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# Reverse Informed Consent: The Unreasonably Dangerous Patient

A. Samuel Oddi

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*A. Samuel Oddi**



* Professor of Law, Northern Illinois University College of Law; Adjunct Professor, Department of Family and Community Medicine, University of Illinois College of Medicine at Rockford. The Author wishes to acknowledge the contribution of his research assistant, Thomas F. Darin, in the preparation of this Article and to thank him for his considerate efforts. The Author also wishes to thank his wife, Lorys F. Oddi, R.N., Ed. D., for suggesting the topic of this Article and for providing technical assistance with respect to health care matters. The Author thanks Rex Julian Beaber, Esq., attorney for Ms. Boulais, for providing a copy of the *Boulais v. Lustig* complaint after obtaining court approval.

## I. INTRODUCTION

Iatrogenic injuries[1]—those caused by health care professionals (HCPs)[2] in the course of treating patients—raise significant ethical, legal, and public policy issues.[3] With the advent of the AIDS epidemic,[4]

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1. *Taber's Cyclopedic Medical Dictionary* 857 (Davis, 17th ed. 1989) defines "iatrogenic disorder" as "[a]ny adverse mental or physical condition induced in a patient by effects of treatment by a physician or surgeon. Term implies that such effects could have been avoided by proper and judicious care on the part of the physician, surgeon, or dentist."

2. This Article uses the term "health care professional" to indicate individuals engaged in primary health care, such as physicians, dentists, nurses, and others who would be categorized as professionals because of, *inter alia*, their specialized training, knowledge, and licensure. Because of the special status of professionals in tort law, the term "health care professional" seems most appropriate in the present context. More generic designations for such personnel include "health care provider" and "health care worker" (HCW), the latter term being used by the Centers for Disease Control (CDC). Although the name of the agency has been changed to Centers for Disease Control and Prevention (CDCP), see Preventive Health Amendments of 1992, Pub. L. No. 102-531, Title III, § 312, 106 Stat. 3469, 3504 (1992), this Article will refer to the agency as the "CDC."

3. The continued practice by incompetent or incapacitated HCPs and the inability or refusal of their professions to sanction them raise both personal and professional ethics issues. A recent study by the Public Citizen's Health Research Group found that disciplinary authorities sanction only about .5% of approximately 585,000 physicians in the U.S. each year. Only 11% of the disciplinary actions are based upon substandard care. In 1991, there were approximately 3000 disciplinary actions compared to an estimated 150,000 to 300,000 victims of medical malpractice. See Public Citizen's Health Research Group, *Comparing State Medical Boards* (1992) (summarized in 2 Health L. Rep. (BNA) 73, 73 (1993)).

Malpractice litigation raises especially difficult legal issues: determining the professional standard of care in light of conflicting expert testimony, establishing a causal connection between the conduct of the HCP and the injury sustained, implying negligence on the basis of the injury under the res ipsa loquitur doctrine, and requiring informed consent on the basis of a patient's need to know rather than according to professional custom. See generally Steven E. Pegalis and Harvey F. Wachsman, *American Law of Medical Malpractice* (Lawyers Co-op, 2d ed. 1992); David W. Louisell and Harold Williams, *Medical Malpractice* (Matthew Bender, 1987 & Supp. 1992).

Pressing public policy issues include the need to control increases in health care costs, improve access to health care services, and curb the "malpractice crisis" that has increased the cost of malpractice insurance and caused the practice of "defensive" medicine and the withdrawal of HCPs from certain areas of practice. See generally President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Securing Access to Health Care: The Ethical Implications of Differences in the Availability of Health Services* (1983); U.S. Dep't of Health and Human Services, *Report of the Task Force on Medical Liability and Malpractice* (1987); *Report of the Tort Policy Working Group on the Causes, Extent and Policy Implications of the Current Crisis in Insurance Availability and Affordability* (1986); Patricia M. Danzon, *An Economic Analysis of the Medical Malpractice System*, 1 Behav. Sci & L. 39 (1983).

4. As of May 31, 1991, the CDC had reported 179,136 cases of AIDS in the U.S. In 1991, AIDS was the second leading cause of death among men ages 25 through 44 and the sixth leading cause of death among women ages 15 through 44. Centers for Disease Control, U.S. Dep't of Health and Human Services, *Update: Mortality Attributable to HIV Infection/AIDS Among Per-*

these issues become even more difficult when the iatrogenic injury results not from the patient's having received treatment below the professional standard of care (which is the usual grist for the malpractice mill) but from an infectious condition of the HCP.[5]

Considerable public attention has been directed to patients who have been exposed to the risk of AIDS by HIV-positive HCPs.[6] It is

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*sons Aged 25-44—United States, 1990 and 1991*, 42 Morbidity and Mortality Wkly. Rep. 481, 481 (1993) ("*Update Mortality*"). Further, the World Health Organization estimates that eight to ten million adults and one million children worldwide are currently infected with HIV. See Centers for Disease Control, U.S. Dep't of Health and Human Services, *The HIV/AIDS Epidemic: The First 10 Years*, 40 Morbidity & Mortality Wkly. Rep. 357, 357 (1991). By March 31, 1993, the actual total number of reported AIDS cases in the U.S. was 289,320. Illinois Dep't of Public Health, *National AIDS Surveillance Statistics*, AIDS/HIV Surveillance Rep. 1, 11 (June 30, 1993).

The National Commission on AIDS reported that as of 1990, 75,000 people had died of AIDS and predicted the epidemic to worsen in the 1990s. The Commission responded by calling for more definitive rules from the government and the enactment of legislation prohibiting discrimination against HIV-infected individuals. National Commission on AIDS, *Report Number Two: Leadership, Legislation and Regulation* (1990) (Pamphlet) (on file with the Author). In 1991, 29,850 died with HIV infection in the United States. *Update Mortality* at 481. See also Warner C. Greene, *AIDS and the Immune System*, 269 Sci. Am. 98, 99 (Sept. 1993), for an analysis of the risks posed by the AIDS virus; Greene reports that the total number of expected cases of HIV infection by the year 2000 has been estimated to vary from 40 million to over 110 million (approximately 2% of the world's population).

5. The ethical issues are compounded for infected HCPs because disclosing their condition could mean the loss of their professional livelihood. Infected HCPs thus face a "moral" dilemma: placing patients at risk to preserve their professional careers. The legal issues that arise when a patient is infected by an HCP include whether a remedy should be provided, the nature of that remedy, and the type of damages for which such patients should be compensated. The public policy issues center around the need to contain the AIDS epidemic and protect patients against exposure while continuing to provide access to health care and preserve the basic rights of HCPs.

6. Newsweek polled a representative sample of 618 adults in order to measure public awareness of AIDS in the health care profession. In response to the question, "Which of the following kinds of health care workers should be required to tell patients if they are infected with the AIDS virus?," 95% responded that surgeons should reveal this information, compared to 94% for "all physicians," 94% for dentists, and 90% for "all health-care workers." The poll had a margin of error of 5%. See Barbara Kantrowitz, *Doctors and AIDS*, Newsweek 48, 51 (July 1, 1991). Additionally, 65% of those polled said that they would discontinue treatment with a health care worker if they knew that worker was infected with the AIDS virus. Id. at 52. Further, 63% said that a surgeon with AIDS should be forbidden to practice. Id. at 54. See also Betsy A. Lehman, *AIDS Tests for Health Caregivers?*, Boston Globe (Science & Tech. section) 27 (Aug. 10, 1992) (discussing public opinion polls in which most interviewees responded that they would want to know if their health care provider was infected with the HIV virus).

The percentage of HCPs infected with the AIDS virus is approximately the same as that of the general work force. Based on Bureau of Labor Statistics data available in 1988, Larry Gostin indicates that the percentage of HCPs with AIDS is 5.4%, compared to 5.7% in the general work force. Larry Gostin, *Hospital Health Care Professionals, and AIDS: The "Right to Know" the Health Status of Professionals and Patients*, 48 Md. L. Rev. 12, 15 n.22 (1989). Through June 30, 1990, there were 5425 HCPs with AIDS in the United States. See Mary E. Chamberland, *Health Care Workers with AIDS—National Surveillance Update*, 266 JAMA 3459 (1991). By June 30, 1992, the number had risen to 8467, so that HCPs represented 4.8% of the known 176,447 AIDS cases reported to the CDC. Centers for Disease Control, U.S. Dep't of Health and Human Services, *Facts About HIV/AIDS and Health-Care Workers*, HIV/AIDS Prevention 1 (July 1992). The

difficult to be unmoved by the tragic example of Kimberly Bergalis and five other patients who contracted AIDS after being treated by a dentist who died of AIDS shortly thereafter.[7] The public outcry of "Physician, heal thyself"[8] was immediate, as were governmental proposals for dealing with the perceived problem.[9] Responses from various interest

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CDC estimates that of 4.5 million HCPs in the U.S., approximately 360 surgeons, 1,200 dentists, 5,000 physicians, and 35,000 other HCPs are HIV-infected. Lehman, Boston Globe at 27.

7. Ms. Bergalis, who was first treated by Dr. Acer in December of 1987, was diagnosed with AIDS in 1989. After Dr. Acer died of an AIDS-related cancer in 1990, Ms. Bergalis publicly disclosed her condition. She died on December 8, 1991, at the age of 23. See Mike Williams, *AIDS Nightmare Ends in Death: Kimberly Bergalis Dies in Her Sleep at 23*, Atlanta J. & Const. A1 (Dec. 9, 1991). See also *A Death Not in Vain; But Don't Draw Wrong Conclusions from Kimberly Bergalis Case*, L.A. Times B6 (Dec. 10, 1991); Bruce Lamber, *Kimberly Bergalis Is Dead at 23; Symbol of Debate Over AIDS Tests*, N.Y. Times D9 (Dec. 9, 1991); Centers for Disease Control, U.S. Dep't of Health and Human Services, *Update: Transmission of HIV Infection During an Invasive Dental Procedure—Florida*, 40 Morbidity & Mortality Wkly. Rep. 21, 23-25 (1991) (discussing the DNA sequencing procedure used to trace the virus in order to prove accurately the transmission of the virus from Dr. Acer to Ms. Bergalis and four other patients). The sixth patient of Dr. Acer was not diagnosed with AIDs until being tested for the military in late 1992. *Florida Dentist Linked to 6th AIDS Victim*, Chi. Trib. 7 (May 7, 1993).

8. *Luke* 4:23 (King James). The betrayal of trust is compounded when a physician places self-interest over patient welfare.

9. Congress responded by proposing a mandatory AIDS testing law for HCPs. See generally 137 Cong. Rec. H5203-05 (daily ed. June 26, 1991) (discussing "Kimberly Bergalis Patients and Health Providers Protection Act of 1991"); 137 Cong. Rec. H5590-91 (daily ed. July 17, 1991) (discussing "The AIDS Pandemic"); 137 Cong. Rec. S10833-37 (daily ed. July 25, 1991) (discussing "Mandatory Disclosure of HIV Status for Health Care Workers"); 137 Cong. Rec. E3015-16 (daily ed. Sept. 12, 1991) (discussing "HIV Dilemma in Health Care Workplace").

The Helms Amendment to the mandatory AIDS testing bill, Amendment No. 734, proposed that any health care worker "who knows he is HIV positive and intentionally provides a medical or dental treatment to a patient without prior disclosure will be imprisoned not less tban 10 years, fined $10,000, or both." See 137 Cong. Rec. S9778 (daily ed. July 11, 1991); 137 Cong. Rec. S10331, 10332 (daily ed. July 18, 1991). Senator Helms's second proposal would have allowed health care workers to test patients for AIDS without their consent. See 137 Cong. Rec. S11381 (daily ed. July 30, 1991); Thomas E. Margolis, *Health Care Workers and AIDS: HIV Transmission in the Health Care Environment*, 13 J. Legal Med. 357, 363-68 (1992) (suggesting that more support for the Helms amendments existed based on the emphasis on patient testing because at the time of the amendments, five cases of HIV transmission from doctor to patient had been reported, as compared to 47 cases of transmission from patient to health care worker).

Kimberly Bergalis endorsed the bill sponsored by Rep. Dannemeyer of California; the Dannemeyer bill was similar to the Helms Amendment, but eliminated the prison term provisions. See Joyce Price, *Lawmakers Reject AIDS Amendment*, Wash. Times A5 (Sept. 28, 1991). The amendments were defeated on Sept. 28, 1991. Id. See generally Jeffrey W. Cavender, Note, *AIDS in the Health Care Setting: The Congressional Response to the Kimberly Bergalis Case*, 26 Ga. L. Rev. 539 (1992).

As of early 1992, only six states—California, Florida, Hawaii, Illinois, Maryland, and Texas—bad passed laws concerning HIV-infected HCPs. Margolis, 13 J. Legal Med. at 385. In Illinois, for example, the Health Department is permitted to inform patients of the infected condition of an HCP when that HCP is diagnosed with AIDS. 410 ILCS 325.5 (Smith-Hurd, 1993). Additionally, Maryland, New Jersey, and New York provide for criminal sanctions against HCPs who are HIV-infected and do not obtain informed consent from their patients before treatment. Margolis, 13 J. Legal Med. at 386. For a lengthier discussion of various state proposals including

groups were equally swift and effective.[10] Despite the flood of proposals

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mandatory testing, adoption of CDC guidelines, and implementation of OSHA's universal precautions, see id. at 386-88.

See also Centers for Disease Control, U.S. Dep't of Health and Human Services, *Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures*, 40 Morbidity & Mortality Wkly Rep. (Supp. July 12, 1991) ("CDC, *Recommendations*"). The CDC determined that:

> 1. Infected [HCPs] who adhere to universal precautions and who do not perform invasive procedures pose no risk for transmitting HIV or HBV to patients;
> 2. Infected [HCPs] who adhere to universal precautions and who perform exposure-prone procedures pose a small risk for transmitting HBV to patients; and,
> 3. HIV is transmitted much less readily than HBV.

Id. at 1.

Based upon these considerations, the CDC recommended the following measures to minimize the risk of HIV and HBV transmission:

> 1. All [HCPs] should adhere to universal precautions, including the appropriate use of hand washing, protective barriers, and care in the use and disposal of needles and other sharp instruments. [HCPs] who have exudative lesions or weeping dermatitis should refrain from all direct patient care and from handling patient-care equipment and devices used in performing invasive procedures until the condition resolves. [HCPs] should also comply with current guidelines for disinfection and sterilization of reusable devices used in invasive procedures.
> 2. Currently available data provide no basis for recommendations to restrict the practice of [HCPs] infected with HIV or HBV who perform invasive procedures not identified as exposure-prone, provided the infected HCPs practice recommended surgical or dental techniques and comply with universal precautions and current recommendations for sterilization/ disinfection.
> 3. Exposure-prone procedures should be identified by medical/surgical/dental organizations and institutions at which the procedures are performed.
> 4. [HCPs] who perform exposure-prone procedures should know their HIV anti-body status. . .
> 5. [HCPs] who are infected with HIV or HBV. . . should not perform exposure-prone procedures unless they have sought counsel from an expert review panel and been advised under what circumstances, if any, they may continue to perform these procedures. *Such circumstances would include notifying prospective patients of the [HCP's] seropositivity before they undergo exposure-prone procedures.*

Id. at 5 (emphasis added) (footnote omitted). For the CDC's general definition of exposure-prone procedures, see id. at 4. For the CDC's definition of universal precautions, see note 204.

10. The following groups opposed the mandatory testing and disclosure of health care workers' HIV status: the American Hospital Association; the American College of Physicians; the American Association of Nurse Anesthetists; the Council of State and Territorial Epidemiologists; the American Dental Association; the Organization for Obstetric, Gynecologic, & Neonatal Nurses; the Association of State and Territorial Health Officials; the United States Conference of Mayors; and the ACLU. See 137 Cong. Rec. S10343-47 (daily ed. July 18, 1991).

The head of the CDC testified during congressional debates over the mandatory AIDS testing bill that the CDC opposed mandatory AIDS testing for health care workers. See Teresa Riordan, *CDC Head Testifies Against Mandatory AIDS Testing of Doctors*, Reuters (Sept. 19, 1991) (available in LEXIS, Nexis Library, Omni File). ActionAIDS, a non-profit organization, also opposed mandatory testing, citing the low risk of transmission. See *ActionAIDS Opposes Mandatory HIV Testing of Health Care Workers*, PR Newswire (Sept. 26, 1991) (available in LEXIS, Nexis Library, Omni File). While opposing mandatory testing, citing the low risk of transmission, the American Dental Association (ADA) recommended in 1991 that HIV-infected dentists stop performing invasive procedures or disclose their HIV status. See *ADA Opposes Mandatory HIV Testing, Challenges Risk Estimates*, PR Newswire (Feb. 21, 1991) (available in LEXIS, Nexis Library, Omni File). Compare *Dental Group Rejects Mandatory AIDS Testing*, UPI BC Cycle (July 16,

and recommendations, however, there appears to be an absence of political will to address the problem; the task therefore is thrown to the legal system.[11] In this instance, the law of torts will be asked to provide the theories of recovery for patients who are infected with HIV by HCPs.[12]

The doctrine of informed consent likely will be advanced to address the issue of recovery.[13] A critical concern of HCPs is that, if they

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1991) (available in LEXIS, Nexis Library, Omni File) (noting that the Academy of General Dentistry also rejected mandatory testing).

The American Medical Association (AMA) also rejected the proposal. See Michael L. Millenson, *AMA Votes Down Mandatory AIDS Tests for Doctors*, Chi. Trib. 1 (June 27, 1991) (news section) (noting that at the same AMA policy-making house of delegates, a resolution was passed to make it easier to test patients for the virus); Kim Painter and Kevin Johnson, *AMA Rejects Mandatory AIDS Testing*, USA Today 1A (June 29, 1991). Compare Allan Parachini, *AMA Urges AIDS Reporting System; Would Tell Carriers' Partners; Endorses Mandatory Tests*, L.A. Times 22 (June 20, 1987) (Part 1) (reporting that the AMA Board of Trustees endorsed mandatory testing for blood donors, prisoners, and military personnel). But see Sanford F. Kuvin, *AIDS Testing: Make It Mandatory; Federal Rules Don't Go Far Enough to Protect Patients and Doctors from Each Other*, Newsday 67 (July 19, 1991) (Nassau and Suffolk edition) (indicating that the risk of transmission is not insignificant and that the CDC's recommended universal precautions often fail, and calling for the mandatory testing of physicians and patients undergoing invasive procedures, citing the higher risk of transmission from patient to physician).

11. The "right to die" cases provide a recent example of a situation in which courts are forced to make life or death decisions in the absence of legislative solutions. See, for example, Judge Bambrick's "Footnote for the Legislature," imploring the legislature to address the right to die issue, in *Randolph v. City of New York*, N.Y. L. J. at 6, 12 (Oct. 12, 1984) (N.Y. Sup. Ct. Oct. 1, 1984), rev'd, 117 A.D.2d 44, 501 N.Y.S.2d 837 (1986), modified, 69 N.Y.2d 844, 507 N.E.2d 298 (1987). Another classic example of this phenomenon drawn from tort law is the adoption of comparative fault by some courts in the absence of legislative action. See, for example, *Hoffman v. Jones*, 280 S.2d 431 (Fla. 1973); *Li v. Yellow Cab Co. of California*, 119 Cal. Rptr. 858, 532 P.2d 1226 (1975). But see note 216 (citing recent state bills relating to informed consent issues).

12. The litigation process is well under way. Dr. Acer's insurance carrier settled Ms. Bergalis's claim for a reported $1 million. See Christine Woolsey, *Insurers Face Claims by Patient of Dentist Who Contracted AIDS*, Bus. Ins. 22 (Feb. 25, 1991). Another former patient of Dr. Acer is suing CIGNA Dental Health of Florida, a dentists' referral plan, alleging that he contracted the AIDS virus as the result of Dr. Acer's negligence. Id. The patient alleged vicarious liability, corporate negligence, and negligent misrepresentation against CIGNA, which approved dentists and "represented [them] to be . . . competent to practice dentistry in all respects." *Driskill v. CIGNA Dental Health of Florida, Inc.*, No. 91-177 (19th Jud. Cir., Martin County, Fla. 1991). Other patients of Dr. Acer may follow a similar course. See *Former 'Teacher of the Year' Contracts AIDS Virus from Dentist*, UPI BC Cycle (Feb. 21, 1991) (available in LEXIS, Nexis Library, UPI File). Three class action suits were filed on behalf of more than 50 former patients against another dentist who died of AIDS. Two claims were settled for a reported $300,000. See David Beasley, *Courts*, Atlanta J. & Const. D6 (June 14, 1992).

Recently, HCPs and hospitals have been sued on numerous occasions for transmitting the AIDS virus to patients through blood transfusions. In 1991 and 1992, seven judgments resulted in nearly $51 million in damages to these patients. See Mike McKee, *AIDS Patients Are Suing Doctors and Winning*, N.J. L. J. 4 (June 1, 1992).

13. See generally W. Page Keeton, et al., *Prosser & Keeton on the Law of Torts* 120, 189-90 (West, 5th ed. 1984) ("Keeton, et al., *The Law of Torts*"); Pegalis and Wachsman, *American Law of Medical Malpractice* at §§ 4.1-4.3 (cited in note 3) (discussing physician and hospital liability for failure to obtain informed consent); Jay Katz, *Informed Consent—A Fairy Tale? Law's Vision,*

are required to inform patients of their HIV status, they not only will be subject to liability but also will be placed in a position of "moral jeopardy," when such disclosure will result in the probable loss or severe restriction of their professional lives.[14] Issues relating to the liability of HCPs to patients are addressed in Part II of this Article.

The converse of the situation discussed above—HCPs infected by patients—has not received the same degree of notoriety,[15] although the probability of patient-to-physician infection appears to be significantly greater.[16] The exposure of HCPs to HIV-infected patients should accelerate with increases in the number and geographic distribution of peo-

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39 U. Pitt. L. Rev. 137 (1977) (discussing shortcomings of the informed consent doctrine in medical practice); Marjorie M. Shultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 Yale L. J. 219 (1985) (analyzing the failure of the informed consent doctrine to protect patients adequately). See also President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Making Healthcare Decisions: The Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship* (1982); Ruth R. Faden and Tom L. Beauchamp (with Nancy M.P. King), *A History and Theory of Informed Consent* (Oxford U., 1986).

14. Other examples of "moral jeopardy" faced by health care professionals include recommending procedures or tests of marginal utility to patients with the knowledge that these services will be reimbursed, referring patients to laboratories or other facilities in which the HCP has a financial interest, and failing to report a colleague who is a substance abuser or has other physical or mental disabilities that could adversely affect patients for fear of professional repercussions.

15. *Boulais v. Lustig*, No. BC038105 (Cal. Super. Ct. 1993) (copy on file with tbe Author), in which a jury returned an award of $102,500 in favor of a surgical technician who was exposed to HIV by a patient who failed to disclose that she had AIDS, has received considerable media coverage. See notes 117-23 and accompanying text for a further discussion of this case.

An interesting aspect of the *Boulais* case is that the defendant patient filed a countersuit against the plaintiff technician and her attorneys for invasion of privacy, alleging "malicious disclosure" because they publicized her name rather than using an alias such as "Jane Doe." See Terry Pristin, *Nurse Cut by Scalpel Names HIV-Positive Patient, Who Countersues*, L.A. Times B3 (Oct. 30, 1991). The California Supreme Court refused to hear the appeal from an order denying dismissal of the invasion of privacy claim. *Boulais v. Lustig*, 1992 Cal. LEXIS 65 at *1 (1992). See also Philip Hager, *High Court Lets AIDS Patient Continue Privacy Invasion Suit*, L.A. Times A27 (Jan. 10, 1992).

16. The CDC estimates that the risk of HIV transmission to an HCP after percutaneous exposure to HIV-infected blood is, on the average, .3%. CDC, *Recommendations* at 3 (cited in note 9). Although the risk of an HCP's transmitting HIV to a patient during a single invasive procedure has not been extensively studied, the CDC estimates the probability of a patient contracting the disease from an HIV-positive surgeon to be between .0024% (1 in 41,667) and .00024% (1 in 416,667). Id. The probability that an HIV-positive surgeon will infect a patient in seven years of practicing medicine ranges from 1% to 18.3%. Id. See also Centers for Disease Control, U.S. Dep't of Health and Human Services, *Estimates of the Risk of Endemic Transmission of Hepatitis B Virus and Human Immunodeficiency Virus to Patients by the Percutaneous Route During Invasive Surgical and Dental Procedure* at 5, 6 (Draft) (Jan. 30, 1991) (summarizing selected risks in the health care setting) ("CDC, *Estimates*").

The risk of a surgeon's contracting HIV from an infected patient in a single operation has been estimated to range from .022% (1 in 4,500) to .0007% (1 in 130,000). See Michael D. Hagen et al., *Routine Preoperative Screening for HIV: Does the Risk to the Surgeon Outweigh the Risk to the Patient?*, 259 JAMA 1357, 1358 (1988). These figures are based upon an estimated rate of HIV-positive patients of between 1 in 10,000 and 15 in 10,000; a risk of infection from a skin

ple with HIV disease[17] (ranging from asymptomatic HIV infection to full-blown AIDS).[18]

Obviously HCPs consent to treat their patients.[19] A patient's potential liability for exposing an HCP to HIV, however, should be based on whether the HCP's consent was informed and whether the HCP assumed any risk associated with treatment knowingly and voluntarily.[20]

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puncture of between 3 in 10,000 and 90 in 10,000; and the probability that a surgeon will sustain a significant skin cut in 1 out of 40 operations. Thus:

$$\frac{1}{40} \times \frac{90}{10{,}000} = \frac{1}{4500} = 2.2 \times 10^{-4}$$

$$\frac{1}{40} \times \frac{3}{10{,}000} = \frac{1}{130{,}000} = 7.6 \times 10^{-6}$$

The risk of infection to the surgeon from an HIV-positive patient is approximately 3 to 9 times greater than the risk of the patient's being infected by the surgeon:

$$\frac{2.22 \times 10^{-4} \text{ to } 7.6 \times 10^{-6}}{2.38 \times 10^{-3} \text{ to } 2.3 \times 10^{-6}} = 9.25 \text{ to } 3.3$$

17. In 1981, 189 cases of AIDS were reported to the CDC, with 76% of the reported cases coming from New York and California. In 1990, nearly two-thirds of the 43,000-plus cases reported were from outside New York and California, representing all U.S. states, the District of Columbia, and the U.S. territories. See Centers for Disease Control, U.S. Dep't of Health and Human Services, *The HIV/AIDS Epidemic: The First Ten Years*, 40 Morbidity & Mortality Wkly. Rep. 358, 358 (1991). See also Centers for Disease Control, U.S. Dep't of Health and Human Services, *AIDS Quarterly Map*, 41 Morbidity & Mortality Wkly. Rep. 265, 281 (1991) (showing the geographic distribution of AIDS cases reported to the CDC from April 1991 through March 1992; District of Columbia, New York, Florida, New Jersey, California, Georgia, Maryland, Nevada, Louisiana, Texas, Hawaii, Connecticut, and Massachusetts represented the jurisdictions with the highest number of cases reported per 100,000 population). The geographical distribution of the number of reported AIDS cases changed slightly from January 1992 through December 1992. The leading states in cases reported per 100,000 population were District of Columbia, New York, Florida, California, New Jersey, Maryland, Delaware, Georgia, Connecticut, Nevada, Texas, Louisiana, and Illinois. Centers for Disease Control, U.S. Dep't of Health and Human Services, *Quarterly AIDS Map*, 42 Morbidity & Mortality Wkly. Rep. 67, 67 (1993).

18. The legislative history of the Americans with Disabilities Act (ADA), 42 U.S.C. §§ 12101-12213 (1988 & Supp. 1991), uses the term "HIV disease." "People with HIV diseases are individuals who have any condition along the full spectrum of HIV infection—asymptomatic HIV infection, symptomatic HIV infection or full-blown AIDS." 136 Cong. Rec. H4623 (daily ed. July 13, 1990) (statement of Rep. Owens). See Chai R. Feldblum, *Workplace Issues: HIV and Discrimination*, in *AIDS Agenda* 271, 277-78 & n.35 (1992). See also note 188 for further discussion of the ADA.

19. HCPs consent to their contact with patients by accepting them as patients and treating them. Consent on the part of HCPs to exposure to AIDS, however, should not be implied by the HCP's general consent to treat a patient. Rather, this Article argues that the law should impose upon patients a duty to disclose material risks, such as HIV-positive status, to their HCPs, just as the doctrine of informed consent imposes an analogous duty upon HCPs.

20. "The defense of assumption of risk is in fact quite narrowly confined . . . first, the plaintiff must know that the risk is present, and be must further understand its nature; and second, his choice to incur it must be free and voluntary." Keeton, et al., *The Law of Torts* at 486-87 (cited in note 13). The defense may also require a third element—that the plaintiff act unreasonably under the circumstances. This third element could result in an overlap with the defense of contributory or comparative negligence. See id. at 497-98.

Accordingly, situations in which HCPs know that patients are infected should be distinguished from situations in which they do not or cannot reasonably know.[21]

In an action by an HCP against a patient, the central issue is whether a duty should be imposed upon patients to inform HCPs of their infectious status. Imposing such a duty on patients would extend the scope of tort law well beyond that presently recognized under the doctrine of informed consent. If tort law imposes a duty upon patients to inform HCPs of their HIV status, then an appropriate standard must be adopted to determine if a breach of that duty has occurred. A causal connection must then be established between the patient's failure to inform and any injury (particularly infection) suffered by the HCP. The causation issue in a patient-to-HCP infection case is considerably more difficult than in a traditional informed consent case, in which the analysis takes the form: But for the failure of the HCP to obtain informed consent, would the patient have consented to the treatment? In the reverse situation (in which a patient's failure to disclose injures an HCP), it must be established that the HCP would not have undertaken the procedure (raising significant ethical and legal issues) had the patient disclosed his or her condition, or that the HCP would have employed a higher degree of care had the patient disclosed (raising issues of the HCP's ability to do so). Part III of this Article will address these issues in the context of the proposed doctrine of reverse informed consent.

Part IV will examine the limitations of the civil liability system in applying tort theories that would impose such reciprocal duties to disclose on HCPs and patients. This Article considers whether the goals of tort law—compensation and deterrence—can be achieved effectively and whether public or private measures may provide more effective—or at least complementary—safeguards in the public interest.

The general issue of whether HCPs and patients should have duties to warn one another of infected status is, of course, not limited to HIV disease, although HIV is the most topical instance. Other infectious and contagious diseases are considerably more virulent—for example, hepatitis virus B (HBV)[22] and tuberculosis (TB) (especially a

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21. If an HCP has actual knowledge of a patient's HIV status, she could approach the risk knowingly, voluntarily, and unreasonably (that is, she could fail to use universal precautions). Furthermore, contributory or comparative negligence may be a defense when a patient infects an HCP, if the HCP does not have actual knowledge of the patient's HIV status but should have known or discovered it.

22. The CDC estimates the risk of HBV transmission to an HCP after percutaneous exposure to HIV-positive blood to be approximately 30%. See CDC, *Recommendations* at 3 (cited in note 9). See also John H. Lemmer, M.D., *Hepatitis B as an Occupational Disease of Surgeons*, 159 Surgery Gynecology Obstetrics 91, 91-100 (1984) (reporting that the overall career risk of a surgeon's suffering acute symptomatic hepatitis is between 10 and 20%; the risk that a surgeon will

treatment-resistant strain that currently is on the increase in certain populations).[23] This Article attempts to deal with the more generalized issue of exposure of patients and HCPs to material risks associated with the infectious, contagious, or otherwise unreasonably dangerous[24] physical conditions of the other.

## II. Direct Informed Consent: Patient Versus Health Care Professional

Before approaching the question of whether patients have a duty to disclose material risks associated with their care to HCPs, it is necessary to establish firmly that the doctrine of informed consent applies to infected HCPs, requiring them to disclose their infected status to their patients. In the traditional case involving consent to treatment, the logic of informed consent is straightforward: Had the patient been in-

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become a chronic carrier during 40 years of practice is approximately 4%). See generally Centers for Disease Control, U.S. Dep't of Health and Human Services, *Protection Against Viral Hepatitis*, 39 Mobidity & Mortality Wkly. Rep. RR-2, 17-21 (1990) ("CDC, *Protection*") (discussing recommendations for prevention of Hepatitis B transmission after accidental percutaneous exposure). Another study reports: "In the case in which the susceptible dentist presumably is unaware of his patient's serostatus, the cumulative annual risk of infection is 57 times as great for HBV as for HIV (0.34% versus 0.006%)." Eli I. Capilouto, *What Is the Dentist's Occupational Risk of Becoming Infected with Hepatitis B or the Human Immunodeficiency Virus?*, 82 Am. J. Pub. Health 587, 588 (1992). The report also indicates that "the risk of dying from HBV infection is 1.7 times greater than the risk of HIV infection, for which mortality is almost certain." Id. at 587. From infected doctor to patient, the risk of transmission probability ranges from .24% (1 in 417) to .024% (1 in 4167). See CDC, *Estimates* at 7 (cited in note 16).

23. See, for example, David L. Wheeler, *Scientists Gear Up to Fight Tuberculosis as Disease Returns in Drug-Resistant Form*, Chron. Higher Educ. A-7 (Sept. 9, 1992) (noting that drug resistant strains of TB have been reported in 36 states and the District of Columbia).

24. The use of the term "unreasonably dangerous patient" is not intended in any way to be offensive or insensitive to sick people in general or to people with AIDS or other infectious or contagious diseases in particular. The term merely identifies patients who may be unreasonably dangerous to HCPs because of the latter's unawareness of material risks attendant to their care. The point of the term is that the patients are *unreasonably* dangerous because they have not informed their HCPs of their infected status. In other words, they would be only *reasonably* dangerous if their HCPs were duly informed. Such information would enable HCPs to deal with patients according to their particular physical conditions. However, the conclusion that HCPs may be considered only reasonably dangerous when they inform patients of their infected status may not be entirely defensible, as discussed below. See notes 74-78 and accompanying text.

The "unreasonably dangerous" language in the Restatement (Second) of Torts § 402A (ALI, 1965) ("Restatement") on products liability provides an appropriate analogy. Strict liability is the general rule for manufacturing and design defects; however, a negligence standard generally is imposed for notice or warning defects, requiring that the manufacturer know or should have known of the risks presented by the product without the notice. See Keeton, et al., *The Law of Torts* at 697-98, 700-01 (cited in note 13). The proposed revision of § 402A for the Restatement (Third) of Torts makes the negligence standard express for warning defects and eliminates the "unreasonably dangerous" language qualifying "defective conditions" in the present version. See James A. Henderson, Jr. and Aaron D. Twerski, *A Proposed Revision of Section 402A of the Restatement (Second) of Torts*, 77 Cornell L. Rev. 1512, 1514 (1992) (quoting and analyzing the proposed revision).

formed of the material risks of the treatment proposed by the HCP, the patient would not have consented to the treatment and therefore would have avoided any injury as a consequence of the risky treatment.[25] An HCP's duty to inform her patients of any material risks associated with a proposed course of treatment would appear to be easily imposed by the nature of the HCP-patient relationship, generally considered a fiduciary relationship,[26] or as an implied term of the contractual relationship between the parties.[27]

### *A. The Basic Elements of a Cause of Action Based on Lack of Informed Consent*

This subpart introduces the basic elements in a cause of action based upon lack of informed consent. These elements are discussed throughout Part II in the analysis of HCPs' duty to disclose.

First, informed consent requires only that HCPs disclose "material" risks. Under the majority rule, whether a particular risk is "material" is determined by the professional (sometimes called "paternalistic") standard, which is derived from the customs of the HCP community.[28] A minority view holds that, because the professional standard undermines the principle of patient autonomy, a "reasonable person" standard should be applied. Under this standard, materiality is determined according to what a reasonable person would need to know in order to make an informed decision to consent to the proposed treatment.[29]

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25. See Keeton, et al., *The Law of Torts* at 191 (cited in note 13).

26. See Fowler V. Harper, Fleming James, Jr., and Oscar S. Gray, 2 *The Law of Torts* § 7.14 at 474 n.11 (Little, Brown, 2d ed. 1986): "It is commonly said that a fiduciary relationship exists between physician and patient. . . . This has occasionally led to the conclusion that physicians may be subject to liability in fraud for nondisclosure of material information, apart from liability in malpractice or battery for failure to obtain informed consent."

In the context of informed consent, the D.C. Circuit explained: "[W]e ourselves have found 'in the fiducial qualities of [the physician-patient] relationship the physician's duty to reveal to the patient that which in his best interests it is important that he should know'." *Canterbury v. Spence*, 464 F.2d 772, 782 (D.C. Cir. 1972) (quoting *Emmett v. Eastern Dispensary & Cas. Hosp.*, 396 F.2d 931, 935 (D.C. Cir. 1967)). See generally Edmund D. Pelegrino, Robert M. Veatch, and John P. Langan, eds., *Ethics, Trust, and the Professions* (Georgetown, 1993).

27. See Barry R. Furrow, et. al., *Health Law* 284-86 (West, 2d ed. 1991); Pegalis and Wachsman, *American Law of Medical Malpractice* §§ 2.3-2.4 (cited in note 3).

28. See Keeton, et al., *The Law of Torts* at 190-91 (cited in note 13). A majority of states have enacted statutory standards of informed consent. See Judith Areen, et al., *Law, Science & Medicine* 384 n.4 (Foundation, 1984). See also Mark S. Rhodes, *Informed Consent*, in 2 Louisell and Williams, *Medical Malpractice* at ¶¶ 22.18-22.68 (cited in note 3) (summarizing the views of the various states).

29. See Keeton, et al., *The Law of Torts* at 191 (cited in note 13); *Canterbury*, 454 F.2d at 782 n.27. See also *Scott v. Bradford*, 606 P.2d 554, 558 (Okla. 1979) (holding that "[a] risk is material if it would be likely to affect patient's decision").

The American Medical Association (AMA) and other professional societies have adopted resolutions requiring that patients be informed.[30] It appears clear, according to various surveys, that patients would want to know of the infectious status of HCPs before consenting to treatment by an infected HCP.[31] Hence, according to either of these standards, the infectious status of the HCP is material and subject to disclosure.

Additionally, in a cause of action based upon lack of informed consent, a causal relationship must exist between the HCP's failure to secure the patient's informed consent and the injury suffered by the patient. The majority rule on causation asks whether a reasonable person would have consented to the proposed treatment had he or she been informed of the attendant risks.[32] The minority rule is a subjective one—whether this particular patient would have consented to the procedure.[33] According to both or either of these standards, a fact-finder could reasonably conclude that a patient would not have consented to treatment after having been informed of the infected status of his or her HCP.

The final element in a cause of action based upon lack of informed consent is that the patient's injury must be of the kind posed by the undisclosed risk.[34] In the case of nondisclosure of the infectious status of an HCP, the most obvious injury would be that the patient contracts the undisclosed infection.[35] If infection does not occur, injury in the

30. Both the American Medical Association and the American Dental Association have issued statements indicating that HIV-infected physicians and dentists should refrain from performing invasive procedures or disclose their seropositive status to patients. See American Medical Association, *Statement on HIV Infected Physicians* (Jan. 17, 1991) (copy on file with the Author); American Dental Association, *Interim Policy on HIV-Infected Dentists*, 122 J. Am. Dental Association 8, 8-9 (Feb. 1991). See also Karen C. Lieberman and Arthur R. Derse, *HIV-Positive Health Care Workers and the Obligation to Disclose*, 13 J. Legal Med. 333, 338-40 (1992) (discussing the positions of various professional organizations).

31. The Newsweek poll shows that approximately 9 out of 10 Americans believe that their physicians should tell them if they have AIDS. Further, 65% of those polled would discontinue treatment with HCPs known to have AIDS. See Kantrowitz, Newsweek at 52 (cited in note 6). Going one step further, a Texas poll asked, "Would you continue seeing your family doctor or dentist if you know one of his or her patients had AIDS?"; 39% of those polled responded they would not. See Candace Windel, *Facing Social Consequences of AIDS; HIV Sways Perception of Doctors*, Houston Chron. 1 (Oct. 27, 1991) (state section). See generally Patricia A. Marshall, et al., *Patients' Fear of Contracting the Acquired Immunodeficiency Syndrome from Physicians*, 150 Arch. Intern. Med. 1501 (1990).

32. See Keeton, et al., *The Law of Torts* at 191 (cited in note 13).

33. Id. at 191-92.

34. As stated in *Scott*, 606 P.2d at 559:

> The final element of [an informed consent] cause of action is that of injury. The risk must actually materialize and plaintiff must have been injured as a result of submitting to the treatment. Absent occurrence of the undisclosed risk, a physician's failure to reveal its possibility is not actionable.

35. This was the unfortunate situation with respect to Kimberly Bergalis and the other five patients infected by their dentist. See note 7 and accompanying text.

form of mental distress based on the fear of contracting the infection will likely be alleged.[36]

### *B. Arguments For and Against a Duty to Disclose*

One argument against the applicability of the informed consent doctrine is that the infected status of the HCP presents such a low risk of infecting patients that it is not "material" and need not be disclosed, as is the case with any other low probability risk.[37] While the risk of patient infection may be small (estimated by the CDC to be between one in 41,667 and one in 416,667 in the case of HIV),[38] the loss suffered by the patient may be life itself. With respect to other infections (for example, HBV), which may not be life-threatening in all cases,[39] the probability of infection is significantly greater (estimated to be between one in 417 and one in 4167).[40] Moreover, risk of infection is not the only consideration. As indicated in *Estate of Behringer v. Medical Center at Princeton*,[41] an accident (surgical in *Behringer*) risks exposure of the patient, thus subjecting the patient to months or even years of testing.[42] The court in *Behringer* applied a risk-benefit analysis and concluded that the risk of HIV infection being transmitted from surgeon to patient, "however small, does exist;" the potential loss of the patient's life is so great a risk as to mandate disclosure.[43]

In any event, the probability that an infected HCP will infect a patient would appear to fall within the range of risks considered "material"[44] in informed consent cases even when the loss is substantially less

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36. Recognition of mental distress damage is more problematic. This issue will be addressed after considering various arguments that may be raised against the applicability of the doctrine of informed consent in regard to infected HCPs. See notes 79-93 and accompanying text.

37. See Mark Barnes, et al., *The HIV-Infected Health Care Professional: Employment Policies and Public Health*, 18 L. Med. & Health Care 311, 323-24 (1990). Note that this article was written prior to the disclosure that six patients had been infected with HIV transmitted by their dentist. See note 7 and accompanying text.

38. See CDC, *Estimates* at 7 (cited in note 16).

39. The mortality rate (or case-fatality rate) for HBV is 1.4%. See CDC, *Protection* at 7 (cited in note 22). But see Lawrence J. Scheiderman and Robert M. Kaplan, *Fear of Dying and HIV Infections vs. Hepatitis B Infection*, 82 Am. J. Pub. Health 584, 584 (1992) (explaining that while there is a 25% chance of hepatitis B infection following accidental exposure, about 5% of those die from either fulminant or chronic progressive disease).

40. See CDC, *Estimates* at 7 (cited in note 16). The estimated risk of transmission of HBV from HCPs to patients is 100 times that of HIV. In another study, the risk of heart surgery patients acquiring symptomatic acute HBV from medical staff after surgery was 9 in 100,000 compared to 25 in 100,000—the occupational risk of infection to surgeons. M.B. Prentice, et al, *Infection with Hepatitis B Virus After Open Heart Surgery*, 304 Brit. Med. J. 761, 763 (1992).

41. 249 N.J. Super. 597, 592 A.2d 1251 (1991).

42. Id. at 1266 n.8, 1279.

43. Id. at 1280.

44. The Supreme Court of Texas has defined "materiality" as including "how the condition manifests itself; the permanency of the condition caused by the risk; the known cures for the

than catastrophic. For example, in *Canterbury v. Spence*, a one percent risk of paralysis from a laminectomy was considered material.[45] In *Hidding v. Williams*, which also involved a laminectomy, a one in 200,000 risk of loss of bowel and bladder control was held to be material.[46] In *Doe v. Johnston*,[47] which involved an HCP's failure to inform a patient of the risk of contracting AIDS from a blood transfusion, the Iowa Supreme Court held that the issue of materiality of a risk is a jury question. There was conflicting expert testimony in *Johnston;* one expert stated the risk of contamination to be one in 250,000, while others reported that it was between one in 100,000 and one in a million.[48]

Furthermore, in terms of risk-utility analysis, a more compelling case can be made for the materiality of disclosure of HCPs' infected status than in the traditional informed-consent-to-treatment situation. In the typical case, if HCPs provide patients with the information necessary to secure the patients' informed consent, patients may choose to (i) undertake the treatment with its perceived benefits in light of the material risks disclosed, or (ii) forego the treatment, thereby avoiding potential risks but also depriving themselves of potential benefits. In contrast, patients who are informed of the infected status of an HCP proposing a specific course of treatment need not forego the potential benefits of the treatment. They may avoid the risk associated with that particular infected HCP and obtain the benefits of the treatment from an uninfected HCP.[49]

One can argue that the doctrine of informed consent is limited to material risks of the proposed treatment itself and does not extend to

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condition; the seriousness of the condition; and the overall effect of the condition on the body." *Barclay v. Cambell*, 704 S.W.2d 8, 10 (Tex. 1986). With respect to HIV, the condition manifests itself by infection, the infection is permanent, no cures exist, and the effect is fatal.

45. *Canterbury*, 464 F.2d at 795. In addition, some courts have held that a physician has a duty under the doctrine of informed consent to warn of the risks of general anesthesia. See *Fogal v. Genesee Hosp.*, 344 N.Y.S.2d 552 (N.Y. App. Div. 1973); *Brown v. Dahl*, 41 Wash. App. 565, 705 P.2d 781 (1985). The CDC estimates the risk of death from general anesthesia to be 100 out of 1 million (.01%). See CDC, *Estimates,* Table 4 (cited in note 16).

46. 578 S.2d 1192, 1195 (La. Ct. App. 1991).

47. 476 N.W.2d 28 (Iowa 1991). Compare *Doe v. Johnston* with *Kozup v. Georgetown Univ.*, 663 F. Supp. 1048 (D.D.C. 1987), aff'd in part, vacated in part, 851 F.2d 437 (D.C. Cir. 1988) (stating that the risk of contracting HIV through blood transfusion was not material because in 1983 the known risk was considered to be almost non-existent—one in 3.5 million).

48. *Johnston,* 476 N.W.2d at 31.

49. Various commentators have made this point. See, for example, Gostin, 48 Md. L. Rev. at 23 (cited in note 6); Steven Eisenstat, *The HIV Infected Health Care Worker: The New AIDS Scapegoat,* 44 Rutgers L. Rev. 301, 313 (1992); Gordon G. Keyes, *Health Care Professionals with AIDS: The Risk of Transmission Balanced Against the Interests of Professionals and Institutions,* 16 J.C. & U.L. 589, 603 n.114 (1990).

the infectious condition of HCPs.[50] This argument would, however, require a narrower reading of informed consent cases than is justified by the policy underlying the doctrine. The court in *Behringer* rejected this argument, quoting broad language from a traditional informed consent case that required disclosure of "any attendant substantial risks"[51] in addition to risks of the treatment itself.[52] In the influential informed consent case *Canterbury v. Spence*,[53] the court spoke in broad terms of the duties of physicians, which extend beyond "proficiency in diagnosis and therapy":

> The cases demonstrate that the physician is under an obligation to communicate specific information to the patient when the exigencies of reasonable care call for it. Due care may require a physician perceiving symptoms of bodily abnormality to alert the patient to the condition. It may call upon the physician confronting an ailment which does not respond to his ministrations to inform the patient thereof. It may command the physician to instruct the patient as to any limitations to be presently observed for his own welfare, and as to any precautionary therapy he should seek in the future. It may oblige the physician to advise the patient of the need for or desirability of any alternative treatment promising greater benefit than that being pursued. Just as plainly, due care normally demands that the physician warn the patient of any risks to his well-being which contemplated therapy may involve.[54]

It would seem well within the underlying philosophy of *Canterbury* to extend HCPs' duty of due care to include the obligation to advise patients of their infected status. Since the doctrine of informed consent is based upon the principle of patient autonomy, there would appear to be little ethical or legal justification for excluding disclosure of the in-

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50. See, for example, Larry Gostin, *The HIV-Infected Health Care Professional: Public Policy, Discrimination and Patient Safety*, 18 L. Med. & Health Care 303, 304 (1990); Eisenstat, 44 Rutgers L. Rev. at 313-14 (cited in note 49). The duty of HCPs who have an infectious condition to inform their patients and to take precautions against spreading the infection was recognized nearly 150 years ago. In *Piper v. Menifee*, 51 Ky. 465 (1851), the court held that a physician infected with smallpox was prima facie liable to a patient who contracted the disease through him. The court stated:

> Suppose a physician, knowing that he has an infectious disease, continues to visit his patients without apprising them of the fact, and without proper precautions on his own part, and thus communicates the disease to one of them? Clearly the physician thus acting would be guilty of a breach of duty, and of his implied undertaking to his patient, which, whether it be regarded in the light of carelessness, or negligence, or fraud, would render him liable for the consequent damage, including as well the suffering and danger and loss of time, as the expense necessarily occasioned by the second disease, thus produced by his own wrongful act.

Id. at 468.

51. *Behringer*, 592 A.2d at 1281 (quoting *Largey v. Rothman*, 110 N.J. 204, 208, 540 A.2d 504 (1988), which held that informed consent required the physician to inform the plaintiff of the risks in undergoing a biopsy procedure).

52. *Behringer*, 592 A.2d at 1281. The *Behringer* court, in finding the risk of harm to patients from HCPs to be material, stated, "[T]he risks can foreseeably include a needlestick or scalpel cut and, even with universal precautions can result in an exchange of the surgeon's blood." Id.

53. 464 F.2d 772 (D.C. Cir. 1972).

54. Id. at 781 (footnotes omitted).

fected status of HCPs if that status presents a material risk bearing upon whether a reasonable patient so informed would consent to that HCP's proceeding with the treatment.[55]

Moreover, it would be difficult for courts to limit the scope of the HCP's duty to disclose material risks associated with treatment while imposing upon HCPs a duty to disclose material risks associated with their own patients to third parties who may foreseeably be exposed to the patients. In the seminal case *Tarasoff v. Regents of University of California*,[56] the court imposed a duty on a psychiatrist to warn a potential victim whom his patient had threatened with violence, although such a warning may entail a breach of the patient's confidence.[57] In earlier cases, courts had imposed a duty on physicians to warn family members of the potential risks associated with the infectious condition of their patients.[58] This duty was imposed even when the physician negligently had failed to diagnose the infectious condition of the patient.[59]

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55. Larry Gostin argues that:

> The doctrine of informed consent was developed to assist patients in making decisions about the benefits and risks of medical treatments, and not to protect them against incompetent or dangerous physicians. If a physician is impaired or there is a real risk of transmission of infection to her patient, then this is a problem that should be remedied by professional standards and licensing requirements.

Gostin, 18 L. Med. & Health Care at 304 (cited in note 50). Aside from the notorious ineffectiveness of sanctioning by professional and licensing authorities, it is unclear why patients should be deprived of the decisionmaking power to avoid a risk carried by an infectious HCP that would not otherwise be imposed on patients by competent treatment. See notes 68-78 and accompanying text for further illustration of this point.

56. 131 Cal. Rptr. 14, 551 P.2d 334 (1976).

57. The therapist is held to a professional standard of care in diagnosing whether the patient presents a "serious danger of violence" requiring notification to the anticipated victim. Id. at 345.

58. See id. (citing cases dealing with the duty owed by physicians to family members). See, for example, *Wojnick v. Aluminum Co.*, 183 N.Y.S.2d 351 (N.Y. 1959) (holding that a husband's employer negligently failed to inform the plaintiff that her husband was diagnosed with tuberculosis during a physical examination conducted at work); *Davis v. Rodman*, 147 Ark. 385, 227 S.W. 612 (1921) (holding that a physician negligently advised that other children could be placed in the same room with a child infected with typhoid fever); *Skillings v. Allen*, 143 Minn. 323, 173 N.W. 663 (1919) (holding that a physician negligently advised the plaintiff that it was safe to visit her daughter, knowing that the daughter had scarlet fever). See generally Diane A. Tomlinson, Comment, *Physicians with AIDS and Their Duty to Patients*, 43 Fla. L. Rev. 561, 564-69 (1991) (discussing the above-mentioned cases).

59. See *Tarasoff*, 551 P.2d at 344 (citing *Jones v. Stankko*, 118 Ohio St. 147, 160 N.E. 456 (1928)). In *Jones*, the plaintiff alleged that the defendant physician had failed to diagnose a patient as having smallpox, and had assured her husband that it was safe to be around this patient; in reliance, her husband contracted smallpox from the patient. Id. at 456-57. See also *Molien v. Kaiser Foundation Hosps.*, 167 Cal. Rptr. 831, 616 P.2d 813 (1980), in which the plaintiff's wife was negligently diagnosed as having syphilis. The court concluded: "It is easily predictable that an erroneous diagnosis of syphilis and its probable source would produce marital discord and resultant emotional distress to a married patient's spouse. . . ." Id. at 817. But see *Accounts Adjustment Bureau v. Cooperman*, 204 Cal. Rptr. 881 (Cal. Ct. App. 1984) (holding that parents failed to state a cause of action for emotional distress when a doctor erroneously diagnosed their child as having a brain disorder although the child only suffered from a mild learning disability).

Infectious HCPs, in contrast, pose a direct risk to patients and may indeed warn their patients of this risk without breaching a confidential relationship.[60]

Arguably, if HCPs must disclose their infectious status (in particular HIV) to patients, then other personal characteristics of the HCP must also be disclosed,[61] a situation that would open the floodgates to potential liability for nondisclosure of a vast array of personal characteristics whenever the outcome of treatment is unfavorable.[62] Imposing a duty on HCPs to disclose their infectious status does not, however, necessarily lead to the conclusion that a significantly broader duty to disclose all characteristics to patients should be imposed. Those characteristics that pose no material risks obviously need not be disclosed. These may include genetic attributes such as gender or race, or personal attributes such as religion or sexual orientation, none of which would be related to competency.[63]

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60. HCPs obviously owe no duty of confidentiality to themselves. In contrast, HCPs placed under a duty to disclose their patients' dangerous conditions to third parties must breach their patients' confidentiality for the benefit of the third parties.

61. See, for example, Eisenstat, 44 Rutgers L. Rev. at 313, 320 (cited in note 49) (arguing that the doctrine of informed consent does not require negligent or alcoholic physicians or those with HBV to reveal that status; thus, HIV-infected physicians also should not be required to reveal that information); Gostin, 18 L. Med. & Health Care at 306 (cited in note 50) (questioning why restrictions should be placed on HIV-infected HCPs, when none are placed on HBV-infected HCPs).

62. The argument would be that had the patient been informed that the HCP was a substance abuser, a Methodist, or a Cubs fan, the patient would not have consented to the treatment.

63. Certain of these characteristics, of course, would be obvious to patients and they would be free to act on the basis of whim, caprice, or prejudice to decline to be treated by HCPs having these particular characteristics. Some genetic attributes may be competency-based, for example, being left-handed. One synonym for "left-handed" is "clumsy, awkward." *Webster's Ninth New Collegiate Dictionary* 682 (1990). President Clinton, during the 1992 presidential campaign, said, "I am pretty clumsy at times. I never thought it had anything to do with being left-handed, but that's something I could blame it on." ABC, *Primetime Live* (Oct. 1, 1992) (television broadcast) (available in LEXIS, Nexis Library, Omni file). Researchers at Harvard Medical School and the National Institute of Aging recently conducted a study on the mortality rates of left-handers versus right-handers in response to a study done in 1991. See Marcel E. Salive, Jack M. Guralnik, and Robert S. Glynn, *Left-handedness and Mortality*, 83 Am. J. Pub. Health 265, 266 (1993). The 1991 study concluded that the average age at death of left-handers was nine years lower than that of right-handers. The newer study criticized the methods of the older one, claiming that the methods led to severely biased results. Id. at 265. The new study concluded, consistent with two 1991 studies, that the studies "taken together . . . strongly suggest that left-handedness is not associated with an elevated risk of death." Id. at 266. Salive, one of the authors of the 1993 study, stated that "[l]efties still may be more accident prone than righties, but just aren't as likely to die as a result." Tim Friend, *Being Lefty May Not Be a Death Risk*, USA Today 1A (Feb. 8, 1993) (interviewing Marcel E. Salive). See also *More Accidents in Left-Handed Children: Doctors*, Reuters, AM Cycle (May 6, 1992) (available in LEXIS, Nexis Library, Omni File) (finding that left-handed boys were twice as likely as right-handed ones to enter a trauma center for accidents and that those same left-handed children were 1.8 times more likely to have been hospitalized previously for treatment).

The question whether the doctrine of informed consent should impose a duty on HCPs to disclose characteristics that may impair their competency to undertake certain treatments with due care is more subtle. Those competency-based characteristics involving physical or mental impairment may include substance abuse (for example, alcohol or drugs),[64] debilitating diseases (for example, Alzheimer's, AIDS-dementia),[65] or susceptibility to error (for example, lack of skill, training, or experience).[66] With respect to competency-impaired HCPs, the doctrine of informed consent provides no additional theory of recovery beyond that of direct negligence. Competency-impaired HCPs must act negligently before they can be held liable. Whether or not an HCP is suffering from substance abuse, a debilitating disease, or accident proneness, a causal connection must always exist between the alleged negligence and the injury suffered. For example, if an operation is performed by a surgeon with Alzheimer's disease and no injury occurs, the patient has no cause of action. This fact should not be surprising, when courts have found that even if a surgeon had not gone to medical school

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64. One may question whether HCPs who smoke cigarettes are competency impaired. This fact may be material to patients opposed to smoking regardless of whether it affects the HCP's competency.

65. Alzheimer's disease is a chronic mental disorder involving "progressive, irreversible loss of memory, deterioration of intellectual functions, apathy, speech and gait disturbances, and disorientation." *Taber's Cyclopedic Medical Dictionary* at 76 (cited in note 1).

AIDS dementia complex (ADC) is a progressively incapacitating syndrome that affects at least two-thirds of people with AIDS. There is a significant change between Stage 1 (mild) (during which the person can perform all but the most demanding aspects of work although there is unequivocal evidence of impaired motor and intellectual function) and Stage 2 (moderate) (during which the person can care for himself but cannot perform more complex aspects of daily life). See Richard W. Price and Bruce J. Brew, *The AIDS Dementia Complex*, 158 J. Infectious Diseases 1079, 1081 (1988).

66. "Studies of accident-producing behavior, extending back well over a quarter of a century, show that some individuals are more likely to have accidents than are people at large." Fowler V. Harper and Fleming James, 2 *The Law Of Torts* § 11.4 at 734 (Little, Brown, 1956). See generally Lynette Shaw and Herbert S. Sichel, *Accident Proneness: Research in the Occurrence, Causation and Prevention of Road Accidents* (Pergamon, 1971). But see Harper, James, and Gray, *The Law of Torts* § 11.4 at 94 n.16 (cited in note 26) (citing more recent studies that have questioned accident-prone persons' impact on overall accident rates). See also Fleming James, Jr. and John J. Dickinson, *Accident Proneness and Accident Law*, 63 Harv. L. Rev. 769, 770 (1950) (citing a study estimating that 10% of workers may be responsible for 75% of accidents). James and Dickinson conclude that in any accident situation, two elements should be considered: "the accident potential of the situation and the reaction of the individual to that potential." Id. at 771. They identify the following factors to be connected with accident-proneness: habits and skills, physical characteristics, psychomotor characteristics, mental characteristics and attitudes, and age and experience. Id. at 772. It might be highly material to patients undergoing surgery to know that there are a number of outstanding claims or judgments for malpractice against a particular surgeon, or that the surgeon is "accident prone" or has no training in the particular type of surgery to be performed, or that the procedure is the first one to be attempted by the surgeon or by anyone.

and was not licensed to practice medicine, a causal relationship must still be shown between the surgeon's conduct and the injury sustained.[67]

### C. *The Causation Hurdle*

If lack of informed consent is the theory on which a claim is based, a patient must prove that his injury occurred as a consequence of a nondisclosed material risk.[68] Assume that a surgeon with Alzheimer's disease fails to inform a patient of his ailment but otherwise completely fulfills the duty to disclose all material risks of the procedure to be performed. Further assume that during the course of the operation the surgeon negligently cuts a glove and there is an exchange of blood with the patient. The operation otherwise is performed with due care; however, one of the disclosed material risks does materialize. For the patient to recover on the basis of direct negligence, the injury must be causally related to the conduct of the surgeon. The exchange of blood produced no injury; thus, a direct negligence cause of action would fail. Because the surgeon disclosed all material risks, an informed consent cause of action also would fail.[69]

Contrast this with the following situation: A surgeon with AIDS discloses all material risks of an operation but fails to inform the patient that the surgeon has AIDS. Assume, as in the previous example,

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67. In the leading case of *Brown v. Shyne*, 242 N.Y. 176, 151 N.E. 197 (1926), the Court of Appeals of New York refused to hold that it was negligent per se for the defendant, an unlicensed chiropractor, to treat the plaintiff; the court required proof of causation: "In order to show that the plaintiff has been injured by defendant's breach of the statutory duty, proof must be given that defendant in such treatment did not exercise the care and skill which would have been exercised by qualified practitioners within the state, and that such lack of skill and care caused the injury. Failure to obtain a license as required by law gives rise to no remedy if it has caused no injury." Id. at 199. See also *Hardy v. Dahl*, 210 N.C. 530, 187 S.E. 788, 791 (1936) (holding that the defendant, who held himself out to be a doctor of "naturopathy," could not be found negligent as a matter of law for failure to obtain a license as required by statute; rather, the plaintiff was required to prove that the defendant did not exercise proper care in the treatment of the plaintiff); *Janssen v. Mulder*, 232 Mich. 183, 205 N.W. 159, 161 (1925) (holding that the unlicensed defendant chiropractor's failure to obtain a license to practice was insufficient to sustain a malpractice charge; rather, the plaintiff was required to show that tbe injury was due to the defendant's negligence or unskillful treatment). Contrast *Whipple v. Grandchamp*, 261 Mass. 40, 158 N.E. 270, 272 (1927) (holding that a chiropractor practicing in violation of the medical licensing statute was negligent as a matter of law).

68. See note 34 (quoting the causation requirement from *Scott v. Bradford*). In *Canterbury* the physician failed to disclose the material risk of paralysis from a proposed laminectomy procedure. *Canterbury v. Spence*, 464 F.2d 772, 779 (D.C. Cir. 1972). If the patient had consented to the procedure after being informed of the risk of loss of bowel and bladder control, he obviously would have no grounds to allege lack of informed consent. The patient in such a situation would have to prove that the loss of bowel and bladder control resulted from the physician's negligent performance of the laminectomy.

69. This reasoning assumes that the patient suffered no cognizable injury in the form of mental distress upon learning that he was operated on by a surgeon with a debilitating disease. That problem is discussed in notes 79-93 and accompanying text.

that the surgeon negligently cuts a glove and a transmission of blood to the patient occurs. Further, assume that after the operation the patient discovers that he is HIV-positive. In this hypothetical, resort to the doctrine of informed consent is unnecessary. The patient has a direct cause of action for negligence because the surgeon was negligent in failing to follow operative procedure and inflicting a cut on herself that infected the patient.[70] Assuming that the surgeon's cut was not negligently inflicted, then a cause of action based on lack of informed consent may be available to the patient. The failure to inform the patient of the surgeon's HIV status created a material risk to the patient whether or not the surgeon was negligent in inflicting the scalpel wound. The paramount issue is whether the HIV-infected surgeon should have disclosed her HIV status so that the patient would have had the opportunity to refuse the operation by that surgeon.

*Hidding v. Williams*[71] demonstrates the confusion that can result from inappropriately interjecting informed consent questions into a case involving competency impairment. *Hidding* was tried on the informed consent theory based upon (i) the surgeon's failure to advise the patient of the risk of loss of bladder and bowel control in one out of 200,000 cases, and (ii) his failure to inform the patient that he was "suffering from alcohol abuse." The court affirmed the trial court's holding and a jury verdict of $307,000. Informed consent provides the classic theory of recovery for the surgeon's failure to inform the patient of the potential loss of bladder and bowel control as a result of laminectomy surgery. Relying upon lack of informed consent to provide recovery for the surgeon's failure to disclose that he was an alcoholic, however, raises a more interesting question.[72]

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70. The fact that the plaintiff's injury resulted from the infectious condition of the surgeon compared to a noninfectious surgeon (who would inflict no injury) may he considered an extension of the well-known doctrine that "defendants take their plaintiffs as they find them"—the "egg-shell skull" doctrine. See, for example, *Dulieu v. White and Sons*, [1901] 2 K.B. 669; *McCahill v. New York Transp. Co.*, 201 N.Y. 211, 94 N.E. 616 (1911) (concerning the death of a man with delirium tremors induced by a broken leg). See also Keeton, et al., *The Law of Torts* at 291-92 (cited in note 13). The extended doctrine would hold that "plaintiffs take their defendants as they find them," if they are injured as a consequence of a condition that a normal defendant would not possess.

71. 578 S.2d 1192 (La. Ct. App. 1991).

72. Judge Gothard, writing for the appellate court, was willing to sustain the lower court on the basis of failure to inform the patient of the defendant surgeon's alcoholism. Id. at 1198. In his concurring opinion, Judge Grisbaum asserted that an across-the-board application of the informed consent doctrine would render a "cause-in-fact relationship between failure to disclose and injury . . . unnecessary." Id. (Grisbaum, J., concurring). According to Grisbaum, the "gut question" is "whether a professed and practicing alcoholic can operate upon any patient without breaching his standard of care." Id. Judge Grisbaum, who suggested making this determination on a case-by-case basis, wrote that the facts and record of *Hidding* supported a finding of liability based upon the physician's failure to disclose his alcoholism. Presumably, Judge Grisbaum found evidence of negli-

Suppose the surgeon had disclosed the one-out-of-200,000 risk of loss of bladder and bowel control. Would the failure to disclose his alcoholism alone provide a cognizable ground for a cause of action based on lack of informed consent? Arguably, had the plaintiff been informed of the surgeon's alcoholism, he would not have consented to the laminectomy and, therefore, would not have sustained the loss of bladder and bowel control. Even if the patient had been informed of the surgeon's alcoholism, however, in the absence of any proof that a causal connection exists between how the operation was performed (that is, negligently) and the injury sustained (the loss of bladder and bowel control), the patient should not recover. Whether an alcoholic surgeon has a higher probability of operating negligently upon a patient and, indeed, causing the loss of bladder and bowel control while performing a laminectomy would appear irrelevant, unless in this particular instance the plaintiff can show that the surgeon deviated from the professional standard of care. However unlikely, a surgeon who is drunk may be able to perform surgery successfully. If the plaintiff can show no negligence on the surgeon's part, no liability should ensue.[73]

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gence beyond the surgeon's alcoholism; otherwise, he would commit the same fallacy of which he accused the court, by assuming a causation-in-fact relationship between the surgeon's alcoholism and the patient's injury. Judge Wicher concurred on the ground of the surgeon's failure to warn of the loss of bowel and bladder control but expressed no opinion on whether alcohol abuse must be disclosed under the Louisiana informed consent statute. Id. at 1198-99 (Wicher, J., concurring in part).

73. Even in the admitted absence of informed consent, the plaintiff must establish a causal connection between that absence and the injury. For example, in *Neal by Neal v. Lu*, 365 Pa. Super. 464, 530 A.2d 103 (1987), the court sustained a jury verdict in favor of a defendant surgeon who had admittedly failed to obtain informed consent to insert a pin into the plaintiff's finger to ensure straightness. Id. at 105. The court found that the plaintiff failed to prove causation sufficient to satisfy the informed consent theory, because "although [the surgeon] never discussed the possibility that he would insert a 'pin' into the finger, none of the evidence establishes, with the appropriate medical certainty, a causal connection between the insertion of the 'pin' and the injuries for which appellants seek to recover." Id. at 111.

It has been argued that while the type of injury (loss of bowel and bladder control) would be the same as that which the surgeon discussed with the plaintiff, the probability of this injury occurring is increased by alcoholism (that is, more than one out of 200,000), thus justifying liability for a surgeon's failure to inform of alcoholism although the HCP did inform the patient of the *types* of risk associated with the procedure. See Jane H. Barney, Comment, *A Health Care Worker's Duty to Undergo Routine Testing for HIV/AIDS and to Disclose Positive Results to Patients*, 52 La. L. Rev. 933, 950-51 (1992). This argument, however, misses the point. The risk of the procedure, namely, the probability of this type of injury occurring *without negligence*, is given as one out of 200,000. If alcoholism increases this risk, the cause must be lack of due care by the surgeon, which the plaintiff must prove along with a causal connection to the injury.

Compare *Hidding* with *Kaskie v. Wright*, 403 Pa. Super. 334, 589 A.2d 213 (1991), in which the court addressed a claim of lack of informed consent on the basis of the surgeon's alcoholism and unlicensed status. The court stated: "[W]e too refuse to expand the informed consent doctrine to include matters not specifically germane to surgical or operative treatment. . . . Are patients to be informed of every fact which might conceivably affect performance in the surgical suite? Moreover, here, no clear nexus has been established between injury and lack of knowledge." Id. at 217.

Suppose that a surgeon fully discloses all material risks of an operation to a patient and, in addition, discloses that he has AIDS and that there is between a one in 416,667 to one in 41,667 risk of transmitting the virus to the patient.[74] The patient consents to the operation.[75] During the course of the operation, the surgeon negligently manipulates a scalpel, self-inflicting a cut that results in an exchange of blood with the patient. The operation is otherwise successful; the patient, however, later tests positive for HIV. Because the patient was fully informed of the risk of HIV infection, it seems that no cause of action based on lack of informed consent would exist. This fact should not, however, affect a cause of action based on the surgeon's negligence in self-inflicting a cut. The defendant surgeon would be hard pressed to argue that the disclosure of her HIV status should insulate her from all liability, including liability based on negligence. If such an argument were accepted, obtaining informed consent would have the same effect as an exculpatory clause, releasing the surgeon ex ante from any claims based on her negligence resulting in the transfer of the virus to the patient. Such exculpatory clauses are universally held unenforceable.[76]

A more difficult question is presented if the transmission of infected blood to the patient was nonnegligent—that is, the transmission occurred by accident.[77] A possible solution would be to consider whether, according to the professional standard of care, the infected HCP should have undertaken the procedure at all. Stated another way,

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74. See note 16 and accompanying text.

75. Arguably, a patient should not be permitted to consent to an invasive procedure by an infectious surgeon. Michael L. Closen, *When a Doctor Has AIDS*, Nat'l L. J. 15 (Sept. 9, 1991). Patients, however, certainly undertake higher risks, including life-threatening ones, on the basis of informed consent. Indeed, the risk presented by the infectious surgeon is much lower than the risks from ordinary negligence by physicians. See Harvard Medical Practice Study, *Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York* at 3 (1990) (copy on file with the Author) (finding a negligence rate of 1% of hospital discharges) ("Harvard Study").

76. See generally Keeton, et al., *The Law of Torts* at 482-84 (cited in note 13). Some state statutes prohibit such agreements. See, for example, 225 ILCS 60/29 (Smith-Hurd, 1993): "Any contract or agreement signed by any person prior to, or as a condition of, such person receiving medical treatment in any form, which releases from liability any physician, hospital or other health care provider for any malfeasance, misfeasance or nonfeasance in the course of administering any medical treatment or service is void and against the public policy of the State of Illinois." See notes 240-43 and accompanying text (discussing exculpatory clauses).

77. For example, an HCP may receive a puncture wound as a result of equipment malfunction or the negligent or accidental conduct of another HCP or a patient. The case of the infectious HCP is nonetheless distinguishable from that of the competency-impaired HCP. While a surgeon with advanced Alzheimer's disease generally should not be performing surgery, if she does operate with due care and no causally related injury occurs, liability should not be imposed upon the surgeon for injuries suffered by the patient due to an unforeseeable earthquake that causes the patient to fall off the operating table. If the surgeon instead has HIV disease and as a consequence of the eartbquake the surgeon's hand is cut, infecting the patient, should liability be imposed?

was the infected HCP under a duty not to perform such a procedure because the HCP's condition would create an unreasonable risk of injury even if due care were taken? The respective professions would be best equipped to identify those procedures that will create such risks.[78]

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78. In July of 1991, the CDC published guidelines to prevent the transmission of HIV in the health care setting. See generally CDC, *Recommendations* (cited in note 9). Among other recommendations promulgated to prevent the transmission of HIV in exposure-prone procedures, the CDC stated that "[e]xposure-prone procedures should be identified by medical/surgical/dental organizations and institutions at which the procedures are performed." Id. at 5. Although these guidelines were only CDC recommendations, Congress gave them the full force of law by enacting 42 U.S.C. § 300ee-2 (Supp. 1993), amended by Pub. L. No. 102-141, 105 Stat. 876 (1991), which provides in pertinent part:

> [E]ach State Public Health Official, shall, not later than one year after the date of enactment of this Act [Oct. 28, 1991], certify to the Secretary of Health and Human Services that guidelines issued by the Centers for Disease Control, or guidelines which are equivalent to those promulgated by the Centers for Disease Control concerning recommendations for preventing the transmission of HIV and the hepatitis B virus during exposure prone invasive procedures. . . have been instituted in the State.

The July 1991 recommendations proposed that doctors who tested HIV-positive should refrain from exposure-prone procedures, unless they informed patients of their condition and consulted with outside experts. See *Plan Revised for Doctors with AIDS*, Chi. Trib. 5 (Dec. 4, 1991) (news section); Jan Gehorsam, *CDC Eases Off on HIV-Infected Health Workers*, Atlanta J. & Const. A11 (Dec. 5, 1991).

In late 1991, however, the CDC retracted some of its earlier recommendations cited in the July 1991 report. In December 1991, the CDC reportedly "abandoned" its plan to list procedures that HIV-infected doctors should not perform. Apparently the December 1991 guidelines, which "would have allowed AIDS-infected medical personnel to continue practicing under certain circumstances without notifying patients of the AIDS status," were necessary to prevent HIV transmission. In response to the policy change, the AMA has said that it will develop a list of exposure-prone procedures. The ADA has said that it will not. See Jerry Schwartz, *U.S. Won't Modify Guidelines on AIDS-Infected Doctors*, Reuters (June 19, 1992) (available in LEXIS, Nexis Library, Omni File). See also *AMA Opinion: National Commission on AIDS Healthcare Settings Guidelines*, Newswire (July 31, 1992) (available in LEXIS, Nexis Library, Omni File) (stating that the AMA called for adopting the CDC guidelines for prevention of transmission of HIV and hepatitis viruses in a health care setting). The change in policy came about as a result of much criticism by the medical community. See Mary Wagner, *HIV Guidelines "Flawed"—Surgeons*, Modern Healthcare 11 (Oct. 28, 1991) (discussing the criticism of the American College of Surgeons, the AMA, the ADA, the American Academy of Orthopedic Surgeons, the California Medical Association, and the public health departments of Michigan, New York, and San Francisco). But see Schwartz, Reuters (June 19, 1992) (reporting that the CDC director, William Roper, decided not to modify the July and December 1991 recommendations).

Further, OSHA regulations also require affected employers to identify and list jobs that carry occupational exposure risk:

> Exposure Determination . . . Each employer . . . shall prepare an exposure determination. This exposure determination shall contain the following:
>
> (A) A list of all job classifications in which all employees in those job classifications have occupational exposure;
>
> (B) A list of job classifications in which some employees have occupational exposure; and
>
> (C) A list of all tasks and procedures of groups of closely related tasks and procedures in which occupational exposure occurs and that are performed by employees in job classifications. . . .

29 C.F.R. § 1910.1030 (c)(v)(2)(i)(A-C) (1992).

### D. What Types of Damages Should Be Awarded?

The validity of the "floodgates" argument may lie in the question of the types of damages awardable in an informed consent case. For example, if recovery were allowed for mental distress on the basis of a surgeon's failure to inform a patient of the surgeon's Alzheimer's disease, the scope of the informed consent doctrine would be expanded well beyond the "material risks" the doctrine presently recoguizes.[79] Consider a more egregious example: a pediatrician who fails to disclose that he is a pedophile. Should a court award mental distress damages to the child-patient or parents when there is no molestation but only competent treatment?[80]

With respect to infectious HCPs who fail to reveal their serostatus, damages based on a patient's actually contracting the infection would clearly fall within the material risk posed by the undisclosed condition.[81] This risk would also appear to include the patient's fear of contracting the infection. In *Johnson v. West Virginia University Hospitals, Inc.*,[82] the plaintiff (a non-employee security guard) recovered 1.9 million dollars for his fear of contracting AIDS on the basis of the defendant hospital's failure to inform him of the HIV status of a patient the plaintiff was asked to restrain. There was evidence of exposure to HIV in that the patient had some of his own blood in his mouth when he bit the plaintiff.[83] The plaintiff, however, tested negative for HIV.[84] In cases in which there is evidence indicating exposure to the

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Moreover, it appears highly important that health care facilities carefully evaluate whether staff privileges should be granted to or withdrawn from infected HCPs, and carefully delineate procedures that may be undertaken to restrict or withdraw staff privileges of infectious HCPs. Compare *Estate of Behringer v. Med. Ctr. at Princeton*, 249 N.J. Super. 597, 592 A.2d 1251, 1254 (1991), in which a hospital immediately withdrew surgical privileges from a surgeon when it learned he was HIV positive. See notes 41-43, 51-52 and accompanying text (discussing *Behringer*).

79. Such a broad reading of the scope of the informed consent doctrine would go beyond *Hidding*. In *Hidding*, the patient experienced a loss of bowel and bladder control—a concrete physical harm as opposed to mental or emotional distress. See notes 71-72 and accompanying text.

80. The plaintiffs likely would allege intentional or negligent infliction of mental distress. Compare *Schurk v. Christensen*, 80 Wash. 2d 652, 497 P.2d 937 (1972) (allowing emotional distress damages to a mother whose child had been molested by a babysitter).

81. See notes 37-48 and accompanying text.

82. 186 W. Va. 648, 413 S.E.2d 889 (1991).

83. Id. at 891 (noting that "[a]t trial, there was evidence that the patient had bitten himself on the arm, and that the patient's own blood was in and around his mouth when he bit the appellee"). But see Stephanie B. Goldberg, *AIDS Phobia—Reasonable Fears or Unreasonable Lawsuits?*, A.B.A. J. 88 (June 1992) (ignoring this evidence of the plaintiff's exposure to HIV). The article's failure to indicate the exposure of the plaintiff to the patient's blood was acknowledged in response to a letter from Clark B. Frame, one of the plaintiff's attorneys, to the editor of the A.B.A. Journal. See A.B.A. J. 8-10 (Sept. 1992) (letter to the Editor).

84. In addition to the bite on his arm, other physical manifestations of the plaintiff's distress included loss of sleep and appetite. *Johnson*, 413 S.E.2d at 891-92. The plaintiff also introduced evidence that his wife refused to have sexual relations with him and divorced him because she

infection, it seems appropriate to award damages for mental distress associated with the fear of acquiring the infectious disease, although the exposed person subsequently tests negative to the infection.[85] Such cases appear directly analogous to "cancer-phobia" cases in which persons who have been exposed to carcinogens but do not presently have

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feared contracting AIDS. In addition, the plaintiff's children avoided him and kept his grandchildren away from him. Id. at 891.

85. Under the so-called "impact" rule, mental distress damages may be awarded as "parasitic" to the plaintiff's physical harm: "With a cause of action established by the physical harm, 'parasitic' damages are awarded and it is considered that there is sufficient assurance that the mental injury is not feigned." Keeton, et al., *The Law of Torts* at 363 (cited in note 13) (footnote omitted). See also id. at 363-64 nn.43-53 (giving examples of minor impacts supporting parasitic damages for mental distress). If this fiction need be extended to justify the award of mental distress damages for exposure to HIV, the foreseeability of testing should provide at least as much assurance of mental distress as would a minor impact. Even without an impact (for example, under the "zone of danger" rule), a person suffering physical consequences as a result of emotional distress (for example, from an exposure to HIV) would fall under the Restatement rule on Physical Harm Resulting from Emotional Disturbance:

> (1) If the actor's conduct is negligent as violating a duty of care designed to protect another from a fright or other emotional disturbance which the actor should recognize as involving an unreasonable risk of bodily harm, the fact that the harm results solely through the internal operation of the fright or other emotional disturbance does not protect the actor from liability.
>
> (2) If the actor's conduct is negligent as creating an unreasonable risk of causing bodily harm to another otherwise than by subjecting him to fright, shock, or other similar and immediate emotional disturbance, the fact that such harm results solely from the internal operation of fright or other emotional disturbance does not protect the actor from liability.
>
> (3) The rule stated in Subsection (2) applies where the bodily harm to the other results from his shock or fright at harm or peril to a member of his immediate family occurring in his presence.

Restatement § 436 (cited in note 24).

According to the majority rule, however, damages will not be awarded under § 436A for emotional distress alone "without bodily harm or other compensable damage." Nonetheless, at least seven jurisdictions will grant emotional distress damages without physical consequences. See *St. Elizabeth Hosp. v. Garrard*, 730 S.W.2d 649, 655 (Tex. 1987). See also *JuDay v. Rotunno and Rotunno*, 225 Cal. App. 3d 1571, 276 Cal. Rptr. 445 (1990) (ordered not published) (awarding the plaintiff $500,000 for emotional distress after her attorneys misappropriated funds). But see *Boyles v. Kerr*, 855 S.W.2d 593 (Tex. 1993) (limiting the broad language in *Garrard* and denying recovery for mental anguish for surreptitious videotaping of the plaintiff's sexual activity with the defendant). Damages may be exceedingly high in an HIV case. See *Jeanne v. Hawkes Hosp. of Mt. Carmel*, 74 Ohio App. 3d 246, 598 N.E.2d 1174 (1991) (awarding the plaintiff $12 million after she received a blood transfusion causing her to contract AIDS, while the plaintiff's mother was denied recovery on her claim for negligent infliction of emotional distress). See David Crump, *Evaluating Independent Torts Based upon "Intentional" or "Negligent" Infliction of Mental Distress: How Can We Keep the Baby from Dissolving in the Bath Water?*, 34 Ariz. L. Rev. 439, 507 (1992) (arguing the propriety of the majority rule that negligent infliction claims should be limited to "cases in which duty can be based upon contractual relationships, independent torts, or properly-limited bystander claims"). It would seem quite probable that exposure to HIV would satisfy the "impact" or "zone of danger" rule. See *Petriello v. Kalman*, 215 Conn. 377, 576 A.2d 474, 481 n.6 (1990) (upholding a jury instruction that stated: "Anxiety over future consequences of an injury is an element of mental suffering that is compensable.").

the disease may recover based on their fear of contracting the disease in the future.[86]

In *Faya v. Almaraz*,[87] the Maryland Court of Appeals went a step further and authorized a cause of action based upon lack of informed consent[88] when a surgeon with AIDS operated on patients without in-

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86. See generally Julie A. Davies, *Direct Actions for Emotional Harm: Is Compromise Possible?*, 67 Wash. L. Rev. 1 (1992); Frances L. Edwards and Al H. Ringleb, *Exposure to Hazardous Substances and the Mental Distress Tort: Trends, Applications, and a Proposed Reform*, 11 Colum. J. Envir. L. 119 (1986); Dale P. Faulkner and Kerin M. Woods, *Fear of Future Disability—An Element of Damages in a Personal Injury Action*, 7 W. New Eng. L. Rev. 865 (1985); John C. Corrigan and Craig J. Whitney, *Asbestos Litigation Under the F.E.L.A.*, 20 Forum 580 (1985).

Plaintiffs may also claim damages based on the increased risk of contracting the infection in the future because of subsequent exposure or long conversion time. Nonetheless, if damages are to be awarded for the increased risk of becoming infected, the plaintiff should provide expert testimony that there is, in fact, an increased risk, such as courts generally have required in toxic substance cases. See, for example, *Sterling v. Velsicol Chemical Corp.*, 855 F.2d 1188 (6th Cir. 1988) (holding that the plaintiffs had failed to prove increased susceptibility to a reasonable medical certainty); *Hogerty v. L and L Marine Services, Inc.*, 788 F.2d 315, 319 (5th Cir. 1986) (holding that recovery for increased risk is limited to where plaintiff could "show that the toxic exposure more probably than not will lead to cancer"). The court, however, permitted recovery for fear of contracting cancer, holding that the plaintiff's right to recover was a jury question. Id. In both *Sterling*, 855 F.2d at 1205-07, and *Hogerty*, 788 F.2d at 317-19, recovery for fear of contracting the disease was permitted. See also *Devlin v. Johns-Manville Corp.*, 202 N.J. Super. 556, 495 A.2d 495, 499-500 (1985) (holding that a plaintiff could not recover for the increased risk of contracting asbestosis but could later recover if the increased risk actualized into asbestosis); *Schwegel v. Goldberg*, 209 Pa. Super. 280, 228 A.2d 405 (1967) (allowing the plaintiff, a five-year-old boy, to recover as part of his damages the increased risk of developing epilepsy, despite the small probability (5%)); *Feist v. Sears, Roebuck and Co.*, 267 Or. 402, 517 P.2d 675 (1973) (holding that it was not error for a jury to hear testimony relating to susceptibility to meningitis although meningitis was not probable but merely a possibility); *Petriello*, 576 A.2d at 474 (allowing testimony concerning the 8 to 16% chance of developing a future bowel obstruction); *DeMaio v. Travelers Ins. Co.*, 1990 LEXIS 2122 at *1 (unpublished) (allowing the jury to decide the question whether the plaintiff's increased risk of contracting asbestosis was a present compensable injury).

Only a minority of courts permit recovery for merely an increased risk of contracting the disease in the future, as opposed to a probability of contracting it. Some courts have permitted a separate cause of action, however, if the disease later develops, even after the statute of limitations has run from the date of the original exposure. See John Patrick Darby, *Tort Liability for the Transmission of the AIDS Virus: Damages for Fear of AIDS and Prospective AIDS*, 45 Wash. & Lee. L. Rev. 185, 205 n.110 (1988) (listing cases). See generally Fournier J. Gale and James L. Goyer, *Recovery for Cancerphobia and Increased Risk of Cancer*, 15 Cumb. L. Rev. 723, 738-39 (1985); Kevin A. LaValle, *Groundwater Contamination: Removal of the Constraints Barring Recovery for Increased Risk and Fear of Future Diseases*, 1988 Detroit C. L. Rev. 65.

87. 329 Md. 435, 620 A.2d 327 (1993).

88. Dr. Almaraz was an oncological surgeon who specialized in breast cancer; both plaintiffs had undergone breast surgery. In addition to negligent failure to obtain informed consent, plaintiffs Faya and Rossi alleged negligence, fraud, and intentional infliction of mental distress. Faya added counts based on negligent misrepresentation and breach of contract. Rossi also alleged loss of consortium, breach of fiduciary duty, and battery. Id. at 330. The court distilled the common issue to be the surgeon's failure to disclose his infected condition: "The gist of the complaints was that Almaraz acted wrongfully in operating on the two women without first telling them he was HIV-positive (and, later ill from AIDS) . . . ." Id.

forming them, although the patients could not prove actual exposure to the virus and had tested negative for HIV.[89] The court approved the awarding of damages based on the patients' reasonable "fear and mental distress" of contracting AIDS if accompanied by a "physical injury," which the court defined as an injury that can be measured objectively.[90] In *Faya*, the court considered allegations of "headache, sleeplessness, and the physical and financial sting of blood tests for the AIDS virus" in addition to fear and mental distress adequate to support an award of damages.[91] The court, however, limited the patients' recovery "for their fear and its physical manifestations. . . for the period constituting their reasonable window of anxiety—the period between which they learned of [the surgeon's] illness and received their HIV-negative results."[92] The court based this time limitation on the current state of knowledge that there is a ninety-five percent certainty that a person will test positive for HIV within six months of exposure to the virus.[93]

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89. The court based the surgeon's duty to disclose his infected condition on the foreseeability of the transmission of the virus during an invasive procedure, citing the AMA's Policy and Code. Id. at 333-34. The court refused to require that the plaintiffs allege actual transmissions as this "would unfairly punish them for lacking the requisite information to do so." Id. at 337.

90. Id. at 338-39 (citing *Vance v. Vance*, 286 Md. 490, 408 A.2d 728 (1979)).

91. *Faya*, 620 A.2d at 338.

92. Id. at 337 (footnote omitted). The court added in the footnote: "We note that the window of anxiety closes once satisfactory information becomes available that puts to rest the fear of injury. Hence, even had the appellants not undergone immediate blood testing, their recovery span would be limited to the same duration, for the fear-relieving information, if known to them, would have been available for their retrieval." Id. at 337 n.10.

93. Id. at 337. It is not apparent why, except as a bright line limitation on liability, a reasonable person could not have fear of contracting AIDS when in 5% (one out of 20) of the cases seroconversion can occur beyond the six-month time limit. Indeed, it has been reported that "[n]ewer molecular biology techniques (polymerase chain reaction) show a small incidence of individuals (< 1%) who are infected with HIV for up to 36 months without generating an antibody response." Harry Hollander and Mitchell H. Katz, *HIV-Related Conditions*, in Steven A. Schroeder, et al., eds., *Current Medical Diagnosis & Treatment* 939, 941 (Lange, 1991). See also *Carroll v. Sisters of St. Francis Health Services, Inc.*, 1992 WL 276717 (Tenn. Ct. App. Oct 12, 1992), in which the court allowed recovery for mental distress to a plaintiff who received a puncture wound after sticking her fingers into an exposed hypodermic needle container. The plaintiff tested negative for over three years. Id. at *6 (Highers, J., dissenting). The court held that the plaintiff need not prove actual exposure to HIV because the medical profession presumes contamination of discarded needles. Id. at *5. The case was remanded to determine if the plaintiff's fear was reasonable, with the court cautioning that the period of recovery for mental distress extended "until other factors make the fear unreasonable." Id. See also *Kerins v. Hartley*, 1993 Cal. LEXIS 786, which follows *Faya* on substantially the same facts, summarizes the AIDS-phobia cases, and concludes:

> [A]ppellant's unabated emotional distress became unreasonable, ergo, not compensable, once the following events occurred: she received access to the operative report and/or in some other manner received assurances that no actual exposure to [the AIDS infected surgeon's] blood had occurred; she received test results negative for the presence of HIV antibodies; and she had the opportunity to obtain counseling on the accuracy and reliability of the testing meth-

### *E. A Pitfall of Disclosure: Loss of Professional Livelihood*

A final argument against imposing a duty on HCPs to disclose their infectious status to patients is that HCPs will then be unable to continue to practice their professions.[94] Once patients are informed that an HCP is infected, word will get around; HCPs have little, if any, means to prevent patients from revealing their condition. Patients generally do not owe a duty of confidentiality to their HCPs.[95] Furthermore, upon disclosure, patients will not only refuse invasive procedures but likely will also terminate the relationship with the HCP.[96] Thus, HCPs have a strong disincentive to disclose their infected status, when such disclosure in all likelihood means loss of professional livelihood.

While disclosing their infected condition may have severe economic and emotional consequences for HCPs, it is not apparent, at least from the viewpoint of tort law, why the risk of exposure should be imposed upon unwary patients. After all, the fiduciary nature of the HCP-patient relationship and the principle of patient autonomy impose the duty to disclose material risks.[97] The placement of HCPs in moral jeopardy does not mean that the jeopardy should be visited on patients as

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ods employed and the very remote probability of seroconversion more than 18 months after surgery.

Id. at *35.

94. See, for example, Eisenstat, 44 Rutgers L. Rev. at 316-17 (cited in note 49), who buttresses this argument with the contention that fear of loss of livelihood would diminish the number of HCPs willing to treat AIDS patients.

95. One could argue that such a duty of confidence may arise if the HCP conditions the acceptance or continued treatment of a patient on the patient's agreeing to maintain the confidence of the HCP. Upon the HCP's disclosure of her infected status, the patient would, of course, be free not to enter into or to terminate the relationship. The tort theory of the "right of privacy" denominated by Dean Prosser as "public disclosure of private facts" may also limit a patient's freedom to disclose the HCP's infectious status. See Keeton, et al., *The Law of Torts* at 856-59 (cited in note 13). Prosser identifies three elements of this tort: "(1) the disclosure of the private facts must be a public disclosure and not a private one; (2) the facts disclosed to the public must be private facts, and not public ones; and (3) the matter made public must be one which would be highly offensive and objectionable to a reasonable person of ordinary sensibilities." Id. at 856-57. Restatement § 652D, cmt. d (cited in note 24) adds a requirement that the matter disclosed not be one of "legitimate concern to the public" (citing *Cox Broadcasting Co. v. Cohn*, 420 U.S. 469 (1975)). Thus, even if a patient discloses the fact that an HCP is HIV-positive to the public (rather than just to family and friends), a serious question may be raised whether the public has an interest in the matter.

Disclosure of HIV status by a private individual should be contrasted with disclosure by a government official or agency, which may involve a violation of the constitutional right of privacy. See Seth F. Kreimer, *Sunlight, Secrets, and Scarlet Letters: The Tension Between Privacy and Disclosure in Constitutional Law*, 140 U. Pa. L. Rev. 1, 136-43 & 136 n.369 (1991) (discussing the constitutional implications of disclosing "intimate information" including HIV status and collecting cases).

96. See notes 6 and 31 (listing surveys on public attitudes toward HIV-positive HCPs).

97. See notes 26-27 and accompanying text.

well.[98] The conflict between the best interests of patients and those of HCPs is nicely summarized in *Matter of Quinlan*, although in a context far less threatening to the personal well-being of HCPs: "Nevertheless, there must be a way to free physicians, in the pursuit of their healing vocation, from possible contamination by self-interest or self-protection concerns which would inhibit their independent medical judgments for the well-being of their . . . patients."[99] Perhaps the problem of moral jeopardy has been overemphasized. If patients are fully informed of the very low risks of transfer associated with infectious diseases (such as HIV) and these risks are placed in their proper perspective by comparison to the magnitude of other risks, reasonable patients may decide to continue in the relationship, particularly if a strong relationship of trust and confidence has already been established between patient and HCP.[100]

If the foregoing analysis is sound, the doctrine of informed consent imposes a duty on HCPs to advise patients of their infected status when that status constitutes a material risk of treatment. In several respects, the application of the informed consent doctrine here has more cogency than in its traditional context, which is concerned with material risks of the proposed treatment itself. First, patients who refuse treatment after being fully informed of the risks of treatment may forego the benefits of the procedure, while patients who refuse to be treated by an infected HCP have the alternative of seeking treatment from an uninfected HCP. Second, while the principle of autonomy applies equally in both contexts, the ethical principle of nonmaleficence[101]

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98. The argument has been made that the "better good" would be served by imposing a duty on HCPs *not* to disclose to patients, to ensure that HCPs will treat infected patients. See Eisenstat, 44 Rutgers L. Rev. at 322 (cited in note 49). This argument seems to undermine both the fiduciary obligation of the HCP to his patients and patient autonomy.

99. *Matter of Quinlan*, 70 N.J. 10, 49, 355 A.2d 647, 668 (1976) (holding that the right of privacy authorizes the discontinuance of a life support system for a comatose patient, who had been on a respirator for nine years).

100. This statement may be true in the relatively large number of cases in which patients perceive their particular HCPs as having unique skills and special familiarity with their particular conditions. This is not to suggest, however, that HCPs should be authorized to proceed on the basis of informed consent with respect to any procedure regardless of how invasive or dangerous, even in the absence of negligence on the part of the HCP.

HCPs may be able to protect themselves from a total loss of income by insurance. A number of insurance carriers offer or are considering offering as part of their coverage a lump sum payment (ranging from $100,000 to $500,000 based on their premiums) to HIV-infected HCPs to induce them to restrict their practices to noninvasive procedures or to withdraw from practice. See Dean Major, *Insurers Pay Docs with HIV to Quit*, Health Week 1, 32 (Nov. 18, 1991).

101. See Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics* 120 (Oxford U., 3d ed. 1989) (notes omitted):

> The concept of nonmaleficence or not inflicting harm has been associated with the maxim *Primum non nocere*, "Above all [or first] do no harm." This maxim has wide currency in discussions of the responsibilities of health-care professionals; yet its origins are obscure.

provides another basis for the imposition of a duty of disclosure upon infected HCPs. Uninfected HCPs who fail to inform patients of material risks of treatment may do so in good faith, albeit negligently. Infected HCPs who fail to inform patients of their status unfortunately find themselves in an ethical dilemma in which self-interest may conflict with patient well-being.

## III. Reverse Informed Consent: Health Care Professional Versus Patient

A number of tort theories can be advanced on behalf of HCPs attempting to recover against patients who fail to inform HCPs of their HIV-infected status. These theories include battery, in which the HCP would assert that the patient's failure to inform of his infectious status vitiated the HCP's consent to treat the patient; thus, the patient intentionally inflicted a harmful or offensive contact on the HCP.[102] It may be assumed, as is the case when patients use the battery theory against HCPs, that consent on the part of the HCP to treat the patient would be implied and that a theory other than battery would be adopted if a duty to disclose were imposed on patients.[103] An HCP may allege fraudulent misrepresentation if a patient intentionally fails to inform the HCP of the patient's infectious status[104] or negligent misrepresentation

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Often proclaimed the fundamental principle in the Hippocratic tradition in medical ethics, it is not found in the Hippocratic corpus, and a venerable statement often confused with it—"At least, do no harm"—is not the most accurate translation of a passage that does appear in Hippocrates. Nonetheless, the Hippocratic oath does express a duty of nonmaleficence together with a duty of beneficence: "I will use treatment to help the sick according to my ability and judgment, but will never use it to injure or wrong them."

102. The classic example of this theory is *De May v. Roberts*, 9 N.W. 146 (Mich. 1881), in which a physician failed to inform the plaintiff that the person accompanying him and assisting in the delivery of her baby was not medically trained.

103. The applicable theory began to shift from battery to informed consent on a negligence basis in the 1960s. See Keeton, et al., *The Law of Torts* at 190 (cited in note 13). See also Allan H. McCoid, *A Reappraisal of Liability for Unauthorized Medical Treatment*, 41 Minn. L. Rev. 381, 434 (1957).

104. See Restatement § 310 (cited in note 24) (Conscious Misrepresentation Involving Risk of Physical Harm), which states:

> An actor who makes a misrepresentation is subject to liability to another for physical harm which results from an act done by the other or a third person in reliance upon the truth of the representation, if the actor
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> (a) intends his statement to induce or should realize that it is likely to induce action by the other, or a third person, which involves an unreasonable risk of physical harm to the other, and
>
> (b) knows
>
> (i) that the statement is false, or
>
> (ii) that he has not the knowledge which he professes.

if the patient negligently fails to so inform.[105] Both of these theories implicitly would require that the patient be under a duty to make such a disclosure. A plaintiff may also rely upon the theories of intentional[106] or negligent infliction of mental distress[107] if the HCP suffered mental distress as a consequence of contact with the patient but is not in fact infected. Whether the patient's failure was intentional or negligent, the requirement that the patient has a duty to inform is implicit.

The common element, whether the HCP's theory is battery, misrepresentation, or infliction of mental distress, is the imposition of a duty on the infected patient to inform the HCP of the patient's infected status.[108] Imposing such a duty on patients stands in sharp contrast to the duty imposed on HCPs to inform patients based upon the HCP-patient relationship. A duty running from the patient to the HCP would be analogous to the doctrine of informed consent as applied to the HCP's duty to the patient. The following analysis will be based upon a theory of "reverse informed consent," which creates a duty running from patient to HCP. A careful analysis of the duty issue must be

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105. See Restatement § 311 (cited in note 24) (Negligent Misrepresentation Involving Risk of Physical Harm), which states:

> (1) One who negligently gives false information to another is subject to liability for physical harm caused by action taken by the other in reasonable reliance upon such information, where such harm results
>
> (a) to the other, or
>
> (b) to such third persons as the actor should expect to be put in peril by the action taken.
>
> (2) Such negligence may consist of failure to exercise reasonable care
>
> (a) in ascertaining the accuracy of the information, or
>
> (b) in the manner in which it is communicated.

106. See Restatement § 46 (cited in note 24) (Outrageous Conduct Causing Severe Emotional Distress), which states:

> (1) One who by extreme and outrageous conduct intentionally or recklessly causes severe emotional distress to another is subject to liability for such emotional distress, and if bodily harm to the other results from it, for such bodily harm.
>
> (2) Where such conduct is directed at a third person, the actor is subject to liability if he intentionally or recklessly causes severe emotional distress
>
> (a) to a member of such person's immediate family who is present at the time, whether or not such distress results in bodily harm, or
>
> (b) to any other person who is present at the time, if such distress results in bodily harm.

Even presuming that the HCP suffers "extreme emotional distress," the critical issue would be whether the patient's failure to inform was "extreme and outrageous conduct," a finding likely to be difficult to sustain if the patient is justifiably concerned about the loss of confidentiality and attendant consequences.

107. See text accompanying notes 79-93 and particularly note 85 (discussing recovery of mental distress damages on the basis of negligent conduct).

108. This was the approach of the court in *Faya v. Almaraz*, 329 Md. 435, 620 A.2d 327 (1993), in which various theories of recovery, including those discussed above as well as breach of contract and fiduciary duty, were alleged, but the court considered lack of informed consent to be the gist of the cause of action. See also note 88.

undertaken, for if such a duty cannot be established, the HCP's case fails regardless of what theory is adopted.

### A. *The Case For and Against a Duty to Disclose*

The assertion that patients are under neither an ethical nor a legal duty to inform their HCPs of material risks associated with their treatment is obviously too broad.[109] In terms of ethical theory, the principles of nonmaleficence, autonomy, and justice[110] are not limited to particular categories of people such as professionals, but extend to all human beings.[111] For example, patients who intentionally fail to disclose their infectious status to reasonably unsuspecting HCPs who are about to undertake treatment that might expose the HCP to infection clearly

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109. For example, Gordon Keyes asserts: "The patient [compared to the HCP] has no corresponding ethical duty to the doctor." Keyes, 16 J.C. & U. L. at 605 (cited in note 49). This assertion fails to recognize the fact that a large number of people would acknowledge some duty running from patient to HCP. Indeed, in a Newsweek poll, 97% of those polled responded "yes" to the question: "Should patients be required to tell physicians, dentists and other health-care workers if they are infected with the AIDS virus?" Kantrowitz, Newsweek at 56 (cited in note 6).

110. For a discussion of nonmaleficence, see note 101. With respect to autonomy, Beauchamp and Childress summarize the views of Immanuel Kant and John Stuart Mill:

> In various writings, Kant argued that respect for autonomy flows from the recognition that all persons have unconditional worth, each having the capacity to determine his or her own destiny. To violate a person's autonomy is to treat that person merely as a means, to treat that person in accordance with one's own goals and without regard to that person's goals. To reject that person's goals and considered judgments or to restrict his or her freedom to act on those goals and judgments is to fail to respect autonomy.
>
> Mill was more concerned about the autonomy—or, as he preferred to say, the individuality—of action and thought. He argued that social control over individual actions is legitimate only if it is necessary to prevent harm to other individuals and that citizens should be permitted to develop their potential according to their personal convictions, as long as they do not interfere witb a like expression of freedom by others. Mill held that a person with true character is one of genuine individuality, whereas a person "without character" is under an oppressive, controlling infiuence by church, state, parents, or family.

Beaucbamp and Childress, *Principles of Biomedical Ethics* at 71-72 (cited in note 101) (notes omitted). Beauchamp and Childress discuss justice in terms of fairness, desert, and entitlement:

> Some moral philosophers, notably John Rawls, have argued that justice is best explicated in terms of fairness. Clearly there are close conceptual connections between these terms, but the concept of justice is also closely linked to desert: One acts justly toward a person when that person bas been given what tbe person deserves. . . . Additionally . . . justice confers an entitlement whether deserved by the person or not. Justice is "giving to each his due," as it was put in some ancient accounts. One who has a claim based in justice has a claim of entitlement and in this strong sense is due something. An injustice, in turn, involves a wrong where one has been denied that to which one is entitled.

Id. at 257 (footnotes omitted).

111. As Rawls stated, "[ethical] principles are to be universal in application. They must hold for everyone in virtue of tbeir being moral persons." John Rawls, *A Theory of Justice* 132 (Harvard U., 1971). "What is right for one person must be right for all persons in relevantly similar circumstances." Beauchamp and Childress, *Principles of Biomedical Ethics* at 18 (cited in note 101). With respect to a duty to disclose a potentially lethal infection, it is not apparent tbat HCPs and patients are dissimilarly situated.

violate the ethical principle of nonmaleficence. Under such circumstances an HCP deserves to be treated as any other human being—not to be subjected to material risks.[112]

The guiding principle of the doctrine of informed consent is autonomy: individuals should have the opportunity to make decisions potentially affecting their personal well-being in an informed manner.[113] The failure of patients to disclose an infectious condition deprives HCPs of their autonomy to decide to refuse to treat the patient, to refer him to another HCP, or to treat him in an alternative or safer manner.

Finally, justice is not served if HCPs are placed in the unequal position of being subjected to material risks that could be avoided or at least mitigated.[114] This proposition is especially true because HCPs have an ethical and legal duty to keep patient disclosures confidential.[115]

On the other hand, imposing a legal duty on patients to disclose material risks associated with their care presents a more difficult question: whether patients' failure to inform HCPs creates an unreasonable risk of injury to the HCP. Although no direct authority exists in support of imposing a duty on patients to inform HCPs of such material risks, one can anticipate how courts would deal with this issue. As Justice Cardozo stated:

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112. A distinction exists between a patient negligently failing to disclose and a patient intentionally withholding information about a material risk. Thus, a situation in which a patient did not subjectively know of the material risk of nondisclosure is ethically distinguishable from a situation in which a reasonable patient should have known of the risk.

113. See, for example, *In re Gardner*, 534 A.2d 947 (Me. 1987), which details the basis for the principle of autonomy or self-determination applied in informed consent cases. The court first quotes John Stuart Mill: "Over himself, over his own body and mind, the individual is sovereign." Id. at 950 (citation omitted). It then quotes Justice Gray of the United States Supreme Court: "No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law." Id. (citation omitted). Finally, the court quotes Judge Cardozo: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault, for which he is liable in damages." Id. (quoting *Schloendorff v. Soc'y of New York Hosp.*, 211 N.Y. 125, 105 N.E. 92, 93 (1914)).

114. See Beauchamp and Childress, *Principles of Biomedical Ethics* at 259 (cited in note 101): "The only principle common to all theories of justice is a minimal principle traditionally attributed to Aristotle: Equals must be treated equally, and unequals must be treated unequally."

115. See, for example, American Medical Association, Principles of Medical Ethics, adopted July 22, 1980, Principle IV in Rena H. Gorlin, ed., *Codes of Professional Responsibility* 191 (BNA, 2d ed. 1990): "A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law." See generally Robert M. Gellman, *Prescribing Privacy: The Uncertain Role of the Physician in the Protection of Patient Privacy*, 62 N.C. L. Rev. 255 (1984); Almeta E. Cooper, *The Physician's Dilemma: Protection of the Patient's Right to Privacy*, 22 S.L.U. L. J. 397 (1978).

> We go forward with our logic, with our analogies, with our philosophies, till we reach a certain point. At first, we have no trouble with the paths; they follow the same lines. Then they begin to diverge, and we must make a choice between them. History or custom or social utility or some compelling sentiment of justice or sometimes perhaps a semi-intuitive apprehension of the pervading spirit of our law must come to the rescue of the anxious judge, and tell him where to go.[116]

*Boulais v. Lustig,* a California case, directly addresses the issue of a patient's duty to disclose an unreasonable risk of injury.[117] In *Boulais,* a surgeon inadvertently cut the plaintiff, a surgical technician, on the finger while the technician was removing sutures from the defendant patient after cosmetic surgery, thereby exposing the plaintiff to the defendant's blood.[118] The plaintiff tested negative for HIV.[119] Allegedly, the defendant did not inform the surgeon or the plaintiff that she had AIDS and, in addition, falsely indicated on medical forms that she was not presently being treated or observed for any medical condition.[120] The jury returned a $102,500 verdict for fraud and negligent infliction of mental distress, including $2,500 in punitive damages.[121] The trial judge granted the defendant's motion for a judgment notwithstanding the verdict on the negligence count but let stand the jury verdict on the basis of fraud. The case was settled.[122] A critical issue in such a case should be whether the defendant patient had a duty to inform the surgeon and the plaintiff (presumably as a foreseeable surgical technician) that she had AIDS prior to undergoing the procedure.[123]

A closely analogous case is *Ordway v. County of Suffolk,*[124] in which a surgeon brought an action against the county for the failure of the police to advise him that a burglary suspect brought into the hospi-

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116. Benjamin N. Cardozo, *The Nature of the Judicial Process* 43 (Yale U., 1921).

117. *Boulais v. Lustig,* No. BC38105 (Cal. Super. Ct. 1993). See note 15.

118. See Penelope McMillan, *Jury Rules Against AIDS Patient,* L.A. Times B1 (Feb. 10, 1993).

119. Id.

120. See *Health Worker Sues Patient over HIV,* Chi. Trib. 8 (Sept. 24, 1991) (news section).

121. With respect to the negligent infliction of mental distress claim, the jury apportioned 60% of the fault to the defendant, 39% to the surgeon and the clinic, and 1% to the plaintiff. One juror indicated that the small amount awarded for punitive damages was based on "consideration of the defendant's status." McMillan, L.A. Times at B1 (cited in note 118).

122. See 2 Health L. Rep. (BNA) 1337 (1993) (stating that the case settled for $15,000).

123. In granting the JNOV on the negligence issue, the judge stated that there is "no duty of a patient to be truthful concerning his/her medical condition with his/her medical care providers [that] has been established by the facts of this case or by court decision or law." Id. See text accompanying notes 141-189 (analyzing this issue). The fraud issue would be more straigbtforward if the defendant intentionally misrepresented her physical condition and the plaintiff relied on that misrepresentation. See note 104. It is interesting to note that tbe defendant was not asked if she was HIV-positive (which she admitted when asked) until the surgeon inflicted the cut. Neither the surgeon nor the plaintiff technician wore gloves during the procedure. See Pristin, L.A. Times at B3 (cited in note 15). The causation issue raised by the HCP's failure to wear gloves is considered by the text accompanying notes 194-213.

124. 583 N.Y.S.2d 1014 (N.Y. Sup. Ct. 1992).

tal for emergency treatment was HIV positive. The county joined the hospital as a third party defendant. The surgeon alleged that he would have used additional precautions had he been informed of the suspect's HIV status and now suffered from "HIV phobia" after having operated twice on the suspect without knowledge that the patient was HIV positive.[125] The trial court categorized the plaintiff's cause of action as "founded on the theory of negligent infliction of emotional distress"[126] and granted summary judgment in favor of the defendants, concluding: "Absent any allegation of an unusual occurrence during the operations themselves [there was no allegation of a cut glove or pierced skin] or indicia of legitimacy in plaintiff's postoperative condition [the surgeon tested negative for HIV before trial and alleged no loss of income], the claim asserted herein is insufficient as a matter of law and defendants are entitled to judgment in their favor. . . ."[127]

Assuming arguendo that the plaintiff could allege cognizable damages, the court further concluded that the county police were under no duty to inform the surgeon of the suspect's HIV status.[128] Although the court's conclusion is dictum, its reasoning raises a number of concerns. First, the court reads the New York Public Health Law Act[129] as establishing a strong public policy in favor of protecting the confidentiality of HIV-infected persons,[130] and refers to the regulations promulgated under the Act as specifically prohibiting the "disclosure of HIV related information *solely* to carry out 'infection control precautions.' "[131] The court then justifies the nondisclosure by the police on the basis that the

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125. The *Ordway* court noted, "Plaintiff claims that had he known of the patient's condition he would have taken 'certain necessary precautions' including the use of 'a full face shield or goggles, a specific type of respirator or breathing protector, double gloves, changing gown every 30 minutes and knee-high boots'." Id. at 1015.

126. Id. The plaintiff did not specifically identify his theory of recovery.

127. Id. at 1017.

128. Id.

129. N.Y. Pub. Health Law §§ 2780-2787 (McKinney, 1988).

130. *Ordway*, 583 N.Y.S.2d at 1017. The court cites N.Y. Comp. Codes R. & Regs. tit. 10, § 63.5(b)(J) [sic—presumably the citation is to § 63.5(j)], which states:

> Confidential HIV-related information shall not be disclosed to a health care provider or health care facility *for the sole purpose of implementing infection control precautions* when such provider or facility is regulated under the *Public Health Law* and required to implement such precautions with all individuals pursuant to this Title. This restriction shall not limit access to HIV-related information by a facility's infection control personnel for purposes of fulfilling their designated responsibilities in the facility.

N.Y. Comp. Codes R. & Regs. tit. 10, § 63.5(j) (1992) (emphasis added). It may be noted that no provision in the Act itself corresponds to the foregoing prohibition.

131. *Ordway*, 583 N.Y.S.2d at 1017.

surgeon made no allegation that he would have altered the treatment if the patient had disclosed his HIV status.[132]

The court further recognizes that there is "something of a paradox" in the Public Health Law Act.[133] Police officers are obligated to maintain the patient's HIV status in confidence, unless, according to the Act, disclosure would "affect [the patient's] treatment."[134] Thus, the paradox: "[H]ow can the Police Officers know the answer to this legislative requirement unless they initially reveal the patient's status to the treating physician?"[135] Nevertheless, the court concludes that under the circumstances of *Ordway,* the police had no duty to disclose the suspect's HIV status to the surgeon.[136] If the physician had alleged that he would have undertaken an alternative course of treatment if informed of the patient's HIV status, by implication, at least, the police would have had a duty to disclose. Of course, this interpretation places the police in the untenable position of being required to make a medical judgment.[137] In the final analysis, a statutory construction that overlooks an important provision of the Act is unsound.[138] Perhaps a better interpretation would consider nondisclosure to be the general rule, with an exception permitting disclosure of a patient's HIV status to an HCP when treatment is involved.[139]

The *Ordway* court does not address the question of whether a patient personally would be under a duty to disclose his HIV status to a surgeon, because the surgeon never brought the patient in as a party. In any event, whatever disclosure the police-surgeon relationship requires, the relationship between the patient and the surgeon certainly is closer;

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132. Id. This holding raises a causation issue, which will be addressed below. See text accompanying notes 196-213.

133. *Ordway,* 583 N.Y.S.2d at 1017.

134. Id. N.Y. Pub. Health Law § 2782(1)(d) provides an exception for disclosure to "a health care provider or health facility when knowledge of the HIV related information is necessary to provide appropriate care or treatment to the protected individual or a child of the individual . . . ."

135. *Ordway,* 583 N.Y.S.2d at 1017-18.

136. Id. at 1018. The court suggests that the conflicting subdivisions of the New York Public Health Law Act will eventually be reconciled. Id.

137. Presumably proof of the availability of alternative treatments would require expert testimony. Indeed, whether or not the use of additional precautions should be considered part of the patient's treatment raises a difficult question.

138. See, for example, Norman J. Singer, 2A *Statutes and Statutory Construction* § 46.06 at 119-20 (Clark, 5th ed. 1992) (stating that "[a] statute should be construed so that effect is given to all its provisions, so that no part will be inoperative or superfluous, void or insignificant . . .") (footnotes omitted).

139. Whatever the applicability of the regulation prohibiting the disclosure of HIV information to HCPs "for the sole purpose of implementing infection control precautions," when medical treatment is involved—in particular, when an operation is planned—a facile interpretation would claim that disclosure in such a case would not be *solely* for infection control but would, at least in part, involve medical judgment insofar as knowledge of the patient's HIV condition would be relevant to the treatment prescribed. N.Y. Comp. Codes R. & Regs. tit. 10, § 63.5(j).

thus the foundation for imposing upon the patient a duty to disclose is stronger.[140]

### B. *The Foundations of a Duty to Disclose*

#### 1. Duty Based on Analogy

A number of analogies may aid in defining the relationship between patients and their HCPs. Certainly, HCPs and patients would not be considered strangers, as defined by tort law. The common law is hesitant to impose an affirmative duty on an actor who has no preexisting relationship with another to warn the latter of a known risk not created by the actor. The Restatement (Second) of Torts Section 314 states this rule as follows: "The fact that the actor realizes or should realize that action on his part is necessary for another's aid or protection does not of itself impose upon him a duty to take such action."[141] As an illustration, the rule provides that a stranger is under no duty to warn a blind person stepping off a curb of an approaching automobile, and the failure to warn by word or touch would not impose liability on the stranger.[142]

At the other end of the spectrum, it would be difficult to define the relationship of patients to their HCPs as identical to that of HCPs to their patients—that is, of a fiduciary nature implying utmost trust and confidence. Indeed, the imposition of the fiduciary relationship results from the professional knowledge of the HCP and the dependent position of the patient.[143]

An appropriate analogy may be based upon the relationship of persons intimate enough to enter into sexual relationships. A considerable body of case law imposes a duty on one sexual partner to disclose to the other that he or she has a sexually transmitted disease (STD).[144] The

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140. Another question not answered by the *Ordway* court is whether the hospital owed a duty to the surgeon to inform him of the patient's HIV status. The hospital was made a third-party defendant by the county. The reported opinion does not indicate whether the police had disclosed the patient's HIV status to the hospital or whether the patient himself had disclosed this fact to the hospital.

141. Restatement § 314 (cited in note 24).

142. Id. cmt. c, illus. 1.

143. See note 26 (discussing the fiduciary relationship).

144. See, for example, *Berner v. Caldwell*, 543 S.2d 686 (Ala. 1989) (allowing a cause of action for negligent transmission of genital herpes because of a state public policy of preventing the spread of sexually communicable diseases); *Kathleen K. v. Robert B.*, 198 Cal. Rptr. 273 (Cal. Ct. App. 1984) (allowing a cause of action based on either the defendant's negligent or deliberate failure to inform the plaintiff that he was infected with a venereal disease); *R.A.P. v. B.J.P.*, 428 N.W.2d 103 (Minn. App. 1988) (allowing a cause of action by a husband against his wife for negligent and fraudulent transmission of herpes); *B.N. v. K.K.*, 312 Md. 135, 538 A.2d 1175 (1988) (allowing a nurse to state a cause of action based on fraud and negligence by alleging that a physi-

cases are not limited to instances in which one partner makes fraudulent misrepresentations denying the presence of an STD.[145] Rather, case law reveals that an affirmative duty to disclose may be imposed independent of overt misrepresentation. Moreover, the cases are not limited to married or engaged couples. For example, the court in *B.N. v. K.K.* held that the defendant need not have a confidential relationship with the plaintiff before being required to inform her that he had genital herpes; rather, the defendant was under a general duty to disclose.[146] It

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cian, who knew he had genital herpes, had intercourse with her without disclosing this information); *Maharam v. Maharam*, 510 N.Y.S.2d 104 (N.Y. App. Ct. 1986) (holding that a wife could maintain a cause of action against her husband for transmission of genital herpes on theories of either fraud or negligence); *S.A.V. v. K.G.V.*, 708 S.W.2d 651 (Mo. 1986) (holding that interspousal immunity would not bar a wife's claim against her husband for the transmission of herpes).

Compare *Ruprecht v. Ruprecht*, 252 N.J. Super. 230, 599 A.2d 604 (Ch. Div. 1991) (holding that while one spouse may sue another for the intentional infliction of emotional distress, a husband failed to state a cause of action when allegations were limited to his wife committing adultery and no transmission of an STD occurred); *Doe v. Doe*, 519 N.Y.S.2d 595 (N.Y. Sup. Ct. 1987) (holding a wife's cause of action for fraud and intentional infliction of emotional distress insufficient when her husband bad a homosexual affair that allegedly placed his wife at risk of getting AIDS).

See generally Robert A. Prentice and Paula C. Murray, *Liability for Transmission of Herpes: Using Traditional Tort Principles to Encourage Honesty in Sexual Relationships*, 11 J. Contemp. L. 67 (1984); Deane Kenworthy Corliss, Comment, *AIDS—Liability for Negligent Sexual Transmission*, 18 Cumb. L. Rev. 691 (1988); Bonnie E. Elber, Note, *Negligence as a Cause of Action for Sexual Transmission of AIDS*, 19 U. Toledo L. Rev. 923 (1988); Daniel M. Oyler, *Interspousal Tort Liability for Infliction of a Sexually Transmitted Disease*, 29 J. Family L. 519 (1990-91); David P. Brigham, Comment, *You Never Told Me . . . You Never Asked: Tort Liability for the Sexual Transmission of AIDS*, 91 Dickinson L. Rev. 529 (1986) (discussing other STD cases); Marcia Baran, Case Note, *Tort Liability for the Transmission of Genital Herpes: A New Legal Duty?* R.A.P. v. B.J.P., 12 Hamline L. Rev. 91 (1988); Louis A. Alexander, Note, *Liability in Tort for the Sexual Transmission of Disease: Genital Herpes and the Law*, 70 Cornell L. Rev. 101 (1984); Kimm Alayne Walton, Note, Kathleen K. v. Robert B.: *A Cause of Action for Genital Herpes Transmission*, 34 Case W. Res. L. Rev. 498 (1984).

145. In *Berner v. Caldwell*, the plaintiff claimed that the defendant either negligently or intentionally failed to disclose to her that he had genital herpes. The plaintiff made no allegation concerning overt misrepresentation, but based her cause of action on a negligence theory. 543 S.2d at 687, 689. In *Maharam v. Maharam*, the court concluded that the plaintiff stated cognizable causes of action for the wrongful transmission of genital herpes based either on theories of fraud or negligence. 510 N.Y.S.2d at 107. Although the plaintiff's fraud count did not allege an overt misrepresentation, the court held that "the thirty-one year marital relationship gave rise to an affirmative 'legal duty to speak,' and the allegation that the husband failed to disclose his condition adequately states a cause of action for constructive, if not actual, fraud." Id. In finding this duty, the court relied in part on a New York Public Health Law that made it a misdemeanor for a person infected with a venereal disease to have sexual intercourse with another individual. Id. See also *B.N. v. K.K.*, in which the court found that the complaint stated a cause of action despite the absence of an overt misrepresentation: "Of course, concealment cannot be the basis of an action in deceit if tbere is no duty to speak. But if there is such a duty, the concealment can result in liability to the same extent that an actual denial of the existence of the fact would." *B.N.*, 538 A.2d at 1183.

146. *B.N. v. K.K.* did not involve a confidential relationship—such as that between husband and wife—but rather involved a romantic relationship between a nurse and a physician. B.N., 538 A.2d at 1177.

was sufficient that the defendant should have known that the relationship was highly likely to cause harm to the plaintiff.[147] If courts impose a duty to disclose non-life-threatening STDs before engaging in sex, it would be no great stretch to impose a duty on patients to disclose a potentially deadly risk to treating HCPs.[148]

### 2. Duty Based on Risk-Utility Analysis

Another approach to the duty issue would involve using the utility of noninforming to contrast the risk created by HCPs' failure to inform patients and the converse risk created by patients' failure to inform their HCPs. The risk-utility approach found in the Restatement[149] would be central to such an analysis.[150] Restatement Section 291 adopts a risk-utility analysis to determine whether a risk is unreasonable; an act is negligent when the magnitude of risk of harm exceeds the utility of that particular course of conduct.[151]

#### *a. The Utility of Nondisclosure*

The quantum of utility is measured by a number of factors set out in Section 292.[152] The first factor noted is "the social value which the

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147. In addressing the negligence count, *B.N.* relied on traditional tort principles, rather than the presence of a confidential relationship to find a duty to disclose:

> One who knows he or she has a highly infectious disease can readily foresee the danger that the disease may be communicated to others with whom the infected person comes into contact. As a consequence, the infected person has a duty to take reasonable precautions—whether by warning others or by avoiding contact with them—to avoid transmitting the disease.
>
> . . . As a consequence [of Dr. K. knowing he had active genital herpes], Dr. K. had a duty either to refrain from sexual contact with Ms. N. or to warn her of his condition. If, as she charges, he negligently failed to do either, he breached his duty.

Id. at 1179. See also *Berner*, 543 S.2d at 686 (allowing a cause of action on traditional tort negligence principles when a woman brought an action against her former boyfriend alleging that he either negligently or intentionally transmitted genital herpes to her).

148. In any event, the relationship between patients and their HCPs certainly must be closer than that arising out of a "one night stand."

149. See Restatement §§ 291-293 (cited in note 24).

150. In *Behringer*, the Restatement's risk-utility approach was used to impose a duty on an HCP to disclose his HIV status to patients. See *Estate of Behringer v. Medical Ctr. at Princeton*, 249 N.J. Super. 597, 592 A.2d 1251, 1281-83 (1991) (relying, in part, on Keyes, 16 J.C. & U.L. at 603-05 (cited in note 49)).

151. Restatement § 291 (cited in note 24) (Unreasonableness; How Determined; Magnitude of Risk and Utility of Conduct) states: "Where an act is one which a reasonable man would recognize as involving a risk of harm to another, the risk is unreasonable and the act is negligent if the risk is of such magnitude as to outweigh what the law regards as the utility of the act or of the particular manner in which it is done."

152. Restatement § 292 (cited in note 24) (Factors Considered in Determining Utility of Actor's Conduct) states:

> In determining what the law regards as the utility of the actor's conduct for the purpose of determining whether the actor is negligent, the following factors are important:

law attaches to the interest which is to be advanced or protected by the conduct."[153] "The conduct" with respect to both HCPs and patients is nondisclosure of the party's infected status. The "interests" involved are not limited to purely public interests, as a comment to Section 292 makes clear: "It may be a purely private interest of the actor or a third person. It may be an interest which is primarily of private advantage, but the public may nonetheless be interested, not merely as the protector of the private interest, but also because the general public good is advanced by the protection and advancement of such private interests."[154]

The public interest presumably served by nondisclosure by HCPs is continued access to health care. In addition, nondisclosure serves the private interests of HCPs in maintaining their privacy and confidentiality and their ability to continue practicing their professions. Interests in privacy, confidentiality, and the privilege to practice one's profession are not, however, purely private; they are also valued by society in general.[155]

In contrast, relatively less social value is attached to nondisclosure by patients. No public interest involved rivals the HCP's provision of health care services. The patient's private interests in privacy, confidentiality, and the potential consequences of general disclosure certainly are no more significant than the interests of HCPs, and general disclosure would result only if HCPs violate their duty of confidentiality to their patients. Because, in contrast, patients have no duty to maintain the confidences of their HCPs, it is quite probable that an HCP's disclosure to a patient will result in general disclosure.[156]

The second factor Restatement Section 292 considers important in assessing utility is "the extent of the chance that this interest will be advanced or protected by the particular course of conduct."[157] A single disclosure by an HCP to a patient is likely to result in a loss of public

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

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

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

153. Id. § 292(a).

154. Id. cmt. a.

155. See generally Laurence H. Tribe, *American Constitutional Law* ch. 15 (Foundation, 2d ed. 1988) (discussing the constitutional bases for rights of privacy and personhood); id. § 15-13 (discussing the right to employment); John E. Nowak and Ronald D. Rotunda, *Constitutional Law* § 16.36 (West, 4th ed. 1991) (discussing the publication of truthful private information).

156. See note 95 and accompanying text.

157. Restatement § 292(b) (cited in note 24).

access to health care and the HCP's personal loss of continued professional practice. Thus, the likelihood of advancing the interests noted above is probably greater when HCPs do not disclose rather than when patients do not disclose, because disclosure of patients' infected status occurs only when HCPs breach patients' confidentiality.

The final important factor in the Restatement Section 292 utility analysis is "the extent of the chance that such interest can be adequately advanced or protected by another and less dangerous course of conduct."[158] Certainly HCPs other than the infected HCP may provide health care. Moreover, the infected HCP's practice may be restricted to noninvasive and less risky procedures, thereby minimizing the risk while maintaining some of the utility afforded by the HCP's services. Thus, the "less risky" alternative may require disclosure by HCPs. The "less dangerous" alternative in the case of infected patients is to require patients to inform HCPs of their infected status and to rely upon the legal obligation of HCPs to maintain this information in confidence.[159]

In sum, application of the Restatement factors indicates a greater utility in nondisclosure on the part of HCPs than on the part of patients. In addition, in the vast majority of cases the public receives significant benefits from health care even when provided by an infected HCP, because the care is provided at a relatively low risk—indeed, at a risk level substantially lower than the risk associated with ordinary malpractice.[160]

### *b. The Risk of Nondisclosure*

Restatement Section 293 identifies four factors as important in assessing the magnitude of risk associated with a particular course of conduct.[161] The first factor identified is "the social value which the law

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158. Id. § 292(c).

159. In addition to the HCP's duty to maintain confidentiality based on the HCP-patient relation, 44 states and the District of Columbia have enacted HIV confidentiality protection statutes. See David A. Hansell, *HIV Antibody Testing: Public Health Issues*, in Paul Albert, et al., eds., *AIDS Practice Manual* 3-14 n.63 (National Lawyers Guild, 3d ed. 1991).

160. See Harvard Study (cited in note 75) (indicating about a 1% incidence of medical malpractice). This is not to say the risk is a reasonable one that may be imposed on patients. The point is made only for purposes of comparative analysis.

161. Restatement § 293 (cited in note 24) (Factors Considered in Determining Magnitude of Risk) states:

In determining the magnitude of the risk for the purpose of determining whether the actor is negligent, the following factors are important:

(a) the social value which the law attaches to the interests which are imperiled;

(b) the extent of the chance that the actor's conduct will cause an invasion of any interest of the other or of one of a class of which the other is a member;

(c) the extent of the harm likely to be caused to the interests imperiled;

attaches to the interests which are imperiled."[162] In the case of HCPs' and patients' failure to warn of their infected (in particular, HIV) status, the interest imperiled may be the life of the uninformed party. One would hesitate to say that HCPs have a greater social value than patients—as a class or as individuals. Certainly society places a high value on the provision of health care services, however, and there is no question that society places a higher economic value on HCPs than on patients.[163] Accordingly, nondisclosure by patients presents a higher risk than nondisclosure by HCPs in the context of whose life is imperiled.

The second Section 293 factor used in assessing risk is "the extent of the chance that the actor's conduct will cause an invasion of any interest of the other or of one of a class of which the other is a member."[164] In terms of probability, it is more likely that HCPs will be infected by nondisclosing patients than the converse, according to presently available data. The risk is three to nine times greater that an HCP will be infected by a patient than that a patient will be infected by an HCP.[165]

The third factor identified in Section 293 is "the extent of the harm likely to be caused to the interests imperiled."[166] HCPs and patients have an identical interest in life. Nonetheless, the loss of life of an HCP, because of the HCP's higher earning capacity, will ordinarily result in damages significantly in excess of those awarded for loss of life of the average patient.[167]

The fourth Restatement factor used in assessing risk is "the number of persons whose interests are likely to be invaded if the risk takes effect in harm."[168] This element is the only risk factor that appears to render nondisclosure to patients by HCPs significantly more risky than the converse—patients' failure to disclose to HCPs. Specifically, the

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(d) the number of persons whose interests are likely to be invaded if the risk takes effect in harm.

162. Id. § 293(a).

163. For example, in 1988, the median weekly earnings of full-time wage and salary workers over the age of 15 were $385, or approximately $20,020 per year. See U.S. Dep't of Labor, Bureau of Labor Statistics, 37 *Employment and Earnings* 219 (Jan. 1990). In the same year, the median physician income was $144,700, the median surgeon income $207,500. Stuart M. Speiser, *Recovery for Wrongful Death: Economic Handbook* § 8-2 at 103 (Lawyers Co-op, 3rd ed. 1988 & 1991 cum. supp.). The median earnings of a surgeon are thus approximately ten times greater than those of the average worker. See also John W. Wright and Edward S. Dwyer, *The American Almanac of Jobs and Salaries* 246-52 (Avon, rev. ed. 1990-91) (noting that in 1987 the average dentist in general practice earned a net income of $120,409, and the average M.D. netted $116,440, with cardiovascular surgeons at the top end of the scale with an average net income of $271,550 per year).

164. Restatement § 293(b) (cited in note 24).

165. See note 16.

166. Restatement § 293(c) (cited in note 24).

167. See note 181 and accompanying text.

168. Restatement § 293(d) (cited in note 24).

CDC has estimated that, while the risk of HIV infection associated with an infected HCP's performing an invasive procedure on a single patient is between .0024 percent and .00024 percent,[169] if the HCP performs 500 operations per year this risk increases to 1.2 percent.[170] Over a seven-year period, the CDC estimates that there would be an 8.1 percent chance of infection from infected surgeons to patients.[171] While the risk of infection from HCPs to patients may be higher according to this factor, however, many HCPs may be involved in the treatment of infected patients. Therefore, multiple exposures to various HCPs in the health care chain who are unaware of the infected status of patients is possible.[172]

In summary, while the fourth Restatement factor may indicate that infected HCPs present a higher risk than do infected patients, the other three factors indicate that infected patients present higher risks than HCPs. The overall balancing of the magnitude of risk against the utility of nondisclosure both by patients and by HCPs shows that the risk-utility balance with respect to nondisclosure by patients is at least in the same order of magnitude as that for nondisclosure by HCPs.[173] Accordingly, if a duty is imposed upon HCPs to disclose their infected status to patients, a converse duty should also be imposed upon infected patients to disclose to their HCPs.

### 3. Duty Based on Economic Analysis

Economic analysis employed in a comparative manner provides another potentially useful method of analyzing whether patients should be under a duty to disclose their infectious status to HCPs.[174] The central theorem of economic analysis in negligence law is Judge Learned

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169. See CDC, *Estimates* at 7 (cited in note 16).

170. Id. The range of risk among specialties is estimated to be .2% to 2.8%.

171. Id. The range of risk among specialties is estimated to be 1% to 18.3%, assuming 3500 operations over seven years.

172. In addition to physicians and nurses, patients may be treated, *inter alia*, by radiology technologists, medical laboratory technologists, respiratory therapists, phlebotomists, physical therapists, occupational therapists, dentists, and podiatrists.

173. Comment b to § 291, with respect to burden of proof, states: "Conduct is not negligent unless the magnitude of the risk involved therein so outweighs its utility as to make the risk unreasonable." Restatement § 291 cmt. b (cited in note 24). This statement implies a balancing of the risk and utility factors. The factor-balancing approach of the Restatement is made more explicit in comment f to § 520 (Abnormally Dangerous Activities): "In determining whether the danger is abnormal, the factors listed in . . . this Section are all to be considered, and are all of importance. Any one of them is not necessarily sufficient of itself in a particular case, and ordinarily several of them will be required for strict liability. On the other hand, it is not necessary that each of them be present, especially if others weigh heavily." Id. § 520 cmt. f.

174. See generally Richard A. Posner, *Economic Analysis of Law* ch. 6 (Little, Brown, 4th ed. 1992); William M. Landes and Richard A. Posner, *The Economic Structure of Tort Law* (Harvard U., 1987).

Hand's equation set forth in *United States v. Carroll Towing Co.*[175] According to Judge Hand's analysis, conduct will be deemed negligent when the burden (B) of taking precautions to avoid the occurrence of injury is less than the product of the probability (P) that the injury will occur in the absence of those precautions and the magnitude of injury (L) that will occur.[176] Thus, precautions must be taken to satisfy economic efficiency when it is cheaper to pay for the precautions to avoid the loss than to pay for the loss itself.[177] Hence, if this analysis is placed in the form of an equation, liability for negligently caused loss will be imposed when:

$B < P \times L$.

If a duty is imposed on HCPs to inform patients of the HCP's infected status, the equation would provide:

$B_{hcp} < P_{hcp-p} \times L_p$, where $B_{hcp}$ is the economic burden of disclosure on HCPs, $P_{hcp-p}$ is the probability of injury due to exposure to nondisclosing, infected HCPs, and $L_p$ is the magnitude of loss to patients.

If a duty is imposed on patients to disclose their infectious status to HCPs, the equation would be:

$B_p < P_{p\text{-}hcp} \times L_{hcp}$, where $B_p$ is the economic burden of disclosure on patients, $P_{p\text{-}hcp}$ is the probability of injury due to exposure to nondisclosing, infected patients, and $L_{hcp}$ is the magnitude of loss to HCPs.

Substituting some numbers from available studies into the equations is useful for comparative analysis. According to CDC estimates,

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175. 159 F.2d 169 (2d Cir. 1947). See Posner, *Economic Analysis of Law* §§ 6.1-6.4 (cited in note 174); Landes and Posner, *Economic Structure of Tort Law* at 85-107 (cited in note 174).

176. The question in *Carroll Towing* was whether an employee would be liable for the loss of a barge that broke away during its bargee's absence. In this context Judge Hand stated:

> Since there are occasions when every vessel will break from her moorings, and since, if she does, she becomes a menace to those about her; the owner's duty, as in other similar situations, to provide against resulting injuries is a function of three variables: (1) The probability that she will break away; (2) the gravity of the resulting injury, if she does; (3) the burden of adequate precautions. Possibly it serves to bring this notion into relief to state it in algebraic terms: if the probability be called P; the injury, L; and the burden, B; liability depends upon whether B is less than L multiplied by P: i.e., whether $B < PL$.

*Carroll Towing*, 159 F.2d at 173.

Landes and Posner indicate that the "correct economic standard of negligence" is the "marginal" form of the Hand formula. Thus, in the formula the "marginal cost of care" would be substituted for B ("the burden or costs of precautions"), and "the marginal reduction in accident damage" would be substituted for PL ("the expected damages from the accident"). See Landes and Posner, *Economic Structure of Tort Law* at 87 (cited in note 174). Because this Article undertakes a comparative analysis, the original Hand formula will be employed.

177. In the marginal form, "it is negligent to use a level of care at which the marginal cost of accident avoidance is less than the marginal benefit from avoidance." Landes and Posner, *Economic Structure of Tort Law* at 87.

the probability of a surgeon infecting a patient during the course of an operation is in the range of one in 42,000 to one in 417,000.[178] This equation yields a probability $P_{hcp\text{-}p}$ of between $2.38 \times 10^{-5}$ and $2.3 \times 10^{-6}$. In the converse situation, in which infection occurs from patient to surgeon, the CDC estimates a higher probability ranging from one out of 4500 to one out of 130,000.[179] Thus, the probability $P_{p\text{-}hcp}$ ranges between $2.22 \times 10^{-4}$ and $7.6 \times 10^{-6}$. The ratio ($R_p$) of the probability of a patient transmitting infection to an HCP ($P_{p\text{-}hcp}$) to the probability of an HCP transmitting infection to a patient ($P_{hcp\text{-}p}$) ranges from 9.25 to 3.3.[180] Accordingly, the probability of an HCP being infected by a patient is between three and nine times greater than the converse.

The same type of comparative analysis can be performed with respect to loss (L). If, for purposes of convenience, damages are limited to those resulting from loss of earnings, assuming that other factors such as age and special and general damages are held constant, HCPs may earn in the order of five to ten times the amount of the average working population in damages.[181] Thus, the ratio ($R_l$) of loss to HCPs ($L_{hcp}$) to loss to patients ($L_p$) is in the range of five to ten.

Multiplying the ratio of probability ($R_p$) and the ratio of loss ($R_2$) results in a product ($R_{pl}$) of expected damages ranging approximately between sixteen and ninety-two.[182] In terms of the burden of taking precautions (B), this means that if an HCP were considered to be negligent in failing to inform a patient of the HCP's infected status, then a patient must undertake a burden sixteen to ninety-two times as great to avoid being found negligent.[183]

What, then, are the relative burdens placed upon HCPs and patients to avoid liability? As previously indicated in the risk-utility analysis, if HCPs must disclose their infected status, this means essentially

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178. See note 16. It should be understood that the present analysis is limited to the probability of a surgeon infecting a patient and vice versa, because of the availability of estimates of risk. The methodology, however, would be the same for other HCP-patient relationships.

179. Id.

180. That is: $R_{p/hcp} = P_{p/hcp} = 2.22 \times 10^{-4}$ to $7.6 \times 10^{-6}$
$P_{hcp/p} = 2.38 \times 10^{-5}$ to $2.3 \times 10^{-6}$
$R_{p/hcp} = 9.25$ to 3.3

181. The higher factor 10 is based upon comparing the median annual earnings of surgeons (approximately $200,000) to the median annual earnings of all workers (approximately $20,000). The factor five is based upon comparing the median earnings of all physicians (over $100,000) to that of all workers. See note 163. It is, of course, true that many HCPs (for example, nurses and radiology technicians) would not have earnings of such magnitude, but these HCPs are less likely to be involved in invasive procedures.

182. That is: $R_{pl} = R_p \times P_l = 3.3 \times 5$ to $9.25 \times 10$
$R_{pl} = 16.5$ to 92.5.

183. Stated another way, economic efficiency would permit the expenditure of approximately 16 to 92 times as much in terms of precautions (B) to avoid HCPs' being infected by noninforming patients compared to the converse, with each party incurring the respective expected damage (PL).

loss of their professional careers.[184] HCPs can, of course, voluntarily withdraw from performing invasive procedures and limit their practices to areas in which there is (presumably) essentially no risk of transmission. Such a course of conduct may result, however, in significant financial loss as well as the likelihood that patients still might refuse to be treated once word of the HCP's infectious status is out.[185]

In contrast, if a duty is placed upon patients to disclose their infected status, the burden imposed on them consists only of the risk of confidentiality being breached by the HCP. This burden would also include the risk attendant to the dissemination of that information throughout the health care system in which the patient is treated.[186] If a breach of confidentiality occurs, the potential for loss to patients is quite significant. However, the enactment of the Americans with Disabilities Act (ADA)[187] has significantly undermined the argument that disclosure by the patient will result in the HCP's refusal to provide treatment. The ADA classifies persons with HIV disease as disabled, and therefore imposes a duty on HCPs to treat them.[188] Moreover,

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184. See text accompanying notes 155-60.

185. See notes 6 and 31.

186. For example, if the patient is hospitalized and the patient's HIV status charted, a large number of HCPs and other hospital personnel may have access to the chart.

187. 42 U.S.C. §§ 12101 et seq. (1988 & Supp. 1993).

188. While it was unclear under the Rehabilitation Act, 29 U.S.C. § 794 (1973), whether the term "handicap" covered persons with HIV disease, there is little question that the ADA's definition of "disability" includes such individuals. The text of the ADA does not specifically refer to HIV or AIDS; however, comments to 42 U.S.C. § 12102(2) do: "[A] person infected with the Human Immunodeficiency Virus is covered under the first prong of the definition of the term 'disability' because of a substantial limitation to procreation and intimate sexual relationships." H.R. Rep. No. 101-485(II), 101st Cong., 2d Sess. 52 (1990), reprinted in 1990 U.S.C.C.A.N. 303, 334. See generally David W. Webber, *AIDS in the Workplace*, in *AIDS and the Law* 45 (Wiley, 2d ed. 1992) (discussing federal and state legal standards applicable to AIDS in the workplace); Jill Cohen, *Access to Medical Care for HIV-Infected Individuals Under the Americans with Disabilities Act: A Duty to Treat*, 18 Am. J. L. & Med. 233 (1992) (discussing common-law and statutory duties to treat people infected with HIV); Kenneth E. Labowitz, *Refusal to Treat HIV-AIDS Patients: What Are the Legal Obligations?*, 28 *Trial* 58 (Mar. 1992) (discussing AIDS under the Rehabilitation Act and the ADA). See also Joel Neugarten, *The Americans with Disabilities Act: Magic Bullet or Band-aid for Patients and Healthcare Workers Infected with the Human Immunodeficiency Virus?*, 57 Brooklyn L. Rev. 1277 (1992).

The ADA subchapter entitled "Prohibition of Discrimination by Public Accommodations" states as a general rule: "No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation." 42 U.S.C. § 12182(a). "Public accommodation" expressly includes "professional office of a healthcare provider, hospital, or other service establishment." Id. § 12181(7)(F). Therefore, the private physician's office is included under the ADA and the private doctor cannot discriminate based on HIV or AIDS, irrespective of whether the doctor receives federal funds. See Labowitz, 28 *Trial* at 59. This is not to say that AIDS patients face no real risk of being refused treatment by HCPs. See Mark Jackson and Nan D. Hunter, *"The Very Fabric of Health Care": The Duty of Healthcare Providers to Treat People Infected with HIV*, in

HCPs have an ethical responsibility to treat infected individuals; an HCP's refusal to treat without justification may result in the imposition of professional sanctions.[189] In any event, in comparing the burdens imposed respectively on HCPs and patients to inform the other of infectious status, it appears reasonably clear that the burden is greater on HCPs than on patients.

In summary, economic analysis suggests that if a duty is imposed on HCPs to disclose their infectious status, a duty should also be imposed on patients to disclose their infectious status to their HCPs, because disclosure imposes a relatively lower burden on patients than physicians, while failure to inform creates a higher probability of injury and greater loss to HCPs than to patients.

### *C. The Elements of a Cause of Action Based on Reverse Informed Consent*

#### 1. The Standard of Care

A duty imposed upon patients to disclose their infected status to HCPs according to one of the foregoing duty analyses would of course not be absolute. As in the case of direct informed consent, the duty of disclosure should be limited to material risks. No duty should be imposed on patients to disclose their infected status to an HCP undertaking a non-invasive procedure, such as a blood pressure test. This analysis raises the question of what standard courts should use to judge the patient's duty to disclose. It would be inappropriate to impose a professional standard of care on patients in regard to what constitutes a

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*AIDS Agenda* at 123 (cited in note 18) (listing instances of and reasons for HCP refusals to treat HIV patients).

189. The official policy of the American Medical Association states: "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 for HIV. Persons who are seropositive should not be subjected to discrimination based on fear or prejudice." American Medical Association, *Annotated Current Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association* 85 (1992). The American Dental Association has a similar position: "A dentist has the general obligation to provide care to those in need. A decision not to provide treatment to an individual because the individual has AIDS or is HIV seropositive, based solely on that fact, is unethical." American Dental Association, *Principles of Ethics and Code of Professional Conduct*, in Gorlin, ed., *Codes of Professional Responsibility* at 161 (cited in note 115). On the ethical duty to treat AIDS patients, see generally Walter J. Friedlander, *On the Obligation of Physicians to Treat AIDS: Is There a Historical Basis?*, 12 Rev. Infect. Dis. 191 (1990); Oscar W. Clarke and Robert B. Conley, *The Duty to 'Attend Upon the Sick,'* 266 JAMA 2876 (1991); Edmund D. Pelligrino, *HIV Infection and the Ethics of Clinical Care*, 10 J. Legal Med. 29 (1989); Bernard Lo, *Obligations to Care for Persons with Human Immunodeficiency Virus*, 4 Issues L. & Med. 367 (1988). See also Jackson and Hunter, *AIDS Agenda* at 136 (cited in note 18) (discussing the imposition of disciplinary sanctions on HCPs for refusal to treat infectious patients).

material risk.[190] A reasonable person standard, which, according to the Restatement formulation, would require the exercise of "such attention, perception of the circumstances, memory, knowledge of other pertinent matters, intelligence and judgment" possessed by reasonable persons, would be justifiable.[191] In addition, the Restatement would hold individuals who have "superior attention, perception, memory, knowledge, intelligence and judgment" to a superior standard.[192] This higher standard is significant because people inflicted with a particular disease often have a considerable body of information concerning that disease.[193]

### 2. The Causation Requirement: A Double-Edged Sword

Assuming that patients would be negligent in failing to inform HCPs of material risks, such as their HIV status, the critical requirement of causation must be satisfied in order to sustain liability on the theory of reverse informed consent. This issue is relatively simple when analyzed in the traditional context of informed consent running from HCP to patient. The sine qua non of giving consent to treatment is the patient being informed of the material risks of that treatment. Whether a particular patient would not have consented to treatment after having been informed of a material risk is a question of fact—either based upon the majority standard of the reasonable person or the minority subjective standard of the particular patient.[194]

With respect to HCPs the causation issue is considerably more difficult. The arguments against causation have a double edge. First, because HCPs have both an ethical and a legal duty (unless an exception applies) to proceed with treatment even when informed of the infectious status of their patients, disclosure would be irrelevant.[195] Second, even if the HCP had been informed of the infectious status of the pa-

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190. Patients as a class obviously cannot be expected to have the "skill and knowledge normally possessed by members" of the health care professions. See Restatement § 299A (cited in note 24) (Undertaking in Profession or Trade): "Unless he represents that he has greater or less skill or knowledge, one who undertakes to render services in the practice of a profession or trade is required to exercise the skill and knowledge normally possessed by members of that profession or trade in good standing in similar communities."

191. Id. § 289(a).

192. Id. § 289(b).

193. For example, diabetics—out of necessity—must manage their own diseases and thus must know how to monitor blood sugar, calculate insulin, select diet, and seek help for destabilizing infections. It may be expected that people with AIDS will be quite familiar with the newest experimental drugs and treatments for AIDS. Infected HCPs, of course, would or should have a professional level of knowledge about their infectious status.

194. See text accompanying notes 32-33.

195. Lawrence Gostin, *HIV-Infected Physicians and the Practice of Seriously Invasive Procedures*, 19 Hastings Ctr. Rep. 32, 34-35 (Jan.-Feb. 1989).

tient, the HCP neither would have nor could have taken greater care in performing the treatment, because universal precautions provide adequate protection and no less risky alternatives are available.[196]

With respect to the first argument, an ethical or legal duty imposed on HCPs to treat infectious patients does not necessarily impose a duty on HCPs to treat those who refuse to disclose a known infectious condition. Reasonable HCPs are likely to ask, in the course of taking patients' medical histories, whether the patients have an infectious disease, have been tested, or have had any symptoms of an infectious disease.[197] If a patient refuses to answer or if the patient's answers reasonably appear deceptive or ambiguous, the HCP should not have a duty to accept this person as a patient or to proceed with treatment.

Presumably, the law has not gone so far as to hold that HCPs must accept any and all persons as patients without requiring that potential patients disclose their HIV status.[198] The right to refuse patients becomes particularly important in a legal regime in which, once a potential patient discloses a seropositive status, HCPs have a legal duty to accept that person as a patient and proceed with treatment if competent to do so.[199] The intent of antidiscrimination statutes designed to benefit the disabled does not require HCPs to accept patients who refuse to disclose their infectious status.[200]

In addition, if patients refuse to disclose their infectious status, in certain instances it becomes impossible for HCPs to determine whether

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196. Id. See also Eisenstat, 44 Rutgers L. Rev. at 331-32 n.155 (cited in note 49) (arguing that hecause HCPs should use universal precautions, they have no need to know a patient's HIV status).

197. This Article does not suggest that this questioning should be a "fishing expedition." Questions asked should be medically or professionally indicated so that the HCP may appropriately diagnose and treat the individual both for the safety of the individual and that of the HCP. See Abe M. Macher, *HIV Disease/AIDS: Medical Background,* in *AIDS and the Law* § 1.9 at 14 (Wiley, 2d ed. 1992) (Suggested Guidelines for Presumption Diagnosis of Diseases Indicative of AIDS).

198. Indeed, the AMA gives the principle of professional autonomy ethical status: "A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services." American Medical Association, *Principles of Medical Ethics,* adopted July 22, 1980, Principle VI, in Gorlin, ed., *Codes of Professional Responsibility* at 191 (cited in note 115). See also Friedlander, 12 Rev. Infect. Dis. at 196 (cited in note 189) (discussing the conflict between the freedom to choose patients, which was added to the AMA Code in the 1912 revision, and the duty to treat patients even during an epidemic).

199. See note 188 (discussing the ADA).

200. For example, the ADA affords standing to invoke the enforcement procedures against HCPs only to "any person who is being subjected to discrimination on the basis of disability in violation" of the Act. 42 U.S.C. § 12188(a)(1) (cited in note 187). It is not apparent whether persons who refuse to disclose their "disability" would qualify.

a proposed treatment is appropriate for a patient with that infection.[201] The justification for requiring patients to disclose is not merely to protect HCPs against undertaking a procedure that might present a risk to themselves; disclosure also protects the infectious person by enabling HCPs to determine that a particular course of treatment is professionally appropriate. Moreover, the patient's failure to disclose eliminates the HCP's opportunity, within the professional standard of care, to refer the patient to someone better qualified to provide the appropriate treatment.[202] Indeed, some state statutes authorize physicians to test patients for HIV, under certain circumstances, without the patient's consent; such statutes reflect a public policy to protect both patients and HCPs.[203]

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201. See, for example, Kathryn L. McCance and Sue E. Huether, eds., *Pathophysiology: The Biologic Bases for Disease in Adults and Children* 265-66 (Mosby, 1990) (stating, "The clinical hallmark of immune deficiency is a tendency to develop unusual or recurrent, severe infections. . . . [E]ven simple procedures, such as penetrating the skin for routine blood tests, may lead to fatal septicemia (bacterial infection of the blood) in the immune-deficient person.").

202. If the HCP is informed of the patient's status, it may indeed constitute malpractice not to refer the patient if the HCP is unqualified to treat the patient. See, for example, Pegalis and Wachsman, *American Law of Medical Malpractice* at § 3:10 (cited in note 3). The Hippocratic oath recognizes the ethical duty to refer: "I will not use the knife, not even on sufferers from stone, but will withdraw in favor of such men as are engaged in such work." The Report of the House Committee on Education and Labor contains an exception to the duty to treat protected patients, which states: "Nothing in this legislation is intended to prohibit . . . a physician from referring a patient with a disability to another physician if that patient is seeking treatment outside the doctor's specialization and if the doctor would make a similar referral for an individual without that disability." H.R. Rep. No. 101-485(II), 101st Cong., 2d Sess. at 105-06 (1990), reprinted in 1990 U.S.C.C.A.N. 303, 388-89. Compare *State by Beaulieu v. Clausen*, 491 N.W.2d 662 (Minn. Ct. App. 1992) (holding that a dentist's referral of an HIV-positive patient to another dental facility violated a state human rights act; the referral was a mere pretext for discrimination because the dentist could have used the same universal precautions).

The ADA itself contains a second exception: "Nothing in this subchapter shall require an entity to permit an individual to participate in or benefit from the goods, services, [and] facilities . . . of such entity where such individual poses a direct threat to the health or safety of others. The term 'direct threat' means a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids or services." 42 U.S.C. § 12182(b)(3) (cited in note 187). The argument against disclosure to HCPs claims that HCPs may then assert that they are unqualified to treat the patient's particular condition.

203. See, for example, Illinois AIDS Confidentiality Act, 410 ILCS 305/8 (Smith-Hurd, 1993) (stating that "[n]otwithstanding the provisions of Sections 4 and 5 of this Act, written informed consent, information and counseling are not required for the performance of an HIV test: . . . (b) when in the judgment of the physician, such testing is medically indicated to provide appropriate diagnosis and treatment to the subject of the test, provided that the subject of the test has otherwise provided his or her consent to such physician for medical treatment"); La. Rev. Stat. Ann. § 40:1300.13(F)(4) (West, 1992) (providing for HIV-related testing without written consent "[w]hen, in the medical opinion of the physician requesting the HIV-related test, the request for informed consent to perform such test would be medically contraindicated"); Tex. Health & Safety Code Ann. § 81.103(b)(5) (Vernon, 1992) (noting that, as an exception to the requirement of confidentiality, the results of an AIDS test may be released to "a physician, nurse, or other health care personnel who have a legitimate need to know the test result in order to provide for their protec-

According to the second prong of the causation argument, even if the HCP had been informed before proceeding with the treatment, the HCP could have exercised no greater degree of care to protect herself from infection from the patient. This argument would be difficult to rebut if universal precautions were universal in their protection and universal in their use. Neither, of course, is true. Universal precautions do not absolutely protect either HCPs or patients.[204] For example, in

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tion and to provide for the patient's health and welfare"); R.I. Gen. Laws § 23-6-14(e) (1992) (providing that an HCP may test for AIDS "[i]n a licensed healthcare facility or in the private office of a physician in the event that an exposure evaluation group . . . determines that a health care provider has a significant exposure to the blood . . . of a patient and the patient . . . refuses to grant informed consent for an HIV test . . ."); Miss. Code Ann. § 41-41-16 (1992) (stating that "[a] hospital or physician, and employees of such hospital or physician, may conduct an acquired immune deficiency syndrome . . . antibody test . . . without specific consent for such tests if the hospital or physician determines that the test is necessary for diagnostic purposes to provide appropriate care or treatment to the person to be tested, or in order to protect the health and safety of other patients or persons providing care and treatment to the person to be tested"); Fla. Stat. Ann. § 381.004(3)(i)(4,8,10,11) (West, 1992) (providing that informed consent is not required "[f]or the performance of an HIV-related test by licensed medical personnel for medical diagnosis of acute illness where, in the opinion of the attending physician, the obtaining of informed consent would be detrimental to the patient . . ."). Compare N.C. Gen. Stat. § 130A-148(h) (1992) (providing that "[a] test for AIDS . . . may also be performed upon any person [by] . . . a physician . . . who is rendering medical services to that person when, in the reasonable medical judgment of the physician, the test is necessary for the appropriate treatment of the person; however, the person shall be informed that a test for AIDS virus infection is to be conducted, and shall be given clear opportunity to refuse to submit to the test prior to it being conducted, and further if informed consent is not obtained, the test may not be performed").

The AMA's position states that "[e]xplicit consent should not always be required prior to HIV testing. . . . [However,] [p]hysicians must be aware that most states have enacted laws requiring informed consent before HIV testing." American Medical Association, *Proceedings of the House of Delegates*, 141st Annual Meeting 97 (June 21-25, 1992) (copy on file with the Author) ("AMA, *Proceedings*"). In its report and recommendations, the AMA explicitly listed the actual consent requirements in the 50 states, noting that Colorado, Connecticut, Delaware, Florida, Hawaii, Illinois, Louisiana, Maine, Michigan, Montana, Ohio, Oregon, Pennsylvania, Rhode Island, Texas, Virginia, Washington, and Wisconsin all provide for some exception when a "patient may have exposed a healthcare worker." Id. at 93, Table 1.

204. Universal precautions are defined to include the following:

> All health-care workers should routinely use appropriate barrier precautions to prevent skin and mucous-membrane exposure when contact with blood or other body fluids of any patient is anticipated. Gloves should be worn for touching blood and body fluids, mucous membranes, or non-intact skin of all patients, for handling items or surfaces soiled with blood or body fluids, and for performing venipuncture and other vascular access procedures. . . . Masks and protective eyewear or face shields should be worn during procedures that are likely to generate droplets of blood or other body fluids to prevent exposure of mucous membranes of the mouth, nose, and eyes.

Centers for Disease Control, U.S. Dep't of Health and Human Services, *Recommendations for Prevention of HIV Transmission in Health-Care Settings*, 36 Morbidity & Mortality Wkly. Rep. 3, 5-6 (Supp. Aug. 21, 1987). See id. at 6 for a more detailed list of universal precautions.

While the CDC recommends universal precautions and OSHA mandates them (see 29 C.F.R. § 1910.1030(d), which states that "[u]niversal precautions shall be observed to prevent contact with blood or other potentially infectious materials"), the precautions do not always protect. Approximately 100,000 accidental needle stick injuries occur in the United States every year. See Jule

*Application of Milton S. Hershey Medical Center of Pennsylvania State University*,[205] a resident assisting in surgery was cut through his surgical glove by the surgeon, potentially exposing the patient to the HIV-infected blood of the resident. In *Boulais v. Lustig*, gloves would not have prevented the surgeon's scalpel from cutting the finger of the surgical technician, risking potential infection from a patient who had undisclosed AIDS.[206] In addition, numerous studies have shown that

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Louise Gerberding, *Reducing Occupational Risk of HIV Infection*, 26 Hosp. Practice 103, 108 (June 15, 1991) (reporting that double-gloving can reduce inner glove perforations by 80%). For a discussion of the need for strict precautions, see Walter E. Finkbeiner, *A Pound of Prevention When There Isn't a Cure*, 115 Archives Pathology Lab. Med. 762, 762 (1991) (stating that "[c]ut injuries . . . are likely to be the most common mode of transmission of blood-borne pathogens such as human immunodeficiency virus and hepatitis B virus").

Universal precautions often cannot prevent puncture injuries. One study found that the median injury rate in surgery was 4.2 cuts per 1000 operating hours. Assuming a 5% patient infection rate, the estimated HIV seroconversion rate of surgeons with over 30 years of practice is less than 1% for 50%, 1 to 2% for 25%, 2 to 6% for 15%, and greater than 6% for 10%. Albert B. Lowenfels, Gary P. Wormser, Rajesh Jain, *Frequency of Puncture Injuries in Surgeons and Estimated Risk of HIV Infection*, 124 Archives Surgery 1284, 1286 (1989). Lowenfels's study reported that, in addition to puncture wounds, 74% of the surgeons interviewed reported one or more episodes per year in which their gowns became soaked with blood, 72% had blood on their hands at the conclusion of surgery, and 46% had performed surgery that resulted in an abrasion or cut. Id. at 1285. See also Mary E. Willy, et al., *Adverse Exposures and Universal Precautions Practices Among a Group of Highly Exposed Health Professionals*, 11 Infection Control Hosp. Epidemiology 351 (1990) (noting that of those responding to the survey, 74% had soiled their hands with blood at least once within the last six months, 51% had splashed blood or amniotic fluid in their faces, and 24% reported one or more needlestick injuries). Another study of a 700-bed general hospital concluded that: "The three infection control programs failed to produce a major reduction in reported needlestick injuries, except for a decrease in recapping injuries associated with the placement of rigid sharps disposal containers in all patient rooms. These observations indicate that new approaches are needed to reduce needlestick injuries." Calvin C. Linnemann, et al., *Effect of Educational Programs, Rigid Sharps Containers, and Universal Precautions on Reported Needlestick Injuries in Healthcare Workers*, 12 Infection Control Hosp. Epidemiology 214, 214 (1991). See also Janine Jagger, *Do Universal Precautions Reduce Needlestick Injuries?*, 266 JAMA 359, 360 (1991) (letter to the editor) (stating that "[t]here is a growing body of evidence indicating that [universal precautions] alone are not sufficient to reduce the risk of needlestick injuries"). But see Edward S. Wong, et al., *Are Universal Precautions Effective in Reducing the Number of Occupational Exposures Among Health Care Workers?*, 265 JAMA 1123, 1123 (1991) (noting that implementing universal precautions led to a decrease in the number of exposure incidents that resulted in direct contact with blood and body fluids from 5.07 to 2.66 exposures per physician per patient care month).

Further, surgical gloves often contain holes or pores regardless of puncture. One study of latex gloves reported that "[t]he safranin test was positive in 27 of 28 (96.4%) leaky gloves tested, indicating a high risk of exposure to potentially infected fluids when leaky gloves are used." Bienvenido G. Yangco and Nathaniel F. Yangco, *What Is Leaky Can Be Risky: A Study of the Integrity of Hospital Gloves*, 10 Infection Control Hosp. Epidemiology 553, 553 (1989). The author concluded, "There is a need for the Food and Drug Administration to establish more stringent guidelines for manufacturing gloves and to verify compliance with these guidelines." Id.

205. 407 Pa. Super. 565, 595 A.2d 1290 (1991), appeal granted, 531 Pa. 640, 611 A.2d 712 (1992).

206. See note 123. Neither the surgeon nor the technician was wearing gloves during the procedure. The jury, which returned a verdict for the plaintiff, must have found that wearing

universal precautions are not universally used.[207] Common sense, however, suggests that HCPs would be more likely to adhere more rigorously to universal precautions when aware of the infectious status of their patients than when they treat "generic" patients.

If the professional standard of care requires use of universal precautions with respect to all patients for all invasive procedures,[208] then contributory negligence may be asserted as a defense by a noninforming, infected patient if an HCP fails to use the required precautions. Nonetheless, the patient would still bear the burden of proving causation—that the use of such precautions would have prevented the HCP from becoming infected.[209] The defense of assumption of risk, of course,

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gloves would not have prevented the cut. The jury did find the plaintiff 1% at fault, possibly based on her failure to wear gloves, or perhaps based on her having her hand in the wrong place. See note 121.

207. A study to determine whether adherence to universal precautions improved after educational programs revealed that the number of infractions actually rose from 57% to 58%. Kenneth R. Courington, Sarah L. Patterson, and Richard J. Howard, *Universal Precautions Are Not Universally Followed*, 126 Archives Surgery 93, 93 (1991). Before the educational programs, infractions with regard to universal precautions occurred in 75% of operating room procedures, 30% of surgical ward procedures, and 75% of surgical intensive care unit procedures. After the education programs, the rates of infraction incidence were 81%, 32%, and 40%, respectively. Id. Therefore, only in surgical intensive care unit procedures did the educational programs appear to have any effect. Compare Gabor D. Kelen, et al., *Substantial Improvement in Compliance with Universal Precautions in an Emergency Department Following Institution of Policy*, 151 Archives Internal Med. 2051, 2051 (1991) (finding that compliance with universal precautions rose from 44% to 72.77% after department policy made the procedures mandatory; nonetheless, in over 25% of the cases, universal precautions were not used).

Another area of significant noncompliance concerns the recapping of needles. The CDC's recommendation noted that universal precautions mandate that needles never be recapped. In one study, however, researchers concluded that the percentage of recapped needles in disposal boxes always exceeded 25%; the percentage exceeded 50% in four instances. Marshall H. Becker, et al., *Noncompliance with Universal Precautions Policy: Why Do Physicians and Nurses Recap Needles?*, 18 Am. J. Infection Control 232, 232 (1990).

Another study concerned the "representative population of healthcare workers who were thought likely to have frequent and intensive exposures to blood and other bodily fluids." Of those responding to a survey, 74% had soiled their hands with blood at least once in the last six months, 51% had splashed blood in their faces, and 24% had needle stick injuries. Despite this, and despite high levels of expert training and knowledge, roughly only one-half (55%) reported compliance with universal precautions. The study concluded that development of new strategies for universal precaution compliance was essential. Willy, et al., 11 Infection Control Hosp. Epidemiology at 351 (cited in note 204). See also Gabor D. Kelen, et al., *Adherence to Universal (Barrier) Precautions During Interventions on Critically Ill and Injured Emergency Department Patients*, 3 J. Acquir. Immune Defic. Syndr. 987, 987 (1990), in which a study found that HCPs fully adhered to universal precautions only 44% of the time. Even more disturbing, the study revealed that only 19.5% compliance occurred during interventions with profuse bleeding. Reasons offered for noncompliance included lack of time (from 47% of those not adhering), the claim that precautions interfered with procedures (33%), and the claim that the materials associated with universal precautions were "uncomfortable" (23%). Id.

208. See note 204 (noting the CDC definition of universal precautions).

209. In *Boulais v. Lustig*, 1992 Cal. LEXIS 65 (1992), the use of universal precautions evidently would not have prevented the injury. See note 206.

would require that the HCP have actual knowledge of the patient's infectious status. In short, HCPs clearly have a greater incentive from the standpoint of self-interest to employ universal precautions when they have knowledge of the patient's infectious condition than when they neither know nor have reason to know.

Whether HCPs will or can take increased care to avoid infections is questionable when it is well known that universal precautions do fail. More specifically, the issue is whether HCPs would use a higher degree of care in treating known infectious patients than in treating those patients about whom they have no knowledge. Tort law, economic theory, and common sense lead to the conclusion that HCPs would take a higher degree of care when dealing with an infectious patient when there is some recognizable risk of transmission; HCPs would likely take a lesser degree of care when there is no risk of infection. As Dean Prosser stated, "As the gravity of the possible harm increases, the apparent likelihood of its occurrence need be correspondingly less to generate a duty of precaution."[210] Whether knowledge of the infected status of a patient will prevent injury is not the issue; rather, the reverse informed consent analysis is concerned with the question whether HCPs should be deprived of the opportunity to exercise care for their self-protection in direct proportion to the risk posed by infected patients.

In terms of economic theory, increasing expenditures for accident avoidance are economically justified as the expected damages from an accident increase (that is, as the probability of loss times the magnitude of loss increases).[211] Stated simply, additional care is economically justified when an increased probability of significant loss exists. Because the risk of infection is at least marginally higher when patients have not informed their HCPs, HCPs' higher expenditures for care of nondisclosing patients are economically justified.[212]

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210. Keeton, et al., *The Law of Torts* at 171 (footnote omitted) (cited in note 13).

211. See Posner, *Economic Analysis of Law* at 148-51 (cited in note 174), for the marginal form of this proposition.

212. On the other hand, the vast majority of patients are not infected; therefore, the use of universal precautions for all patients in order to vindicate patients' right not to disclose does not seem to be economically justified. Universal precautions have been estimated to add hundreds of millions of dollars in additional costs per year to already burgeoning healthcare costs: "Infection control costs more than doubled after implementations of universal precautions. . ." *Universal Precautions Reduce Worker Exposures, Help Raise Costs*, Hosp. Infection Control 147, 187 (Nov. 1989). See also Bradley N. Doebbeling and Richard P. Wenzel, *The Direct Costs of Universal Precautions in a Teaching Hospital*, 264 JAMA 2083, 2083 (1990) (stating that "[u]niversal precautions are estimated to have cost at least $336 million in the United States in fiscal year 1989 after adjustment for inflation"). Compare Steve Taravella, *OSHA, CDC Issue Rules on Infection Control*, 21 Mod. Healthcare 3, 3 (Dec. 9, 1991) (stating that "[e]mployers—mainly health facilities, medical offices and correctional sites—will spend $821 million annually to comply, OSHA

One commentator has made an argument, presumably based on common sense, that HCPs may be more likely to act negligently if informed of the infectious status of their patients because of the increased stress associated with treating such patients.[213] This approach to health care appears to ignore the "under the circumstances" requirement used to evaluate whether an HCP's conduct is negligent. One may seriously question the common sense of witholding any information from HCPs that might affect their well being, let alone that of their patients.

In short, the fact that HCPs may not be able to refuse to treat infectious patients does not preclude the establishment of a causal relationship between a patient's failure to inform and damages suffered by an HCP. This causal relationship may be established by the fact that HCPs may refuse to treat the patient, or may refuse to undertake a particular procedure that, according to the appropriate professional standard, is contraindicated for an infectious person. In addition, patients' failure to disclose their infectious status denies HCPs the opportunity to treat patients in a more careful manner. *But for* the patient's failure to disclose, the HCP would have employed a standard of care (more protective of the HCP) appropriate to the increased probability of loss due to the infected condition of the patient.

### 3. Damages

The final element necessary to complete a cause of action based upon reverse informed consent is damages suffered by the HCP as a consequence of the patient's failure to disclose. The clearest case for recovery arises when an HCP actually becomes infected as a consequence of treating a patient who fails to disclose infected status. Addi-

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estimated"). These anticipated extra costs could be devastating to hospitals and medical institutions already in severe financial crises. Id.

Predicting the costs of universal precautions is often very difficult, making it harder for health care providers to plan ahead financially because they are unable to predict accurately overhead costs of operation. See *Universal Precautions' Cost Exceeds Estimates—Study*, 20 Mod. Healthcare 13, 13 (Oct. 29, 1990). OSHA had estimated that hospitals would have to spend $195 million to comply with universal precautions in 1989, but the actual costs of compliance were $299 million. OSHA's estimated figure was off by more than one-third (35%). Id. In *American Dental Association v. Martin*, 984 F.2d 823 (7th Cir. 1993), the court indicated that the $821 million compliance costs estimated by OSHA would not break the health care industry.

213. See Gostin, 48 Md. L. Rev. at 29 (cited in note 6) (stating that "[i]ndeed, knowledge that a patient is HIV-positive may well increase the occupational risk to HCPs, perhaps because the HCP is overly conscious of the threat of HIV and thus becomes hesitant and awkward"). It appears to be mere conjecture that HCPs, who are accustomed to stress, would be more careful and more competent in treating a patient if they did not know of the patient's infected condition. Compare Eisenstat, 44 Rutgers L. Rev. at 331-32 n.155 (cited in note 49) (arguing against mandatory testing of patients "since it would create a false sense of security among HC[P]s").

tionally, awarding damages to HCPs for fear of contracting the infectious disease seems at least comparable to the converse situation in which a patient is exposed to an infected HCP.[214] Indeed, HCPs involved in the treatment of infected patients may have a heightened fear of infection because of repeated opportunities for exposure and their knowledge of the devastating progression of the disease. One would also presume that because of their professional knowledge, HCPs would be aware of the need and the ethical responsibility for undergoing testing in appropriate circumstances.[215]

In summary, on the basis of the foregoing analysis, it appears that reverse informed consent may provide a viable cause of action for HCPs who are infected as a result of treating patients who fail to inform their HCPs of their infected status. The cause of action may not be as straightforward nor as compelling, perhaps, as that based upon the traditional duty running from HCPs to their patients. Nonetheless, the adoption of the reverse informed consent doctrine appears to be justifiable within traditional tort theory and analysis; in addition, the doctrine effectuates public policy and the ethical principles of nonmaleficence, autonomy, and justice, which apply equally to HCPs and patients.

## IV. Limits of Civil Liability

As mentioned in the Introduction, the judicial system is often forced to deal with problems that the executive and legislative branches do not have the political will to address.[216] Thus, however imperfectly

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214. See notes 79-93 and accompanying text (discussing damages).

215. The American Medical Association announced its latest position with respect to HIV testing at its 1992 Summer Annual Meeting. The AMA remained opposed to mandatory testing of physicians. AMA, *Proceedings* at 97 (cited in note 203). The Board of Trustees further recommended that "[a]ny physician who performs patient care procedures that pose a significant risk of transmission of HIV infection should *voluntarily* determine his/her serostatus at intervals appropriate to risk." Id. (emphasis added). Thus, the AMA has made it an ethical consideration for physicians to test themselves for HIV, although this testing is voluntary. The recommendations further state that the HIV-infected physician should "disclose his/her serostatus to a state public health official or local review committee. . . . This review committee may recommend to the appropriate authority restrictions upon the physician's practice, if they believe there is a significant risk to patients' welfare." Id. Therefore, the AMA apparently does not require HIV-infected physicians to disclose this information to the patient. This position presumably is due in part to the AMA's position that the risk of transmission from an infected HCP "remains immeasurably small": "[T]he AMA reaffirm[s] its previous policy and continues to enhance its campaign to educate patients on the extremely small risks of iatrogenic (physician-induced) HIV infection." Id. at 98.

216. See note 11. The use of criminal sanctions for failure to inform has been proposed; the Helms Amendment provides one example of such a proposal. See note 9. A Delaware bill, introduced in 1991, would make it a misdemeanor for either HCPs or patients to fail to inform the other of their HIV-positive status. See Donald H. J. Hermann, *State Legislatures Consider Bills Dealing with HIV-Infected Health Care Providers in Face of CDC Inaction*, 24 J. Health & Hosp.

equipped the judicial system may be to resolve such problems, it must do so. This dilemma is complicated by the realization that the civil liability system often has difficulty in fulfilling the policy goals attributed to it, let alone solving broader public policy issues. The policy goals generally attributed to the tort system are to provide compensation for those injured by tortious conduct and to deter tortious conduct.[217] The question considered in this Part is whether these policy goals can be achieved by imposing liability on patients who fail to inform HCPs of their infected status if their HCPs consequently suffer compensable injuries. The Article again undertakes this analysis in a comparative manner in order to evaluate the relative efficacy of tort law in achieving its goals of compensation and deterrence by imposing liability on noninforming patients as compared to noninforming HCPs.

### *A. Compensation*

With respect to the goal of compensation, assuming that liability will be imposed on HCPs who fail to inform patients of their infected status, what is the likelihood that injured patients would be able to satisfy any judgment imposed upon the HCP? If the HCP is covered by appropriate malpractice insurance, which will be the case in most instances because such policies generally cover causes of action based upon informed consent, then the likelihood of compensation should be

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L. 215, 215-16 (1991) (discussing this bill and other state proposals). Whether the threat of criminal sanctions will provide a sufficient incentive for infected persons to disclose poses the same problems as does the threat of civil liability. See also S.B. 1519, 40th Leg., Reg. Sess., 1992 Ariz. Laws (declaring an HIV-infected physician's failure to inform patients before performing surgery unprofessional conduct); H.B. 191, 136th Gen. Assem., Reg. Sess., 1991-92 Del. Laws (requiring testing of HCPs every six months and requiring disclosure of positive results to patients); S.B. 20, 13th Leg., 1st Reg. Sess., 1993 Fla. Laws (providing for mandatory HIV-testing of patients prior to entering a hospital without requiring informed consent); S.B. 54, 17th Leg. Sess., 1st Reg. Sess., 1993 Haw. Laws (requiring HIV-infected physicians and dentists to inform prospective patients); H.B. 3048, 87tb Gen. Assem., Reg. Sess., 1991-92 Ill. Laws (requiring HIV-positive HCPs to inform patients before conducting invasive procedures); S.B. 116, 88th Gen. Assem., Reg. Sess., 1993-94 Ill. Laws (deleting a provision authorizing physicians to perform HIV tests after obtaining general consent to treatment); H.B. 4519, 87th Leg., Reg. Sess., 1993 Mich. Laws (requiring periodic testing for certain HCPs and patients); S.B. 88, 215th Gen. Assem., 1st Reg. Sess., 1993 N.Y. Laws (creating a duty on the part of physicians, dentists, and patients to disclose their HIV-status).

217. The major purposes of tort law have been stated as follows:

> (1) to provide a peaceful means for adjusting tbe rights of parties who might otherwise "take the law into their own hands"; (2) to deter wrongful conduct; (3) to encourage socially responsible behavior; and, (4) to restore injured parties to their original condition, insofar as the law can do this, by compensating them for their injury.

William L. Prosser, et al., *Cases and Materials on Torts* 1 (Foundation, 8th ed. 1988). The first three purposes may be generally described as aspects of deterrence; the three purposes also serve the same social goals as criminal law. See George C. Christie and James E. Meeks, *Cases and Materials on the Law of Torts* 5-6 (West, 2d ed. 1990).

quite high, at least within the limits of the policy.[218] Even if the damages exceed the policy's limits, the patient may be able to obtain satisfaction out of the HCP's personal resources.[219]

In contrast, patients generally do not carry liability insurance that would cover HCPs infected by noninforming patients. Thus, any compensation that an HCP may recover would, in most instances, come out of the personal assets of patients. Nonetheless, some patients may carry some form of liability insurance (such as homeowners or rental liability insurance) that provides coverage for "bodily injury" caused by an "occurrence." The HCP may recover provided that infection of an HCP by a noninforming patient falls within the definitions of these terms.[220] Case law seems to support the applicability of the standard form of

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218. See, for example, *South Carolina Medical Malpractice Liab. Ins. v. Ferry*, 291 S.C. 459, 354 S.E.2d 378 (1987), which held that an insurer's liability under a standard medical malpractice insurance policy is limited to the "performing or rendering of 'professional' acts or services. . . . A 'professional' act or service is one arising out of a vocation, calling, occupation, or employment involving specialized knowledge, labor, or skill, and the labor or skill involved is predominantly mental or intellectual, rather than physical or manual." Id. at 380 (quoting *Marx v. Hartford Accident and Indem. Co.*, 183 Neb. 12, 157 N.W.2d 870, 871-72 (1968)). The *Ferry* court held that allegations against the insured dentist, including "fail[ure] to obtain a proper informed consent," were covered by the policy. *Ferry*, 354 S.E.2d at 380-81.

219. See note 163 (discussing median salaries of HCPs).

220. The standard homeowner's insurance policy provides coverage with respect to personal liability as follows:

> If a claim is made or a suit is brought against an *insured* for damages because of *bodily injury* or *property damage* caused by an occurrence to which this coverage applies, we will:
> 1. pay up to our limit of liability for the damages for which the *insured* is legally liable. Damages include prejudgment interest awarded against the insured.
> 2. provide a defense at our expense by counsel of our choice, even if the suit is groundless, false or fraudulent. We may investigate and settle any claim or suit tbat we decide is appropriate. Our duty to settle or defend ends when the amount we pay for damages resulting from the *occurrence* equals our limit of liability.

American Bar Association, *Annotations to the Homeowners Policy* 17-18 (ABA, 2d ed. 1990) (emphasis in original) ("ABA, *Homeowners Policy*"). The ABA defines "bodily injury" as "bodily harm, sickness or disease, including required care, loss of services and death that results." Id. at 1. The annotation defines "occurrence" as "an accident, including continuous or repeated exposure to substantially the same general harmful conditions, which results during the policy period, in . . . bodily injury . . ." Id. at 2 (emphasis omitted).

According to these general definitions, the transmission of HIV (at least when the insured does not know of his or her condition) appears to be an "occurrence" and the resulting transmission constitutes "bodily injury," HIV being a "sickness or disease." A more difficult question asks whether the mere fear of contracting AIDS would constitute a "bodily injury." In *Holcomb v. Kincaid*, 406 S.2d 646 (La. Ct. App. 1981), the court held that a complaint alleging humiliation, embarrassment, and mental anguish stated a claim for "bodily injuries" for which the insurer was obligated to defend:

> We attach significance to the fact that the policy defines bodily injury to mean "sickness or disease" in the instant case. These broad terms must include mental distress which persists over a period of time and necessitates the taking of some medication and interferes with one's performance at work. . . . We are unable to separate a person's nerves and tensions from his body. It is common knowledge that worry and anxiety can and often do have a direct effect on other bodily functions.

homeowner insurance in the context of reversed informed consent.[221] For example, in *Loveridge v. Chartier*,[222] the Wisconsin Supreme Court held that a homeowner's policy covered damages arising from the insured's sexual intercourse with an underage girl who contracted herpes from him. Although the insured's action constituted a misdemeanor, the court reasoned that the sexual contact was not per se intentional, as is rape or molestation; hence, the transmission of herpes could not be termed intentional.[223] According to this line of reasoning, even a patient's intentional withholding of information about the patient's infected status from an HCP would not fall within the "intentional" exclusion of a standard homoeowners policy.[224]

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Id. at 649 (citations omitted). See also *McGuire v. Am. States Ins. Co.*, 491 S.2d 606 (Fla. Dist. Ct. App. 1986), aff'd, 510 S.2d 1227 (1987) (holding that a material issue of disputed fact existed regarding whether the plaintiff's complaints based on malicious prosecution and false imprisonment, which the plaintiff claimed had caused mental distress, headaches, and muscle spasms, constituted "bodily injury" involving sickness or disease sufficient to invoke the provisions of a standard policy). But see *Transamerica Ins. Co. v. Doe*, 173 Ariz. 112, 840 P.2d 288, 291 (Ariz. Ct. App. 1992) (holding that the insureds did not have a claim for "bodily injury" under an auto insurance policy based upon exposure to the blood of an automobile accident victim with AIDS; the court did not consider the need for testing and fear of contracting AIDS to be bodily injuries). For a discussion of whether fear of contracting AIDS while still testing negative should be sufficient to sustain a cause of action in the context of negligent infliction of emotional distress, see notes 79-93 and accompanying text.

221. *See North Star Mutual Ins. Co. v. R.W.*, 431 N.W.2d 138 (Minn. Ct. App. 1988). In *North Star*, T.F. was insured under a standard homeowner's policy and engaged in voluntary sexual intercourse with R.W. at T.F.'s home. R.W. alleged that T.F. negligently transmitted herpes to her through the intercourse. T.F. alleged that he did not know he had herpes until a subsequent medical exam. Id. at 139. The appellate court held that herpes was a "disease" and constituted a bodily injury. Id. at 140. In finding that T.F.'s actions were an "accident" under the definition of "occurrence" in the policy, the court stated: "The claim is based on negligence principles. Accordingly, we hold that this is a material issue of fact for a jury to decide." Id. at 141. See also *State Farm Fire and Casualty Co. v. Irene S.*, 526 N.Y.S.2d 171 (N.Y. App. Div. 1988) (holding that although injuries from the defendant's intentional acts of rape would not be covered by a standard policy, unintended injuries such as the transmission of herpes would be covered); *State Farm Fire & Casualty Co. v. Eddy*, 267 Cal. Rptr. 379 (1990) (holding that an insurer had a duty to defend the insured in an action based upon transmission of genital herpes by way of voluntary sexual intercourse).

222. 161 Wis.2d 150, 468 N.W.2d 146 (1991).

223. Id. at 151. If intent to injure were inferred from the defendant's criminal acts, insurance coverage would not apply because of the liability exclusion for intentional acts. See note 224 and accompanying text. In *Loveridge*, the court refused to infer an intent to injure: "In Wisconsin, the fact that a law is intended to prevent harm is insufficient to support an inference that as a matter of law an insured intended to harm someone when the insured violated the law. . . . . [C]onsensual sexual intercourse between an adult and a 16- or 17-year-old does not create a 'substantial risk of injury or death.' " Id. at 152-53 (quoting *Raby v. Moe*, 153 Wis.2d 101, 450 N.W.2d 452, 457 (1990)).

224. The standard homeowner's insurance policy excludes personal liability coverage for bodily injury "which is expected or intended by the insured." ABA, *Homeowners Policy* at 18 (cited in note 220). Thus, even if a patient knew that he or she had AIDS, one could argue that coverage should still apply because, given the small chance of transmission, a patient could hardly "intend"

In any event, the tort goal of providing compensation appears to be more readily achievable by patients seeking recovery from HCPs than the converse, but the possibility of HCPs recovering from patients is not entirely foreclosed.

### B. Deterrence

The goal of deterrence is less well served with respect to both HCPs and patients. As is the general case with respect to insurance coverage, the deterrence goal may be undermined by failing to impose any direct liability upon HCPs, because the policy carrier pays any judgments within the policy limits.[225] The potential for increased premiums or the potential for cancellation of the policy may, however, provide a deterrent effect.[226] In the case of infected HCPs with limited career and life expectancy, however, such a deterrent hardly provides an effective incentive to disclose. Moreover, HCPs face a great disincentive to inform patients of their infected status, because such disclosure is likely to result in the loss of professional livelihood or, at minimum, a severe restriction in the individual HCP's scope of practice. Thus, the deterrent effect arising from the fear of liability based upon failure to secure informed consent from patients would likely have minimum im-

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transmission through a surgical or other medical procedure, even if the patient's failure to inform the physician was considered either a crime or a tort.

See *Alber v. Farm Bureau Mutual Ins. Co.*, 187 Mich. App. 557, 468 N.W.2d 282 (1991). In *Alber*, the insured engaged in sexual intercourse with the plaintiff, who, although 27 years old, was mildly retarded. Id. at 283. As a result, the insured was charged with third-degree criminal conduct. Id. at 284. The court held that the intentional act exclusionary clause in the homeowner's policy did not relieve the defendant of the duty to defend: "[T]he exclusionary clause is applicable only if the insured subjectively intended both his act and the resulting injury. . . . While Smith readily admits that he intended to have sexual intercourse with [plaintiff], he has consistently denied any intent to injure [plaintiff], as well as any awareness that she was incapable of giving consent." Id. (citations omited). See also *North Star*, 431 N.W.2d at 143 (considering it a material issue of fact whether the insured's sexual intercourse resulting in transmission of herpes was "intentional" conduct); *Eddy*, 267 Cal. Rptr. at 382-84 (prohibiting indemnification of the insured for conduct the insured knew to be unlawful if the insured knew at the time he had intercourse that he was acting unlawfully by potentially transmitting genital herpes).

225. See Landes and Posner, *The Economic Structure of Tort Law* at 9-10 (cited in note 174). The authors question the deterrent effect of tort law by noting that people are "dominated by a concern for personal safety rather than the legal and hence financial consequences of behavior—especially on the part of those who carry liability insurance"; nonetheless, Landes and Posner maintain that the available empirical evidence indicates a deterrent effect, even in the area of automobile accidents in which liability insurance is widespread. See also Pegalis and Wachsman, *American Law of Medical Malpractice* at 2-9 (cited in note 3); Harvard Study at 2-3, 2-8 (cited in note 75) (claiming that "to suggest that liability insurance fully insulates doctors from the impact of the tort system is somewhat unrealistic"); Peter A. Bell, *Legislative Intrusions into the Common Law of Medical Malpractice: Thoughts About the Deterrent Effect of Tort Liability*, 35 Syracuse L. Rev. 939, 990 (1984) (concluding that malpractice liability has a deterrent effect).

226. See Landes and Posner, *The Economic Structure of Tort Law* at 10-11 (cited in note 174).

pact on HCPs. Nonetheless, malpractice insurance carriers have an economic incentive to cancel policies of infectious HCPs.[227] Further, health care institutions employing or granting staff privileges to infected HCPs would be likely to restrict the practice of those HCPs.[228]

Patients, who are less likely to have insurance coverage, are deterred by the fear of having their personal assets attached to satisfy judgments against them. In many instances, infected patients are likely to be judgment-proof; in such cases, little effective economic incentive to disclose exists. Moreover, patients, like HCPs, have strong disincentives to disclose their infected status, for fear of not receiving health care treatment and of losing health insurance coverage and employment. Indeed, patients may be induced to misrepresent their infected status if they fear HCPs will not accept them as patients or continue to treat them.[229] Some deterrent effect may exist, however, because patients often will not have sufficient personal assets to pay for health care and other needs if they face liability for failure to disclose.

Although neither compensation nor deterrence appears to be effectively served with respect to HCPs seeking redress in tort against noninforming patients, this fact does not undermine the validity of the proposed cause of action based upon reverse informed consent. Individual plaintiffs (including HCPs), of course, would be primarily concerned with compensation rather than deterrence. If any possibility of compen-

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227. See generally Mark S. Rhodes, *Health Insurance*, in *AIDS and the Law* at 287 (cited in note 188) (discussing exclusions, testing, and statutory limitations); Mark H. Jackson, *Health Insurance: The Battle over Limits on Coverage*, in *AIDS Agenda* at 146 (cited in note 18) (discussing discriminatory exclusions and caps on benefits). See also *McGann v. H & H Music Co.*, 946 F.2d 401 (5th Cir. 1991) (holding that an employer did not violate ERISA when it reduced the maximum benefits available to persons with HIV under a group medical plan from $1 million to $5000).

228. See, for example, *Estate of Behringer v. Med. Ctr. at Princeton*, 249 N.J. Super. 597, 592 A.2d 1251 (1991) (discussing a hospital that required informed consent and barred an HIV-positive surgeon from performing invasive procedures). See generally Carol J. Gerner, *AIDS in the Healthcare Workplace: Rights and Responsibilities*, 1 Annals Health L. 119 (1992) (reviewing cases). Under the ADA, employees with AIDS qualify as disabled; therefore, employers may be restricted from firing or reassigning a "qualified individual with a disability" who, "with or without reasonable accommodation, can perform the essential functions of the employment position that such individual holds or desires." 42 U.S.C. § 12111(8) (West, 1992). See Feldblum, *Workplace Issues: HIV and Discrimination*, in *AIDS Agenda* at 270, 279-84 (cited in note 18) (discussing the ADA in the context of employment relations). Infected HCPs, however, are fighting back; for example, an HIV-positive surgeon has filed complaints in federal district court and with the Equal Employment Opportunity Commission after a hospital suspended his clinical privileges. See 1 Health L. Rep. (BNA) 381 (1992). In response to a letter from the U.S. Dep't of Health and Human Services, a hospital reinstated an HIV-infected nurse, who had been reassigned to a secretarial position, to her critical care position. Id. at 411.

229. The ADA and other nondiscrimination statutes theoretically may bar HCPs from refusing to provide treatment based on a patient's infectious status. Infectious patients may find it more realistic, however, to rely on nondisclosure to obtain treatment rather than to rely on the vagaries of the law.

sation exists based upon the particular financial condition or insurance coverage of a patient, undoubtedly the HCP, or someone acting on her behalf, will take civil action.

### C. *The Effectiveness of Other Measures of Protection*

Alternative public and private measures may protect HCPs against nondisclosing patients if the tort system effectively cannot. There are significant public policy interests in protecting HCPs. HCPs are highly valuable members of society who provide necessary health care services to the general public as well as to infected individuals. Exposing HCPs to unreasonable risks created by nondisclosing patients if those risks could be made reasonable by disclosure would offend public policy.[230] In addition, requiring disclosure by patients to HCPs furthers the public policy goal of reducing the spread of infectious disease, not only to HCPs but also to others who may be at risk.[231] Also, imposing a duty on patients to disclose their infectious status would serve the goal of providing wide access to health care to infectious patients. Such disclosure should minimize the fear of HCPs, and may encourage them to continue practicing in high-risk fields. Finally, patients themselves may be protected by disclosing their infectious status to their HCPs, because disclosure enables their HCPs to diagnose and treat them according to the most appropriate professional standards.

As previously mentioned, a number of states have enacted statutes authorizing physicians to order HIV testing of patients without patients' informed consent, provided that testing is medically indicated.[232] The constitutionality of such legislation will likely be tested. In any event, it is unlikely that such legislation will be uniformly adopted, and it is unclear whether physicians would rely widely upon such statutes, although physicians are the only HCPs authorized by state statutes to act without patient consent. Moreover, patients who are aware of the statutes may be even more disinclined to reveal personal characteristics and symptoms to their physician for fear of being tested.[233]

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230. This paradox is recognized (but not resolved) in *Ordway* (discussed in text accompanying notes 124-40).

231. See Larry Gostin and William J. Curran, *AIDS Screening, Confidentiality, and the Duty to Warn*, 77 Am. J. Pub. Health 361, 364 (1987) (discussing the duty of physicians to screen patients for AIDS and to warn third parties). Disclosure to third parties may be regulated by statute. For example, under the Illinois AIDS Confidentiality Act, 410 ILCS 305/9(a) (Smith-Hurd, 1993), a physician may notify the spouse of a patient who tests positive for HIV if the patient refuses to do so or a reasonable period of time has elapsed without notification. The statute immunizes the physician from criminal and civil liability for good faith disclosure or nondisclosure.

232. See note 203.

233. Indeed, patients may forego health care because of the fear of being tested in jurisdictions that have statutes permitting testing without the patient's consent.

In the absence of any significant deterrent effect on patients imposed by the tort system, and the unlikelihood of any effective public deterrent being provided, concerned HCPs may adopt certain private measures for their own protection. Many of these measures are obvious and presumably HCPs already take many of these precautions. These steps include the careful taking of patient histories, asking patients directly whether they are infected or have been tested, and requesting test results. If a patient has not been tested, an HCP should question the patient carefully about common symptoms of infectious diseases. Although the professional standard of care now requires the use of universal precautions with respect to all patients, more rigorous usage may be indicated, particularly with respect to patients who are less than forthright in their disclosures. In high risk situations in which universal precautions are not fully effective, HCPs could condition their willingness to treat on patients' agreement to be tested. Indeed, in any situation in which testing is medically (that is, professionally) indicated, conditioning treatment on testing appears justifiable.[234]

Those HCPs who have the professional autonomy to do so may restrict their practices to those patients found acceptable to them, provided refusal to accept a patient is not based on impermissible grounds (such as race, creed, color, national origin, or disability).[235] Thus, HCPs would be justified in refusing to accept or to treat patients who refuse to comply with a request to be tested, provided the request is reasonable and based on professional standards. If an HCP-patient relationship exists, termination of that relationship also would be justifiable after the patient has been afforded a reasonable period of time in which to retain other health care services.[236]

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234. If the professional standard of care indicates testing, informed consent imposes a duty on the HCP to inform the patient of material risks associated with the test. Courts have also held that HCPs have a duty to inform the patient of the material risks of not undergoing the test. See *Truman v. Thomas*, 165 Cal. Rptr. 308, 611 P.2d 902 (1980) (recognizing a duty to inform a patient of the "potentially fatal consequences of allowing cervical cancer to develop undetected by a pap smear"). After so informing patients or potential patients, HCPs should have the option of refusing to enter or continue a patient-HCP relationship with those patients who refuse professionally indicated testing. In fact, the CDC once took the position that all patients should be routinely encouraged to undergo testing. See *CDC Proposes Routine Patient Tests for AIDS*, Mod. Healthcare 3 (Sept. 23, 1991). The CDC based this proposal on the notion that many HCPs "prefer to know whether a patient is infected so they can adhere more closely to universal precautions." Id.

235. See Michael C. Macdonald, et al., *Health Care Law* § 20.01[4] (Matthew Bender, 1992) (summarizing antidiscrimination statutes). Many HCPs (in particular, employees), of course, do not have full professional autonomy, a fact which raises serious questions about their practical ability to refuse to treat patients who refuse to disclose their infected status.

236. See Council on Ethical and Judicial Affairs, American Medical Association, *Code of Medical Ethics Current Opinions* § 8.11 at 39 (AMA, 1992):

> Neglect of Patient: Physicians are free to choose whom they will serve. The physician should, however, respond to the best of his or her ability in cases of emergency where first aid treat-

A more formalized approach to the HCP-patient relationship may provide advantages to both parties by specifying the requirement that both parties disclose infected status and the consequences of nondisclosure. The contractual relationship between HCPs and patients generally arises by implication, although HCPs commonly employ written informed consent forms.[237] HCPs could require an express contract under which persons are accepted as patients on the condition that they disclose their infectious status, if known (including test results), or submit to an appropriate test. The contract should specify that the HCP is obligated to accept the person as a patient if infectious and that the HCP is obligated to maintain all patient information in confidence.[238] The contract might further require that if, during the course of the relationship, the patient becomes infectious, or if the HCP within his or her medical judgment believes the patient requires testing, the patient will disclose or comply; failure to do so may result in termination of the relationship upon reasonable notice sufficient for the patient to obtain other health care.[239]

The imposition on patients of such contractual obligations to disclose need not raise the specter of adhesion contracts and exculpatory clauses. A contract that imposes a positive duty on patients to disclose their infectious status is not a contract of adhesion in the sense in which that term is commonly used. Conditioning the HCP-patient relationship on patient disclosure should be sharply contrasted with condi-

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ment is essential. Once having undertaken a case, the physician should not neglect the patient, nor withdraw from the case without giving notice to the patient, the relatives, or responsible friends sufficiently long in advance of withdrawal to permit another medical attendant to be secured.

237. See text accompanying note 27.

238. One could argue that the HCP offers little, if any, consideration for the promise of disclosure by patients, because HCPs have a legal and ethical duty to accept infectious patients for treatment and to maintain their confidentiality. HCPs have no duty, however, to accept nondisclosing patients, at least when nondisclosure occurs in non-emergency circumstances. Moreover, a cause of action based on breach of contract may provide a more effective remedy for patients than reliance on statutory or common-law theories.

239. A practical means by which HCPs can impose disclosure requirements may be through "patient history forms," which individuals commonly fill out prior to their first visit with an HCP. The form could include questions designed to elicit information regarding whether the individual has an infectious disease or symptoms indicative of such a disease. The form should close with a statement to the effect that failure to answer questions or misrepresentations could result in the HCP's refusal to accept that individual as a patient or to continue the relationship; the form should state further that any injuries sustained as a consequence of misrepresentation by the patient could result in civil liability. Individuals should be asked to sign an insurance form-like averment that the answers given are accurate to the best of their knowledge. This approach may sound draconian, but it would lay the groundwork for a fraudulent misrepresentation action, such as the action used to advantage in *Boulais v. Lustig*. See notes 15, 117-23 and accompanying text. Hopefully, HCPs would carefully explain the form and the reasons underlying its adoption to prospective patients.

tioning treatment on the patient's agreement to waive any claim for recovery against the HCP for negligent treatment. For example, in *Tunkl v. Regents of University of California*,[240] the California Supreme Court held unenforceable a contract provision in which, as a condition of treatment in the hospital, charity patients were required to release the hospital from liability for negligent conduct of its employees occurring during the course of treatment.[241] The court noted that, as a general rule, exculpatory provisions in contracts that affect "the public interest" are invalid and delineated a number of characteristics such contracts would possess. These characteristics center around whether the party seeking exculpation is engaged in an activity subject to public regulation and which is of great public importance, makes its services available to the public, has decisive bargaining strength, offers only a "standardized adhesion contract of exculpation," and requires the other party to bear the risk of its carelessness.[242]

While any contract between an HCP and a patient may be categorized as involving "the public interest," *Tunkl* focused on the exculpatory nature of the contract. In contrast, the present proposal does not intend to exculpate or release HCPs from liability or to encourage all HCPs to employ a standardized contract.[243] Under the proposed contract, acceptance or continuation as a patient is made contingent only upon the disclosure of the patient's infectious status; HCPs remain obligated to accept and treat disclosing patients and to maintain the patient's confidentiality within the professional standard of care. HCPs would, of course, retain the option of accepting patients without testing or disclosure, but this should be done at the discretion of the HCP.

In sum, the safest course of conduct for concerned HCPs may be to resort to self-help in the form of careful evaluation of persons prior to

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240. 32 Cal. Rptr. 33, 383 P.2d 441 (1963).

241. In *Tunkl*, the document the plaintiff signed was entitled "Conditions of Admission" and provided:

> RELEASE: The hospital is a nonprofit, charitable institution. In consideration of the hospital and allied services to be rendered and the rates charged therefor, the patient or his legal representative agrees to and hereby releases The Regents of the University of California, and the hospital from any and all liability for the negligent or the wrongful acts or omissions of its employees, if the hospital has used due care in selecting its employees.

Id. at 442.

242. Id. at 444-46.

243. Other commentators have gone so far as to argue that HCPs should be permitted to shift the risk of substandard treatment to patients by contract. See generally Richard A. Epstein, *Medical Malpractice: The Case for Contract*, 1976 Am. B. Found. Res. J. 87; Clark C. Havighurst, *Decentralizing Decision Making: Private Contract Versus Professional Norms*, in Jack A. Meyer, ed., *Market Reforms in Health Care* 22 (Am. Enterprise Inst., 1983); Glen O. Robinson, *Rethinking the Allocation of Medical Risks Between Patients and Providers*, 49 L. & Contemp. Probs. 173 (1986) (critiquing the *Tunkl* factors in the malpractice context).

accepting them as patients, and the utilization of an express contractual provision conditioning acceptance or continuance as a patient on the patient's agreement to disclose infected status or to undergo testing.

## V. CONCLUSION

The primary goal of this Article has been to establish the viability of a cause of action based upon "reverse informed consent," according to which a duty is imposed on patients to inform their HCPs of material risks—in particular HIV-infected status—associated with the patients' care. The Article's thesis has been advanced by a two-step comparative analysis. First, the doctrine of informed consent was shown to impose a duty on HCPs to disclose their infectious status to patients prior to treatment. Second, the Article compared this proposition with its converse: the imposition of a duty on patients to inform their HCPs of the patients' infectious status. On the basis of analogy, risk-utility, and economic analyses, the Article concludes that placing a duty upon patients to disclose is clearly justified when a comparable duty is imposed upon HCPs to secure informed consent by disclosing their infectious status to their patients. The standard proposed for determining whether a patient has breached the duty to disclose asks whether a reasonable person would or should have known that nondisclosure presented a material risk to an HCP undertaking a particular treatment.

Causation presents a more difficult problem with respect to patients' failure to disclose than with respect to HCPs' failure to disclose in an informed consent context. This Article maintains that causation can be satisfied by demonstrating that a patient's failure to disclose deprived an HCP of the opportunity to consider less risky alternatives to the proposed treatment, to refer the patient to other HCPs if professionally indicated, or to employ a higher degree of care as warranted by the patient's infected status. Damages present substantially the same problems in both traditional and reverse informed consent cases.

While the Article asserts that tort theory clearly supports the adoption of a doctrine such as reverse informed consent, the policy goals of tort law—compensation and deterrence—cannot be fully implemented for two reasons: because patients are not deep-pocket defendants as a rule and because patients are unlikely to be deterred from nondisclosure in view of their fears of being refused treatment and of loss of confidentiality. In view of the unlikely possibility that public measures will be imposed to induce disclosure by patients to their HCPs, the Article proposes that concerned HCPs take private measures to protect themselves. These measures may take the form of careful evaluation prior to accepting or treating patients, or the utilization by

HCPs of an express contract conditioning acceptance and continuation as a patient upon the patients' agreement to disclose and obligating HCPs to accept and continue the HCP-patient relationship upon that disclosure.