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HEALTH CARE WORKERS' ABILITY TO RECOVER IN TORT FOR TRANSMISSION OR FEAR OF TRANSMISSION OF HIV FROM A PATIENT

Richard DeNatale* and Shawn D. Parrish†

I. INTRODUCTION

Persons who work in the health care field, or health care workers (HCWs), frequently confront HIV- and AIDS-related issues because their profession brings them into continuous close contact with persons who are infected with HIV. As early as 1990, the attention of Congress and the national media has focused on the possibility that HIV-infected HCWs might infect their patients. Since that time, a number of legislatures and courts have considered whether a HCW who infects a patient should bear legal responsibility for the infection, and if so, under what circumstances. Until recently, however, no court has considered where the legal responsibility should lie in the reverse situation, where a HCW becomes infected through contact with a patient. Specifically, no published decision has dealt with the question of whether, and under what set or sets of circumstances, a patient has a legal duty to warn his or her HCW if he or she is HIV positive.

The answer to this question depends on the resolution of a host of other issues. When is it foreseeable to a person with HIV that there is a risk that he or she will pass the disease on to another? What benefits or detriments do potential plaintiffs derive from a disclosure by the HIV-infected person that he or she has HIV? How would these benefits stack up

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against the burdens imposed on the person who has HIV? How would the imposition of such a duty affect national policy on containing the spread of HIV in the health care setting?

It can be expected that these issues will arise in the courts with greater frequency.¹ The estimated one million Americans infected with HIV² will continue to seek health care. For a number of reasons, at least some of these HIV-infected patients will not disclose their infection to their health care providers. During medical procedures, mishaps will occur that may expose the HCW to the patient's infection — in a few cases this will result in infection of the HCW. Some of these HCWs will seek redress in the legal system. They will ask courts to adapt existing causes of action such as fraud, infliction of emotional distress, or battery, or to craft new ones under such theories as strict liability for disease transmission or “reverse informed consent.”³

The legal system's response to such scenarios will significantly impact both the health care community and individuals with HIV. Court decisions will affect the rights of HIV-infected individuals and their access to health care, and influence the efforts of the health care community to prevent transmission of the virus to HCWs.

¹. These issues have recently received attention in the media, through a discussion of Olympic diver Greg Louganis' disclosure of his HIV infection and, in particular, on an incident during the 1992 Olympic games in which Mr. Louganis received emergency stitches for a cut to his scalp without disclosing to the attending doctor his HIV status. Jere Longman, Olympian Blood: Debate About HIV Tests Sparked by Diver with AIDS, N.Y. TIMES, Feb. 26, 1995, § 4, at 2; Richard Sandomir, Agonizing over Disclosure of AIDS, N.Y. TIMES, Feb. 26, 1995, § 8, at 6. Indeed, as this article will show, the media focus on Mr. Louganis' failure to disclose and the risk to the doctor betray a misconstruction of the risk of HIV transmission and the respective duties of doctor and patient.


³. A. Samuel Oddi, Reverse Informed Consent: The Unreasonably Dangerous Patient, 46 VAND. L. REV. 1417 (1993). The underlying assumption of Oddi's argument is that HCWs and patients have a reciprocal duty to each other. Id. at 1482. However, this assumption is questionable at best. HCWs and patients are differently situated. HCWs, due to their superior knowledge and expertise, owe a fiduciary-like duty to their patients. On the other hand, patients do not owe a reciprocal duty since they lack that specialized knowledge.
This article examines whether there should be a tort for a patient's failure to disclose HIV infection that results in infection or fear of infection by a HCW. Section II assesses the magnitude of the risk of HIV infection from patients to HCWs. Section III reviews the legal issues applicable to this issue. Section IV surveys the case law concerning responsibility for HIV transmission. Section V addresses the key issue of whether a duty exists on the part of a patient to disclose his HIV status to HCWs. This article concludes that such a duty does not and should not exist under tort law principles. Furthermore, such a duty would impede the policies adopted by the government and the health care establishment to prevent the transmission of HIV.

II. The Magnitude of the Problem

Several published studies have attempted to quantify, through a variety of approaches, the risk that a HCW will become infected through contact with a patient. This evidence suggests that the patient's risk of transmission from a HCW is extremely low. As of 1991, there were only twenty-four documented cases of health care workers becoming infected after exposure to patients' blood.4

Nor is transmission likely between a HCW and his or her patients. As of July, 1992, apart from five patients of the same Florida dentist,5 no cases documenting transmission of

4. See American Dental Ass'n v. Martin, 984 F.2d 823, 824 (7th Cir. 1993).
5. See Update: Investigations of Patients Who Have Been Treated by HIV-Infected Health-Care Workers, 41 MORBIDITY & MORTALITY Wkly. Rep. 344-47 (1992). That article contained a study conducted by the CDC after the discovery that a dentist, Dr. Acer, had possibly infected five of his patients. Id. at 344. One of the patients, Kimberly Bergalis, became a national spokesperson for the position that HIV-infected health care workers should not be permitted to treat patients. Id. The study found that of the approximately 1100 of Dr. Acer's patients the CDC evaluated, 0.5% were infected by the dentist. Id.

As of May 13, 1992, the CDC was aware of HIV test results for 15,795 patients treated by 32 HIV-infected HCWs (other than the Florida dentist). Id. at 345. The CDC could not confirm that the HCWs had passed the virus on to any of these other patients. Id. "Data from these investigations, as well as risk estimates derived from modeling techniques, continue to indicate that the risk for HIV transmission from an infected HCW to a patient during an invasive procedure is very small." Id. at 346. See also Kerins v. Hartley, 33 Cal. Rptr. 2d 172, 176 (Ct. App. 1994) (discussing the case of Dr. Acer); NATIONAL COMM'N ON AIDS, PREVENTING HIV TRANSMISSION IN HEALTH CARE SETTINGS 17 (1992) (citing five other "look back" studies which found that HIV-infected HCWs performed numerous invasive procedures without transmitting HIV to patients). There have been suggestions that the dentist failed to employ proper infection...
HIV from a health care worker to a patient had been reported. The Centers for Disease Control (hereinafter CDC), the federal agency that coordinates the federal government's strategy on controlling the spread of HIV, has estimated that the chance that an HIV-infected HCW will infect a patient after percutaneous exposure is 0.3%. Another source has estimated that the possibility that an HIV-infected HCW will infect a patient during an invasive procedure is only about one in 15,000.

A number of factors account for this low risk and the small number of cases of transmission. First, some incident must occur that would permit transmission; the most common example is where a surgeon pricks his finger with a needle or scalpel. One study found that surgeons receive actual cuts to their fingers in 2.5% of surgical operations. The CDC has estimated that percutaneous exposure, including actual cuts, occurs in approximately 6.9% of invasive surgical procedures.

control procedures. Anthony DePalma, AIDS Dentist's Dangerous Professional Practices, S.F. CHRON., June 27, 1991, at A12. Significantly, the office of that dentist, Dr. Acer, violated standard infection control procedures in a number of ways. Zev Remba, HIV, 19 ACAD. GEN. DENTISTRY IMPACT 16, 17 (1991). Masks were worn infrequently and occasionally gloves were not changed between patient contacts, but were merely washed. Id. His office did not follow a set schedule of procedures for cleaning equipment. Id. Handpieces and air/water syringe tips were wiped with alcohol or immersed in germicide at irregular intervals. Id. Sometimes disposable items like saliva ejectors and prophylaxis cups were reused after being immersed in germicide. Id.

6. See Update: Investigations of Patients Who Have Been Treated by HIV-Infected Health-Care Workers, supra note 5, at 344-47.

7. "Percutaneous" is defined as that which is effected or performed through the skin. MERRIAM-WEBSTER COLLEGIATE DICTIONARY 862 (10th ed. 1993).


9. See Kerins v. Hartley, 33 Cal. Rptr. 2d 172, 176 (Ct. App. 1994). This figure was calculated by multiplying the chance of percutaneous injury times the chance that actual infection will occur after percutaneous injury (assumed to be 0.3%, relying on the CDC statistics). Id.


11. CDC Recommendations, supra note 8, at 4.
Furthermore, since the discovery of the HIV virus, the government and the medical community have developed infection control measures to prevent transmission of the virus in health care procedures. This system, developed by the CDC, is commonly known as the "universal precautions." Since 1991 the universal precautions have been binding on nearly all health care employers through OSHA regulations. The philosophy underpinning the universal precautions is that every patient should be treated as potentially infectious, not just those patients the HCW suspects are HIV infected. Accordingly, HCW's should take — and increasingly do take — these precautions with every patient. Quantitative studies have demonstrated that these measures significantly reduce the risk of infection both to health care workers and patients. As HCWs adopt the universal precautions in all health care settings, the risk of HIV infection should fall to a level even lower than the current statistics indicate. Nevertheless, while the universal precautions are legally mandated, HCWs do not always follow them in practice.

Second, assuming the opportunity arises, there must be transmission resulting from blood to blood contact and subsequent infection with the virus. An event, such as a needle stick, in which transmission is possible, does not always re-

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12. 29 C.F.R. § 1910.1030 (1995). See American Dental Ass'n v. Martin, 984 F.2d 823, 824 (7th Cir. 1993) (upholding the validity of regulations except as to sites not controlled by employer, hospital, nursing home, or other entity not controlled by an entity subject to the rule).

13. American Dental Ass'n, 984 F.2d at 825.

14. One study performed at two hospitals in Richmond, Virginia, compared the number of incidents of actual exposures to blood and body fluids before and after the hospitals required its physicians to adhere to universal precautions. Edward S. Wong et al., Are Universal Precautions Effective in Reducing the Number of Occupational Exposures Among Health Care Workers?, 265 JAMA 1123 (1991). Fifty-four percent of the physicians practiced barrier precautions before universal precautions were implemented and 73% did so after they became mandatory. Id. The study found that universal precautions led to a decrease in the number of exposure incidents, from 5.07 to 2.66 exposures per physician per patient care month, and an increase in "averted exposures" (in which direct contact was prevented by the use of barrier techniques), from 3.41 averted exposures per patient care month to 5.90 exposures per patient care month. Id. See also Adelisa L. Panililio et al., Blood Contacts During Surgical Procedures, 265 JAMA 1533 (1991) (study of types of blood contacts made during surgeries indicated that use of barrier precautions such as face shields, fluid resistant gowns, and glove use would have prevented more than half of the observed blood contacts).
sult in successful transmission. One study that evaluated the efficiency of HIV transmission where a HCW is stuck by a surgical needle contaminated with the virus found the probability to be less than one percent.\textsuperscript{15}

Finally — although less is known about this aspect of HIV infection — successful infection following a transmission of some of the virus, by which is meant the sustained presence of HIV in the body, depends on a number of factors. These factors include the concentration of the virus in the infected person's blood, the amount of blood transferred, the recipient's general health and level of immunity, and other factors.\textsuperscript{16}

III. Overview of Theories of Liability

Most HCWs who sue patients for failure to disclose HIV status will bring their action under a theory of negligence. The HCW will claim that the patient had a duty to disclose their HIV status, but failed to do so. A typical negligence cause of action has five elements: (1) existence of a legal duty to avoid creating a risk of harm to the plaintiff; (2) breach of that duty; (3) an actual causal link between the breach and harm; (4) proximate causation; and (5) resulting damages to the plaintiff.

The fundamental element in establishing tort liability is whether a duty exists. Under prevailing negligence principles, a duty arises if it is reasonable under all the circumstances that a person should perform that duty. Thus, the question of whether it is reasonable for a patient to disclose HIV infection — which translates into a weighing of the benefits and risks of disclosure versus nondisclosure — is the critical issue for claims of negligent nondisclosure.

Depending on the facts of individual cases, a plaintiff may also assert other common law tort theories. In addition to a negligence cause of action (and its derivative tort, negli-

\textsuperscript{15} CDC Recommendations, supra note 8, at 683. See also Henderson et al., supra note 8, at 743-44.

\textsuperscript{16} J. Louise Gerberding et al., Risk of Transmitting HIV, Cytomegalovirus, and Hepatitis B Virus to Health Care Workers Exposed to Patients with AIDS and AIDS-Related Conditions, 156 J. INFECTIoUS DISEASES 1, 6 (1987). HIV's relative lack of virulency contrasts with that of Hepatitis B, which is transmitted in the same manner as HIV. Thomas A. Peterman & James W. Curran, Sexual Transmission of Human Immunodeficiency Virus, 256 JAMA 2222, 2225 (1986).
gent infliction of emotional distress), a complaint might al-
lege that the patient committed a fraud or intentionally in-
flicted emotional distress. However, the intent element and
other heightened requirements of these claims make them
less appealing since a would-be plaintiff must prove these ad-
titional elements. Moreover, such legal theories could only
arise in situations where the patient affirmatively misrepre-
sented his or her HIV status, rather than simply failed to dis-
close this status.  

Although this article focuses on the duty element as the
critical issue in these cases, some courts have focused on
other elements and imposed strict limitations on them. For
instance, courts have begun to impose a stricter standard of
proof of damage in cases alleging emotional distress damages
for fear of acquiring a disease. Virtually all of the reported
cases involving a failure to warn of HIV infection are actions
for emotional distress damages in which the plaintiff has not
tested HIV positive, but merely fears that he has acquired
HIV. Such claims are possible because, while an accurate
test exists to detect the existence of HIV infection, it can often
take three to six months after an exposure to HIV until sero-
logic tests are positive for antibodies to the virus.  

Thus, after an exposure incident, a person may have to wait up to
to three to six months before the test can resolve whether infec-
tion has occurred. A plaintiff may bring claims for HIV ex-
posure during this latency period, even though sufficient time
may not have passed and she has not tested HIV positive.

17. These situations arise more commonly than may be supposed. HCWs
typically request patients to provide at least cursory written or oral medical
histories during the course of treatment. Usually these histories touch upon
some aspects of HIV infection status — such as past conditions, medications,
treating physicians. Thus, in order to support a fraud claim, a HCW bringing
suit may allege these specific statements were false or misleading.

18. See infra note 161.

19. See E. Bailey et al., Absence of the Human Immunodeficiency Virus
(HIV) Proviral Sequences in Seronegative Hemophilic Men and Sexual Part-
ers of HIV Seropositive Hemophiliacs, 32 TRANSFUSION 104 (1992) (abstracted
in 267 JAMA 2816 (1992)) (accuracy of HIV test and lack of a prolonged latency
period); Gupta et al., Low Prevalence of HIV in High Risk Seronegative Homo-
sexual Men Evidenced by Culture and Polymerase Chain Reaction, 6 J. AIDS
143 (1992) (lack of prolonged latency period in most
cases, but acknowledging rate instances of seroconversion more than six
months after infection).
Typically, even after testing negative, these plaintiffs will pursue claims for emotional distress damages for the period before a definitive negative test result is obtained.

In early cases claiming fear of HIV transmission as damages in a cause of action, the courts were split regarding the standard applicable to the alleged damage when unsupported by medical proof. Many courts required that the plaintiff establish proof of potentially HIV transmissible contact with an HIV-contaminated article before they would permit such claims to be presented to a jury. Others merely required that the plaintiff allege an incident in which transmission might have occurred. Under the less stringent standard, an allegation that a plaintiff had been stuck by a hypodermic needle, whose chain of custody could not be established, would be sufficient to state a cause of action.

In recent years, the highest courts of three states that had applied the less stringent rule, California, Tennessee, and Minnesota, adopted a stricter standard in evaluating claims for fear of acquiring HIV. In Potter v. Firestone Tire & Rubber Co., the California Supreme Court held that an action based on fear of developing cancer must be based on both actual exposure to a cancer causing substance and reliable medical or scientific evidence showing that the exposure would more likely than not lead to cancer in the future. Subsequently, that same court ordered the California Court of Appeal to reevaluate, in light of Potter, a case involving a patient's claim against a surgeon for fear of HIV transmission. Upon remand, the court of appeal held that the plaintiff had failed to show that it was "more likely than not" that she would develop AIDS based on evidence that she had undergone an operation conducted by an HIV-positive surgeon.

24. Kerins v. Hartley, 33 Cal. Rptr. 2d 172, 179 (Cal. App. 1994). The court observed that "the detailed operative report of the surgery does not indicate that any cuts were sustained by Dr. Gordon, or that there were any other unu-
Tennessee and Minnesota have adopted an "actual exposure" rule. In *Carroll v. Sisters of Saint Francis Health Services, Inc.*, the plaintiff, an elderly woman visiting her ailing sister in the hospital, sued a hospital for negligence after she accidentally pricked herself with a hypodermic needle when she stuck her hand in a needle container that she mistook for a paper tower dispenser. The Tennessee Supreme Court reversed the ruling of the court of appeals, and held that the plaintiff failed to demonstrate that the needle was actually contaminated with HIV or had been used on an HIV-infected person. In *K.A.C. v. Benson*, the Minnesota Supreme Court held that a patient could not maintain a cause of action against an HIV-infected physician who had performed invasive procedures on the patient while wearing gloves. The Court held that only where the plaintiff can show "actual exposure" to HIV could the patient maintain a cause of action for fear of HIV transmission:

Documented modes of HIV transmission include: unprotected sexual intercourse with an HIV-infected person; using contaminated needles; contact with HIV-infected blood, blood components, or blood products by parenteral mucous membrane or non-intact skin; transplants of HIV-infected organs and/or tissues; transfusions of HIV-infected blood; artificial insemination of HIV-infected semen; and perinatal transmission from mother to child around the time of birth.

sexual occurrences during the lengthy surgery," *id.* at 174, and used a statistical approach to conclude that the possibility that an incident occurred — such as a needle prick — in which the needle had the blood of the HIV-positive surgeon, was only approximately 1 in 15,000. See *id.* at 175 n.3; see also supra note 9 and accompanying text. Given the negative result plaintiff had received on an HIV test, plaintiff failed to prove that it was "more likely than not" that she would develop AIDS. *Kerins*, 33 Cal. Rptr. 2d at 179.

The *Kerins* ruling was anticipated by another panel of the California Court of Appeal in *Herbert v. Regents of the University of California*, 31 Cal. Rptr. 2d 709 (1994). In *Herbert*, the court applied the *Potter* "more likely than not" standard to find that the plaintiff had not proved entitlement to recovery for fear of HIV transmission for an accidental needle stick where there was no showing the needle contained HIV. *Id.* at 711-12.


27. 527 N.W.2d 553 (Minn. 1995).


29. *Id.* at 558 (footnote omitted).
These decisions reflect an increasing hostility to cases involving plaintiffs who claim that they fear they will acquire a disease. Rules such as the one requiring plaintiffs to prove that there was an actual potential for exposure, such as an HIV-infected needle, or the “more likely than not” rule adopted in California, will cut back considerably on the number of cases brought for fear of acquiring AIDS.

Both of these rules, however, focus on the likelihood that the plaintiff actually will acquire AIDS, or become HIV infected. They do not affect the legal duty of the defendant: if the plaintiff can prove that he or she was actually exposed to HIV, under California law “more likely than not” exposed to HIV, a defendant can be held liable for future trauma.

IV. SURVEY OF THE CASE LAW

No case has ever held that a patient has a duty to disclose her HIV status to a HCW. Neither has any court imposed a duty in a closely analogous situation. But, there is a considerable body of case law regarding HIV transmission. Many of these cases have concluded that the plaintiff stated a legal cause of action for HIV transmission. In most of these cases, however, factors other than a straightforward balancing of the risk of harm against the burden of imposing the duty account for the imposition of liability. In particular, most of the cases involve either parties in a special relationship with each other, such as sexual partners, or situations where one party owes a heightened duty of care to the other, such as the special duty owed by the HCW to the patient. The reasoning in these cases does not justify imposing a duty on a patient to disclose HIV status to a HCW. A patient does not have a special relationship with a HCW. Nor does a patient owe a heightened duty of care to a HCW. We then examine the only two decisions on point. The first allowed a HCW to sue for fear of HIV infection. The second squarely held that a patient has no duty to disclose her HIV status to a HCW.

30. See infra notes 32-38 and accompanying text.
31. See infra notes 39-43 and accompanying text.
A. Disclosure by Sexual Partners

Numerous cases have held that a sexual partner with a sexually transmitted disease has a duty to warn the other partner of the infectious condition. In *Doe v. Johnson*, the court squarely held that a person can be held liable for failure to warn a sexual partner that he has HIV. The court denied defendant Earvin "Magic" Johnson's motion to dismiss such a complaint and held that a sexual partner infected with HIV has a duty to warn before engaging in sexual relations. In dicta, other courts have indicated that a person has a duty to disclose his HIV status to a sexual partner. In *Petri v. Bank of New York*, the court stated that the special relationship between sexual partners can give rise to claims under negligence theories for failure to warn, or under misrepresentation theories (if misrepresentation is present) if the defendant was HIV positive. However, the court dismissed the complaint for plaintiff's failure to establish that he actually had HIV.

32. Berner v. Caldwell, 543 So. 2d 686, 687 (Ala. 1989); Doe v. Roe, 267 Cal. Rptr. 564 (Ct. App. 1990) (person with genital herpes has duty to warn potential sexual partner of infectious condition); Kathleen K. v. Robert B., 198 Cal. Rptr. 273, 276 n.3 (Ct. App. 1984); B.N. v. K.K., 538 A.2d 1175 (Md. 1988); C.A.U. v. R.L., 438 N.W.2d 441, 442-43 (Minn. Ct. App. 1989) (holding that although there is a duty to avoid transmission of a dangerous communicable disease, respondent had no duty to warn sexual partner that he had AIDS when it was not reasonably foreseeable that he had or could transmit the disease); R.A.P. v. B.J.P., 428 N.W.2d 103 (Minn. Ct. App. 1988); Mussivand v. David, 544 N.E.2d 265 (Ohio 1989); see generally Gregory G. Sarno, Annotation, Tort Liability for Infliction of Venereal Disease, 40 A.L.R. 4th 1089 (1995).
35. The *Doe* opinion provides a very detailed assessment of whether one sexual partner owes a duty to warn the other sexual partner that he or she has HIV before engaging in sexual relations. *Id.* at 1393. The court expressly found that no special relationship exists between sexual partners and that no heightened duty of care exists because of the relationship. *Id.* Nevertheless, it is clear that the court based its conclusion on the particularized context of a sexual relationship: The court's assessment of the burden placed on a defendant considered only the burden associated with one sexual partner informing another that he or she has HIV positive. *Id.*
37. See also *Doe v. Roe*, 267 Cal. Rptr. 564 (Ct. App. 1990) (trial court recognized existence of special relationship between sexual partners).
39. *Id.* at 613-14. At least two other cases have dismissed complaints alleging a sexual partner's negligence in failing to warn of his or her HIV status, although the bases for the dismissals in these cases were failure to properly allege causation or damages, not the absence of a duty to warn. See *Neal v.*
Similarly, in *J.B. v. Bohonovsky*, the court granted defendant estate's motion for summary judgment against plaintiff's claims that the decedent had committed the intentional tort of exposing defendant to HIV and of intentionally inflicting emotional distress. Here plaintiff had failed in two ways to meet the necessary threshold for his case to proceed. First, in the absence of any proof that he was infected with HIV, plaintiff had failed to demonstrate the physical injury needed to sustain an action for intentional exposure to HIV. Second, plaintiff had not substantiated his claim of emotional distress through his sworn testimony or that of an expert.

In granting the motion, the court observed in an aside that a person who knowingly has AIDS has the duty to disclose it and take the steps necessary to protect against its transmission to others.

These decisions have limited applicability to the issue of a patient's duty to disclose HIV infection to a HCW. Their analysis of the duty question is based on the existence of a special relationship between sexual partners or on the particularized circumstances of a sexual relationship. The balancing calculus of these decisions seems to be predicated on the understanding that there is little or no value in an HIV-positive person having unprotected sex, as balanced against the sexual partner's interest in deciding whether to risk becoming infected through sexual contact. If the infected person wishes to keep her HIV status confidential, that person can forego sexual activity.

**B. Disclosure by Medical Professionals**

Under the doctrine of informed consent, health care professionals have a duty to disclose to patients information that a reasonable patient would want to know, or, in some jurisd-

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42. *Id.* at 800.
43. *Id.* at 798.
44. *Id.* at 797.
45. None of these courts have examined whether it is reasonable for the plaintiff to presume that his prospective sexual partner is HIV negative and, based on that presumption, engage in unprotected sex. Arguably, such behavior is unreasonable given the current level of awareness of HIV today.
dictions, information that a reasonable professional would disclose. In the context of HIV infection, only one published decision has discussed whether a physician can be held liable for failing to disclose positive HIV status prior to performing a procedure on a patient.\(^4\) That court held that a physician’s failure to make such a disclosure can constitute negligence, battery, and intentional infliction of emotional distress.\(^4\)

In *Faya v. Almaraz*,\(^4\) the Maryland Court of Appeals upheld two complaints alleging negligence, negligent failure to obtain informed consent, fraud, and intentional infliction of emotional distress against the estate of an HIV-infected surgeon on the basis that the surgeon failed to inform his patients of his condition before performing surgery on them.\(^4\) In discussing why the physician’s failure to warn constituted an action in negligence, the court stated:

> Under the allegations of the appellants’ complaints, taken as true, it was foreseeable that Dr. Almaraz might transmit the AIDS virus to his patients during invasive surgery. Thus, we are unable to say, as a matter of law, that Dr. Almaraz owed no duty to the appellants, either to refrain from performing the surgery or to warn them of his condition. This is so even though the medical literature indicates that, with proper barrier techniques, the risk of

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47. *Id.* at 333.
48. 620 A.2d 327 (Md. 1993).
49. The *Faya* court cited the decision of the lower court in *Carroll v. Sisters of Saint Francis Health Servs., Inc.*, 1992 WL 276717 (Tenn. Ct. App. Oct. 12, 1992), *rev’d*, 868 S.W.2d 585 (Tenn. 1993), for the proposition that a plaintiff could recover for fear of AIDS even when the plaintiff could not show actual HIV exposure, because the key factor was whether plaintiff’s fear was supported by “sufficient indicia of genuineness and reasonableness.” *Faya*, 620 A.2d at 336-37. The Tennessee Supreme Court later overturned *Carroll* and held that a plaintiff must prove actual exposure to HIV to recover damages for fear of acquiring AIDS. *Carroll v. Sisters of Saint Francis Health Servs., Inc.*, 868 S.W.2d 585, 586 (Tenn. 1993). In noting that the *Faya* court had relied on the lower court opinion in *Carroll* to embrace a “reasonableness” standard as opposed to an actual exposure test, the Tennessee Supreme Court pointed out that Maryland’s was the only state court of last resort to accept the reasonableness standard. *Carroll*, 868 S.W.2d at 591-92. The Tennessee Supreme Court then criticized the reasonableness standard in the context of emotional distress for fear of acquiring HIV. *Id.* at 593. These objections dealt with the fear of false claims for emotional distress. *Id.* First, the reasonableness standard was too lax to screen out fraudulent claims due to the inherently subjective nature of claims of emotional distress. *Id.* Second, the standard removed the “objective component” that assured that plaintiff’s claims were founded in an independently verifiable event. *Id.*
HIV transmission is extremely low, for legal scholars have long held that the seriousness of potential harm, as well as its probability, contributes to a duty to prevent it.\(^{50}\)

In *Kerins v. Hartley*,\(^{51}\) a case involving an HIV-positive doctor who performed invasive surgery on a patient, the California Court of Appeal indicated that the surgeon had a duty to use due care during the surgery to ensure that his blood did not come into contact with his patient, and to comply with CDC guidelines governing performance of exposure-prone procedures.\(^{52}\) The court went on to hold, however, that the patient had not established that it was “more likely than not” that she would become HIV infected, and was barred from recovery on that basis.\(^{53}\)

Administrative agencies charged with developing guidelines for the medical profession, both at the federal and state level, have come to different conclusions on this issue. In its 1991 guidelines, the CDC encouraged doctors who performed basic procedures and feared HIV infection to be tested.\(^{54}\) In addition, an expert review panel procedure was established to evaluate whether an HIV-positive doctor could continue to perform basic procedures.\(^{55}\) These guidelines stated that an HIV-infected physician should not perform an exposure-prone basic procedure without informing the patient of his infection.\(^{56}\) At least one court faced with deciding whether a physician or HCW had breached his or her duty has looked to the CDC guidelines to determine the contours of that duty.\(^{57}\) However, some states have adopted different guidelines. New York, for example, has stated that disclosure of HIV status by a doctor is not necessary.\(^{58}\)

\(^{50}\) Faya v. Almaraz, 620 A.2d 327, 333 (Md. 1993).

\(^{51}\) 33 Cal. Rptr. 2d 172 (Ct. App. 1994).

\(^{52}\) *Kerins*, 33 Cal. Rptr. 2d at 177-78.

\(^{53}\) *Id.* at 179.

\(^{54}\) *CDC Recommendations*, supra note 8, at 5.

\(^{55}\) *Id.*

\(^{56}\) *Id*. But see Thaddeus Nodzenski, *HIV-Infected Health Care Professionals and Informed Consent*, 2 S. Cal. Interdisciplinary L.J., 299, 325 (1993) (noting that imposing a duty on HCW's to disclose their HIV status may not be feasible due to limitations on the HIV antibody test, such as “false positives, false negatives, and the time it takes for HIV antibodies to develop”).


\(^{58}\) N.Y. State Dept of Health, Policy Statement & Guidelines to Prevent Transmission of HIV Through Medical/Dental Procedures 1 (1992) [hereinafter 1992 N.Y. Policy Statement]. Those guidelines state that “[r]equiring health care workers to inform patients or employers that they are
New York rejects disclosure because it would serve as a disincentive for doctors to discover their HIV status. Furthermore, disclosure would jeopardize their careers without decreasing the risk of transmitting HIV to patients. New York's policy also states that "HIV infection alone does not justify limiting [a HCW's] professional duties[, and] there is no need to alter . . . [such a person's] practice unless his health status impairs his job performance." Thus, New York's policy does not focus on the risk of HIV transmission, but rather on the risks caused by HCWs whose professional skills are impaired by AIDS. To protect patients from HIV transmission during invasive procedures, the policy envisions a voluntary expert review panel evaluation, which would place limitations, if necessary, on an infected HCW's practice. The panel would examine the presence of weeping lesions, compliance with infection control procedures, and the nature of the invasive procedures performed.

Connecticut has staked out an intermediate position between the CDC guidelines, which require disclosure, and the New York policy, which specifically rules out disclosure. Like New York, Connecticut's guidelines assume that HIV infection alone does not justify limiting a HCW's professional duties. Like New York, Connecticut's guidelines refer an infected HCW to an expert review panel that focuses on compliance with the universal precautions, the nature of the work, and whether the illness interferes with the ability to perform the work in deciding whether the HCW should continue to provide services. Significantly, the panel will review on a case-by-case basis whether the HCW should disclose his HIV status to a patient.

HIV-positive will only serve as a deterrent to workers seeking voluntary testing and medical evaluation. It would also endanger the professional careers of competent and needed health personnel who pose no risk to patients." Id. at 2.

59. Id.
60. Nodzinski, supra note 56, at 330.
62. Id.
63. Id.
64. Id.
66. Id.
67. Id.
68. The Connecticut policy does not state specific guidelines for determining if disclosure is advisable. See id.
Michigan's guidelines also provide for disclosure of a HCW's status on a case-by-case basis. But unlike Connecticut, Michigan specifies the factors to consider in making the determination: whether exposure has occurred, an assessment of specific risks, confidentiality issues, and available resources. But courts in other states have taken positions contrary to these guidelines.

The issue of whether a physician is required to disclose his or her HIV-positive status to a patient is therefore unresolved. Federal and state medical agencies have adopted various approaches to the issue. And, only one decision, *Faya*, has squarely held that such a failure constitutes negligence and battery.

This authority on a physician's duty to disclose HIV infection has only limited applicability to the question of whether a patient has such a duty to disclose. The relationship between the patient and the HCW is a dependent one, in which the patient relies on the HCW's greater skill and knowledge. For this reason, as a general rule, HCWs owe a heightened duty to avoid the creation of a risk of harm to patients. But the inverse is not true. HCWs are not in a dependent position vis-à-vis the patient; and the patient does not have a reciprocal heightened duty of care to the HCW that may give rise to a duty to disclose.

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70. Id.
71. A few courts have permitted hospitals to prevent HIV-infected HCWs from performing invasive procedures. E.g., Estate of Behringer v. Princeton Medical Ctr., 592 A.2d 1251, 1255 (N.J. Super. Ct. Law Div. 1991); see also Leckelt v. Board of Comm’rs, 909 F.2d 820 (5th Cir. 1990) (upholding hospital's firing of male nurse for refusal to submit to an HIV test).
72. In an unpublished decision, the Minnesota Court of Appeals appears to have agreed with the approach taken by the *Faya* court in holding that a physician's failure to warn his or her patients that he or she has HIV can constitute negligent infliction of emotional distress or "negligent nondisclosure claim." K.A.C. v. Benson, Nos. C6-93-1203, C5-93-1306, C4-93-1328, 1993 WL 515825 (Minn. Ct. App. Dec. 14, 1993), rev'd, 527 N.W.2d 553 (Minn. 1995). However, the K.A.C. opinion relied on both *Faya* and *Kerins* in deciding that a physician has a duty to disclose that he or she is HIV positive to a patient. Id.
73. But see generally Oddi, supra note 3. Professor Oddi argues that a patient has a duty to disclose his or her HIV status to a HCW based on the HCW's duty to disclose to the patient the material risk of a medical procedure. *Id.* at 1417 n.19. His fundamental premise is that patients and doctors are similarly situated with respect to each other and thus owe each other a reciprocal duty. *Id.* Yet that premise is questionable at best. The HCW's superior expertise and
C. Possible HIV Transmission in Other Contexts

A handful of cases have dealt with other situations where plaintiffs have alleged that defendants negligently caused them to be exposed to HIV. These cases do not necessarily involve disclosure issues; they involve, more generally, alleged duties to prevent possible HIV transmission. The cases fall into three categories: (1) cases where the defendants have custody over an HIV-infected individual; (2) cases where the defendants control the premises where possible HIV infection occurs; and (3) products liability cases. The facts of these cases limit their applicability to the issue of whether a patient must disclose his HIV status to a HCW.

The first category of cases involves institutional settings where patients with AIDS are under custodial care. Courts have imposed on such institutions a duty to supervise such patients who may become violent and infect others, or at least to warn persons called to restrain violent patients that the patient has AIDS or is HIV infected. In Johnson v. West Virginia University Hospitals, Inc.,\textsuperscript{74} the court affirmed a verdict for a guard bitten by an AIDS patient, on the theory that the hospital failed to follow its own regulations requiring the posting of a notice near a patient if the patient is infected.\textsuperscript{75} In Hare v. State,\textsuperscript{76} the court recognized that the state had a duty to supervise an AIDS-infected prisoner sent to a hospital for medical treatment who bit a surgical technician at the hospital.\textsuperscript{77}

In a similar vein, one court has indicated that an institution that places an HIV-infected patient in the care of another person can be liable for failing to warn the care giver of the patient's HIV infection. In J.B. v. Sacred Heart Hospital,\textsuperscript{78} the Eleventh Circuit Court of Appeals apparently accepted the plaintiff's argument that a hospital could be liable for failure to warn a patient's brother, who transported the patient to another treatment facility, that the patient had knowledge places her in a completely different position with respect to the patient. See discussion supra note 3.

\textsuperscript{74} 413 S.E.2d 889 (W. Va. 1991).
\textsuperscript{75} Johnson, 413 S.E.2d at 893-94.
\textsuperscript{77} Hare, 570 N.Y.S.2d at 126.
\textsuperscript{78} 996 F.2d 276 (11th Cir. 1993), certifying question to 635 So. 2d 945 (Fla.), and conformed to answer, 27 F.3d 506 (11th Cir. 1994).
AIDS. The plaintiff alleged that while transporting the patient, the patient began thrashing about, dislocating his heparin lock. The plaintiff came into contact with the patient's blood when he placed his hand, which had been cut during a fishing accident, on the patient's heparin lock. Subsequently, the plaintiff tested positive for HIV.

One case suggests a contrary result. In *Funeral Services by Gregory, Inc. v. Bluefield Community Hospital*, the court upheld the trial court's dismissal of an action by an embalmer, alleging battery against a hospital that released to him the body of a patient who had died of AIDS. The court held that the complaint failed to show the intent necessary to sustain a cause of action based on battery, although it expressly held open the possibility that such facts might constitute negligence.

A second category of cases has indicated that owners of premises, including employers, have a duty to keep the premises clear of items contaminated with HIV. In *Marchica v. Long Island Railroad*, a railroad employee alleged under the Federal Employers' Liability Act (FELA) that his employer negligently failed to maintain a safe working place by allowing homeless persons, including intravenous drug users, to break into a trainman's room at a railroad station. When

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79. *Sacred Heart Hosp.*, 996 F.2d at 278.
80. *Id.* at 277. A heparin lock is attached to the patient's arm and provides a port for inserting an intravenous needle into the patient's vein. *Id.*
81. *Id.*
82. *Id.* The court was unable to decide, for the purpose of evaluating defendant's statute of limitations defense, whether the action should be characterized as one for general negligence or for medical malpractice under Florida state law. *Id.* at 277-78. The court of appeals certified the question to the Florida Supreme Court, which ruled that the lawsuit was not founded on medical malpractice. *J.B. v. Sacred Heart Hosp.*, 635 So. 2d 945, 949 (Fla. 1994). The court of appeals then reversed the district court and permitted the plaintiff to proceed on a general negligence theory, since plaintiff was not obligated to comply with the special procedures and statute of limitation in Florida malpractice law. *J.B. v. Sacred Heart Hosp.*, 27 F.3d 506, 507 (11th Cir. 1994).
84. *Funeral Servs. by Gregory, Inc.*, 413 S.E.2d at 84-85.
85. *Id.* at 81-82.
86. *Id.*
87. 31 F.3d 1197 (2d Cir. 1994).
89. *Marchica*, 31 F.3d at 1205.
the employee tried to secure a grate in the room as he was instructed to do, he slipped and fell in a trash receptacle causing a hypodermic needle concealed in the garbage to pierce his hand. The employee sued his employer for recovery of emotional distress damages for fear of acquiring AIDS. The court upheld a jury verdict in the plaintiff’s favor, reasoning that even though plaintiff had not tested positive for HIV and had not demonstrated that the needle contained HIV, the physical injury test for negligent infliction of emotional distress was stated.

In Castro v. New York Life Insurance Co., plaintiff stuck his hand in the trash on defendant’s premises and was stuck by a needle. The court held that plaintiff stated a cause of action for fear of acquiring HIV based on defendant’s failure to discard hypodermic needles appropriately.

A third category of cases involves the duty of a product manufacturer to produce reasonably safe products. In Seimon v. Becton Dickinson & Co., a nurse who was pricked by a self-injecting syringe sued the syringe manufacturer for emotional suffering caused by the possibility that she was infected with HIV during the incident. The Ohio Court of Appeals recognized that there might exist some set of facts under which a syringe manufacturer would have a duty to avoid injury to users of its product, but held that the plaintiff had not shown that she was, in fact, exposed to HIV. She therefore could not maintain a cause of action for fear of acquiring AIDS.

These cases all involve particular factual contexts limiting their importance for deciding whether a patient has a duty to warn a HCW when he or she has HIV. As shown above, the cases involve some special control by a defendant over the possible risk of HIV infection — either through custody of an infected individual, control of premises containing

90. Id. at 1200.
91. Id.
92. Id. at 1205, 1208.
94. Castro, 588 N.Y.S.2d at 695.
95. Id. at 698.
97. Seimon, 632 N.E.2d at 604.
98. Id. at 605.
99. Id. at 604-05.
HIV-contaminated needles, or the manufacture of an unreasonably dangerous product. Courts have premised this duty on "special relationships:" the premises owner's special duty to keep the premises free of hidden hazards, the employer's duty to provide a safe work environment for the employee, and the manufacturer's duty to avoid placing an unreasonably unsafe product into the stream of commerce. None of these cases provide support for a general duty to warn someone when that person is about to enter into a situation in which a risk of HIV transmission exists.\textsuperscript{100}

D. Cases Involving a HCW as Plaintiff

Only two decisions — one published, one unpublished — have addressed the duty to inform a HCW that a patient is HIV positive before that HCW performs an invasive procedure on the patient. Both of these cases held that, under a negligence analysis, no duty exists.\textsuperscript{101}

The first case involved claims against an officer with custody of a patient. In Ordway v. County of Suffolk,\textsuperscript{102} the court

\textsuperscript{100} Another set of cases held that a provider of HIV-infected blood, or a substance contaminated with HIV, can be liable for exposing a plaintiff to HIV. In Marriott v. Sedco Forex International Resources, Ltd., 827 F. Supp. 59 (D. Mass. 1993), the court held that, under the Jones Act, an oil rig worker could sue the oil rig owner for supplying a hepatitis vaccine, which possibly contained HIV, for negligent infliction of emotional distress. \textit{Id.} at 73-74. In Lubowitz v. Albert Einstein Medical Center, 623 A.2d 3 (Pa. Super. Ct. 1993), the plaintiff sued her physician and his hospital for allegedly introducing HIV infected placental blood into her body during an in vitro fertilization procedure. \textit{Id.} The court affirmed the trial court's grant of summary judgment on the ground that HIV tests administered after the procedure demonstrated that the plaintiff had not been infected with HIV. \textit{Id.} In so ruling, however, the court observed that "[w]e realize that there are factual questions with respect to the appellees' negligence . . . ." \textit{Id.} at 5. At least, the court indicated that such facts might constitute negligence. \textit{Id.} In Howard v. Alexandria Hospital, 429 S.E.2d 22 (Va. 1993), the court held that a patient who alleged fear of HIV after she had undergone a surgery in which unsanitary instruments were used could maintain a cause of action in negligence. \textit{Id.} at 25. These cases are inapposite to any decision to impose a requirement that HIV-infected patients warn their HCWs. These cases are more akin to (strict) product liability than negligent failure to warn cases.

\textsuperscript{101} Although no case has held that nondisclosure by a patient can occasion liability to a HCW, a patient's failure to inform a physician of a relevant fact concerning his or her health can constitute contributory negligence or form the basis for a comparative negligence defense. See Caroll J. Miller, Annotation, \textit{Patient's Failure to Reveal Medical History to Physician as Contributory Negligence or Assumption of Risk in Defense of Malpractice Action}, 33 A.L.R. 4th 790 (1984).

\textsuperscript{102} 583 N.Y.S.2d 1014 (Sup. Ct. 1992).
Health care workers and HIV

granted summary judgment in favor of the county when a correctional officer brought an HIV-positive prisoner to a physician for medical treatment. The physician alleged that the officer should have warned him of the patient's HIV status so that he could have taken heightened infection control precautions when performing surgery on the patient. Noting that the complaint alleged a theory that was "on the frontier of liability for negligence," and that it was "paramount that plaintiff show a specific duty on the part of the defendant," the court found that the officer had no duty to disclose to the physician. In doing so, the court relied on the existence of a state statute that prohibited disclosure of HIV test results.

While this case did not directly involve a patient's duty to disclose HIV infection to a HCW, its holding has implications for this question. Ordway involves the same argument that a HCW might make in support of a patient disclosure requirement: that disclosure would permit the HCW to take heightened infection control precautions to minimize the risk of HIV transmission. But Ordway also involves statutory protection of the confidentiality of HIV test results. Thus, on a fundamental level, the situation in Ordway addresses similar burdens and benefits that are relevant to a determination of the existence of a patient's general duty of disclosure to a HCW.

The other decision — an unpublished one — involved the very issue addressed in this article. In Boulais v. Lustig, a surgical assistant sued a patient for failing to disclose her HIV status. The HCW had been cut by a scalpel that may have had some of the patient's blood on it; the HCW argued that, had she been informed of the patient's HIV infection, the HCW would have taken additional infection control precautions that would have prevented the injury.

103. Ordway, 583 N.Y.S.2d at 1017.
104. Id.
105. Id.
106. Id.
107. Id.
108. Ordway, 583 N.Y.S.2d at 1017.
109. See discussion infra part V.
110. No. BC038105, slip op. (Super. Ct. L.A. County June 18, 1993). A word of disclosure is merited here. The authors of this article were counsel for the patient/defendant in this case, and argued that she had no duty to disclose her HIV status to her HCWs. The case has been resolved through a settlement.
In *Boulais*, the trial court held that a patient had no duty to disclose that she was HIV positive to her HCW. The jury initially found in favor of the plaintiff; however, the court granted defendant’s motion for judgment notwithstanding the verdict on the negligence claim. In so ruling, the court relied on both an analysis of general negligence principles and public policy:

No duty of a patient to be truthful concerning his/her medical condition with his/her medical care providers has been established by court decision or law. Physicians and health care providers owe a duty of care to patients. However, no such corresponding duty of patients has been established by court decision or statute. Further, the stated governmental policy regarding AIDS and HIV-positive patients is to maintain the confidentiality of their medical condition. An imposition of a duty of a patient to disclose truthfully, when asked, their medical condition would not be consistent with such governmental policy.

The *Boulais* decision — though unpublished and containing only the briefest analysis — raises the major issues involved in the question of a patient’s duty to disclose HIV status. As a starting point, *Boulais* emphasizes the different duties of HCWs and patients — while a HCW owes the patient a duty to avoid a risk of harm to the patient, the patient owes no such reciprocal duty to the HCW. The decision then notes that, under general negligence principles, no court has found a duty by a patient to disclose HIV status. Finally, this conclusion is buttressed by public policy concerns that are the basis for statutes that guarantee the confidentiality of a patient’s HIV status.

V. Duty

The issue of whether a legal duty to another exists is always, in the first instance, a task for the court, not the jury,

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111. The court, however, permitted the verdict for plaintiff on the fraud claim to stand. The record contained evidence that the defendant misrepresented information that would have tended to reveal her HIV status on an intake form she filled out prior to surgery.

112. *Boulais v. Lustig*, No. BC038105, slip op. (Super. Ct. L.A. County June 18, 1993) (minute order granting motion for judgment notwithstanding the verdict). Under California court rules, trial court decisions such as this one have no precedential value and may not be cited as authority to any court. See *Cal. R. Cr. 977*. 
In determining whether to permit a health care worker to sue a patient for actual HIV transmission, or for fear of HIV transmission, a court might frame a patient’s duty in a number of ways. In its broadest formulation, patients might have to inform the health care facility that they have HIV, or even that they are at risk of HIV infection. A less stringent duty, at least in theory, would require a patient to avoid affirmative misrepresentations of HIV status. However, in reality such a duty would be little different from the broader formulation, because patients are routinely asked general questions about their medical history and condition that would implicate some aspect of HIV infection.

This article argues that no duty does, nor should, exist on the part of a patient to disclose HIV infection to a HCW. First, we consider whether patients have a special relationship to their HCWs that would establish such a duty. Second, we consider whether a weighing of the benefits and burdens associated with such a duty justifies the creation of a general duty to disclose. Third, we consider how governmental policies on HIV prevention affect the issue. Finally, we consider whether, and in what respect, this particular question may be beyond the authority and competence of a court to decide.

A. Does a Special Relationship Exist?

In some cases, a special relationship exists between a plaintiff and a defendant that creates a heightened duty of care on the part of the defendant. Although HCWs, particularly physicians, have a fiduciary-like relationship with their patients, no case has ever held that patients have a similar duty toward their physicians or HCWs. Courts have rec-

114. See supra part V.A.
115. See supra part V.B.
116. See supra part V.C.
117. See supra part V.D.
118. In Doe v. Roe, 267 Cal. Rptr. 564 (Ct. App. 1990), the court held that a person has a duty to disclose infectious diseases to a sexual partner based on the existence of a special relationship between sexual partners. Id. at 567. See also Petri v. Bank of New York, 582 N.Y.S.2d 608 (Sup. Ct. 1992).
ognized that patients and doctors are differently situated. As one court has noted:

Health-care providers and institutions should consider ethical aspects of the doctor-patient relationship in examining the risk posed by health-care providers infected with HIV. The patient and doctor occupy unequal positions in the relationship. The doctor is trained to recognize, diagnose, and avoid contracting the patient's disease. The doctor stands in a position of trust — a fiduciary position — in relation to the patient. . . . The patient, on the other hand, has no corresponding ethical duty to the doctor. The patient is neither trained nor expected to ascertain the provider's health status. While secretive patients may transmit their diseases to unwary doctors, doctors are responsible for both their own health and the health of their patients.119

A central tenet of medical malpractice law is that the patient has a right to receive information about the risks and benefits of any procedure before the patient is deemed to have consented to the medical procedure.120 The basis for the physician's duty to disclose risks is the physician's superior knowledge of medical procedures and their risks.121 Patients are in a completely different position. Unlike HCWs, patients lack specialized knowledge and medical training. They must therefore depend on the disclosure by HCWs of risks and benefits of treatment.

Physicians and other HCWs know that the patients they see may be infected with HIV; they are more likely to recognize this fact than other groups in American society. Furthermore, HCWs cannot reasonably rely on the failure of a patient to state that he or she is HIV positive to conclude that the patient is HIV negative — if only because most persons who are infected do not know it.122 Thus, no relationship

121. Id. "The average patient has little or no understanding of the medical arts, and ordinarily has only his physician to whom he can look for enlightenment with which to reach an intelligent decision." Id. at 780.
akin to special relationships elsewhere recognized by the law can be said to exist.

B. Is There a General Duty to Avoid a Risk of Harm?

Whether a general duty arises in the negligence context depends on a number of factors. Every person has a duty to avoid creating an "unreasonable" risk of harm to every other person and to use "ordinary" caution in carrying out any activity. Courts have often framed the issue as a balancing test, where the likelihood of harm and the benefit to be gained by imposition of the duty is balanced against the burden attendant to the duty. Courts sometimes resolve the imposition or non-imposition of a duty by reference to the public policy implications of the new duty.

1. The Risk of Harm and the Benefit of Disclosure

The issue of whether the risk of harm justifies requiring a patient to disclose his or her HIV status actually encompasses three distinct considerations: (a) the gravity of the harm; (b) the likelihood that the conduct will cause harm; and (c) the benefit gained by reducing the likelihood of harm through the imposition of a duty. In its most mathematical formulation, this issue is resolved by balancing quantified risk against the burden of imposition of the duty. Quantified risk is obtained by multiplying the reduced likelihood that the harm will occur if a duty is imposed by the magnitude of the harm averted.

Rep. 509 (1987) (noting that most of the 1.0 to 1.5 million infected persons in the U.S. are unaware that they are infected with HIV).

123. E.g., Tarasoff v. Regents of the Univ. of Cal., 551 P.2d 334, 342-43 (Cal. 1976); Restatement (Second) of Torts § 282 (1965).


126. See, e.g., U.S. v. Carroll Towing Co., 159 F.2d 169 (2d Cir.), reh'g denied, 160 F.2d 482 (2d Cir. 1947).
In practice, there is no easy way to perform the calculation to arrive at a quantified risk; nor is there a way to quantify the burden imposed by a duty. Clearly, the consequences of HIV transmission are devastating. Nevertheless, the law permits many activities which might result in the death of another. For example, there is no duty not to drive an automobile, although the consequence of being hit by one can be extremely harmful.

In its July 1992 report, “Preventing HIV Transmission in Health Care Settings,” the National Commission on AIDS observed:

In making risk calculations, people tend to overlook palpable, everyday risks, such as those associated with driving a car or smoking cigarettes, as compared with more

127. In determining the magnitude of the risk in transmission of HIV cases, Professor Oddi has applied the property damage analysis in the Restatement (Second) of Torts. Oddi, supra note 3, at 1458. Section 293(a) states that the first factor to consider is “the social value which the law attaches to the interests which are imperiled.” RESTATEMENT (SECOND) OF TORTS § 293(a) (1965). Professor Oddi argues that since society places a higher value on the services of HCWs than those of patients, “non-disclosure by patients presents a higher risk than by [HCWs] in the context of whose life is imperiled.” Oddi, supra note 3, at 1458. Thus, the interests of the imperiled HCWs outweighs the interests of the imperiled patients on the basis of whom society values more. Id. Similarly, section 293(c) states that another factor to consider is “the extent of the harm likely to be caused by the interests imperiled.” RESTATEMENT (SECOND) OF TORTS § 293(c) (1965). Professor Oddi argues that since a HCW’s earning capacity is generally higher than that of the average patient, he suffers more if he is infected than if he infects a patient. Oddi, supra note 3, at 1458.

While this approach has a certain analytical appeal, it is morally questionable at best. Professor Oddi’s position implies that a person’s earning capacity is a surrogate for that person’s value to society. While this idea makes it easy to calculate “value,” most persons probably feel that value should not be measured solely in monetary terms. Under the analysis Oddi suggests, the “value” of a mother raising three children instead of holding a paying job would be less than the “value” of a paid fast-food worker.

128. See generally Doe v. Johnson, 817 F. Supp. 1382, 1392 (W.D. Mich. 1993) (balancing “very high” risk associated with HIV transmission in deciding whether sexual partner has a duty to warn that he or she has HIV).

129. Instead, a driver has a legal duty to maintain reasonable control of the automobile and to be vigilant of the possibility of danger to others. If a “reasonable” driver would have avoided the accident, the driver is liable for the consequences. The decision to permit the use of automobiles is based on the burden of imposing a duty not to do so. The individual driver (and society) benefits greatly from being permitted to drive. The fact that death may result from any given activity is not dispositive of the question of whether a duty to refrain from engaging in the activity exists.
remote, but dreaded risks. Perceptions of risk are heightened if the source of the risk is not observed or detectable. Unfamiliar risks or those involving scientific unknowns are particularly dreaded, as are risks from sources beyond one’s control. HIV transmission in the health care setting is one example of a risk in which the public has taken great interest. As knowledge about HIV has evolved and as experts have publicly disagreed on many aspects of HIV transmission, there has been much public skepticism. Some pronouncements by experts and government officials have fueled public fears unnecessarily....

Nevertheless, many of the cases considering HIV-related issues have emphasized the severity of consequences from acquiring HIV, and ultimately AIDS, in arriving at decisions. In Doe v. Johnson, a case brought by a plaintiff against basketball star Magic Johnson, a federal district court considered whether a claim for “negligent transmission of HIV” stated a cause of action under Michigan law. The court was clearly swayed by the severity of the risk of acquiring HIV, observing that “[d]eath is often the consequence of this disease,” and stating that “[w]hen an individual has knowledge[,] . . . the burden on that individual in revealing his or her HIV virus information is minimal when compared to the high risks of the disease.”

This tendency of the courts to overemphasize the magnitude of the harm in AIDS cases has a number of sources. First, lay people generally do not assign weight to a risk according to the actual probability that the risk will materialize. This bias leads to systematic and predictable errors in judgment in dealing with situations of uncertainty. Hence, the serious consequences of AIDS leads courts to overemphasize the magnitude of its harm without discounting for the likelihood of its transmission.

133. Id. at 1392.
134. Id. at 1393.
135. Amos Tversky & Daniel Kahneman, Judgment Under Uncertainty: Heuristics and Biases, 185 SCIENCE 1124 (1974) (concluding that the heuristic devices that people use to calculate probabilities in situations of uncertainty have no connection to the statistical likelihood of an event’s occurrence).
136. Id. at 1131.
Furthermore, because of the stigma attached to the disease and the persons who carry the virus, one cannot help but suspect that the courts are especially sympathetic to plaintiffs who allege that someone has given them HIV. A number of courts have alluded to the particularly emotional reactions of many people to HIV. 137

This stigma has its origin in how the public perceives the danger of AIDS. AIDS falls within the category of dangers described as "dread risks." 138 A "dread risk" is defined by a "perceived lack of control, dread, catastrophic potential, fatal consequences, and the inequitable distribution of risks and benefits." 139 Significantly, the higher a risk scores on the dread risk scale, the higher its perceived risk in the public eye. 140 AIDS clearly qualifies as a "dread risk" — it inspires dread in the public at large and is nearly always fatal. As a dread risk, the public and courts perceive AIDS to be a greater risk than it actually is. 141 For these reasons, courts

137. See M.M.H. v. United States, 966 F.2d 285, 286, 291 (7th Cir. 1992) (action for misdiagnosis of HIV may state a cause of action for emotional distress damages even in the absence of physical injury because AIDS is "a fatal disease that is shrouded in mystery and stigma"); Kathleen K. v. Robert B., 198 Cal. Rptr. 273, 276 n.3 (Ct. App. 1984) (permitting action for misrepresentation that one does not have genital herpes, because "[like AIDS, genital herpes] is now known by the public to be a contagious and dreadful disease"). Other courts have bordered on giving official sanction to conduct that would otherwise be considered reprehensible because the conduct was motivated by an irrational fear of HIV. In Poff v. Caro, 549 A.2d 900 (N.J. Super. Ct. Law Div. 1987), the court held that a landlord violated state laws barring housing discrimination on the basis of sexual orientation and disability when he refused to rent an apartment to three gay men whom he feared would get AIDS. The court recommended against imposing harsh fees or penalties against the landlord, however:

[T]he landlord's refusal to rent did not appear to be motivated by spite or malice directed against any particular group, but rather out of fear that his family might be exposed to a terrifying disease . . . . The fact that those fears are ill-founded does not detract from their reality to the person who fears.

Poff, 549 A.2d at 905.


139. Id.

140. Id.

141. Id. In addition, it has been suggested that HIV's presence in blood, semen, saliva, and tears also accounts for the stigma attached to AIDS. Id. These fluids are cultural symbols for impurity, pollution, and danger. See id. Since HIV (and ultimately AIDS) is transmitted through these heavily symbolic media, HIV infection represents a kind of personal defilement, as well as an actual danger. Id.
are likely to assign the risk of AIDS more weight than the statistics would otherwise indicate.\textsuperscript{142}

\textbf{b. The Reduced Likelihood of the Harm}

The key inquiry is whether the averted danger outweighs the burden of imposing a duty on a patient to disclose HIV status to a HCW. Even in "high risk" interactions such as invasive surgery, the risk of HIV transmission from patient to HCW is very small. As of 1991, there were only twenty-four confirmed cases in which health care workers had become infected through contact with patients.\textsuperscript{143} This low figure is understandable in light of the number of factors that must coincide before transmission occurs: some sort of accident, such as a needle prick or scalpel cut, that would provide a conduit for transmission; actual contact with infectious material; and actual viral infection. A few courts have acknowledged the difficulty of transmitting HIV.\textsuperscript{144} But the majority of cases contain little or no discussion of how small the risk actually is.\textsuperscript{145}

Moreover, the key question is whether the risk of harm is reduced by patient disclosure of HIV status. The assertion that HCWs who are unaware that they are providing care to an HIV-positive patient face a substantially greater risk of harm is highly suspect. Published studies have questioned whether HCWs can behave any more carefully around patients whom they know to be HIV positive than with patients about whom they have no information about their serologic status.

One study at a major urban hospital questions an essential premise of a claim based on failure to disclose — namely, that the HCW's knowledge that a patient is HIV positive will enable the HCW to take extraordinary precautions in order to avoid HIV transmission.\textsuperscript{146} Nurses at San Francisco General

\begin{itemize}
\item \textsuperscript{142} Mary Douglas, Purity and Danger 114 (1966); Leon Eisenberg, The Genesis of Fear: AIDS and the Public's Response to Science, 14 Law, Med. & Health Care 243, 245 (1986).
\item \textsuperscript{143} American Dental Ass'n v. Martin, 984 F.2d 823, 824 (7th Cir. 1993).
\item \textsuperscript{144} Id. "The AIDS virus is not... easily transmitted in the sorts of contact that patients usually have with health care workers." Id. See also Doe v. Johnson, 817 F. Supp. 1382, 1392-93 (W.D. Mich. 1993).
\item \textsuperscript{145} See Kerins v. Hartley, 33 Cal. Rptr. 2d 172, 175, n.3 (Ct. App. 1994).
\item \textsuperscript{146} Gerberding et al., Risk of Exposure of Surgical Personnel to Patients' Blood During Surgery at San Francisco General Hospital, 322 New Eng. J. Med. 1788 (1990).
\end{itemize}
Hospital kept notes of the number of exposures to blood in 1307 consecutive surgeries.\textsuperscript{147} The study found that regardless of whether the operating room personnel knew that the patient had HIV, the incidence of exposure to blood was approximately the same.\textsuperscript{148} If knowledge of a patient's HIV status does not affect the health care worker's chances that he or she will be exposed, then not disclosing one's HIV status presents no risk to the health care worker.\textsuperscript{149}

A HCW's knowledge of a patient's HIV status may in fact increase the risk of harm. The CDC's universal precautions approach would be undermined by a rule requiring patient disclosure. As discussed more fully in part V.C, if a duty to disclose were imposed, some HCWs might rely on the patient's disclosure of his or her HIV status in deciding whether to employ universal precautions. Lulled by a false sense of security, HCWs would not follow the universal precautions unless a patient indicated that he was HIV negative. Since many persons do not know their HIV status, and since the HIV antibody tests require up to six months to give definitive results, HCWs cannot rely on patients' representations of HIV-negative status.

2. **Burden Imposed by the Duty**

The impact of disclosure may well cause more than psychological damage, particularly for a patient who must disclose his HIV condition to a HCW.\textsuperscript{150} A number of studies

\textsuperscript{147} Id.

\textsuperscript{148} Id. at 1788-93. \textit{See also} Tokars et al., \textit{Percutaneous Injuries During Surgical Procedures}, 267 JAMA 2899, 2899-2904 (1992).

\textsuperscript{149} Some authors have questioned the element of causation in a negligence action based on a patient's failure to disclose his HIV status. \textit{See} Lawrence Gostin, \textit{HIV-Infected Physicians and the Practice of Seriously Invasive Procedures}, 19 HASTINGS CTR. REP. 32 (Jan.-Feb. 1989) (patient disclosure irrelevant since HCWs have a legal and moral duty to test even when informed of a patient's HIV status); Steven Eisenstat, \textit{The HIV Infected Health Care Worker: The New AIDS Scapegoat}, 44 RUTGERS L. REV. 301 (1992) (patient disclosure irrelevant since HCWs already are obligated to follow universal procedures and thus cannot undertake any additional precautions).

\textsuperscript{150} While Professor Oddi admits that a patient who discloses his HIV status bears a burden, he underestimates the weight of that burden and ascribes too much significance to the ability of laws and professional norms to control prejudice against individuals infected with HIV. Oddi, \textit{supra} note 3, at 1462. He argues that the burden consists "only of the risk of confidentiality being breached by the [HCW]." \textit{Id}. He does concede, however, that if confidentiality is breached, the potential for loss is great, although he does not explore the ramifications of that potential loss. \textit{Id}. However, the burden imposed by the
have revealed that many HCWs, including physicians, prefer not to deal with HIV-infected patients at all. More to the point, a very high percentage of primary care physicians, perhaps as many as fifty percent, take steps to avoid treating HIV-infected patients. This unwillingness to provide treatment has its source in the unfavorable attitudes physicians hold towards gay men, who make up a large section of the HIV-infected population. An HIV-infected patient required to disclose his or her status may be refused treatment.

duty to disclose goes further. In light of the prejudices felt by members of the health care community and the reality of discrimination against patients with HIV, Professor Oddi’s reliance on the protections extended to such patients by the Americans With Disabilities Act (hereinafter ADA), 42 U.S.C. §§ 12101-12213 (1988 & Supp. 1993), and American Medical Association ethical norms is unrealistic.

151. See Martin F. Shapiro et al., Residents’ Experiences in, and Attitudes Toward, the Care of Persons with AIDS in Canada, France, and the United States, 268 JAMA 510 (1992). This article reported the results of a questionnaire survey mailed to residents in their last year in internal medicine or family medicine in Canada, France and the United States. Id. Twenty-three percent of U.S. physicians surveyed indicated that they would not care for AIDS patients if they had a choice. Nineteen percent of the U.S. physicians also reported that they knew of an AIDS patient who had been refused treatment by a medical specialist, and 39% of U.S. physicians reported that they knew of an AIDS patient who was refused treatment by a surgeon. Id. See also Jeffrey Kelly et al., Stigmatization of AIDS Patients by Physicians, 77 Am. J. Pub. Health 789, 790 (1987) (study finding that physicians are much more unwilling to deal with patients with AIDS than patients with leukemia, even in casual interactions that carried no risk of transmitting HIV). This stigmatization suggests that HIV-infected individuals will encounter more attitude negativity and avoidance than patients with other serious illnesses. Id. at 791. Furthermore, that study found that physicians considered AIDS patients to be “more deserving of what [had] happened to [them]” than leukemia patients. Id. at 790. See R. Nathan Link et al., Concerns of Medical and Pediatric House Officers About Acquiring AIDS from Their Patients, 78 Am. J. Pub. Health 455, 457 (1988) (finding that 25% of house officers surveyed would not continue to care for AIDS patients if given a choice).

152. See C. Lewis & K. Montgomery, Primary Care Physicians’ Refusal to Care for Patients with the Human Immunodeficiency Virus, 156 W.J. Med. 36, 38 (1992) (telephone survey of primary care physicians in Los Angeles found that “almost half” of such physicians “may have already rejected HIV-infected patients or plan not to accept them as regular patients”). A few courts have taken note of the fact that physicians, as well as the general public, “irrationally” fear patients with HIV. Doe v. Barrington, 729 F. Supp. 376, 384 n.8 (D.N.J. 1990); Estate of Behringer v. Medical Ctr., 592 A.2d 1251, 1272 n.12 (N.J. Super. Ct. Law Div. 1991).

153. William C. Matthews, Physician’s Attitudes Toward Homosexuality — Survey of a California County Medical Society, 144 W.J. Med. 106, 109-10 (1986) (survey found 25% of respondents had strongly negative attitudes towards homosexuality and 30% would not admit a homosexual applicant to medical school). Since this survey occurred before widespread publicity linking
and may have to search out physicians willing to provide basic medical care, even for conditions that are unrelated to HIV status.

A HCW's knowledge that a patient is HIV positive can also influence the quality of treatment the patient receives. One study of six neonatal intensive care units in New York City found that HCWs recommended less aggressive treatment for infants who had HIV-positive mothers than for infants with similar conditions who did not have such mothers — even though the respondents were asked questions regarding treatment of a condition thought to be unrelated to HIV disease, a duodenal atresia. This finding suggests that patients with HIV, particularly those not in a position to participate in decisions regarding their own medical care, such as infants, incompetents, and patients whose hospitalization is paid for through public funding, may receive inferior medical treatment solely because of the perception that their lives are worth less because they have HIV.

A patient who must disclose his HIV status to a HCW also faces the possibility that this fact will not remain confidential, exposing him to the stigma and prejudice that persons with AIDS and HIV so often experience. Ethical norms bind physicians to keep information provided to them confidential. And many, if not all states, require all per-

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155. 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. Unauthorized disclosure of a person's serologic status can lead to social opprobrium among family and friends, as well as loss of employment, housing and insurance.


156. AMERICAN MEDICAL ASS'N, PRINCIPLES OF MEDICAL ETHICS § 9 (1957) provides:

A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.
sons receiving information regarding another person's HIV status to keep that information confidential.\textsuperscript{157} In practice, however, there is no way to guarantee that information regarding a patient's HIV status will not be disseminated beyond the patient's health care providers.\textsuperscript{158}

The creation of a patient's duty to disclose his HIV status can also lead to the disclosure of private facts that do not necessarily mean the patient is HIV positive. As noted above, a duty to disclose may not be limited to cases in which the patient has actual knowledge that he has HIV.\textsuperscript{159} Some cases

\textit{Id.}

\textsuperscript{157} See infra note 171, containing a list of such statutes enacted in the 10 largest states.

\textsuperscript{158} In Estate of Behringer v. Medical Center, 592 A.2d 1251 (N.J. Super. Ct. Law Div. 1991), the court described how the efforts of a hospital to keep the fact that one of its physicians (who was also a patient at the hospital) had tested HIV positive failed:

According to stated policy, charts were limited to those persons having patient-care responsibility, but in practical terms, the charts were available to any doctor, nurse or other hospital personnel. Despite the CDC's recommendation that access to HIV results be limited, the medical center had no policy physically restricting access to the HIV test results or the charts containing the results to those involved with the particular patient's care.

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Given the significance of a physician-patient with a diagnosis of AIDS and the lack of special procedures directed at securing confidentiality, the inevitable happened.\ldots [W]ithin hours, word of plaintiff's illness was "on the street."

\textit{Id.} at 1262-63. See also Doe v. Methodist Hosp., 639 N.E.2d 683, 683-84 (Ind. Ct. App. 1994) (describing how plaintiff's HIV status was revealed to his co-workers after plaintiff informed paramedics that he was HIV positive).

\textsuperscript{159} In cases in which a duty to disclose the existence of an infectious disease was found, some courts have decided that a duty to disclose exists when the defendant actually knew or reasonably should have known he or she was infected.

For example, in Doe v. Johnson, 817 F. Supp. 1382 (W.D. Mich. 1993), the court held that the complaint, alleging emotional distress deriving from fear that the plaintiff would acquire HIV, stated a cause of action against her sexual partner to the extent that the defendant had knowledge he was actually infected with HIV, knew that he had symptoms associated with the virus, or knew of a prior sex partner who was diagnosed as having the virus, but rejected plaintiff's contention that defendant had a duty to warn if he had engaged in "high risk" sexual activity, or if he belonged to a group at high risk for HIV. \textit{Id.} at 1393. See also Kozup v. Georgetown Univ., 663 F. Supp. 1048 (D.D.C. 1987), \textit{aff'd in pertinent part}, 851 F.2d 437 (D.C. Cir. 1988); C.A.U. v. R.L., 438 N.W.2d 441, 443 (Minn. Ct. App. 1989) (although an HIV-infected sexual partner could not have known he was infected given the state of medical knowledge in 1985, a sexual partner after plaintiff informed paramedics that he was HIV positive).
have indicated that a person who has a duty to disclose to another that he has HIV also has such a duty if the person has manifested symptoms associated with HIV, or has had sex with a partner known to be infected with HIV. And at least one case has considered, but rejected, the notion that a person who has engaged in high risk sexual behavior owes a duty to disclose this fact to his sexual partner.\textsuperscript{160} Thus, patients may be required to divulge to HCWs information of the most personal sort, such as sexual orientation, sexual history, sexual practices, and past drug use. Should the duty to disclose be expanded this far, even persons not confirmed as HIV positive may experience stigma and the same barriers to medical treatment that persons who are know to be HIV positive face.\textsuperscript{161}


\textsuperscript{161} Arguably, even a negative result on an HIV test would not extinguish a duty to disclose risk factors. The six month “window” period during which a person may have HIV but not test positive for HIV antibodies means that a negative HIV test is no guarantee that the person does not have HIV.

Testing individuals for the AIDS virus usually entails performing an Enzyme Linked Immunosorbant Assay (hereinafter ELISA), and confirming a positive finding by the Western Blot test. These tests do not directly identify the presence of HIV. Rather, they detect whether the individual’s immune system has developed antibodies to the virus (“seroconversion”). Antibodies are formed as a means to combat viruses and infections. The HIV antibody usually forms within several weeks to months after HIV infection. Thus, a positive ELISA and Western Blot test indicates only that the individual has been infected, and is capable of transmitting the virus. It does not indicate that the persons has AIDS, or if or when the person will develop the syndrome.

In addition, the fact that an individual tests negative for the presence of the antibody does not indicate that he or she is not presently infected. Because the tests detect the presence of the antibody only, if seroconversion has not yet occurred an individual will receive a negative test result, yet still carry the virus. Given that it may take six months or longer after transmission before antibodies are produced, an individual will receive negative test results during that time, and yet be infected and infectious. There exists, therefore, a “window” between the time a person becomes infected, and when he or she seroconverts. Thus, the ELISA and Western Blot test are underinclusive, because they do not detect those infected individuals who have yet to seroconvert.

Moreover, neither the ELISA nor the Western Blot test is 100% accurate in detecting all individuals who have actually seroconverted.
C. Public Policy

Reducing the transmission of HIV in the health care setting is an important public policy concern. In deciding whether to recognize a cause of action for HIV transmission in this context, courts or legislatures should consider its impact on public policy.

Imposing liability on a patient for not disclosing his or her HIV status is inconsistent with American public policy. As discussed in greater detail below, imposing a duty on a patient to disclose his or her HIV status subverts three significant goals of public health care policy: (1) it undermines the important federal policies aimed at preventing HIV transmission in the health care setting; (2) it reduces the access of HIV-positive patients to health care; and (3) it undercuts the public policy in most jurisdictions that individuals, including patients, should be permitted to keep their HIV status private.

First, requiring patients to disclose to HCWs that they are HIV positive threatens to undermine the existing approach to reduce HIV transmission in the health care field. OSHA regulations promulgated in 1991 require that every health care facility follow a great number of procedures designed to reduce the risk of occupational exposure to HIV. HCWs must follow these procedures, the universal precautions, during the treatment of every patient, not just while treating those who are known or suspected to be infected with HIV. The regulations state that they must be

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The accuracy of these tests is measured by the proportion of the infected people who actually test positive (sensitivity), and the proportion of the uninfected individuals who actually test negative (specificity). The ELISA is credited with a 99.7% sensitivity rate and a 98.5% specificity rate. The Western Blot, when used to confirm a positive ELISA test, has a 99.3% sensitivity rate, and a 91.6% specificity rate. Testing would also result in falsely identifying infected HCWs as being uninfected. Due to the window of infection, HIV tests will not locate those HCWs who are infected but have yet to form antibodies to the virus. Thus, even with screening once or twice a year, some infected HCWs will still be unidentified. The ramifications of these false results would be that those HCWs incorrectly informed of their negative status may feel a false sense of security, and thus relax their compliance with infection control procedures. As a result, patients of these HCWs would actually be placed at an increased risk of infection.

Eisenstat, supra note 149, at 328-29.
163. Id.
followed for every patient because there is no reliable way to know whether a given patient is infected with HIV. Patients may not know they are infected, or they may be reluctant to inform their health care provider that they are infected. The problem of obtaining reliable information regarding any given patient's HIV status would remain even if every patient were tested for HIV because current methods test for antibodies to HIV, not HIV itself. Because antibodies to HIV usually do not form until three to six months after HIV infection has occurred, the test does not detect HIV in patients who have been recently infected.

Requiring a patient to disclose that he has HIV undermines the universal precautions system. The CDC, which developed the universal precautions approach, found that informing HCWs which patients have HIV reduces the likelihood that the HCWs will follow HIV infection control procedures when treating patients who are not identified as HIV positive. Many HCWs tend to assume that if a patient has not been identified as HIV positive, the patient is not likely to be HIV positive. They will then often not follow infection control procedures that do not appear to be warranted, although such procedures are mandated by federal law. Reliance on seronegative test results also undercuts the CDC's policy that universal precautions be followed on a routine basis. The policy envisions HCWs using universal precautions until doing so becomes second nature — especially important with respect to less trained and sophisticated HCWs. Mistakes will occur more often if people have to think about precautions on a case-by-case basis, depending on the perceived danger of HIV transmission. When using the universal precautions becomes rote, errors will occur less frequently.

164. Id.
165. See Commentary, The Risk of Contracting HIV Infection in the Course of Health Care, 265 JAMA 1872 (1991) (statement authored by New York Academy of Medicine recommending against mandatory testing of health care workers because, inter alia, the inability of the HIV test to detect HIV reliably until six months after exposure would mean that mandatory testing would not necessarily prevent transmission of HIV in the health care setting).
167. See Joint Advisory Notice, 52 Fed. Reg. 41818, 41820 (1987) (noting that false sense of security derived from patients' seronegative results may reduce the level of routine vigilance).
Second, mandatory disclosure will reduce HIV-infected persons’ access to health care treatment. As noted above, several studies have revealed that many health care facilities and professionals refuse to treat HIV-infected persons — either by refusing to treat, by declining to treat based on a bad faith medical judgment that the risks of the procedure outweigh the anticipated benefits of treatment, by referring the patients to physicians who are willing to treat, or by specializing in areas not likely to involve the care of HIV-infected persons.\(^ {168} \) Even assuming that most patients with HIV can find facilities to provide regular ongoing care,\(^ {169} \) requiring them to disclose their HIV status when they seek treatment may mean that they will have difficulty finding treatment when they cannot go to their regular provider for care, such as in emergencies or when in rural areas or areas not well served by medical facilities.\(^ {170} \)

Third, in many jurisdictions, state legislatures have enacted statutes to preserve the individual’s right to keep his HIV status a private matter.\(^ {171} \) The California statute, for

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168. The 1991 Report of the National Commission on AIDS, America Living with AIDS, reported:

The reasons [HCWs have been reluctant to care for HIV infected persons] include low reimbursement rates for people whose care is paid for by Medicaid; a lack of familiarity with and understanding of treatment for the disease; fear of becoming infected during the course of treating patients; discomfort in treating gay men or intravenous drug users; and unease in dealing with the psychological stresses of caring for dying young patients with multiple physical and psychological needs.


169. In fact, there probably will not be enough facilities willing to treat HIV-related conditions to meet the increasing number of patients with this condition. One study noted that, based on a survey of physicians in Los Angeles, only 15% of physicians who do not currently treat patients with HIV would be willing to do so. See Lewis & Montgomery, supra note 152, at 38.

170. A number of health care professional organizations and ethicists have stated that it is unethical for health care workers to refuse to treat patients based on their HIV status. See, e.g., Council on Ethical & Judicial Affairs, Ethical Issues Involved in the Growing AIDS Crisis, 259 JAMA 1360 (1988) (“A physician may not ethically refuse to treat a patient whose condition is within the physician’s current realm of competence solely because the patient is seropositive.”).

example, imposes civil and criminal penalties for disclosing a person's HIV status absent a legal right to do so. This law advances the policy of ensuring the confidentiality of the HIV status of its citizens. Such laws reflect a decision that a person's right to confidentiality outweighs the needs of others to know whether a given person has HIV absent a legal right to the information. Courts asked to impose a duty to disclose should hesitate when confidentiality laws exist, because these laws suggest that the legislature has already consid-


172. For example, in Ordway v. County of Suffolk, 583 N.Y.S.2d 1014 (Sup. Ct. 1992), the court relied on the existence of an HIV confidentiality statute to define a police officer's duty of care in transporting an HIV-infected prisoner to a physician for medical care. The court found that the statute requiring all individuals having knowledge of another person's HIV status to keep that information confidential meant that the police officer's duty to keep the information confidential outweighed any duty he may have had to inform the physician that the prisoner was HIV positive. Id. at 1017.

However, some courts have interpreted their state's HIV confidentiality statutes as not furthering any independent privacy interest on the part of the patient. In In re Milton S. Hershey Medical Center, 634 A.2d 159 (Pa. 1993), the Pennsylvania Supreme Court upheld a lower court's decision which authorized two hospitals to disclose that one of their physicians was HIV positive to the physician's patients. The court observed:

"Disclosure was clearly consistent with the primary purpose of the HIV Act. That purpose ... was to reduce the spread of HIV and AIDS."

... Confidentiality was not the purpose of the Act, but rather was the means chosen to further the Act's goal of limiting the spread of HIV and AIDS.

Id. at 162-63.

In Johnson v. West Virginia University Hospitals, Inc., 413 S.E.2d 889 (W. Va. 1991), the West Virginia Supreme Court of Appeals upheld an award of emotional distress damages against a hospital which failed to disclose to a police officer that a patient he had been called to restrain had AIDS. Id. at 894. The court rejected the hospital's argument that damages for failure to disclose that a patient was HIV positive was inconsistent with the state's law guaranteeing the confidentiality of HIV test results. Id. at 895. "This case does not involve a situation where a patient was tested for AIDS. Rather, in this case, hospital personnel failed to warn an unsuspecting officer of an AIDS-infected patient's condition." Id. at 895. In a footnote, the court displayed some ambivalence toward this argument, contending that even if the statute prohibited the hospital from posting a warning of the patient's condition, the hospital could not rely on the statute because its own regulations mandated such a warning. Id. at 895 n.6. Some courts have recognized the inherently private nature of a person's HIV status, independent of any statute. See Doe v. Methodist Hosp., 639 N.E.2d 683, 686 n.1 (Ind. Ct. App.) (Najam, J., dissenting).
ered and reached a decision regarding whose interests are paramount.\textsuperscript{173}

D. Authority and Competence of the Courts

With growing frequency, courts will face the question of whether a patient must disclose HIV infection to HCWs. In most cases, plaintiffs will ask the courts to decide this issue which executive agencies and legislatures have already addressed. As set forth above, a great number of policy considerations would be implicated by such a decision. Under long held principles of jurisprudence, courts should refrain, when possible, from making public policy; ordinarily, this is the proper function of the legislature and executive agencies.\textsuperscript{174} At the very least, courts should not decide cases in a manner that contravenes public policy.

At both the federal and state level, executive agencies have promulgated various policies to deal with the AIDS epidemic. Those policies have rejected the idea of mandatory disclosure of HIV status. At the federal level, the CDC’s universal precautions approach rejects the idea of differential treatment for HIV-positive patients and calls for strict infection control practices with all patients.\textsuperscript{175} OSHA adopted the same approach by making those precautions binding on all health care facilities.\textsuperscript{176} Similarly, the Department of Labor and the Department of Health and Human Services published a Joint Advisory Notice recommending that all bodily fluids be treated as if contaminated with HIV.\textsuperscript{177} Several state departments of health have agreed with the CDC that

\textsuperscript{173} Nevertheless, in some jurisdictions, courts have construed the HIV confidentiality statutes to permit a HCW to disclose a patient’s HIV status. For example, one opinion by the West Virginia Supreme Court of Appeals suggests that a hospital has a duty to post a notice next to the patient’s bed if the patient is HIV positive. See Johnson v. West Va. Univ. Hosps., Inc., 413 S.E.2d 889 (W. Va. 1991). These rulings arguably misconstrue the intent of the legislature.

\textsuperscript{174} E.g., Dumas v. Cooney, 1 Cal. Rptr. 2d 584 (Ct. App. 1991) (court declined to impose liability in a medical malpractice case in which the plaintiff alleged that as a result of the physician’s delayed diagnosis of plaintiff’s lung cancer, a lower than 50% chance that the cancer could have been treated was lost. The basis for the decision was that policy considerations, such as encouraging unwarranted testing and potential impact on health insurance premiums, would “intrude upon the Legislature’s task of weighing such matters of public policy.”).

\textsuperscript{175} CDC Recommendations, supra note 8.


universal precautions are the best way to prevent HIV transmission in the health care setting, thus adopting a view that patient disclosure is not necessary or desirable.

This consideration assumes especially great importance when the question before the court has been considered by lawmaking bodies. In many ways, asking a court to require a patient to disclose his HIV status is similar to asking it to rule on whether a health care facility may test a patient for HIV without obtaining the patient's consent. In the case of mandatory testing, the physician or health care facility runs an HIV test on a blood sample taken before the invasive procedure is performed to ascertain the patient's HIV status — the same information the patient must divulge if the courts impose a duty to disclose.

Congress has also considered and rejected mandatory testing of all patients. In August and September 1991, legislation was introduced in Congress regarding the issue of HIV in the health care setting, including the "Kimberly Bergalis" amendment that would have mandated testing of patients and HCWs involved in invasive procedures. On October 3, 1991, Congress passed a version of the bill that did not include the Kimberly Bergalis amendment; instead, the bill permitted each state to either adopt the CDC guidelines or propose a substitute measure equivalent to the CDC guidelines.

Administrative agencies and legislatures at the federal and state level have formulated policies to deal with AIDS in the health care setting. These policies reject the idea of mandatory patient disclosure and emphasize the use by HCWs of universal precautions to prevent transmission of HIV. Courts should hesitate to impose a duty to disclose when that would disrupt the emerging public policy.

VI. CONCLUSION

A patient should be under no duty to disclose his or her HIV status to a HCW. Neither the traditional test for legal duty, in which the risk of harm is weighed against the burden of the duty, nor existing public health policies support the existence of such a duty.

The issue of whether a duty exists is always a question that a court must consider and rule on before the question of whether a duty was breached is submitted to the jury. And it is the duty of the courts, not juries, to define the outer limits of what is reasonable. One part of a court's analysis is whether there is any significant risk to the type of conduct that the duty under consideration would proscribe. Another significant component of a court's job is to assess whether imposing a duty violates public policy.

Even before the CDC promulgated the system of universal precautions, studies concluded that the risk of patient to HCW transmission of HIV is extremely low. After universal precautions became binding on all health care providers in 1993, the likelihood of transmission from patient to HCW should be even less, because these strict infection control procedures greatly reduce the risk of transmission. Thus, the imposition of a legal duty to disclose HIV status on a patient would serve little good — and, as a matter of public health policy, may even do harm.

The concept of universal precautions is dependent upon an unwavering presumption on the part of all HCWs that all patients are potentially infectious. The reason for such an assumption is not obvious. Proponents of extending liability to patients who do not disclose their HIV status argue that the HCW derives a benefit from knowing a patient is HIV positive because the HCW can take heightened precautions when treating that patient. This argument has superficial logical appeal, but misses the important psychological insights upon which the architects of universal precautions based their system.

The first insight is that human beings learn work habits best when the patterns are repeated again and again, so that it becomes automatic. Permitting HCWs to treat patients differently, based on knowledge or assumptions about the patient's HIV status, breaks up the routine and so interferes with the behavior that must be learned. The second, and more important insight, is that having HCWs apply different (and lesser) infection control procedures to persons who are known or believed to be HIV positive creates a suggestion that this group of patients is without members who are HIV positive. That erroneous assumption, made thoughtlessly
during the bustle of work at a modern hospital, can lead to lax behavior and increase the likelihood of transmission.

Requiring a patient to disclose his or her HIV status to a HCW imposes a clear cost to the patient. Sadly, after nearly fourteen years of living with the disease, many people in American society, including HCWs, still view AIDS and HIV with a special horror and revulsion. A patient might be refused treatment, or may decide not to seek treatment, if required to disclose his or her HIV status.

Recent rulings in a number of states, including such large jurisdictions as California, have imposed greater requirements on the type of showing a plaintiff must make to recover for transmission, or fear of transmission, of the disease. While this is a welcome trend, these cases have focused on the type of evidence necessary to establish causation or damages. They leave untouched the real issue — whether a duty to disclose exists at all — and therefore leave open the possibility that patients will be sued for not disclosing their HIV status. It is time that the idea that a patient has a duty to disclose disease status is challenged directly.