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HEALTH CARE WORKER'S LEGAL DUTY TO DISCLOSE HIV-POSITIVE STATUS TO PATIENTS BEFORE PERFORMING INVASIVE PROCEDURES

INTRODUCTION

For over a decade Acquired Immune Deficiency Syndrome (AIDS) has plagued our nation.¹ As of March 31, 1993, the Centers for Disease Control (CDC) had received reports of 289,320 cases of AIDS, and the total number of reported deaths had reached 182,275.² It is estimated that the Human Immunodeficiency Virus (HIV) has infected over one million persons in the United States.³ AIDS has been an elusive foe. To date there is no vaccination, no cure, and the end result is virtually always death. It is easy to understand why AIDS frightens the public and public health officials.⁴ Recently, the AIDS dilemma developed a frightening new dimension. The public must now be concerned about contracting AIDS from those who combat disease: health care workers (HCWs).⁵ Federal health officials confirmed that in January of 1991 a Florida dentist had infected Kimberly Bergalis and probably four other patients with HIV.⁶ The infection of Kimberly Bergalis is the first documented case in which

1. *The Second 100,000 Cases of Acquired Immunodeficiency Syndrome—United States, June 1981-December 1991*, 41 MORBIDITY & MORTALITY WKLY. REP. 28 (Jan. 17, 1992) [hereinafter *The Second 100,000 Cases*]. The first case of AIDS was reported from the United States in 1981. *Id.*

2. Telephone Interview with the CDC National AIDS Clearinghouse at 1-800-458-5231 (June 2, 1993).

3. Marcia Angell, *A Dual Approach to the AIDS Epidemic*, 324 NEW ENG. J. MED. 1498 (1991).

4. *The Second 100,000 Cases*, *supra* note 1. From June 1981 through August 1989, the first 100,000 cases of AIDS had been reported to the CDC. *Id.* From September 1989 through November 1991, state and territorial health departments reported an additional 100,000 cases. *Id.*

5. *Recommendation for Prevention of HIV Transmission in Health-Care Settings*, 36 MORBIDITY & MORTALITY WKLY. REP. 2S (Aug. 21, 1987). Health-care workers are defined as persons whose activities involve contact with patients or with blood or other body fluids from patients in a health-care setting. *Id.* This includes students and trainees. *Id.* During the course of this paper HCW will most often be referring to those health care workers who engage in exposure prone invasive surgical procedures such as surgeons and dentists. *See also Guidelines For Protecting The Safety And Health of Health Care Workers*, U.S. Dep't of Health and Human Serv. (Sept. 1988).

6. *Update: Transmission of HIV Infection During an Invasive Dental Procedure—Florida*, 40 MORBIDITY & MORTALITY WKLY. REP. 21 (Jan. 18, 1991).

HIV was transmitted from a health care worker to a patient.⁷ This incident provoked great public concern. One opinion poll indicating that ninety-five percent of respondents believed HIV-infected surgeons should be required to disclose their status to patients prior to performing surgery.⁸ Sixty-Five percent of the respondents said they would discontinue all treatment with an HIV-infected HCW.⁹

Iatrogenic¹⁰ transmission of HIV raises a myriad of complex issues regarding the manner in which society deals with infectious diseases like AIDS. Some believe there is a fundamental tension between protecting the public health and the civil liberties of those who are infected. Others contend that any good public health policy will also protect the civil liberties of those infected.¹¹ This balance is at the heart of the question whether and to what extent disclosure of a HCW's positive HIV status to patients should be required. It is a question posed to the medical community, the legal community, and society at large. Many have answered the question but there is no social consensus. Politicians have attempted to answer the question by proposing a myriad of politically expedient laws.¹² The medical community finds no consensus among its ranks,¹³ and the legal community faces a virtually unprecedented issue.¹⁴

Many say that infected physicians are not only ethically obligated to disclose their infected status to their patients, but are also legally obligated under the doctrine of "informed consent."¹⁵ Due to the deadly nature of AIDS, many feel an invasive procedure¹⁶ by an infected physician poses a material risk which warrants a patient's consideration before undergoing surgery. Others argue that the low risk

7. *Id.*

8. Barbara Kantrowitz et al., *Doctors and AIDS*, NEWSWEEK, July 1, 1991, 48, 51.

9. *Id.* at 52.

10. Iatrogenic transmission of HIV denotes the transmission of the virus from a HCW to a patient. *TABER'S CYCLOPEDIA MEDICAL DICTIONARY* 884 (16th ed. 1989).

11. Sheldon H. Landesman, *The HIV-Positive Health Professional: Policy Options for Individuals, Institutions, and States*, 151 *ARCHIVES OF INTERNAL MED.* 665 (1991).

12. *The Fear That a Doctor or Dentist Has AIDS: Punitive Legislation is No Substitute for Professionalism*, L.A. TIMES, July 25, 1991, at B6.

13. Landesman, *supra* note 11, at 656.

14. *But see* *Behringer v. Medical Ctr. at Princeton*, 592 A.2d 1251 (N.J. Super. Ct. Law Div. 1991).

15. *See infra* section III and IV.

16. An invasive procedure may be defined as:

[A] surgical entry into tissues, cavities, or organs or repair of major traumatic injuries 1) in an operating or delivery room, emergency department, or outpatient setting, including both physicians' and dentists' offices; 2) cardiac catheterization and angiographic procedures; 3) a vaginal or cesarean delivery or other invasive obstetric

of transmission,¹⁷ the practical insufficiency of disclosure, the adverse effect on HCWs, and the possible adverse effect on the health-care system make mandatory disclosure an inappropriate response to the problem of HCW to patient transmission of AIDS.¹⁸

This comment will address the legal controversy surrounding the duty of an HIV-infected HCW to disclose his or her infected status. The comment begins by looking at the inception of the controversy and then discusses various solutions offered by members of the medical community and the federal legislature. Next, the comment considers legal repercussions that might arise where a HIV-infected HCW fails to disclose his or her status before performing an exposure-prone invasive procedure. Finally, the comment concludes by giving the opinion of this author regarding the desirability and probable fate of mandatory disclosure.

I. POLITICAL AND MEDICAL MEASURES

In 1991, the fear of HCW-to-patient transmission of HIV became a reality. DNA sequencing tests confirmed with 99.994 percent certainty that a Florida dentist transmitted HIV to Kimberly Bergalis and probably to four other patients.¹⁹ At the time of the dental procedure, Bergalis had no identifiable risk factors, and Dr. Acer had the same rare strain of the virus that Bergalis was later found to have.²⁰ The plight of Kimberly Bergalis drew national attention because it demonstrated that a person can avoid risky behavior and still contract and die from AIDS.

The nationwide attention surrounding Bergalis and her lobbying efforts in support of strict HIV testing and disclosure laws was largely

procedure during which bleeding may occur; or 4) the manipulation, cutting, or removal of any oral or perioral tissues, including tooth structure, during which bleeding occurs or the potential for bleeding exists.

Recommendation for Prevention of HIV Transmission in Health-Care Settings, *supra* note 5, at 6S-7S.

17. See, e.g., Lois J. Frankel, *Commentary: AIDS Testing of Health Care Workers*, 16 *NOVA L. REV.* 1161, 1165 (1992); Norman Daniels, *HIV-Infected Professionals, Patient Rights, and the 'Switching Dilemma'*, 267 *JAMA* 1368 (1992). The risk of HIV infection from a surgeon is less than the chance of being killed by lightning, by a bee, and by being hit by falling aircraft. *Id.* at 1369.

18. See, e.g., Steven Eisenstat, *The HIV Infected Health Care Worker: The New AIDS Scapegoat*, 44 *RUTGERS L. REV.* 301 (1992).

19. *Possible Transmission of Human Immunodeficiency Virus to a Patient during an Invasive Dental Procedure*, 39 *MORBIDITY & MORTALITY WKLY. REP.* 489 (July 27, 1990); *Update: Transmission of HIV Infection during an Invasive Dental Procedure—Florida*, *supra* note 6.

20. *Possible Transmission of Human Immunodeficiency Virus to a Patient during an Invasive Dental Procedure*, *supra* note 19.

responsible for public awareness and the immediate responses to the problem by the medical community and lawmakers. Following the Bergalis tragedy, both the political and medical communities responded with guidelines concerning infected HCWs and their patients. Responses to the crisis vary and there is vast dispute concerning the proper approach. Disputes center upon strength of patient protection and privacy rights of HCWs.

A. *The Medical Community*

The response of the medical community to the Bergalis tragedy was initially cautious. The American Medical Association (AMA), the American Dental Association (ADA), the American Academy of Orthopaedic Surgeons, and the American College of Obstetricians and Gynecologists temporarily recommended that HIV-infected members who perform invasive procedures either disclose their seropositive status²¹ to their patients or refrain from performing invasive procedures which pose an identifiable risk of transmission.²²

In July 1991, the CDC issued updated guidelines for the prevention of HIV transmission in the health care setting.²³ These guidelines recommended certain restrictions on the practice of infected HCWs involved in "exposure prone" invasive procedures.²⁴ Medical, surgical, and dental organizations were counseled to identify "exposure prone" invasive procedures within their area of expertise.²⁵ The guidelines emphasized adherence to universal procedures, sanitary and other prophylactic techniques designed to minimize the risk of transmission, and advised HIV-infected HCWs to refrain from exposure-prone invasive procedures until consulting with an expert review panel as to when they may perform such procedures.²⁶ For example,

21. A seropositive status means that a person possesses a specific antibody which indicates a correspondingly specific infection. *STEDMAN'S MEDICAL DICTIONARY* 1408 (25th ed. 1990).

22. See Karen C. Lieberman & Arthur R. Derse, *HIV-Positive Health Care Workers and the Obligation to Disclose*, 13 *J. LEGAL MED.* 333, 338-39, n.38 (1992).

23. *Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures*, 40 *MORBIDITY & MORTALITY WKLY. REP.* 1, 5-6 (July 12, 1991).

24. *Id.* Universal procedures include such precautions as hand-washing, proper use and disposal of needles or other sharp instruments and proper disinfection of reusable devices. *Id.* Additionally, HCWs with exposed lesions should refrain from direct patient care and from handling patient care equipment. *Id.*

25. *Id.*

26. *Id.*

an infected HCW might perform an invasive procedure with the patient's informed consent.²⁷ While HCWs were counseled that they should know their HIV status, mandatory testing was not recommended because of its significant costs.²⁸ The universal precaution aspect of the guidelines garnered nearly unanimously support in the medical community, but the disclosure recommendations met with mixed reaction.²⁹

B. *The Legislature*

Legislators initially responded to the Bergalis tragedy with several proposals ranging from those that would impose criminal sanctions upon health care providers who knowingly treated patients without proper disclosure of their infected status³⁰ to those that mandated HIV testing of HCWs.³¹ These proposals never emerged from committee.³²

Congress finally settled on legislation requiring states to adopt the CDC guidelines or their equivalent.³³ Enactment of the CDC guidelines gave rise to controversy regarding the guideline's disclosure recommendations, the ambiguous definition of exposure-prone invasive procedures, and potential effectiveness problems due to the strictly advisory nature of the guidelines. Arguably, the guidelines alone may not adequately address public reservations about the dangers of HIV transmission in the health care setting.

27. *Id.*

28. *Id.*

29. David M. Price, *What Should We Do About HIV-Positive Health Professionals?*, 151 ARCHIVES OF INTERNAL MED. 658-59 (1991); Larry Gostin, *The HIV-Infected Health Care Professional*, 151 ARCHIVES OF INTERNAL MED. 663-65 (1991); Landesman, *supra* note 11, at 655-57.

30. 137 CONG. REC. S9778 (daily ed. July 11, 1991) (reporting on the Helm's amendment which provided for a fine of not more than \$10,000 and/or imprisonment of not less than 10 years for an infected HCW's knowing treatment of a patient without disclosure).

31. 137 CONG. REC. E2377-78 (daily ed. June 26, 1991) (reporting the Kimberly Bergalis Patient & Health Providers Act of 1991).

32. See T.E. Margolis, *Health Care Workers and AIDS: HIV Transmission In the Health Care Environment*, 13 J. LEGAL MED. 357, 368 n.81. (1992) (Helm's Amendment); *id.* at 374 n. 119 (Bergalis Act).

33. See 137 CONG. REC. H7404-05 (daily ed. Oct 3, 1991) (regarding 42 U.S.C. § 634). Under the Act, the states were given one year to adopt guidelines comparable to those of the CDC or forfeit their assistance under the Public Health Services Act, 42 U.S.C. § 301 *et seq.* The Senate version of the bill required states to adopt the exact CDC guidelines, but a House proposal resulted in the modification of the law to allow states to adopt the equivalent of the CDC guidelines. See 137 CONG. REC. S14346 & H7405 (daily ed. Oct. 3, 1991). The measure, P.L. 102-141 was signed into law by President Bush on October 28, 1991.

The CDC guidelines require adherence to universal precautions and require infected HCWs to either disclose their infected status to patients or to refrain from exposure prone invasive procedures. While virtually all health experts endorse the universal precautions, the disclosure requirement is a significant source of controversy. Some contend that infected HCWs have an ethical and legal duty to inform patients before performing exposure-prone invasive procedures.³⁴ Opponents of disclosure contend that there is no valid reason to require such disclosure citing the low risk of transmission,³⁵ the possible adverse effects on the health care system,³⁶ and the infringement on the privacy rights of the infected HCW.³⁷

The boundaries of the "exposure-prone invasive procedure" concept are ambiguous. In the beginning, the CDC solicited assistance from leading medical organizations in developing a list of exposure-prone procedures.³⁸ These organizations argued that there was no scientific reason to preclude infected HCWs from performing any invasive procedure and therefore refused to recommend any procedures for the list.³⁹ The CDC then shifted the responsibility for identifying exposure-prone procedures to local public health panels on a case-by-case basis.⁴⁰ This case-by-case approach frustrates the development of a uniform definition. This approach will most likely produce a diversity of definitions which, of course, will provide fertile grounds for interjurisdictional legal problems.

Because the CDC guidelines are advisory and not compulsory, medical facilities do not have to strictly enforce their provisions. The guideline's lack of an enforcement mechanism lead some to question their effectiveness in protecting patients from HIV transmission from HCWs. To strengthen patient and HCW protection, Senators Ted Kennedy (D-Mass) and Robert Dole (R-Kan) introduced a proposal

34. See, e.g., Dorsett D. Smith, *Physicians and the Acquired Immunodeficiency Syndrome*, 264 JAMA 452 (1990); Barbara Gerbert et al., *Physicians and Acquired Immunodeficiency Syndrome: What Patients Think about Human Immunodeficiency Virus in Medical Practice*, 262 JAMA 1969 (1989).

35. Larry Gostin, *Hospitals, Health Care Professionals, and AIDS: The "Right to Know" the Health Status of Professionals and Patients*, 48 MD. L. REV. 12, 15 (1989); Daniels, *supra* note 17, at 1368-69.

36. Eisenstat, *supra* note 18, at 316.

37. Larry Gostin, *The HIV Infected Health Care Professional: Public Policy, Discrimination, and Patient Safety*, ARCHIVES OF INTERNAL MED. 663 (April 1991).

38. *Medical Groups Oppose Plan to List Exposure-Prone Invasive Procedures*, 29 Gov't EMPL. REL. REP. (BNA) No. 1440, 1490 (1991).

39. *Id.*

40. Peggie Rayhawk, *Health Care Workers with HIV: The Policy Confusion Continues*, INTERGOVERNMENTAL AIDS REPORTS 4 (Dec. 1991).

requiring the Occupational Safety and Health Administration (OSHA) to issue a set of compulsory guidelines.⁴¹ Accordingly, OSHA promulgated the *Occupational Safety and Health Standards* which included a relevant section concerning occupational exposure to HIV.⁴² The OSHA regulations require employers to develop written infection control plans and to observe universal precautions.⁴³ They also provide enforcement provisions such as inspection and civil penalties.⁴⁴ The OSHA regulations met with little criticism because they provided for no intrusive infection controls like testing or disclosure.

Despite the CDC guidelines and the OSHA regulations, the public harbors significant reservations about being unknowingly treated by an infected HCW.⁴⁵ Health care professionals see universal precautions and infection control as the best methods to prevent physician-to-patient transmission of HIV; however, the public has not been easily convinced.⁴⁶ Public unrest has prompted some elected state officials to endorse strict testing and disclosure guidelines,⁴⁷ and some states are considering such strong measures.⁴⁸ The Texas legislature has actually enacted a law explicitly stating that the informed consent doctrine applies in the context of HIV-infected health care workers.⁴⁹

II. THE RIGHT TO INFORMED CONSENT

Though the debate continues in the medical community and among state legislatures, the disclosure dilemma may find its ultimate

41. Pub. Law No. 102-170, 105 Stat. 1113-14 (1991).

42. 29 C.F.R. § 1910.1030 (1992).

43. *Id.*

44. *Id.*

45. A Gallup Poll performed for NEWSWEEK indicated that 90 percent of the respondents thought that HIV-infected HCWs should be required to disclose their conditions, and 65 percent of respondents stated that they would discontinue treatment by an infected HCW. Kantrowitz et al., *supra* note 8 at 51-52.

46. *Id.*

47. Larry Tye, *Many States Tackling Issue of AIDS-Infected Health Care Workers*, BOSTON GLOBE, May 27, 1991, at 29.

48. AIDS POLICY CENTER, THE GEORGE WASHINGTON UNIVERSITY, STATE BILLS RELATED TO HIV INFECTED HEALTH CARE PROVIDERS—INTERGOVERNMENTAL HEALTH POLICY PROJECT (1992) (discussing Maryland S.B. 7 (1992), New Jersey A.B. 4918 (1991), New York A.B. 4835 (1991), Delaware S.B. 275 (1992), Massachusetts H.B. 1303 (1992), Michigan H.B. 5291 (1992), Michigan S.B. 633 (1992), Missouri H.B. 1514 (1992), and New Hampshire S.B. 410 (1992)).

49. See TEX. HEALTH AND SAFETY CODE ANN. § 85.201 (West 1992). The statute in question reads: "A health care worker who performs an exposure prone procedure . . . shall notify a prospective patient of the health care worker's seropositive status and obtain the patient's consent before the patient undergoes an exposure prone procedure, unless the patient is unable to consent." *Id.*

solution in a court of law. It is likely that courts will require infected HCWs to disclose their status to patients before performing exposure-prone invasive procedures. Any HCW who performs an invasive medical procedure without prior disclosure and the patient's informed consent will likely do so at the risk of incurring liability.⁵⁰

A. *Introduction to the Doctrine of Informed Consent*

The doctrine of informed consent is well established in the field of medical malpractice. It is based upon the principle that a physician has a duty to adequately disclose to a patient the proposed diagnostic, therapeutic, or surgical procedure to be undertaken, the material risks involved with such treatment, and the alternatives available.⁵¹

Generally, consent given by a patient without full knowledge of the risk involved is not informed consent and is therefore ineffective.⁵² The doctrine is derived from at least two concepts. First, the doctrine is premised upon the concept of individual autonomy.⁵³ This concept posits that the patient should decide what is in his or her best interest and should make decisions based on his or her own personal judgment.⁵⁴ According to American jurisprudence, all competent adult patients have a right to determine what is done to their bodies.⁵⁵ Hence, the doctrine of informed consent helps ensure that it is the patient, not the physician, who ultimately decides the course taken regarding matters of the patient's health.

Secondly, the doctrine recognizes that the average patient has little or no understanding of the medical arts and usually looks to his or her physician for the information needed to reach an intelligent decision.⁵⁶ Because of this relationship, the physician stands in a position of trust and confidence with respect to the patient, creating a duty on

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

51. *Canterbury v. Spence*, 464 F.2d 772, 780-83 (D.C. Cir. 1972). There is a therapeutic exception which allows the surgical procedure without consent when disclosure would be so detrimental to the patient's well being that it would be unfeasible to adequately inform the patient. *Id.* at 789. There is also an emergency exception which allows the surgical procedure without consent where the patient is incapable of consenting and where imminent harm from the failure to treat immediately outweighs any possible effect from the proposed treatment. *Id.* at 788-89.

52. *Id.* at 780.

53. *Id.* at 781.

54. *Cobbs v. Grant*, 502 P.2d 1, 10 (Cal. 1972).

55. *Canterbury*, 464 F.2d at 780 n.12 (quoting *Schloendorff v. Society of New York Hosp.*, 105 N.E. 92, 93 (N.Y. 1914)).

56. *Id.* at 780.

the part of the physician to exercise the utmost good faith.⁵⁷ The fiduciary nature of this relationship imposes duties of good faith and fair dealing on the physician that exceed those duties existing in ordinary arms' length transactions between two people.⁵⁸ This duty requires the physician to reveal to the patient that which is in the patient's best interest to know,⁵⁹ even if it is not in the best interest of the physician to make such a disclosure.

The concepts of "patient autonomy" and "fiduciary relationship" support the contention that patients have a right to know, and physicians have a duty to disclose whether the patient is being exposed to significant risk. The existing controversy is over exactly what a physician must disclose in order to fulfill his or her duty to a patient. The application of the doctrine of informed consent to specific cases provides a more explicit idea of the scope of the physician's duty to the patient.

B. *Setting the Standard for the Doctrine of Informed Consent*

In 1972 the D.C. Circuit Court of Appeals set the standard followed by most jurisdictions for the doctrine of informed consent. *Canterbury v. Spence*⁶⁰ confronted the issue of whether a negligible risk required disclosure in order for a patient's consent to be informed and therefore effective.⁶¹ Canterbury sustained personal injuries resulting from an operation performed by Dr. Spence who performed a laminectomy⁶² to correct a suspected ruptured disc. Dr. Spence told Canterbury's mother that the operation was no more serious than any other operation; however, the day after surgery Canterbury was paralyzed from the waist down and remained permanently disabled.⁶³ Canterbury sued Dr. Spence alleging that Spence negligently failed to disclose a risk of serious disablement inherent in the performed operation.⁶⁴ Dr. Spence argued that the risk was so slight that it did not require disclosure and, furthermore, it would be bad medical practice to disclose the minimal risk because disclosure might deter the patient

57. See *Campbell v. Oliva*, 424 F.2d 1244, 1250 (6th Cir. 1970).

58. See *Canterbury*, 464 F.2d at 782.

59. See, e.g., *Phillips v. Good Samaritan Hosp.*, 416 N.E.2d 646, 648 (Ohio Ct. App. 1979).

60. 464 F.2d 772 (D.C. Cir. 1972).

61. *Id.*

62. *Id.* at 777. A laminectomy is "the excision of the posterior arch of the vertebra." *Id.*

63. *Id.* at 777-78.

64. *Id.* at 778.

from undergoing needed surgery or produce adverse psychological reactions which could affect the success of the operation.⁶⁵ The court held that a doctor must disclose all risks which a reasonable patient would consider material in deciding whether to consent to the medical treatment.⁶⁶

The *Canterbury* court ruled that where a plaintiff shows there was a material risk associated with the treatment issued, which the physician failed to disclose, and which if disclosed would have caused a reasonable patient in the plaintiff's position to forego the course of treatment that injured the plaintiff, then the physician is liable for the failure to disclose.⁶⁷ This ruling provides a framework for deciding whether the HIV-infected status of a physician is information which a physician must disclose to be in accordance with the doctrine of informed consent.

C. *What Information Must a Physician Disclose in Order to Fulfill His or Her Obligation to a Patient?*

Since the doctrine of informed consent does not require that all risks be disclosed to the patient, it is often unclear which risks require disclosure. "Material" risks must be disclosed, yet materiality is a subjective decision. Two primary standards have emerged regarding what information must be provided in order for the physician to fulfill his or her obligation to the patient. One standard relies on the learned medical opinion of the reasonable physician while the other standard focuses on what a reasonable patient would consider material.

Under the physician standard, a physician has a duty to disclose those risks which a reasonable physician, under the same or similar circumstances would disclose.⁶⁸ Those jurisdictions that use this standard rationalize that the determination of what the patient needs to know is essentially one of medical judgment requiring insight provided by the experience and expertise of those trained in such matters.⁶⁹ The landmark case establishing the physician standard is *Natanson v. Kline*. The *Kline* court said the determination of risks

65. *Canterbury v. Spence*, 464 F.2d 772, 778 (D.C. Cir. 1972).

66. *Id.* at 782, 786-87.

67. *Id.*

68. See, e.g., *Riedisser v. Nelson*, 534 P.2d 1052, 1054-55 (Ariz. 1975); *Stauffer v. Karabin*, 492 P.2d 862, 865 (Colo. Ct. App. 1971); *Green v. Hussey*, 262 N.E.2d 156, 160 (Ill. App. Ct. 1970); *Natanson v. Kline*, 350 P.2d 1093, 1106 (Kan. 1960) *clarified*, 354 P.2d 670 (Kan. 1960); *Roberts v. Young*, 119 N.W.2d 627, 630 (Mich. 1963); *Marchlewicz v. Stanton*, 213 N.W.2d 317, 320 (Mich. Ct. App. 1973); *Bly v. Rhodes*, 222 S.E.2d 783, 787 (Va. 1976).

69. *Natanson v. Kline*, 350 P.2d 1093 (Kan. 1960) *clarified*, 354 P.2d 670 (Kan. 1960).

that should be disclosed is a medical judgment and that so long as the disclosure was sufficient to assure an informed consent, the physician's choice of plausible courses should not be called into question.⁷⁰ However, it must appear, all circumstances considered, that the physician was motivated only by the patients' best therapeutic interests and that he or she proceeded as competent medical persons would have done in a similar situation.⁷¹

While many states apply the physician standard to informed consent cases, the situation involving an infected physician's failure to disclose his or her HIV positive status is one in which courts will find it difficult to apply the physician standard. Courts using the physician standard presuppose that the physician's decision whether or not to disclose is motivated only by the patients' best therapeutic interests.⁷² In most cases the disclosure revolves around risks that are inherent in the medical procedure. The present situation is different because the risks at issue are those that are created not from the procedure, but from the physician. Where risks exist in a medical procedure, the patient has no alternative but to either forego the medical procedure or subject himself to the risks. However, in the context of an HIV-infected physician, the patient can alleviate the risk of infection without foregoing the medical procedure by simply using the services of a different physician. Thus, it cannot be assumed that the decision about disclosure is solely motivated by the patients' best therapeutic interests. The physician's decision may be motivated by personal interests such as privacy, confidentiality, or the ability to continue in his or her practice.⁷³ This possibility is less likely in the typical informed consent situation where the physician puts no personal interests at stake by disclosing risks. The existence of the physician's self interest makes it necessary to treat such situations differently from the typical informed consent situations where the physicians' interests are more aligned with the patients' interests. Because there are no assurances that HIV-infected physicians are acting in their patient's best interest, courts will find it difficult to justify handing the disclosure decision to those physicians.

70. *Id.*

71. *Id.* at 1106.

72. *Id.*

73. Larry Gostin, *HIV-Infected Physicians and the Practice of Seriously Invasive Procedures*, 19 HASTINGS CENTER REP. 32, 34 (Jan./Feb. 1989).

Allowing the physician to make such a decision is at odds with the strongly held conception of the patient's right of self determination. In *Canterbury*, the court rejected the physician standard, reasoning that it is the prerogative of the patient, not the physician, to determine where his interests lie.⁷⁴ The court viewed the physician standard as being at odds with any strong conception of the patient's right of self determination. In fact, the physician standard totally disregards the patients' right to determine what risks they are willing to expose themselves to. Since courts strongly favor the right of personal autonomy, they are likely to rule that the physician standard is not applicable in the context of an HIV-infected physician. More applicable is the reasonable patient approach which gives the patient the appropriate decision-making responsibility.⁷⁵

In fact, many states, by action of courts and legislatures, have abandoned the physician standard for the reasonable patient standard.⁷⁶ The reasonable patient standard places a duty on the physician to disclose that which a reasonable patient would consider material to his or her decision.⁷⁷ The landmark informed consent decision adopting the reasonable patient standard is *Canterbury v. Spence*.⁷⁸ The *Canterbury* court viewed the patient's right of self determination as shaping the boundaries of the duty to disclose. The court reasoned that the patient's right to self determination can only be effectively exercised if the patient possesses enough information to enable an intelligent decision.⁷⁹ Thus, the court viewed the scope of the physician's communication to the patient as being measured by the patient's need, which is the need for information material to an intelligent decision.⁸⁰

Even under this rigorous patient standard, physicians are not expected to make full disclosure of every conceivable risk.⁸¹ It is unrealistic to expect physicians to discuss every risk surrounding a proposed medical procedure no matter how small or how remote. For instance,

74. *Canterbury v. Spence*, 464 F.2d 772, 787 (D.C. Cir. 1972).

75. The reasonable patient approach has been adopted by many jurisdictions. See Lieberman & Derse, *supra* note 22, at 346 n.82. See also *Cobbs v. Grant*, 502 P.2d 1 (Cal. 1972); *Sard v. Hardy*, 379 A.2d 1014 (Md. 1977); *Wilkinson v. Vesey*, 295 A.2d 676 (R.I. 1972); *Keogan v. Holy Family Hosp.*, 622 P.2d 1246 (Wash. 1980) (en banc); *Scaria v. St. Paul Fire & Marine Ins. Co.*, 227 N.W.2d 647 (Wis. 1975).

76. See ALLAN ROSOFF, *INFORMED CONSENT* (1981).

77. *Canterbury v. Spence*, 464 F.2d 772, 787 (D.C. Cir. 1972).

78. *Id.* at 772.

79. *Id.* at 786-87.

80. *Id.*

81. *Id.* at 786.

physicians are not obligated to disclose risks that are inherent in all operations, such as the risk of infections.⁸² The reasonable patient approach requires physicians to disclose only those risks that an average, reasonable patient would consider material under the same or similar circumstances.⁸³

D. *What Risks Are Material to the Reasonable Patient?*

If courts are likely to require disclosure of risks that are material to a reasonable patient, it must be determined what risks would be material to a reasonable patient's decision. A risk is material if a reasonable person in the patient's position would attach significance to the risk;⁸⁴ however, it is often hard to determine whether a reasonable patient would find a certain risk significant. Determining the materiality of a risk involves measuring the chance that the harm will occur and the gravity of the harm should it occur.⁸⁵ When the risk of harm is improbable, the focus must be on its gravity. As the severity of a potential harm becomes greater, the need to disclose an improbable risk grows.⁸⁶ Thus, the fact that a risk is remote will not always terminate the duty to disclose under the doctrine of informed consent. For example, In *Hartke v. McKelway* the plaintiff alleged that her physician's failure to disclose a .1 percent to .3 percent risk that a tubal cauterization procedure might not succeed in preventing a future pregnancy was a failure to obtain her informed consent.⁸⁷ The plaintiff wished to prevent future pregnancies because she had a history of gynecological and pregnancy-related problems. The court concluded that a reasonable person in the plaintiff's position would likely attach significance to the risk.⁸⁸ Courts have been especially receptive to claims where the gravity of the harm has been severe.⁸⁹ In a situation

82. *Canterbury v. Spence*, 464 F.2d 772, 787 (D.C. Cir. 1972).

83. *Id.* at 786-87.

84. *Id.* (quoting Waltz & Scheuneman, *Informed Consent to Therapy*, 64 Nw. U. L. Rev. 628, 639-40 (1970)).

85. Mary K. Logan, *Informed Consent*, 122 J. AM. DENTAL ASS'N 18, 19 (1991). See also *Harbeson v. Parke-Davis, Inc.*, 746 F.2d 517, 523 (9th Cir. 1984); *Adams v. Richland Clinic, Inc.*, 681 P.2d 1305, 1310 (Wash. Ct. App. 1984).

86. W. PAGE KEETON ET AL., *PROSSER AND KEETON ON THE LAW OF TORTS* § 31, at 171 (5th ed. 1984).

87. *Hartke v. McKelway*, 707 F.2d 1544 (D.C. Cir. 1983) (viewing serious consequences of pregnancy for patient, a jury could properly conclude that .1 percent to .3 percent chance of undisclosed risk of subsequent pregnancy following sterilization procedure was material) *cert. denied*, 464 U.S. 983 (1983).

88. *Id.*

89. *Longmire v. Hoey*, 512 S.W.2d 307 (Tenn. App. 1974). Cases which have held that failure to advise of a remote risk may be a basis for liability have done so on the basis of the

involving minimal risk of a grave harm, a patient might be relieved by the minimal risk of harm, but might reasonably find the risk significant because the severity of the harm is considerable. Though it cannot be said with certainty how any one situation will be resolved, courts are likely to require disclosure of a risk when the possible harm is extremely serious, even if the likelihood of that harm occurring is minimal.⁹⁰

E. *Is the Potential Exposure to AIDS from an Infected Physician a Material Risk?*

Opponents of mandatory disclosure contend that the risk of HCW-to-patient transmission is not material because it is extremely small.⁹¹ While small, the risk is not negligible due to the severity of the potential harm. The risk to the patient is ultimately death. Courts have specified that even a small chance of death may well be significant.⁹² Thus, it would be reasonable for a patient to consider the HIV-infected status of a physician material to a decision whether or not to undergo invasive surgical procedure. Though a strong argument can be made that the risk of HIV infection is so small as to be immaterial, the gravity of the risk renders it material and the risk should be disclosed.

Moreover, knowledge of the risk provides the patient with an opportunity to avoid the risk of transmission entirely and still receive all the therapeutic benefits of the procedure by simply choosing an equally competent physician to perform the procedure. Furthermore, public sentiment, as captured in opinion polls, leaves no doubt that the vast majority of Americans believe such information is material⁹³ and that HCWs should be required to tell patients if they are infected

devastating nature of that which was risked. *Id.* at 310. Examples of such risk are a complete or partial paralysis, blindness, deafness or death. *Id.* See also, *Salis v. United States*, 522 F. Supp. 989 (M.D. Pa. 1981) (holding that a one percent to two percent risk of serious complications should have been disclosed); *Cobbs v. Grant*, 502 P.2d 1 (Cal. 1972) (stating that minimal disclosure requires revelation that a given procedure inherently involves known risk of death or serious bodily harm).

90. See, e.g., *Canterbury v. Spence* 464 F.2d 772, 788 (D.C. Cir. 1972) (specifying that a "very small chance of death . . . may well be significant" as well as "a potential disability which dramatically outweighs the potential benefit of the therapy or the detriments of the existing malady"); see also Lois M. Mousel, *The Risk of Health Care Workers Transmitting AIDS to Patients: Legal and Policy Implications; Is Disclosure the Answer?*, 14 CRIM. JUST. J. 81, 93-4 and n.88 (1992).

91. Mark Barnes et al., *The HIV-Infected Health Care Professional: Employment Policies and Public Health*, 18 LAW MED. & HEALTH CARE 311, 327 n.56 (1990).

92. *Canterbury*, 464 F.2d at 787; *Wilkinson v. Vesey*, 295 A.2d 676, 689 (R.I. 1972).

93. See Kantrowitz et al., *supra* note 8, at 52.

with the AIDS virus.⁹⁴ Some argue that these public sentiments do not reflect the expressions of reasonable patients. These people contend that such sentiments are the product of a public hysteria over AIDS that clouds rational judgment.⁹⁵ If patients are acting on irrational fears, the answer is to improve patient education and awareness about HIV and AIDS not to abrogate the informed consent procedure.

F. Causation

The informed consent analysis does not stop with the determination that a risk is material.⁹⁶ The patient must prove not only that the physician failed to disclose material information, but also that a reasonable patient would not have consented to the treatment in question had he or she been properly informed.⁹⁷ The *Canterbury* court recognized that nonfulfillment of the physician's duty to disclose alone did not establish liability to the patient.⁹⁸ Any unrevealed risk that should have been made known has to materialize, otherwise the omission is legally without consequence.⁹⁹ Furthermore there has to be a causal connection between the physician's failure to adequately disclose and the damage to the patient.¹⁰⁰ Courts have recognized that a causal connection exists only when disclosure of significant risks incidental to treatment would have resulted in a decision against the treatment.¹⁰¹

94. *Id.*; see also, Gerbert et al., *supra* note 34, at 1971; *New AHA Guidelines Urge Universal AIDS Precautions*, 16 MED. STAFF NEWS 2 (Aug. 1987).

95. Gerbert et al., *supra* note 34, at 1971; Nancy Dickey, *Physicians and Acquired Immundeficiency Syndrome: A Reply to Patients*, 262 JAMA 2002 (1989).

96. In a professional liability suit based on informed consent, the plaintiff must be able to prove, by a preponderance of the evidence, that the physician had a duty to disclose certain information, that the physician failed to disclose that information, that the patient would not have consented to the treatment had full disclosure been made and that the patient suffered an injury as a result of the physician's failure to adequately inform the patient. Logan, *supra* note 85, at 18.

97. *Canterbury v. Spence*, 464 F.2d 772, 790-91 (D.C. Cir. 1972). Various courts have rejected the reasonable patient standard, opting instead for a subjective causation test requiring the patient to prove only that he or she would have refused the particular treatment had all material risks been disclosed. *Id.* See, e.g., *Scott v. Bradford*, 606 P.2d 554, 559 (Okla. 1979) (holding that in a medical malpractice action a patient suing under the theory of informed consent must allege and prove that if he had been informed of the risk, he would not have submitted to the treatment).

98. *Canterbury*, 464 F.2d at 789.

99. *Id.*

100. *Id.*

101. See *id.*; *Shetter v. Rochelle*, 409 P.2d 74, 83-84 (Ariz. Ct. App. 1965) *modified*, 411 P.2d 45 (Ariz. Ct. App. 1966); *Natanson v. Kline*, 350 P.2d 1093, 1106-07 (Kan. 1960) *clarified*, 354 P.2d 670 (1960); *Hunter v. Burroughs*, 96 S.E. 360, 369 (Va. 1918).

The factual issue on causality calls for an objective rather than a subjective determination.¹⁰² The problem is that at the post injury stage the patient knows the consequences of the medical procedure, something he or she did not know at the time the decision was made to proceed with the procedure. Any answer a plaintiff/patient gives would probably, intentionally or unintentionally, be tinged by the fact that the un-communicated hazard has in fact materialized.¹⁰³ Because of the credibility problem, the causality issue is better resolved on an objective basis. The preferable approach is to decide the issue in terms of what a reasonable person in the patient's position would have decided if adequately informed of all material risks.¹⁰⁴ If adequate disclosure could reasonably be expected to cause a patient to decline treatment because of the revelation of the kind of risk that resulted in harm, causation is shown.¹⁰⁵

Reasonableness may be evidenced by the patient acting in a way that most similarly situated people would act. Polls indicate that a majority of people would refuse to undergo surgery or other invasive procedures performed by an HIV infected physician.¹⁰⁶ Such polling data is evidence that a reasonable patient would likely forego an invasive procedure by an HIV-infected physician.

Furthermore, it is almost beyond argument that given an opportunity for the same medical benefit without the risk of death, however small it might be, a reasonable patient would forego the risk. In other types of informed consent cases, disregarding a particular treatment because of inherent risks in the procedure is not without its own risks. A patient must choose between the risks inherent in the procedure, and the risks of foregoing the procedure. However, when the inherent risk is infection by a HIV-positive physician, the risk dilemma can be avoided. When informed about the physician's status, the patient may choose an equally talented, uninfected physician to perform the procedure. This assumes another physician would be available to perform the procedure; however, in most circumstances, the assumption

102. *Canterbury*, 464 F.2d at 790.

103. *Id.* (quoting Jon R. Waltz & Thomas W. Scheuneman, *Informed Consent to Therapy*, 64 Nw. U. L. REV. 628, 647 (1970)).

104. *Id.* at 790; Jon R. Waltz & Thomas W. Scheuneman, *Informed Consent to Therapy*, 64 Nw. U. L. REV. 628, 648 (1970).

105. *Id.* at 790; *Shetter v. Rochelle*, 409 P.2d 74, 83-84 (Ariz. Ct. App. 1965) *modified*, 411 P.2d 45 (Ariz. 1966); *Natanson v. Kline*, 350 P.2d 1093, 1106-07 (Kan. 1960) *clarified*, 354 P.2d 670 (Kan. 1960); *Hunter v. Burroughs*, 96 S.E. 360, 369 (Va. 1918).

106. Of those surveyed, 65 percent would refuse to undergo surgery or other invasive procedures performed by an HIV-infected HCW. Kantrowitz et al., *supra* note 8, at 52.

is logical. Changing physicians is certainly reasonable since it allows the patient to lose none of the medical benefits while eliminating any risks associated with the infected physician. In fact, it is almost unreasonable to choose to undergo invasive treatment by an HIV-infected physician.

III. IS THE DOCTRINE OF INFORMED CONSENT APPLICABLE TO CASES INVOLVING HIV-INFECTED PHYSICIANS?

Despite what appears to be a compelling argument that physicians must disclose their HIV-positive status or face liability based upon the doctrine of informed consent, some contend that remote risks associated with a physician are completely outside the doctrine.¹⁰⁷ It is argued that the doctrine was established so that patients could render informed decisions concerning the risks and benefits of surgical procedures and not as a means to protect themselves from dangerous or incompetent physicians.¹⁰⁸ This argument is bolstered by the fact that the doctrine does not require physicians to disclose other personal conditions, such as alcoholism, which would expose their patients to increased risks. Those that support this contention ask if the doctrine should require physicians to reveal their HIV-positive status if the doctrine does not require an alcoholic physician to reveal that status.

While the doctrine of informed consent might require disclosure of a condition such as alcoholism, possible differences in the conditions warrant different treatment. A physician suffering from chronic alcoholism could increase the odds of exposure to an existing risk inherent in a particular procedure; however, the physician would not actually increase the number of risks to which the patient is exposed. In such a situation, the patient may be aware of all the existing risks that are inherent in the particular surgical procedure. If so, requiring disclosure about the physician's condition would not reveal any new risks inherent in the medical procedure; rather, it would reveal information concerning the physician's ability. Protecting patients from incompetent or dangerous physicians is the sole responsibility of the

107. Chai R. Feldblum, *A Response to Gostin, "The HIV-Infected Health Care Professional: Public Policy, Discrimination, and Patient Safety,"* 19 *LAW MED. & HEALTH CARE* 134 (1991); Logan, *supra* note 85, at 20.

108. Larry Gostin, *The HIV-Infected Health Care Professional: Public Policy, Discrimination, and Patient Safety*, 18 *LAW MED. & HEALTH CARE* 303, 304 (1990).

professional licensing authorities.¹⁰⁹ But the licensing authority affords no protection for patients from additional risks. Where a physician suffering from alcoholism increases the chance of harm from an existing risk, an HIV-infected physician adds a new risk to the repository of possible injuries the patient could sustain during surgery. Requiring disclosure of a physician's HIV-positive status is not merely a means of protecting a patient from a dangerous or incompetent physician; rather, it is a means of assuring that the patient is informed about an additional material risk to which he or she will be subjected if the procedure is performed by the infected physician. At least one court supports the notion that the doctrine of informed consent requires pre-surgery disclosure to patients of the infected status of an HIV-positive physician.¹¹⁰ A Superior Court in New Jersey recognized that a physician has a duty to disclose to patients prior to performing surgery, his HIV seropositive status, and to disclose the risk of potential surgical accidents which could lead to exposure.¹¹¹ Dr. William Behringer was a surgeon who had operating privileges at the defendant medical center. Behringer was also admitted as a patient to the medical center where he tested positive for HIV and was diagnosed with pneumocystic carinii pneumonia. These findings lead to the determination that Behringer was suffering from AIDS. Attempting to resolve the dilemma surrounding infected surgeons, the hospital, at one point, required the use of a special "informed consent form" to be presented to patients about to undergo surgery by HIV-positive surgeons. As a result of the imposition of conditions on his continued performance of surgical procedures at the medical center, Behringer brought an action against the medical center seeking damages for violation of the New Jersey law against discrimination. On the issue of informed consent, the court held that risk of surgical accident involving an AIDS-positive surgeon and implications thereof would be a legitimate concern to a surgical patient, warranting disclosure of the risk.¹¹² The court recognized the patient's right to personal autonomy, reasoning that the ultimate arbiter of whether the patient is to be treated invasively by an AIDS infected surgeon should be the patient.¹¹³ The court was persuaded that the risk involved would be

109. *Id.*

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

111. *Id.*

112. *Id.* at 1280.

113. *Id.* at 1283.

material to a reasonable patient.¹¹⁴ Focusing on the gravity of the harm, the court concluded that the ultimate risk to a patient from an infected physician is so absolute and so devastating that it would be untenable to argue against informed consent.¹¹⁵

IV. LIKELY CONSEQUENCES IN COURT

The doctrine of informed consent imposes a duty on HIV-infected HCWs to disclose their seropositive status to patients before performing invasive procedures. The *Behringer* court held as such, and has been cited with approval.¹¹⁶ However, the controversy is not settled. Often the harm that can arise from a risky endeavor is outweighed by the utility of that endeavor.¹¹⁷ There are strong public policy arguments to be made on behalf of the physician as well as on behalf of the patient. Courts must still balance the competing interests of the HCW and the patient. In balancing the competing interest courts must determine whether the risk of physician-to-patient transmission of AIDS and the magnitude of the harm if such risk is realized is greater than the burden on the physician produced by disclosure.¹¹⁸ The probability of actual exposure appears to be quite low,¹¹⁹ but the consequences of the risk is death. Certainly disclosure will have a devastating impact on the infected physician, both personally and professionally.¹²⁰ Nevertheless, as evidenced by *Behringer*, courts are

114. *Estate of Behringer v. Medical Ctr. at Princeton*, 592 A.2d 1251, 1280 (N.J. Super. Ct. Law Div. 1991).

115. *Id.* at 1283.

116. *In Re Milton S. Hershey Med. Ctr.*, 595 A.2d 1290, 1296 (Pa. Super. Ct. 1991).

117. Unreasonable risk is defined as risk that is of such magnitude as to outweigh what the law regards as the utility of the act or manner in which it is done. RESTATEMENT (SECOND) OF TORTS § 291 (1965). Section 292 states that the social value advanced by the conduct, the extent of the chance that such an interest will be advanced by the particular conduct, and the extent that such interest can be adequately advanced by another less dangerous course of conduct are factors weighed in determining the utility of an actors conduct. *Id.* § 292. Section 293 considers four factors for determining the magnitude of the risk:

- (a) the social value which the law attaches to the interests which are imperiled;
- (b) the extent of the chance that the actors conduct will cause an invasion of any interest of the other or of one of a class of which the other is a member;
- (c) the extent of the harm likely to be caused to the interests imperiled;
- (d) the number of persons whose interests are likely to be invaded if the risk takes effect in harm.

Id. § 293.

118. KEETON ET AL., *supra* note 86, at 170-71.

119. The CDC places the risk of the virus being transmitted from an infected surgeon to a patient between 1 in 42,000 and 1 in 417,000. Tye, *supra* note 47.

120. Upon disclosing their HIV status, HCWs have had their ability to practice severely limited. Barnes et al., *supra* note 91, at 325 nn.7-14. They have lost most of their patients, have lost hospital admitting privileges, and have experienced other forms of discrimination which make the ability to practice almost impossible. *Id.*

likely to find that the risk of HIV transmission is a material risk warranting disclosure under the doctrine of informed consent.

V. CONCLUSION

Requiring disclosure of infected HCWs is controversial because it has a devastating impact on the professional and social status of the HCW, while the risk is seemingly small to the uninformed patient. Those infected are deserving of compassion and should be protected from unjust discrimination and unnecessary infringements on privacy. However, the protection should not come at the expense of the unconsenting patient who is unknowingly placed at risk by the failure to disclose. Universal precautions and strict infection control are valuable solutions to the prevention of transmission in the health care setting, but the implementation of such solutions alone relegate patients to passive roles in deciding what is in their best interest. Patients are entitled to play an active role in deciding what risk to take, and physicians have a duty to reveal information to the patient that is in the patient's best interest to know. The guardian of the patient's right to participate in such a decision is the doctrine of informed consent. Even though the risk of HCW to patient transmission is arguably low, the possible result is death. With so much at stake, the assessment of the importance of the risk cannot be made by anyone but the patient and the assessment cannot be made without disclosure. The *Behringer* decision suggest that courts understand the significance of the risk and will provide legal protection to those patients who are not informed by an infected HCW.

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