HIV-Positive Medical Practitioners: Legal and Ethical Obligations to Disclose

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INTRODUCTION

The first incidence of the Acquired Immunodeficiency Syndrome (AIDS) in the United States was reported in 1981.1 Two years later researchers isolated and identified the AIDS virus, and subsequently named it the human immunodeficiency virus (HIV).2 AIDS is presently incurable, and infection invariably results in death.3 HIV may be transmitted a variety of ways, including but not limited to sexual intercourse with an infected individual, exposure to infected blood or blood products, and perinatally from mother to child.4

Since the first reported case of AIDS, many have debated

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4 See Gabel, supra note 2, at 986.
whether infected medical practitioners are obligated to disclose their status to patients prior to performing invasive procedures. Some argue that the risk of transmission is so remote that an infected practitioner has no obligation to disclose. Others argue that an obligation to disclose exists notwithstanding the alleged remote possibility of transmission.

This article argues that infected practitioners have both a legal and ethical obligation to disclose their status to patients prior to engaging in invasive procedures. This contention emanates from requirements of the informed consent doctrine; guidelines issued by the Centers for Disease Control (CDC), the American Medical Association (AMA), and the American Dental Association (ADA); the Hippocratic Oath; decisions from Pennsylvania, New Jersey, and Maryland; and research indicating uncertainty of the risks of transmission from practitioner to patient.

EMERGENCE OF AIDS

In 1981, five homosexual men became ill with an unusual infection called Pneumocystis Carinii Pneumonia (PCP). Their infection represented the first incidence of AIDS in the United States. Since this first reported case, public reaction to AIDS has been swift and brutal while the rate of infection has esca-

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5 See, e.g., Darrell Fun, HIV-Infected Healers: Do Patients Have a Right to Know, 21 THE BRIEF 6, 8-9 (1992) (arguing that requiring physician to take precautions to prevent spread of disease does not encompass disclosure of his or her HIV status).
6 See Larry Gostin, Hospitals, Health Care Professionals, and AIDS: The "Right to Know" the Health Status of Professionals and Patients, 48 MD. L. REV. 12, 51 (1989) (stating that if patients are required to be tested for HIV same reasoning should be applied to require testing of practitioners).
7 See Recommendations for Prevention of HIV Transmission in Health-Care Settings, 36 MORBIDITY & MORTALITY WKLY. REP. No. 2S, 6S (Supp. 1987) (defining serious invasive procedure as "surgical entry into tissues, cavities, or organs, or repair of major traumatic injuries").
8 See Update: Acquired Immunodeficiency Syndrome - United States, 30 MORBIDITY & MORTALITY WKLY. REP. 248, 250 (1981) (providing case history of first five men infected with HIV); see also 60 Minutes (CBS television broadcast, Mar. 19, 1995) (reporting that first case of AIDS in world was treated in England in 1959).
9 See Doe v. Barrington, 729 F. Supp. 376, 384 n.8 (D.N.J. 1990) (listing various public reactions to those infected with HIV). Among examples cited in Barrington were refusals to rent apartments to homosexuals, fire bombing the home of HIV infected hemophiliac children, doctors' refusals to treat infected patients, and requiring an infected defendant to wear a mask in court. Id. at 384-85.
AIDS is a very well-known disease originally associated with traditionally dis-
lated. By January 1992, the CDC documented 202,730 cases in the United States. By January 1992, the CDC documented 202,730 cases in the United States. In 1993, AIDS became the leading cause of death among men and women between the ages of 25 through 44, as the incidence of infection climbed to 441,528. It is estimated that more than one million people are infected with HIV.

TRANSMISSION OF THE AIDS VIRUS

Contrary to rumor, there is no evidence that one can contract HIV from insect bites, or from donating blood. Rather, infection with HIV generally results from sexual intercourse with infected individuals, contact with blood or blood products, or from mothers to infants either perinatally or through breast milk. Periods between infection with the virus and full-blown AIDS can be up to seven years, and it has been noted that longer incubation periods may be possible. However, once an individual develops AIDS, life expectancy shrinks to two years.

See Estate of Behringer v. Medical Ctr., 592 A.2d 1251, 1269 (N.J. Super. Ct. Law Div. 1991). The stigma which attaches to infection is not only great, but invites intolerable social consequences. See id. at 1269 (“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.”) (quoting Gostin, supra note 6, at 46).


See Update: Acquired Immunodeficiency Syndrome - United States, 1994, 44 MORBIDITY & MORTALITY WKLY. REP. 64, 67 (1995). By 1992, AIDS had already become the leading cause of death in men between the ages of 25 through 44 according to the Centers for Disease Control (CDC). See Update: Acquired Immunodeficiency Syndrome - United States, 1993, 42 MORBIDITY & MORTALITY WKLY. REP. 125, 125 (1993). However, a 1996 CDC report on births and deaths released on September 11, 1997, and reported in the Philadelphia Inquirer concluded that as a result of a 26% drop overall in the rate of AIDS related deaths during 1995-96, AIDS is no longer the number one, but is now the second leading cause of death of individuals ages 25-44. AIDS Drops Back as Young Adults' Killer, PHILA. INQUIRER, Sept. 12, 1997, at A28.

See Lieberman & Derse, supra note 3, at 337.

See HIV/AIDS: Knowledge and Awareness of Testing and Treatment - Behavioral Risk Factor Surveillance System, 40 MORBIDITY & MORTALITY WKLY. REP. 300, 302 (1991). According to a CDC survey, a substantial number of respondents expressed belief that one can contract HIV through donating blood or insect bites. See id.

See Gabel, supra note 2, at 986.


See Fun, supra note 5, at 8.
TRANSMISSION FROM PRACTITIONER TO PATIENT

Extensive and in-depth studies into transmission from practitioner to patients in the medical environment currently do not exist.\(^7\) However, existing studies and estimates indicate a very low risk.\(^8\) CDC estimates put the risk of a practitioner-to-patient infection at 0.0024%.\(^9\) Despite this apparently remote risk of infection, a practitioner-to-patient transmission has been reported.\(^20\) This case involved a Florida dentist, David Acer, who infected five of his patients, including Kimberly Bergalis, whose tragic condition garnered extensive publicity.\(^21\)

According to reports, Ms. Bergalis was not in a high-risk group for HIV.\(^22\) That is, she neither used drugs intravenously, nor had blood transfusions, nor actively engaged in sexual relations with multiple partners. She reported having had only two boyfriends prior to her infection. The two men were screened and both tested negative for HIV. Reports indicated that Dr. Acer reported occasional needle sticks but stopped doing so after testing positive for HIV. During the dental treatment, he allegedly wore gloves and a mask.\(^23\)

A CDC investigation into Dr. Acer’s conduct concluded that he was the source of Ms. Bergalis’s infection.\(^24\) The report from the investigation, however, posited three caveats. First, it expressed uncertainty as to whether Dr. Acer’s blood came into contact with Ms. Bergalis’s during the procedure.\(^25\) The uncertainty allegedly resulted from lack of detailed information regarding disinfection and sterilization practices of Dr. Acer’s den-
tal office. Second, it cautioned that the possibility of a different source of infection could not be ruled out, since Ms. Bergalis’s HIV status prior to the dental procedure was unknown. Finally, the report noted that the DNA method used in comparing Dr. Acer’s and Ms. Bergalis’s genes was relatively new.

Despite the foregoing caveats, the CDC investigation concluded, based on the viral sequencing found, that Dr. Acer most probably infected Ms. Bergalis. Assuming arguendo that the Acer-Bergalis infection was unusual, it still provides evidence of practitioner-patient transmission. Additionally, “the CDC estimates that, as of 1990, between 13 and 128 medical and dental patients may have been infected with HIV through surgical and dental procedures.”

LEGAL OBLIGATION TO DISCLOSE UNDER THE INFORMED CONSENT DOCTRINE

The informed consent doctrine, generally regarded as part of the negligence doctrine, but classified as a battery in Pennsylvania and a few other states, requires a practitioner to inform a patient of all material risks, benefits, and alternatives attendant upon a proposed treatment option. The informed consent doctrine has two variations. In a majority of jurisdictions, governed by what is popularly known as the prudent physician...
standard, a practitioner has an obligation to disclose to a patient only information which a reasonable practitioner would consider disclosing under the same or similar circumstances. A minority of jurisdictions, however, follow what is known as the reasonable patient standard, under which a practitioner is required to disclose all pieces of information which a reasonable patient would consider material in deciding whether to undergo a proposed treatment.

Central to the issue of disclosure of HIV status under either variation of the informed consent doctrine is the materiality of the risk of transmission from practitioner to patient.

A. Materiality of the Risk of Transmission Under the Reasonable Patient Standard and the Obligation to Disclose

In Canterbury v. Spence, a patient brought a suit against his physician, alleging in part that the physician breached the informed consent doctrine by failing to warn him of a one-percent risk of paralysis from a laminectomy. The trial court directed a verdict for the defendant physician upon a motion. On appeal, however, the Court of Appeals for the District of Columbia Circuit reversed.

Addressing plaintiff’s contention that a one-percent risk of paralysis from a laminectomy was material, and therefore warranted disclosure, the appellate court held that “due care normally demands that the physician warn the patient of any risks to his well-being which contemplated therapy may involve.” Broadly interpreting materiality, the Canterbury court emphasized that “[a] risk is thus material when a reasonable person, in what the physician knows or should know to be the patient’s position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to [undergo] the proposed therapy.” Additionally, Canterbury stressed that “all risks po-

35 See Canterbury, 464 F.2d at 786 (holding that patient’s right of self-decision should determine boundaries of duty of disclosure).
37 See id. at 778.
38 See id.
39 See id. at 779 (stating that patient’s testimony made out prima facie case that physician was in violation of his duty to disclose).
40 Id. at 781.
41 Id. at 787 (first alteration in original) (quoting Jon R. Waltz & Thomas W.
potentially affecting [a patient's] decision must be unmasked." 42

An argument opponents of disclosure frequently make is that the risk of practitioner-to-patient transmission is so remote that it should be considered immaterial. 43 Although risk of practitioner-patient transmission is probably very small, the actual rate of transmission is uncertain. 44 A reasonable patient may consider this uncertainty material when deciding to undergo or forego a proposed treatment option. Even assuming arguendo the adequacy of current studies pointing to the remote risks of transmission, the patient should be permitted to decide whether a remote risk in the AIDS context is material.

Even if the practitioner-to-patient transmission rate is less than the one-percent risk held to be material in Canterbury, it should be noted that a one-percent risk is not a benchmark of materiality. 45

In Hartke v. McKelway, 46 a patient alleged that her physician breached the informed consent doctrine by failing to inform her of a 0.1% to 0.3% risk of pregnancy following a laparoscopic cauterization. 47 In upholding the trial court's determination that this remote risk of pregnancy was material, the Court of Appeals for the District of Columbia Circuit held that the physician had an obligation to disclose. 48 Relevant to the Hartke court, was the realization that pregnancy posed a great threat to the patient's health. 49 In addition, the court determined that the physician was aware that had she been informed, she would have consid-

42 Canterbury, 464 F.2d at 787.
43 See Fun, supra note 5, at 41. Mr. Fun argues that disclosure is unnecessary because of the remote risk of infection from practitioner-to-patient. See id.
44 See Tomlinson, supra note 1, at 563 (noting that "[e]xtensive studies do not exist concerning the risk of HIV transmission from a health care provider to a patient"); see also Gostin, supra note 6, at 21 (stating that "no systematic attempt has been made to discover which physicians are HIV-positive and whether their patients contract HIV").
45 See Hartke v. McKelway, 707 F.2d 1544, 1549 (D.C. Cir. 1983) (holding 0.1 to 0.3% risk material).
46 707 F.2d 1544.
47 See id. at 1547 (stating that Dr. McKelway failed to disclose risk of one to three out of one thousand that sterilization procedure Ms. Hartke was to undergo would not be effective).
48 See id. at 1549.
49 See id. at 1548-49 (stating that plaintiff had a history, known to her doctor, of high-risk pregnancies and post-delivery complications).
The Hartke rationale is relevant to the issue of disclosure in the AIDS context. AIDS invariably results in death. It presently has no cure. It is foreseeable to an infected practitioner that a reasonable patient undergoing invasive procedures would attach significance to the possibility of transmission, no matter how small the risk. This is especially likely in light of facts indicating that invasive procedures frequently result in needle sticks and scalpel cuts. “Studies indicate that surgeons will cut or puncture a glove in approximately one out of every four [25%] cases and will sustain a significant skin cut in one out of every forty [2.5%] cases.”

Arguments against disclosure, predicated on the alleged immateriality of the risk of transmission from practitioner to patient, fail to appreciate that under Canterbury, it is the patient, not the practitioner, who ultimately decides whether a risk is material or not before undergoing or foregoing a treatment option. Under the reasonable patient standard espoused in Canterbury, it does not matter whether a patient’s fear of a risk of harm appears unwise from a practitioner’s perspective. This is because “[t]he keystone of this doctrine is every competent patient’s right to self-determination.”

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50 See id. at 1549 (stating that had plaintiff known of risks, she may have reasonably changed her mind to consider a hysterectomy or to have her boyfriend, later her husband, undergo a vasectomy).
51 See supra note 3 and accompanying text.
52 See supra note 3 and accompanying text.
53 See Gostin, supra note 6, at 23. Professor Gostin argues that “[i]nformation that their physician is seropositive, at least in the subjective view of most patients, is highly relevant to the treatment decisions patients must make.” Id. He also stressed that “[a] patient usually has a choice of physicians, and many would not choose a physician who is infected with HIV.” Id. His argument was bolstered by a University of California - San Francisco study entitled, Public Perception of Healthcare Workers and HIV Mixed, AIDS Wkly., Feb. 15, 1993, which found that 37% of 1,350 adults questioned would change physicians if they knew the physician was HIV positive. The study also found that 93% of the survey respondents thought that infected professionals should be required to disclose their status to their patients. Id.
54 Gostin, supra note 6, at 20; see also Troyen Brennan, Transmission of the Human Immunodeficiency Virus in the Healthcare Setting: Time for Action, 324 New Eng. J. Med. 1504, 1504 (1991) (noting that “[r]ecent studies have shown that needle-stick injuries are common”).
55 See Canterbury, 464 F.2d at 781 (stating that it is patient’s choice to determine direction his treatment will take).
56 See id. at 787 (stating that “the issue on nondisclosure must be approached from the viewpoint of the reasonableness of the physician’s divulgence in terms of what he knows or should know to be the patient’s informational needs”).
adult’s right to forego treatment, or even cure, if it entails what for him are intolerable consequences or risks however unwise his sense of values may be in the eyes of the medical profession, or even the community.”

A patient has the right to determine where his or her interests lie. Therefore, even a very small risk of death, which eventually results from infection with HIV, may be material to a patient, requiring disclosure. It is also worth noting that as the severity of a risk outcome increases, the importance attached to the probability of an infection actually materializing decreases, and the duty to disclose assumes heightened importance.

B. Materiality of Risk of Transmission Under the Prudent Physician Standard and the Duty to Disclose

Analysis under the prudent physician standard of informed consent also supports disclosure. Commentators and studies indicate that practitioners are very reluctant to treat infected patients. In particular, a study published in the American Journal of Medicine found that half of primary-care physicians surveyed would not treat HIV-infected patients, if given a choice, even though the risk of transmission from patient to practitioner is equally low, or even less than the risk of infection from practitioner-to-patient.

67 Wilkinson v. Vesey, 295 A.2d 676, 687 (R.I. 1972). This statement in Wilkinson is especially poignant since some arguments against disclosure focus on patients’ alleged absence of rational calculation of risks in the AIDS context. While some of these arguments have merit, a patient still may refuse treatment by an infected doctor if he or she deems the risk of transmission significant.

68 See Canterbury, 464 F.2d at 786 (holding that patient’s right of self-decision controls).

69 See Hartke v. McKelway, 707 F.2d 1544, 1549 (D.C. Cir. 1983) (holding that 0.1 to 0.3% risk of pregnancy after sterilization procedure was material).

70 See Wilkinson, 295 A.2d at 688 (“What is a reasonable disclosure in one instance may not be reasonable in another.”).

71 See Brennan, supra note 54, at 1504-05. Dr. Brennan noted that “[a]lthough most physicians recognize a duty to treat patients with HIV infection, this does not translate into a universal willingness to do so.” Id.; see also Gostin, supra note 6, at 12-13. Professor Gostin points out that despite the remote possibility of practitioner-patient transmission, healthcare workers, especially those engaged in invasive procedures, claim a right to know whether their patients are HIV-infected, and to screen them for HIV even without their consent. See id.


73 See Gostin, supra note 6, at 21.

74 See Brennan, supra note 54, at 1505. Dr. Brennan opined that “[a] single in-
Judging from the foregoing survey, it appears reasonable to conclude that a majority of practitioners consider the risk of transmission material in deciding whether to render treatment. As such, a practitioner has an obligation to disclose his or her HIV status even under the prudent physician standard.

Any attempts to reserve to the practitioner a right to consider risk of patient-to-practitioner transmission material while denying the same to a patient will undermine the backbone of the informed consent doctrine, which rests on the concept that "[every human being of adult years and sound mind has a right to determine what shall be done with his [or her] own body."

The appellate courts that have examined the risk of HIV transmission from practitioner-to-patient have split, either finding the risk material and thus, warranting disclosure, or finding a patient's fear of risk of exposure unreasonable as a matter of law.

SELECTED CASES ON DISCLOSURE

A. Estate of Behringer v. The Medical Center at Princeton

In early June 1987, the plaintiff, a board certified surgeon, with attending and surgical privileges at the defendant Medical Center ("Center"), felt ill. Following a distress call to the Center, the plaintiff was admitted to the emergency room. Upon examining the plaintiff, the treating physician determined that performance of a bronchoscopy was necessary. Results of the bronchoscopy revealed that the plaintiff had AIDS.
News of the plaintiff's diagnosis spread quickly within the Center, and eventually reached its president, Dennis Doody. Mr. Doody immediately canceled the plaintiff's pending surgical cases. Subsequent to Mr. Doody's action, the Board of Trustees, following a special meeting, voted to require HIV positive surgeons to disclose their status to patients prior to surgery. After several months of intense consultations between the medical and dental staff, hospital administration, and the Board of Trustees, the Center adopted a measure prohibiting any HIV positive practitioner from performing any "procedures that pose any risk of [HIV] transmission to the patient." Based on the foregoing policy, the Center suspended the plaintiff's surgical privileges.

The plaintiff filed suit alleging, in part, that the Center's policy violated New Jersey's statutory prohibition against discrimination by requiring HIV positive surgeons to disclose their status to patients prior to surgery.

Addressing the plaintiff's specific allegations that "1) the risk of transmission of HIV from surgeon to patient is too remote to require informed consent, and 2) the law of informed consent does not require disclosure of the condition of the surgeon," the court noted:

70 See id. at 1257. Since Mr. Doody's decision to suspend plaintiff's surgical privileges was based on insufficient research, the chairman of the department of surgery privately investigated the matter and urged that plaintiff be allowed to continue his surgical practice. In order to suspend a physician's surgical privileges, the policy of the Center requires a vote by the department chair, president of the Center, president of the medical and dental staff, chairman of the board of trustees, and the physician in charge of the service. Although Dr. Doody's vote for suspension was defeated, plaintiff's surgical privileges remained suspended. The matter was ultimately brought to the attention of the board of trustees. See id.

71 See id. at 1258.

72 Id. at 1260. The Center adopted, in relevant part, the following policy: "2. A physician or health care provider with known HIV seropositivity may continue to treat patients at The Medical Center at Princeton, but shall not perform procedures that pose any risk of HIV transmission to the patient." Id. at 1260 (emphasis omitted).

73 The Law Against Discrimination Act "prohibit[s] any unlawful discrimination against any person because such person is or has been at any time handicapped or any unlawful employment practice against such person, unless the nature and extent of the handicap reasonably precludes the performance of the particular employment." N.J. STAT. ANN. § 10:5-4.1 (West 1993). The New Jersey Superior Court in Poff v. Caro, 549 A.2d 900, 903 (N.J. Super Ct. Law Div. 1987), determined that a person suffering from AIDS has a handicap within the meaning of the Law Against Discrimination Act.

74 See Behringer, 592 A.2d at 1274.

75 Id. at 1279.
It is [this] court’s view that the risk of transmission is not the sole risk involved. The risk of a surgical accident, i.e., a needlestick or scalpel cut, during surgery performed by an HIV-positive surgeon, may subject a previously uninfected patient to months or even years of continual HIV testing. Both of these risks are sufficient to meet the Jansen standard of “probability of harm” and the Largey standard requiring disclosure.

The court emphasized that an “infected surgeon, even if the virus drastically shortens his surgical career, can be expected to perform numerous operations. Assuming that the surgical patient’s risk is exceedingly low (1/130,000), the risk that one of his patients will contract HIV becomes more realistic the more operations he performs.” Ultimately, the court, in its assessment of the materiality of risk, concluded that “the risk of accident and implications thereof would be a legitimate concern to the surgical patient, warranting disclosure of this risk in the informed-consent setting.”

Responding to plaintiff’s argument that a better approach to disclosure would be a case-by-case analysis, by the hospital and its medical staff, of a practitioner’s ability to continue with invasive procedures, the court stressed:

While this approach may be an appropriate starting point, it cannot be dispositive of the issue. Plaintiff’s position fails to account for “any risk” and, more important, fails to consider the

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76 In Jansen v. Food Circus Supermarkets, 541 A.2d 682, 688 (N.J. 1988), the New Jersey Supreme Court held that an employer may, consistent with the statutory prohibition against discrimination, remove an employee from a certain position if the employee poses a reasonable probability of substantial harm to others. In order to determine if the employee poses a threat, “an employer may consider whether the handicapped person can do his or her work without posing a serious threat of injury to the health and safety of ... other employees.” Id. at 687-88 (citing Panettieri v. C.V. Hill Refrigeration, 388 A.2d 630 (N.J. Super. Ct. App. Div. 1978)).

77 In Largey v. Rothman, 540 A.2d 504 (N.J. 1988), the New Jersey Supreme Court adopted the reasonable patient standard and overruled Kaplan v. Haines, 241 A.2d 235 (N.J. 1968), which made the prudent physician standard applicable in New Jersey. The Largey court emphasized that a practitioner must disclose all information to a patient which may affect the patient’s decision whether or not to undergo a proposed treatment option. Largey, 540 A.2d at 509 (“The foundation for the physician’s duty to disclose ... is found in the idea that ‘it is the prerogative of the patient, not the physician, to determine for himself the direction in which his interests seem to lie.’”) (quoting Canterbury v. Spence, 464 F.2d 772, 781 (D.C. Cir. 1972)).

78 See Behringer, 592 A.2d at 1279.

79 Id. at 1280. The risk would be 1/1,300 assuming one hundred operations, and would increase to 1/126 assuming five hundred operations. See id.

80 Id. (emphasis added).

81 See id. at 1281.
patient's input into the decision-making process. The position plaintiff seeks to implement is replete with the "anachronistic paternalism" rejected in both *Canterbury v. Spence* ... and by the Supreme Court in *Largey v. Rothman*.

In its evaluation, the court also quoted Professor Gostin’s statement that "[a] reasonably prudent patient would find information that his physician is infected with HIV material to his decision to consent to a seriously invasive procedure because the potential harm is severe and the risk, while low, is not negligible." The court also made it clear that while infected practitioners may be adversely affected by a disclosure requirement, non-infected practitioners will step in to provide needed care to patients.

B. *Faya v. Almaraz*

Two years after *Behringer*, two companion appeals involving disclosure came before the Maryland Court of Appeals. Facts recited by the court of appeals show that two years after testing HIV positive, defendant Rudolf Almaraz, M.D., an oncological surgeon with operating privileges at Johns Hopkins Hospital in Baltimore, performed invasive surgeries on plaintiffs Sonja Faya and Perry Mahoney Rossi at the Hospital.

Three weeks after Dr. Almaraz’s death from AIDS-related complications, the plaintiffs learned of his HIV and AIDS infections from a local newspaper. Subsequently, the plaintiffs filed suit against Dr. Almaraz’s estate, his professional business entity, and the hospital for compensatory and punitive damages. Plaintiffs alleged, in part, that Dr. Almaraz breached the informed consent doctrine by failing to inform them prior to surgery of his HIV and AIDS infections.

Following a defense motion, the trial court dismissed the complaint for failure to state a claim upon which relief could be granted. The trial court indicated that the plaintiffs failed to

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62 Id. (internal citation omitted).
63 Id. at 1283 (emphasis added).
64 See id. at 1282.
65 See id. at 329.
66 See id. at 329-30. On October 27, 1989, Dr. Almaraz was diagnosed with cytomegalovirus retinitis, an eye infection signaling full-blown AIDS. Nevertheless, he operated on plaintiff Rossi approximately three weeks later on November 14, 1989. See id.
67 See id. at 329-30.
68 See id. at 330.
sufficiently allege actual exposure to the AIDS virus, and they
tested negative for the virus.99 Plaintiffs appealed to the court of
special appeals. However, before the intermediate appellate
court could review the appeal, the court of appeals granted cer-
tiorari.90

Addressing the issue of whether Dr. Almaraz should have
informed the plaintiffs of his HIV status prior to surgery, or
should have refrained from performing the surgeries, the court
held "we cannot say as a matter of law that no duty was imposed
upon Dr. Almaraz to warn the appellants of his infected condi-
tion or refrain from operating upon them."91 On the issue of vi-
carious liability against the hospital, the court held:

Because it is undisputed that Almaraz enjoyed "operative
privileges" at Hopkins, we cannot say as a matter of law that
the facts alleged in the appellants' complaints are legally insuf-
ficient on their face to aver an agency relationship. Thus, the
trial court erred in dismissing appellants' basic negligence
complaints against Hopkins.92

In support of its decision, the court noted that AIDS is an in-
fec tious disease and stressed that an important premise underly-
ing the duty to inform is the foreseeability of harm. The court
then emphasized that "under the allegations of the appellants' com-
plaints, taken as true, it was foreseeable that Dr. Almaraz
might transmit the AIDS virus to his patients during invasive
surgery."93 In support of the decision, the court quoted AMA
guidelines cautioning HIV-positive practitioners against per-
forming invasive procedures when a risk of HIV transmission is
present.94

To counter defense arguments on the remote risk of trans-
mission from practitioner to patient, the court reiterated that
"legal scholars have long agreed that the seriousness of potential
harm, as well as its probability, contributes to a duty to prevent
it."95 The court poignantly noted that "while it may be unlikely
that an infected doctor will transmit the AIDS virus to a patient
during surgery, the patient will almost surely die if the virus is

99 See id. at 330-31.
90 See id. at 331.
91 Id. at 334.
92 Id. at 339.
93 Id. at 333.
94 See id. at 334.
95 Id. at 333 (citing RESTATEMENT (SECOND) OF TORTS § 293(c) cmt. c (1965)).
transmitted."\(^{96}\)

C. *In re Hershey Medical Center*\(^{97}\)

In the same year *Faya* was decided, the question of disclosure came up for review before the Pennsylvania Supreme Court. However, the issue involved disclosure after surgery. The facts of the case indicated that following a scalpel cut during surgery, appellant, John Doe, M.D., a resident surgeon at both Hershey Medical Center and the Harrisburg Hospital, voluntarily underwent an HIV blood test.\(^{98}\) The test result came back positive for the HIV virus. Subsequently, Dr. Doe withdrew from participation in further surgical procedures, informed the hospitals, and took a leave of absence.

Following Dr. Doe's revelation of his positive HIV status, "in recognition of the fact that, in a small but nevertheless significant percentage of surgical procedures, surgeons suffer cuts that result in possible transfers of blood to patients,"\(^{99}\) the hospitals conducted investigations to ascertain the number of patients who may have been at risk of contact with Dr. Doe's blood. At the conclusion of the investigations the hospitals filed petitions "alleging that there was, under the Confidentiality of HIV-Related Information Act (HIV Act),\(^{100}\) a 'compelling need' to disclose information regarding Dr. Doe's condition to the patients potentially affected thereby as well as to certain physicians on the medical staffs."\(^{101}\) The hospitals asserted that "disclosure ... was necessary to prevent the spread of HIV and to provide treatment, testing, and counseling."\(^{102}\) In opposition Dr. Doe

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\(^{96}\) Id.

\(^{97}\) 634 A.2d 159 (Pa. 1993).

\(^{98}\) See id. at 160.

\(^{99}\) Id.

\(^{100}\) 35 PA. CONS. STAT. §§ 7601-7612 (1993) (footnote added).

\(^{101}\) *Hershey*, 634 A.2d at 160. The Confidentiality of HIV-Related Information Act provides in relevant part:

(a) Order to disclose.—No court may issue an order to allow access to confidential HIV-related information unless the court finds, upon application, that one of the following conditions exists:

(1) The person seeking the information has demonstrated a compelling need for that information which cannot be accommodated by other means.

(2) The person seeking to disclose the information has a compelling need to do so.

35 PA. CONS. STAT. § 7608(a) (1993).

\(^{102}\) *Hershey*, 634 A.2d at 160.
countered that a "compelling need" was lacking, "and that he was entitled to confidentiality under the [HIV] Act."103

After a hearing, the trial court granted the petitions, but limited disclosure of Dr. Doe's identity to physicians in the obstetrics and gynecology departments (the relevant departments), and to other physicians "authorized in writing by a patient for whom Dr. Doe participated in a surgical procedure or obstetrical care."104 Dr. Doe appealed alleging that the trial court abused its discretion by finding that the hospitals demonstrated a "compelling need" under the HIV Act. The superior court affirmed.105

The Supreme Court of Pennsylvania accepted the appeal. Noting that the HIV Act failed to define the term "compelling need," the court emphasized that HIV was infectious and that infection with AIDS invariably results in death.106 Stressing that the legislative purpose behind the Act was curtailing the spread of HIV and AIDS,107 the court held that "[t]he possibility that disclosure would help to limit the spread of HIV, and thereby save lives, provided the trial court with an ample basis for concluding that a compelling need for disclosure had been established."108

The court noted that the trial court's order was narrowly drawn to protect Dr. Doe's privacy concerns while accommodating the hospital's need for disclosure. The court also stressed that the maxim, salus populi suprema lex (the welfare of the people is the supreme law), should be applied given the nature of the case.109

The Hershey case is instructive on the obligation to disclose. Even though it involved disclosure after a surgical accident, it is apparent that the court would have construed a failure to disclose a positive HIV status prior to surgery to be violative of the

103 Id.
104 Id. The order also authorized the hospitals to describe Dr. Doe "in letters to patients and in media releases as a physician in our joint Obstetrics and Gynecology residency program" and by setting forth the relevant period of such service." Id.
105 See id. at 159.
106 See id. at 161-62.
107 The HIV Act states in part: "(c) Intent.—It is the intent of the General Assembly to promote confidential testing on an informed and voluntary basis in order to encourage those most in need to obtain testing and appropriate counseling." 35 PA. CONS. STAT. § 7602(c).
108 Hershey, 634 A.2d at 162.
109 See id. at 163.
informed consent doctrine.

D. Kerins v. Hartley

Approximately one week after performing invasive surgical procedures on plaintiff Jean R. Kerins, defendant James S. Gordon, M.D., tested positive for HIV. Subsequently, Dr. Gordon informed his partners at the Women's Medical Group of Santa Monica (WSG) of his test results, but he continued engaging in invasive procedures. Two years later, Dr. Gordon developed full-blown AIDS, and his partners prevented him from performing any invasive procedures. He announced his illness on television after filing a discrimination suit against the individuals “who had refused to permit him to return to his surgical practice.”

Upon observing Dr. Gordon's television announcement, the plaintiff underwent a test for HIV. The result came back negative. Notwithstanding the negative result, the plaintiff filed suit against Dr. Gordon and WSG, seeking monetary damages for emotional distress allegedly resulting in part from Dr. Gordon's commission of a battery. To support the battery allegation, the plaintiff alleged that her consent to surgery was conditioned on Dr. Gordon's good health. The plaintiff argued that Dr. Gordon's failure to disclose his positive HIV-status at the time of surgery constituted technical battery because it vitiated her original consent. The trial court dismissed the action on a defense motion for summary judgment. On appeal, the court of appeals reversed, holding that the issue called for a jury determination. On reconsideration, however, the appellate court affirmed the trial court’s decision.

The court’s decision to sustain the summary judgment ruling implies that disclosure of positive HIV-status was not required at the time of the surgery in light of a 1986 CDC guideline em-

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110 33 Cal. Rptr. 2d 172 (1993).
111 See id. at 174-75.
112 See id. at 175.
113 See id.
114 See id. at 174.
115 See id. at 180-81.
116 See id. at 174.
117 See id.
118 See id.
phasizing universal barrier precautions as the best means of preventing HIV transmission from practitioner to patient.\textsuperscript{119} In support of its ruling, the court opined that the plaintiffs' "fear of developing AIDS is not based on knowledge, corroborated by reliable medical or scientific opinion."\textsuperscript{120} However, the court noted that the imposition of a legal obligation on infected practitioners to disclose their status to patients exceeded the scope of the issues presented.\textsuperscript{121}

To the extent that Kerins implied nondisclosure based on CDC guidelines, such implication is misplaced. Although CDC guidelines are unquestionably significant on the issue of AIDS, the guidelines are not even regulatory; therefore, they are not dispositive on the legal obligations of a practitioner to his or her patients.\textsuperscript{122}

**THE ETHICAL OBLIGATION TO DISCLOSE**

Existing ethical guidelines for practitioners also support the argument for disclosure. Both AMA and ADA guidelines recommend that infected doctors either refrain from performing invasive procedures, or inform their patients of their HIV status prior to surgery.\textsuperscript{123} AMA guidelines state that if a risk of transmission exists a practitioner has an ethical obligation to inform the patient and to refrain from engaging in any activity which carries "an identifiable risk of transmission."\textsuperscript{124} Furthermore, the AMA recommends that a seropositive physician consult colleagues to decide what activities he or she can safely pursue.

\textsuperscript{119} See id. at 177.

\textsuperscript{120} Id. at 181.

\textsuperscript{121} See id.

\textsuperscript{122} See Gostin, supra note 6, at 26 (noting that CDC guidelines may be used in negligence cases to set professional standard of care, but they are not regulatory in nature).

\textsuperscript{123} See Council on Ethical & Judicial Affairs, Ethical Issues Involved in the Growing AIDS Crisis, 259 JAMA 1360-61 (1988) [hereinafter Ethical Issues] (discussing ethical dilemmas faced in light of AIDS epidemic); see also Lawrence K. Altman, AIDS-Infected Doctors and Dentists Are Urged to Warn Patients or Quit, N.Y. TIMES, Jan. 18, 1991, at A18 (discussing recommendations made by AMA and ADA). The ADA stated, "that until uncertainties about the transmission of the virus were resolved, dentists carrying the AIDS virus 'should refrain from performing invasive procedures or should disclose their seropositive status.'" Id.

\textsuperscript{124} Altman, supra note 123, at A18. The council stated that "[a] physician who knows that he or she has an infectious disease should not engage in any activity that creates a risk of transmission of the disease to others." Ethical Issues, supra note 123, at 1361.
without posing a risk to patients.\textsuperscript{125}

Meanwhile, in 1987, the CDC recommended a case-by-case inquiry by an infected practitioner's personal physician, the employing hospital, and the local medical board to determine whether the practitioner should continue invasive procedures.\textsuperscript{126} Despite the 1987 recommendation, a 1991 CDC recommendation suggested that an infected practitioner should inform patients prior to performing invasive procedures.\textsuperscript{127}

It is clear that medical ethical guidelines favor disclosure. Although ethics recommendations do not have the force of law,\textsuperscript{128} they provide a basis for assessing the standard of care imposed in their respective professions.\textsuperscript{129}

Although AMA, ADA, and CDC guidelines appear to support disclosure of HIV status prior to invasive procedures, opponents of disclosure may question their validity and substance. Therefore, a brief analysis of the guidelines is warranted. It could be argued that professional conduct is ethically valid if it is required and/or encouraged within the relevant profession, as well as, legally sanctioned.\textsuperscript{130}

The Hippocratic Oath, sworn to and emphasized by the medical profession, requires a practitioner only to undertake

\textsuperscript{125} See id.
\textsuperscript{126} See Recommendations for Prevention of HIV Transmission in Healthcare Settings, 36 MORBIDITY \& MORTALITY WKLY. REP. No. 2S, 16S (Supp. 1987).
\textsuperscript{127} See Recommendations for Preventing Transmission of HIV and Hepatitis B Virus to Patients during Exposure Prone Invasive Procedures, 40 MORBIDITY \& MORTALITY WKLY. REP. No. RR-8, 5 (1991) (stating that healthcare workers “who are infected with HIV ... should not perform exposure-prone procedures unless they have ... been advised under what circumstances, if any, they may continue to perform these procedures. Such circumstances would include notifying prospective patients of the [healthcare worker’s] seropositivity before they undergo exposure-prone invasive procedures”).
\textsuperscript{128} See Lieberman \& Derse, supra note 3, at 341 (discussing the differences in opinion among the nation’s health care organizations on issue of disclosure).
\textsuperscript{129} See Tomlinson, supra note 1, at 575. Ms. Tomlinson argues that AMA guidelines provide some evidence that the medical profession acknowledges the duty to inform in HIV situations. See id. at 573; see also Faya v. Almarez, 620 A.2d 327, 334 (Md. 1993) (citing with approval AMA Code of Ethics which provides “[a] physician who knows that he or she is [HIV] seropositive should not engage in any activity that creates a risk of transmission of the disease to others”) (alteration in original); Ethical Issues, supra note 123, at 1361.
\textsuperscript{130} See ARRAS \& HUNT, Ethical Theory in the Medical Context, reprinted in BARRY R. FURROW ET AL., BIOETHICS: HEALTHCARE LAW AND ETHICS 7 (West 1991) (noting that whether action is wrong or right depends on whether society approves of that action).
measures which benefit the patient.\textsuperscript{131} AMA principles of Medical Ethics,\textsuperscript{132} which define essentials of honorable behavior for medical practitioners, implore practitioners to respect the law and patients' rights, and to deal honestly with patients.\textsuperscript{133} Additionally, the medical profession consistently opines that practitioners should err on the side of protecting patients when risks are unclear.\textsuperscript{134}

Disclosure is consistent with the Hippocratic Oath's admonition to practitioners only to undertake measures beneficial to the patient. Because the risk of transmission from practitioner to patient is uncertain, a practitioner's disclosure of his or her infection benefits the patient. Such a disclosure allows the patient to decide where his interests lie.

Disclosure also accords with a practitioner's ethical obligation to deal with the patients honestly and to respect their rights, since it appears that most patients prefer to be informed of their physician's HIV status.\textsuperscript{135}

Furthermore, disclosure of HIV infection assures compliance with the informed consent doctrine, which requires disclosure of all material information affecting a treatment option. Finally, the ethical guidelines advance the medical profession's admonition to practitioners to place the interest of patients above theirs in the event of a conflict. Patients have an interest in knowing whether a practitioner is infected before any invasive procedures. Infected practitioners, on the other hand, have an interest in keeping their infection confidential. The competing interests pose a conflict.

EXCEPTIONS TO DISCLOSURE

Notwithstanding its requirements, the informed consent doctrine provides two exceptions to disclosure.\textsuperscript{136} Each of the ex-

\textsuperscript{131} See Oath of Hippocrates, reprinted in FURROW ET AL., supra note 130, at 29-30.
\textsuperscript{132} See AMERICAN MEDICAL ASSOCIATION, Principles of Medical Ethics, reprinted in FURROW ET AL., supra note 130, at 31.
\textsuperscript{133} See id. at 32.
\textsuperscript{134} See generally id.
\textsuperscript{135} See supra note 53 and accompanying text (discussing importance that patients place on right to be told of their physician's HIV status); see also Fun, supra note 5, at 42 (stating that 80% of people surveyed said that HIV infected physicians should inform patients of their status).
exceptions involves a privilege not to disclose. First, under the therapeutic privilege, a practitioner may withhold information of a material risk from a patient if disclosure would so adversely affect the patient's mental state so as to foreclose the ability to make a rational decision concerning a proposed treatment. Secondly, a practitioner is privileged from the disclosure requirement in an emergency situation where the patient is "unconscious or otherwise incapable of consenting[, no close relative is available to consent], and harm from a failure to treat is imminent and outweighs any harm threatened by the proposed treatment."

May an infected practitioner, consistent with these two exceptions, withhold his or her illness from patients prior to invasive procedures? An infected practitioner's failure to disclose will not likely be influenced by a desire to protect a patient from an irrational fear of AIDS. On the contrary, a practitioner's motivation for nondisclosure involves, at least in part, a desire to protect his or her practice and privacy. Assuming arguendo that a practitioner's primary motive for nondisclosure is to protect a patient from an irrational fear of AIDS, the exception to the informed consent doctrine still is not sufficient to permit nondisclosure. The exception is premised upon a physician's determination that disclosure would threaten a patient's well-being. Arguing that the informed consent doctrine does not permit nondisclosure "simply because divulgence might prompt the patient to forego therapy the physician feels the patient really needs" is not sound. Upon disclosure of infection, a patient is not likely to endanger his or her welfare by foregoing necessary treatment. Rather, if disclosure would affect the patient's decision to accept treatment, the patient would probably proceed to a non-infected practitioner.

In emergency situations, however, where a patient requires invasive treatment and is unconscious and incapable of consenting, and no relative is available to evaluate the risk of transmission from an infected practitioner, the question of disclosure be-

137 See id.
138 See id. at 789.
139 Id. at 788.
140 But see Fun, supra note 5, at 10 (explaining that exceptions to informed consent doctrine are designed to protect patient not practitioner).
141 See Canterbury, 464 F.2d at 789.
142 Id.
comes murky. If the patient would die unless immediate action was taken, it would be reasonable for the infected practitioner to proceed with an invasive procedure, provided precautionary measures were taken to avoid his blood from coming into contact with the patient’s, and provided further, that a non-infected practitioner is unavailable to attend to the patient.

RECOGNITION OF A THIRD EXCEPTION FOR NON-DISCLOSURE?:  
POLICY ARGUMENTS

In light of the foregoing conclusion that the two legal exceptions do not shield infected practitioners from disclosure, and of strong adverse reactions to infected individuals by segments of the population, a question arises as to whether another exception for infected practitioners should be carved out on public policy grounds. Some commentators have argued for such an exception.1

Strong arguments exist for this nondisclosure exception. First, infected practitioners have a right to protect their identity from public disclosure, consistent with privacy rights. The law has recognized positive HIV-status as within the zone of privacy.14 Second, a great stigma attaches to HIV status.145 Third, disclosure of a practitioner’s infection will almost certainly ruin his or her practice.146 Last, loss of the services of infected practitioners in fields with substantial numbers of HIV infected patients would be costly.

Notwithstanding strong arguments for a third exception, stronger countervailing arguments exist. First, although the risk of practitioner-patient transmission is probably low, the risk of transmission is not the sole risk involved. The risk of a surgical accident may subject a patient to emotional distress and months of continual testing. Experience demonstrates that once contracted, infection with the AIDS virus invariably results in death. Second, an infected practitioner has the options of

143 See Fun, supra note 5, at 43 (arguing that third exception is supported on public policy grounds because of stigma of AIDS, loss of skilled services, right to privacy, and loss of education and training).
145 See id. at 384.
146 See Fun, supra note 5, at 42 (explaining that stigma of AIDS results in physician's fear of loss of professional livelihood).
changing specialty to non-invasive procedures, or practicing with a smaller patient base in the event some patients decide to withdraw their patronage. These options are understandably difficult, but no one has a guaranteed right to practice a chosen profession without limitations.\textsuperscript{147} An infected patient, on the other hand, has no viable options. Such a patient has to live with the stigma of infection, and the knowledge that death will painfully draw near sooner or later. Third, although loss of infected practitioners in some medical fields may adversely affect many patients, the overall impact on medical services would be minimal. From 1981 to 1991, the health care industry employed only 5,815 infected individuals.\textsuperscript{148} Furthermore, if disclosure results in a mass desertion of infected practitioners, non-infected practitioners will take their places.

\textbf{CONCLUSION}

The informed consent doctrine and medical ethical guidelines both require HIV-positive practitioners to inform their patients of their status prior to invasive procedures. Although strong public policy arguments exist for a non-disclosure exception, the finality of infection, uncertainty about the rate of transmission, and the right of patients to determine where their interests lie, all militate against an exception for non-disclosure.

\textsuperscript{147} See DeBarge, supra note 30, at 1021.

\textsuperscript{148} See Tomlinson, supra note 1, at 563. According to Ms. Tomlinson, dental and surgical workers constituted an estimated 1,584. See id.