychological state. It certainly would not be as harmful as performing the test without the patients' knowledge and then informing them of the result.

Nevertheless, physicians sometimes believe that an HIV test is beneficial to the patient for reasons of diagnosis or treatment. In those instances, the HCP would have to explain the potential benefits and risks to the patient, who would then have the final word on whether to be tested.

The most telling argument in favor of disclosure and informed consent is that the physician's motivation often is founded not upon the patient's interests, but upon the interests of the physician. The physician's ethical prerogative to practice medicine, even to perform

157. *Keogan v. Holy Family Hosp.*, 95 Wash. 2d 306, 316-17, 622 P.2d 1246, 1253-54 (1980) (en banc).

158. See Meisel, *The "Exceptions" to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Decisionmaking*, 1979 WIS. L. REV. 413, 439-53.

159. See, e.g., *Canterbury v. Spence*, 464 F.2d 772, 789 (D.C. Cir. 1972), cert. denied, 409 U.S. 1064 (1973); *Harnish v. Children's Hosp. Medical Center*, 387 Mass. 152, 157, 439 N.E.2d 240, 244 (1982).

a simple blood test, lies in the fact that the patient stands to benefit from the intervention. Physicians, of course, are permitted to act for the benefit of others, provided they have the patient's informed consent. The patient thus should at least be aware that the HCP intends to use the blood for other purposes.

With involuntary HIV testing, however, the physician is purporting to act for the benefit of others when there is no evidence that others will in fact benefit and, moreover, the physician does not have his or her patient's permission to do so. The physician might argue that the ethical rules are bent only slightly because the patient really is not harmed. But as one physician concluded: "We trade on a deceit—a minor deceit but undoubtedly a deceit—if without either explicit or implicit permission we start using our patients for the benefit of others."¹⁶⁰

HIV testing without consent, therefore, is similar to medical research not intended for the benefit of the patient. The legal and ethical arguments in favor of informed consent, with special safeguards against abuse, are well rehearsed. There is perhaps no other area of human endeavor where consent and autonomy matter more.

HIV testing without knowledge or consent goes against the very purpose of the test: facilitating education and counseling. The prevailing view is that patients should be informed of the potential consequences of positive HIV test results; the possibility that the test may be falsely positive; the behavior that is desirable to help prevent further spread of HIV; the potential psychological impact; and the locations where the patient can get personal, social, and financial support in coping with the burden of the disease.¹⁶¹ By neglecting to inform the patient that the test will be performed, HCPs fail to provide the patient with the dignity and help that is now uniformly accepted in the practice of medicine.

There are, moreover, serious ethical questions raised by failing to treat the patient as a partner. How can HCPs inform their patients of HIV-positive test results when the patients never knew the test was being performed in the first place? If the sole purpose of a test were the physician's perceived safety, would the physician withhold a positive test result from the patient? To do so would be to breach a duty of care toward the patient. Withholding relevant health care information from a patient is untenable. The future di-

160. Gillon, *supra* note 116, at 823.

161. For a discussion of informed consent and counseling in relation to an HIV test, see *CONFRONTING AIDS UPDATE*, *supra* note 31, at 71-74.

agnosis, care, and treatment of the patient could be jeopardized if the information were kept secret. Yet, to disclose the information, as the physician must, would be to impose a potential burden of stigma and discrimination on the patient, which the patient neither invited nor even knew about.

The justifications for fully informed consent to HIV testing, then, are that it respects a patient's autonomy and privacy in law, it complies with the well-accepted clinical standards of care, and it maintains the ethical integrity of the medical profession and the dignity and worth of the patient.

IV. HIV SCREENING IN HOSPITALS: LEGAL AND FINANCIAL BURDENS

Hospitals should have no interest in collecting sensitive health care information when they can do nothing with that information to improve HCP safety or patient care. This section will show that hospitals would bear additional legal and financial burdens by implementing screening programs.

Collection of information creates a demand for its use that could result in legal liability for the hospital. Three potential ways to use, or fail to use, the information could be costly for the hospital: discrimination against the patient by refusing care or providing substandard care; unauthorized disclosure of the data to family, employers, landlords, or insurers; or failure to protect sexual and needle-sharing partners, who are in immediate danger of contracting the patient's infection.

A. Refusal to Treat or Substandard Treatment

Surveys of physician attitudes have consistently shown that many are fearful of, and some would even refuse to treat, AIDS patients.¹⁶² Physicians are accustomed to having some freedom in de-

162. See, e.g., Gerbert, Majuire, Badner, D. Greenspan, J. Greenspan, Barnes & Carlton, *Changing Dentists' Knowledge, Attitudes and Behaviors Relating to AIDS: A Controlled Educational Intervention*, 116 J. AM. DENTAL A. 851, 851 (1988) (education increased willingness of health care professionals to treat AIDS patients); Kelly, St. Lawrence, Smith, Hood & Cook, *Stigmatization of AIDS Patients by Physicians*, 77 AM. J. PUB. HEALTH 789, 789-91 (1987) (physicians exhibited harsh attitude judgments and much less willingness to interact, even in routine conversation, with patients whose illness was identified as AIDS); Lewis, Freeman & Corey, *AIDS-Related Competence of California's Primary Care Physicians*, 77 AM. J. PUB. HEALTH 795, 795 (1987) (a majority of physicians interviewed lacked AIDS-related knowledge and skills; competency was associated with physician's level of discomfort in dealing with homosexuals); Valenti & Anarella, *Survey of Hospital Personnel on Understanding of the Acquired Immunodeficiency Syndrome*, 14 AM. J. INFEC-

cluding who they will treat, and they are confronted for the first time in a generation with the prospect that they may contract their patients' lethal infections.¹⁶³ Were physicians to have ready access to the serologic status of all of their patients, there is a good chance that some would refuse to treat them, or would provide substandard treatment.¹⁶⁴ As employers of these physicians, hospitals would face legal liability.

The legal duty to treat patients with AIDS has been established under common law, as well as under federal and state handicap statutes. Once a patient is accepted for treatment by a hospital or physician a therapeutic relationship exists. After this health care provider/patient relationship is established, the provider has a duty not to abandon the patient. The general rule is that a provider/patient relationship continues until "it is terminated by mutual consent; it is terminated by the patient; the services are no longer needed; or the provider withdraws *after* reasonable notice to the patient."¹⁶⁵ AIDS patients characteristically need different levels of care at different stages of the disease. During the time the patient needs services, the hospital and the physician that have accepted the patient for treatment must continue that treatment.¹⁶⁶

A number of statutes designed to safeguard against discrimination of handicapped people probably would bar any refusal to treat or provide adequate treatment, solely because the person had AIDS or HIV infection. Most legal commentators have concluded that

TION CONTROL 60, 62 (1986) (AIDS invoked anxieties even among well-educated physicians and nurses). See also Faulstich, *Psychiatric Aspects of AIDS*, 144 AM. J. PSYCHIATRY 551, 554 (1987) ("Medical personnel must admit and confront their own concerns about AIDS, perhaps involving unfounded beliefs about modes of disease transmission or negative attitudes toward caring for homosexuals and drug abusers."); Ponsford, *AIDS in the OR: A Surgeon's View*, 137 CANADIAN MED. A.J. 1036, 1036 (1987) ("[s]ome American surgeons have resolved their dilemma by turning away patients who are HIV-positive or who they think might be positive"). For an historical perspective on physicians' willingness to treat infectious diseases, see Kim & Perfect, *To Help the Sick: An Historical and Ethical Essay Concerning the Refusal to Care for Patients with AIDS*, 84 AM. J. MED. 135 (1988); Zuger & Miles, *Physicians, AIDS, and Occupational Risk: Historic Traditions and Ethical Obligations*, 258 J. A.M.A. 1924 (1987).

163. See R. BAYER, *supra* note 112.

164. See generally Albert, *A Right to Treatment for AIDS Patients?*, 92 DICK. L. REV. 743 (1988); Annas, *supra* note 59; Benesch & Homisak, *The Duty to Treat AIDS Patients*, 24 TRIAL 22 (May 1988); Brennan, *supra* note 3; Emanuel, *Do Physicians Have an Obligation to Treat Patients with AIDS*, 318 NEW. ENG. J. MED. 1686 (1988).

165. Annas, *supra* note 59, at 845 (emphasis in original).

166. See *supra* note 164; see also *infra* notes 169-180 and accompanying text. During a period when no harm will accrue to the patient, however, the hospital or physician probably may terminate the relationship.

federal and state handicap laws apply to persons who are, or are perceived to be, infected with HIV.¹⁶⁷ Section 504 of the Rehabilitation Act of 1973 (the Rehabilitation Act) provides that "[n]o otherwise qualified handicapped individual . . . shall solely by reason of his handicap, be . . . subjected to discrimination."¹⁶⁸

Until recently, it was not clear that a person with HIV was "handicapped" within the meaning of the Rehabilitation Act because of a controversial Justice Department memorandum¹⁶⁹ and the express refusal of the Supreme Court to decide the issue.¹⁷⁰ A 1987 amendment to the Rehabilitation Act, however, makes it clear that persons with a currently infectious disease or infection, including HIV, are handicapped if they do not "constitute a direct threat to health or safety" and are able "to perform the duties of the

167. See Kushen, *Asymptomatic Infection with the AIDS Virus as a Handicap Under the Rehabilitation Act of 1973*, 88 COLUM. L. REV. 563, 565 (1988); Mitchell, *Employment Discrimination and AIDS: Is AIDS a Handicap Under Section 504 of the Rehabilitation Act?*, 38 U. FLA. L. REV. 649, 670 (1986); Pabst, *Protection of AIDS Victims from Employment Discrimination Under the Rehabilitation Act*, U. ILL. L. REV. 355, 378 (1987). See generally Hentoff, *The Rehabilitation Act's Otherwise Qualified Requirement and the AIDS Virus: Protecting the Public From AIDS Related Health and Safety Hazards*, 30 ARIZ. L. REV. 571 (1988); O'Connor, *Defining "Handicap" for Purposes of Employment Discrimination*, 30 ARIZ. L. REV. 633 (1988); Parnet, *AIDS and the Limits of Discrimination*, 15 LAW, MED. & HEALTH CARE 61 (1987); Sagot-Diaz, *Employment Discrimination Against AIDS Victims: Rights and Remedies Available under the Federal Rehabilitation Act of 1973*, 39 LAB. L.J. 148 (1988).

168. 29 U.S.C. § 794 (Supp. IV 1986).

169. Prior to the Supreme Court's decision in *School Bd. of Nassau County v. Arline*, 480 U.S. 273, *reh'g denied*, 107 S. Ct. 1913 (1987), the Justice Department held the opinion that Section 504 of the Rehabilitation Act of 1973 (the Rehabilitation Act) did not apply to persons with HIV since they could not be regarded as handicapped. See Cooper, *Application of Section 504 of the Rehabilitation Act to Persons with AIDS, ARC or Infection with the AIDS Virus* (June 23, 1986) (available from Office of Legal Counsel, Department of Justice, Room 5224, 10th St. & Pennsylvania Ave., N.W., Washington, D.C. 20530). Although the Supreme Court in *Arline* did not reach the issue of the Rehabilitation Act's applicability to AIDS, 480 U.S. at 282 n.7, the Court did rule that the government could not use the artificial distinction between infection and disease as a basis for discrimination. *Id.* at 282. The Justice Department recently changed its opinion, saying that the Rehabilitation Act does apply to persons with HIV. See Culvahouse Jr., *Application of Section 504 of the Rehabilitation Act to HIV Infected Individuals* (Sept. 27, 1988) (available from Office of Legal Counsel, Department of Justice, Room 5224, 10th St. & Pennsylvania Ave., N.W., Washington, D.C. 20530).

170. *Arline*, 480 U.S. at 282 n.7 (Section 504 could apply to a teacher with tuberculosis (TB) if she posed no health hazard to children and others in the school). For further analysis of the Supreme Court's decision in *Arline*, see Frome, *School Board of Nassau County v. Arline: A Basis for AIDS Antidiscrimination Suits*, 19 U. WEST L.A. L. REV. 203 (1987); Lipshutz, *Arline: Real Protection Against Discrimination for Society's New Outcasts?*, 17 STETSON L. REV. 517 (1988); Pankow, *AIDS and the Rehabilitation Act After School Board of Nassau County v. Arline*, 21 CREIGHTON L. REV. 943 (1988); and Wasson, *AIDS Discrimination Under Federal, State, and Local Law After Arline*, 15 FLA. ST. U.L. REV. 221 (1987), case-note, *School Board v. Arline: Will AIDS Fit the Mold?* 41 ARK. L. REV. 639 (1988).

job."¹⁷¹ Moreover, the lower courts have consistently held that HIV-related impairments, including asymptomatic HIV infection, are covered under the Rehabilitation Act.¹⁷² Former President Reagan also directed all federal agencies to protect HIV-infected employees against discrimination.¹⁷³

The major problem with the Rehabilitation Act is that it applies only to programs receiving federal financial assistance, and does not extend into the private sector. All fifty states and the District of Columbia, however, have handicap statutes similar to the federal Rehabilitation Act.¹⁷⁴ In all but five jurisdictions¹⁷⁵ handicap statutes prohibit discrimination against private as well as public employees. Many state courts, human rights commissions, and attorneys general have expressly found that the handicap laws apply to AIDS or HIV infection.¹⁷⁶

To underscore the importance of protecting persons with HIV from discrimination, many states and municipalities have enacted AIDS-specific statutes or ordinances. These state antidiscrimination statutes characteristically target specific areas such as employment,¹⁷⁷ housing,¹⁷⁸ or insurance.¹⁷⁹ Some local ordinances, such as those in San Francisco and Los Angeles, are even more comprehensive, prohibiting discrimination in business establishments, public accommodations, educational institutions, and city facilities or services.¹⁸⁰

Hospitals and physicians, therefore, would risk liability if they

171. Civil Rights Restoration Act of 1987, Pub. L. No. 100-259, 102 Stat. 28 (1988).

172. *See, e.g.*, *Chalk v. Orange County Dep't of Educ.*, 832 F.2d 1158, 1158 (9th Cir. 1987); *Ray v. School Dist. of DeSoto County*, 666 F. Supp. 1524, 1536 (M.D. Fla. 1987); *Local 1812, American Fed'n of Gov't Employees v. United States*, 662 F. Supp. 50, 54 (D.D.C. 1987).

173. R. Reagan, Statement Announcing a Federal Human Immunodeficiency Virus Epidemic Action Plan, *reprinted in* 24 WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS 990 (Aug. 2, 1988).

174. Gostin, *supra* note 95.

175. The five jurisdictions are Alaska, Arkansas, Delaware, Idaho, and Michigan. Gostin, *supra* note 95.

176. *See, e.g.*, *Shuttleworth v. Broward County*, 639 F. Supp. 654, 656 (S.D. Fla. 1986).

177. States having such antidiscrimination employment statutes include California, Florida, Hawaii, Maine, Massachusetts, Oregon, Texas, Washington, and Wisconsin. Gostin, *supra* note 95.

178. States having such antidiscrimination housing laws include California, Florida, and Hawaii. Gostin, *supra* note 95.

179. States having such antidiscrimination insurance statutes include California, Delaware, District of Columbia, Florida, Hawaii, Illinois, Maine, New Hampshire, New York, Oregon, Rhode Island, West Virginia, and Wisconsin. Gostin, *supra* note 95.

180. *See* Gostin & Ziegler, *A Review of AIDS-Related Legislative and Regulatory Policy in the United States*, 15 LAW, MED. & HEALTH CARE 5, 13-14 (1987).

used HIV-related information to refuse treatment to persons who are, or are perceived to be, HIV-positive. This provides another powerful reason for hospitals to avoid actively collecting this information.

B. Confidentiality

Individuals infected with HIV, whether HCP or patient, are concerned with maintaining the confidentiality of their health status. HIV infection is associated with sexual practice and drug use, universally regarded as personal and sensitive activities. In addition, the majority of people infected with HIV in the United States are members of groups that are traditionally disfavored. Even before the AIDS epidemic, gays and intravenous (IV) drug users were subject to persistent prejudice and discrimination.¹⁸¹ AIDS brings with it a special stigma. Attitude surveys show that even though most Americans understand the modes through which HIV is spread, a significant minority still would exclude those who are HIV-positive from schools, public accommodations, and the workplace.¹⁸² Unauthorized disclosure of a person's serologic status can lead to social opprobrium among family and friends, as well as loss of employment, housing, and insurance.

HCPs and patients in hospitals, therefore, have strong grounds for desiring personal privacy and confidentiality of their serologic status. Their cooperation with hospital and public health authorities is dependent upon their expectation of privacy. Two serious consequences of a policy of routine screening are that patients may choose to avoid or postpone treatment, and HCPs may seek to evade any testing requirement. Trust in and compliance with many public health programs depend upon the maintenance of a person's privacy.

Hospitals that systematically collect the HIV status of patients or HCPs will find it very difficult to keep that information confidential. Numerous staff members, third-party payors, and others have access to a hospital's health records. Even elaborate schemes developed by some hospitals, such as keeping separate AIDS records or having a special coding or marking for AIDS records, have not overcome the problem. Further, if hospitals keep a systematic record of

181. See generally Note, *The Constitutional Status of Sexual Orientation: Homosexuality as a Suspect Classification*, 98 HARV. L. REV. 1285 (1985) (arguing that lesbians and gays should be protected as a suspect class under the fourteenth amendment).

182. Blendon & Donelan, *supra* note 110, at 1024.

HIV-positive patients or HCPs there will be strong pressures to release lists of names. Pressure to release names of those who test HIV-positive could come from many sources: the public health department may desire the information for purposes of medical surveillance and contact tracing; state boards of medical licensure or patients themselves might seek to know which physicians are HIV-positive; persons engaged in litigation might seek this information to establish that they contracted HIV, for example, from a surgeon or patient, or as the result of a blood transfusion.¹⁸³

Thus, by collecting sensitive health care data, hospitals may find themselves under great pressure to disclose that information. Another possibility is that the information may be disclosed intentionally or carelessly by persons with access to medical files. If a person's HIV status is disclosed intentionally or negligently without the person's consent, a hospital could face substantial liability.

Such liability could arise under the common law or by statute.¹⁸⁴ In most states courts have held that there is an enforceable common-law duty inherent in a physician/patient relationship to keep sensitive health care information confidential.¹⁸⁵ Failure to maintain confidentiality is actionable at law and can result in damages.¹⁸⁶

Remarkably, almost half the states in America now have special statutes protecting the confidentiality of AIDS-related information.¹⁸⁷ Most of these statutes broadly protect the identity of individuals seeking an HIV test, their seropositive status, all unauthorized disclosures of the medical record, and information obtained from interviews for the purposes of partner notification.¹⁸⁸

Common-law and statutory requirements across the country,

183. A Texas court of appeals, for example, has held that HIV-positive blood donors' records could be subject to court-ordered disclosure in the interests of justice. *Tarrant County Hosp. Dist. v. Hughes*, 734 S.W.2d 675, 680 (Tex. Ct. App. 1987). Compare *Rasmussen v. South Fla. Blood Servs., Inc.*, 500 So. 2d 533, 538 (Fla. 1987) (privacy interests of blood donors and society's interest in maintaining strong volunteer blood donations system outweighed victim's interest).

184. See Dickens, *Legal Limits of AIDS Confidentiality*, 259 J. A.M.A. 3449, 3449 (1988) (concerning laws that mandate the maintenance of strict confidentiality of medical data); Stein, *AIDS and the Confidentiality of Medical Records*, 11 J. AMBULATORY CARE MGMT. 39, 40 (1988); Stryker & Natale, *The Legal Limits of AIDS Confidentiality*, 260 J. A.M.A. 3273, 3273-74 (1988) (letters to the editor replying to Dickens article).

185. See, e.g., *Alberts v. Devine*, 395 Mass. 59, 69, 479 N.E.2d 113, 120 (1985). See also Dickens, *supra* note 184, at 3449.

186. See Dickens, *supra* note 184, at 3449.

187. See Gostin, *supra* note 95.

188. *Id.*

therefore, require hospitals to maintain strict confidentiality of health care information. By systematically collecting this data without any clear benefit, hospitals would needlessly open themselves up to potential liability.

C. *Duty to Protect Sexual and Needle-Sharing Partners*

Were hospitals to collect HIV-related information, they also could face liability for failing to notify a patient's sexual or needle-sharing partner of the risk of contracting the virus. While the duty to keep personal information confidential is strict, it may be overridden by other duties owed by the holder of the information. Courts have held that HCPs must disclose confidential information to those for whom the patient poses a foreseeable danger.¹⁸⁹ Some courts have established a *duty* to protect,¹⁹⁰ while others have merely carved out an exception to the principle of confidentiality making it *lawful* to disclose confidences when necessary to protect third parties in foreseeable danger.¹⁹¹

The duty or power to protect usually applies only to identifiable persons at risk and not to "statistically probable victims."¹⁹² Accordingly, a reasonably specific and high degree of potential harm, such as with a known sexual or needle-sharing partner, is required

189. This theory of liability stems from *Tarasoff v. Regents of the Univ. of Cal.*, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976), where the court sustained a cause of action against a psychologist who did not warn a third party of his patient's intention to murder her. The patient later murdered the third party. The court concluded that once a therapist determines or should have determined that a patient poses a serious danger to another, that therapist bears a duty to warn the potential victim. *Id.* at 430, 551 P.2d at 340, 131 Cal. Rptr. at 20. *Accord* *Lipari v. Sears, Roebuck & Co.*, 497 F. Supp. 185, 193 (D. Neb. 1980). *See also* Hermann & Gagliano, *AIDS, Therapeutic Confidentiality, and Warning Third Parties*, 48 Md. L. Rev. 55 (1989).

190. *Lipari v. Sears, Roebuck & Co.*, 497 F. Supp. 185, 193 (D. Neb. 1980) (under Nebraska law, a psychotherapist owes an affirmative duty to third persons to whom the psychotherapist's patient poses an unreasonable risk of harm); *Cairl v. State*, 323 N.W.2d 20, 26 (Minn. 1982) (if duty to warn exists at all, the duty requires warning only insofar as latent dangers posed to identifiable, specific persons); *McIntosh v. Milano*, 168 N.J. Super. 466, 489-90, 403 A.2d 500, 511-12 (1979) (a mental health professional may have a duty to protect a potential victim of his or her patient if the patient poses a probable danger to the person); *Peck v. Counseling Serv. of Addison County*, 146 Vt. 61, 68, 499 A.2d 422, 427 (1985) (mental health agency had a duty to warn that the outpatient had threatened to burn down his parents' barn).

191. *Alberts v. Devine*, 395 Mass. 59, 68-69, 479 N.E.2d 113, 119-20 (1985) (recognizing exception to duty of confidentiality where there is serious danger to the patient or others); *Simonsen v. Swenson*, 104 Neb. 224, 228-29, 177 N.W. 831, 933 (1920) (physician was not liable for disclosure of confidential information where he in good faith and with reasonable care believed it was necessary to prevent spread of disease).

192. *Cairl*, 323 N.W.2d at 26 n.9.

before there is a duty or a power to protect.¹⁹³

HCPs, therefore, may have a legal obligation in some jurisdictions to protect a sexual or needle-sharing partner of a patient with HIV infection. The HCP may fulfill that obligation by, first, advising the patient of the nature of the infection, how it is spread, and precautions that can be taken. If, however, the patient is unlikely to heed the advice, the HCP may have to notify third parties of the foreseeable risk, which could necessitate further questioning of the patient and contact tracing.

It is not at all clear whether current doctrine actually would impose a legal duty to protect sexual or needle-sharing partners of patients with HIV. There is reason to believe that successful litigation may be extremely difficult because of the absence of precedent in cases dealing with infectious diseases,¹⁹⁴ and because establishing that an HCP's failure to warn *caused* a person to contract HIV would be very difficult.¹⁹⁵ In addition, the steps that an HCP must take to

193. For example, in *Gammill v. United States*, 727 F.2d 950 (10th Cir. 1984), a United States Army physician failed to inform a nearby community of an outbreak of hepatitis. The plaintiffs, who contracted the disease, claimed that the Army had a duty to disclose the risk to the public through the county health department. The court held that there was no legal duty to warn the general public; before a duty to warn arises, the physician must be aware of specific risks to particular persons vulnerable to hepatitis. *Id.* at 954. Thus, a reasonably specific and high degree of potential harm is required before the court will dispense with the obligation of confidentiality. See also *Derrick v. Ontario Comm. Hosp.*, 47 Cal. App. 3d 145, 153, 120 Cal. Rptr. 566, 571 (1975) (hospital has no duty to warn members of the general public that one of its patients being released is suffering from a contagious disease).

Some courts do not require that there be an identifiable victim to establish liability. See, e.g., *Lipari*, 497 F. Supp. at 194 (in order to establish liability there must be foreseeability to an injured party or a class of persons of which the injured party was a member). Rather, liability is established by the existence of foreseeable danger to any member of a targeted class of people. *Id.* at 194-95. If a patient threatens violence and possesses the means to carry it out, a duty to protect may arise.

194. The duty to protect predates *Tarasoff v. Regents of the Univ. of Cal.*, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976). Most of the precedent for *Tarasoff* was from old infectious disease cases. See, e.g., *Davis v. Rodman*, 147 Ark. 385, 391, 227 S.W. 612, 641 (1921) (duty of physician to advise family members and others liable to be exposed of patient's typhoid fever); *Skillings v. Allen*, 143 Minn. 323, 324, 173 N.W. 663, 664 (1919) (knowing plaintiff's child had scarlet fever, physician negligently advised plaintiff's wife that it was safe to visit the child); *McIntosh v. Milano*, 168 N.J. Super. 466, 475, 403 A.2d 500, 509 (1979) (dictum that doctor has duty to warn third parties against possible exposure to infectious disease). While these cases are often said to have established a duty to warn, they do not firmly support such a proposition. Most of these cases involved misdiagnosis of an infectious condition so that family members were placed at risk, or misinformation so that the physician incorrectly informed the family that the disease was not infectious. The cases, therefore, do not squarely concern a breach of confidence, since the family already knew the patient was suffering from a disease.

195. HIV infection usually produces no symptoms until several years after the infec-

fulfill the duty to protect have never been established clearly by the courts: does the duty only require counseling of the infected patients themselves, or does it necessitate tracing intimate contacts and providing a warning?

HCPs, then, are caught in an ethical dilemma between the duty to maintain confidentiality and the duty to protect sexual and needle-sharing partners of patients with HIV infection. The very fact that the law has not provided clear guidance to HCPs on whether their primary responsibility is to their patient or to third parties gives additional reason to pause before systematically collecting and acting upon this sensitive information.

D. Financial Considerations

In addition to the legal burdens of implementing HIV screening programs in health care settings, such screening also creates significant financial burdens. For example, screening requires the administration and interpretation of initial and confirmatory screening procedures. These entail significant expenses for the administration of laboratories, test equipment, and personnel.¹⁹⁶ Moreover, screening only indicates that a person is positive at a particular point in time. Thus, to be certain of identifying all infected cases, periodic retesting would be required. The cost for each case found in a low risk population, such as all patients entering a hospital, would be prohibitively expensive. The substantial costs of investing in such a screening program must be measured against the equally large expenditures needed for research, education, counseling, and treatment.

The costs of performing the HIV tests alone would be significant for hospitals that implement "routine" screening. But the costs would become even greater if the program complies with CDC requirements of pre- and post-test counseling in every case. Any hospital embarking on such a program of screening would have to be prepared to spend a substantial amount of funds with no clear

tion is contracted. For example, almost no cases of AIDS occur during the first 2 years after infection is discovered, but after 8-1/2 years, approximately 40% of infected cases develop AIDS. *CONFRONTING AIDS UPDATE*, *supra* note 31, at 35-36. By the time a person develops serious symptoms, it will be exceedingly difficult to go back and demonstrate that an identifiable patient transmitted the infection, and that an identifiable HCP could have prevented it by giving a warning. This point becomes even more obvious when a victim has to demonstrate that one particular sexual or needle-sharing partner, among many, was the cause of the infection.

196. See Merlis, *Acquired Immunodeficiency Syndrome (AIDS): Health Care Financing & Services*, IB87219 CONG. RES. SERV. 3 (Jan. 4, 1988).

expectation of impeding the spread of HIV or assisting patients in the hospital.

V. SUMMARY AND CONCLUSIONS

Legislative proposals for screening in health care settings have been introduced in several states.¹⁹⁷ Such proposals often focus on hospital patients and not on HCPs. Hospital patients undergoing seriously invasive procedures, however, also run a risk of exposure to HIV. Thus, an analysis of proposals for mandatory screening should be applicable to both populations. At the very least, when the government wishes to compel hospital patients to be tested, it should justify why the same reasoning does not apply to HCPs.

The sole legitimate objective of systematic mandatory screening in health care settings is to reduce the spread of HIV. Introduction of such a screening program would be justified only if (1) the risk of transmission in the setting is significant, (2) screening would decrease the risk, and (3) the human and economic costs of screening were not disproportionate to the benefit to be achieved. The goal of this article has been to demonstrate that mandatory HIV screening in health care facilities would not meet any of these criteria.

Considerable evidence now demonstrates that health care settings do not pose an unusually high risk of transmission of HIV that would justify mandatory screening.¹⁹⁸ The reasons for this conclusion are that hospital patients are predominantly the elderly and the very young, the two categories least likely to harbor HIV; routine medical and nursing procedures do not create a significant risk of exposure to HIV; and even percutaneous or mucous membrane exposure usually does not lead to seroconversion. Indeed, the risk of occupational exposure to HIV in health care settings is well below the risk HCPs already incur for HBV. The possibility of HBV infection is far higher and the aggregate mortality from occupational exposure is far greater than for HIV.¹⁹⁹ Yet, there have been no serious proposals for HBV screening, even after many documented cases of transmission both to HCPs and patients.²⁰⁰

197. See generally Gostin & Ziegler, *A Review of AIDS-Related Legislative and Regulatory Policy in the United States*, 15 *LAW, MED. & HEALTH CARE* 5 (1987).

198. See *supra* notes 65-66 and accompanying text.

199. *Id.*

200. See generally Gerety, *Hepatitis B Transmission Between Dental or Medical Workers and Patients*, 95 *ANNALS INTERNAL MED.* 229 (1981); Leftau et al., *Transmission of Hepatitis B with Resultant Restriction of Surgical Practice*, 255 *J. A.M.A.* 934 (1986); Shaw, Barrett & Hamm, *Lethal Outbreak of Hepatitis B in a Dental Practice*, 255 *J. A.M.A.* 3260 (1986).

Even if the risk of AIDS transmission in health care settings were considerably greater than research has thus far indicated, mandatory screening still would be justifiable only if it significantly decreased the rate of transmission. As this article has indicated, however, screening would not decrease occupational exposure; indeed, such exposure could increase with screening. There is no data to suggest that if HCPs knew patients were seropositive they could take any additional precautions to reduce the risk of contracting HIV. In fact, in most cases of occupational exposure to date, HCPs already knew the patients were infected.

Moreover, screening merely indicates whether, at a particular time, a patient has antibodies to HIV. Although the ELISA is highly sensitive,²⁰¹ it is well recognized that there is a window of time, ranging from weeks to months, when a person may be infected but not develop the antibody. This "window period" may be considerably longer in some cases, lasting for a year or more.²⁰² Screening programs, therefore, would detect most—but not all—cases of infected patients. If HCPs were falsely reassured that a patient was seronegative, they might not follow necessary infection-control guidelines when working with that patient. If a patient tests negative for HIV antibodies, it would be a serious error in judgment to relax efforts to protect against accidental exposure to blood. Accordingly, the information provided by the test should not alter high standards for infection control.

Finally, any marginal public health benefit of a "right to know" a person's serologic status would be outweighed by the substantial human and economic costs of a screening program. The law of informed consent almost certainly applies to HIV-antibody tests because of the significant impact on the individual.²⁰³ Studies indicate that positive HIV test results can cause severe psychological distress, including an increased risk of suicide,²⁰⁴ and can result in public ostracism and discrimination.²⁰⁵ In addition, HCPs have a professional obligation to obtain permission for HIV antibody tests because of the critical importance of pre- and post-test counseling.²⁰⁶

Widespread HIV screening could be prohibitively expensive.

201. For a discussion of ELISA, see *supra* note 109.

202. See *supra* note 104 and accompanying text.

203. See *supra* notes 137-142 and accompanying text.

204. See *supra* notes 144-145 and accompanying text.

205. See *supra* note 147 and accompanying text.

206. See *supra* notes 150-161 and accompanying text.

Periodic testing would be required to ensure that accurate and current results were obtained. The costs of laboratory work and careful counseling before and after tests were administered would have to be borne by hospitals that already are financially overstretched.²⁰⁷

Systematic collection of sensitive HIV test results also could result in liability for health care providers. Hospital employees may give substandard treatment, or even refuse to treat, positive-testing patients, in violation of federal and state statutes protecting handicapped persons.²⁰⁸ In addition, hospitals could not guarantee the confidentiality of the information, thus exposing themselves to potential liability under common-law doctrine and modern AIDS confidentiality statutes.²⁰⁹ In some jurisdictions, hospitals and HCPs might be under a legal obligation to notify sexual or needle-sharing partners at risk of infection. Failure to warn in such cases could result in liability.²¹⁰

Compulsory screening in health care facilities, then, would not be an efficacious public health policy: there is little documented risk of occupational transmission; knowledge of a patient's HIV-antibody test result would be unlikely to further decrease the already low risk; and screening would pose wholly disproportionate psychological and social burdens on the individual, and financial burdens on the HCP and the health care facility. This conclusion is shared by each of the major public health authorities that have considered the subject: the WHO,²¹¹ the CDC,²¹² the AHA,²¹³ the AMA,²¹⁴ and the American Nurses' Association.²¹⁵

Health care facilities need a sensible, effective alternative to HIV screening. The best alternative is universal precautions, which already are recommended by the CDC²¹⁶ and OSHA.²¹⁷ Such a policy would significantly decrease the risk of occupational exposure to HIV and other blood-borne viruses, and would limit the potential liability of HCPs and hospitals. The precautions would do so with

207. See *supra* note 196 and accompanying text.

208. See *supra* notes 162-180 and accompanying text.

209. See *supra* notes 181-188 and accompanying text.

210. See *supra* notes 189-195 and accompanying text.

211. See generally WHO Criteria for HIV Screening, *supra* note 114.

212. See generally CDC Recommendations: No. 2S, *supra* note 1.

213. Am. Hosp. Ass'n, Advisory Committee on Infections, Statement on Employee Protection for Blood-Borne Diseases (June 25, 1987).

214. See AMA Board of Trustees, *supra* note 153.

215. ANA Reaffirms Support for CDC Guidelines, Hospital News, National Capitol Area, July 1987, at 6.

216. See *supra* notes 67-78 and accompanying text.

217. See *supra* notes 80-84 and accompanying text.

little or no impact on patients' rights to autonomy, confidentiality, and nondiscriminatory treatment. If we choose, instead, to follow the shrill voices of both HCPs and patients for a "right to know," we will ultimately undermine trust in our health care institutions without any public health utility.