

Winter 1995

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### Recommended Citation

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# OBLIGATIONS OF HIV-INFECTED HEALTH PROFESSIONALS TO INFORM PATIENTS OF THEIR SEROLOGICAL STATUS: EVOLVING THEORIES OF LIABILITY

THEODORE R. LEBLANG, J.D.\*

## INTRODUCTION

For more than a decade, the risk of transmission of Human Immunodeficiency Virus (HIV) in the health care setting has received considerable attention. Comprehensive guidelines, recommendations, and regulatory standards have been promulgated with a view toward substantially reducing the potential for HIV transmission both to and from health professionals.<sup>1</sup> These efforts have met with considerable success. They have not, however, diffused compelling inquiry regarding the rights of health professionals to know the serological status of their patients and the reciprocal rights of patients to know the serological status of their attending health professionals. The objective of this Article is to examine the latter question, with emphasis on evolving duties of health professionals to inform patients of their serological status prior to providing health care when there is risk of transmission of HIV. This discussion is augmented by consideration of potential civil liability for failure to make such disclosure.

Placing this discussion in context, it is important to observe that abundant commentary is already a matter of record regarding whether, and to what extent, HIV-infected health professionals

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1. See, e.g., Labor, 29 C.F.R. § 1910.1030 (1992); Centers for Disease Control and Prevention, *Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures*, 40 MORBIDITY & MORTALITY WKLY. REP. 1 (Supp. No. RR-8, July 12, 1991); Centers for Disease Control and Prevention, *Recommendations for Prevention of HIV Transmission in Health-Care Settings*, 36 MORBIDITY & MORTALITY WKLY. REP. 3-18 (Supp. Aug. 21, 1987).

should be restricted in their practice. This is also true of the subject of whether, and to what extent, patients have a right to know the serological status of their health care providers.<sup>2</sup> These questions have been debated against the background of a considerable body of evidence establishing that the possibility of transmission of HIV from infected health professionals to patients is extremely remote.<sup>3</sup>

In light of this epidemiologic evidence, some commentators have concluded that HIV-infected health professionals should not be precluded from caring for patients so long as their practices scrupulously adhere to recognized infection control standards.<sup>4</sup> The American Medical Association has offered the following guidance:

A physician who knows that he or she is seropositive should not engage in any activity that creates a risk of transmission of the disease [HIV] to others. A physician who has HIV disease or who is seropositive should consult colleagues as to which activities the physician can pursue without creating a risk to patients.<sup>5</sup>

It is of interest that this statement makes no reference to any obligation on the part of a physician to disclose his or her serological status to patients before providing medical care.<sup>6</sup> Arguably, disclosure is not mandated because it would significantly invade the pri-

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2. See Mark D. Johnson, *HIV Testing of Health Care Workers: Conflict Between the Common Law and the Centers for Disease Control*, 42 AM. U. L. REV. 479 (1993); Karen Lieberman & Arthur Derse, *HIV-Positive Health Care Workers and the Obligation to Disclose: Do Patients Have a Right to Know?*, 13 J. LEGAL MED. 333 (1992); Nancy Dickey, *Physicians Infected With AIDS*, 265 JAMA 2338 (1991) (letter); Troyen Brennan, *Transmission of the Human Immunodeficiency Virus in the Health Care Setting—Time for Action*, 324 NEW ENG. J. MED. 1504 (1991); Larry Gostin, *The HIV-Infected Health Care Professional: Public Policy, Discrimination, and Patient Safety*, 18 LAW, MED. & HEALTH CARE 303 (1990); George Annas, *Legal Risks and Responsibilities of Physicians in the AIDS Epidemic*, 18 HASTINGS CENTER REP. 26 (Supp. Apr./May 1988).

3. See, e.g., C. Fordham von Reyn et al., *Absence of HIV Transmission From an Infected Orthopedic Surgeon: A 13-Year Look-Back Study*, 269 JAMA 1807 (1993) (estimating risk of transmission is 4.37/100,000 patients); Gordon Dickinson et al., *Absence of HIV Transmission From an Infected Dentist to His Patients: An Epidemiologic and DNA Sequence Analysis*, 269 JAMA 1802 (1993) (finding risk is mathematically close to zero when universal precautions are followed); Audrey Smith Rogers et al., *Investigation of Potential HIV Transmission to the Patients of an HIV-Infected Surgeon*, 269 JAMA 1795 (1993) (reporting that transmission is unlikely to occur more frequently than once per 1,000 person-hours of surgical exposure); Richard Danila et al., *A Look-Back Investigation of Patients of an HIV-Infected Physician: Public Health Implications*, 325 NEW ENG. J. MED. 1406 (1991) (finding risk is so low that it cannot be measured accurately); Ban Mishu et al., *A Surgeon with AIDS: Lack of Evidence of Transmission to Patients*, 264 JAMA 467 (1990) (reporting risk is too remote to be quantified).

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

5. AMERICAN MEDICAL ASSOC., ANNOTATED CURRENT OPINIONS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS 9.131 (1992).

6. *Id.*

vacy of the HIV-infected health professional, while yielding limited public health benefit.<sup>7</sup> Moreover, because the risk of HIV transmission is so remote, disclosure of such information would not appear to be required pursuant to established principles of informed consent.

Until recently, such views regarding disclosure seemed persuasive. However, beginning in 1991, and continuing through late 1993, courts in four jurisdictions independently articulated a yet to be dissented from theory. These four courts found that regardless of the remote possibility of transmission of the Acquired Immuno-deficiency Syndrome (AIDS) virus from an HIV-infected physician to a patient, the serological status of the physician is the type of information that reasonable patients may deem important before deciding to undergo treatment. Accordingly, causes of action against HIV-infected health professionals, based on informed consent principles and other liability theories, have been upheld throughout the country. Similarly, there is evidence that state regulatory authorities may be moving in the same direction.

This Article discusses these important common law and regulatory developments. Emphasis is placed on discussion of what appears to be an evolving legal trend favoring patients' rights to know the serological status of their attending health professionals before consenting to treatment. This discussion takes place in the context of a review of the four opinions that established the trend favoring patients' rights.

## I. COMMON LAW DEVELOPMENTS

In the 1991 case of *Estate of Behringer v. Medical Center at Princeton*,<sup>8</sup> a New Jersey court rendered perhaps the first common law decision addressing the question of whether a risk of exposure to the AIDS virus by an HIV-infected surgeon should be disclosed to a patient in the context of obtaining informed consent. The estate of William H. Behringer brought suit against the medical center at which he had been a member of the medical staff. The doctor was diagnosed as suffering from AIDS at the time of the incidents at issue in the case.<sup>9</sup>

In a rather complex and lengthy opinion, the court focused on a variety of issues, including the extent to which the medical center could regulate the surgical activities of Dr. Behringer. The court

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7. See Michael Lederman & Maxwell Mehlman, *Physicians Infected with HIV*, 265 NEW ENG. J. MED. 2337 (1991) (letter); Larry Gostin, *supra* note 2, at 304 (arguing against the need for requiring disclosure by the health professional of his or her HIV status but also suggesting careful monitoring of HIV-infected professionals).

8. 592 A.2d 1251 (N.J. Super. 1991).

9. *Id.*

specifically characterized the case as one that addressed, in part, "the apparent conflict between a doctor's rights under the New Jersey Law Against Discrimination (LAD) . . . and a patient's 'right to know' under the doctrine of 'informed consent.'"<sup>10</sup>

In *Behringer*, when Dr. Behringer's diagnosis became known to the medical center administration, his surgical privileges were temporarily restricted.<sup>11</sup> The restrictions were lifted on Dr. Behringer's privileges with the stipulation that he disclose his serological status to prospective patients in the context of obtaining their informed consent.<sup>12</sup> A special informed consent document was developed that was to be presented to any medical center patient about to undergo surgery by an HIV-infected surgeon. The form contained specific language reciting that the patient had been informed that the surgeon had "a positive blood test indicative of infection with HIV (Human Immunodeficiency Virus) which is the cause of AIDS."<sup>13</sup> The form contained a further recital indicating that the patient had "also been informed of the potential risk of transmission of the virus."<sup>14</sup>

In concluding that the medical center's informed consent requirement was reasonable and not violative of the New Jersey LAD, the court stated: "It is axiomatic that physicians performing invasive procedures should not knowingly place a patient at risk because of the physician's physical condition."<sup>15</sup> The court recognized that there was considerable controversy with respect to whether, and to what extent, patients may be placed at risk by virtue of undergoing an invasive surgical procedure performed by a physician who is infected with AIDS. Moreover, the court noted statistical evidence establishing, among other things, that the risk of HIV transmission to a surgical patient may be as low as 1 in 130,000. Nevertheless, the court observed that although "the debate will rage long into the future as to the quantifiable risk of HIV transmission from doctor to patient, there is little disagreement that a risk of transmission, however small, does exist," even though it may be reduced by appropriate use of universal precautions.<sup>16</sup>

The court concluded that because Dr. Behringer's otolaryngology practice involved contact with mucous membranes during surgery, even a substantially remote risk of a surgical accident would be a source of sufficient concern to a patient to justify disclosure as

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10. *Id.* at 1254.

11. *Id.*

12. *Id.* at 1255.

13. *Estate of Behringer*, 592 A.2d at 1258.

14. *Id.*

15. *Id.* at 1277.

16. *Id.* at 1280. The court also expressed concern that when an infected surgeon performs numerous operations, the aggregate risk to patients becomes more significant. *Id.* at 1283 n.20.

part of the informed consent interchange.<sup>17</sup> This is particularly true in light of the implications of such an accident, including HIV testing during an extended time period, with the resulting anxiety of awaiting test results. The risk might also lead to modifications of lifestyle and child-bearing plans throughout the testing period, even if test results eventually were negative.

In rendering its decision, the court emphasized that New Jersey has a strong commitment to the concept of a fully informed patient.<sup>18</sup> The court stated that "New Jersey's strong policy supporting patient rights, weighed against [Dr. Behringer's] individual right to perform an invasive procedure *as a part* of the practice of his profession, requires the conclusion that the patient's rights must prevail."<sup>19</sup> Because the ultimate risk to the patient may be so absolute and devastating, the court considered it to be unacceptable to argue against full disclosure in these situations.<sup>20</sup> Thus, in the view of the court, so long as the debate continued regarding whether there was "any" risk of transmission of the AIDS virus, an informed consent requirement that includes disclosure of the possibility of the risk, albeit remote, is justified.

The second significant case dealing with informed consent was decided in early 1993. Maryland's highest court, in *Faya v. Almaraz*,<sup>21</sup> addressed the question of whether a surgeon, infected with the AIDS virus, is legally obligated to inform patients of his condition prior to performing surgery upon them.<sup>22</sup> In *Almaraz*, two patients, Sonja Faya and Perry Rossi, underwent surgery performed by Dr. Rudolph Almaraz, a surgeon who specialized in the treatment of breast cancer.<sup>23</sup> Despite the fact that Dr. Almaraz

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17. *Id.* at 1280.

18. *Estate of Behringer*, 592 A.2d at 1282. New Jersey is among those jurisdictions that have adopted the "prudent patient" informed consent standard. Under this standard, disclosure is based on the patient's informational needs. Risks must be disclosed which a reasonably prudent patient would consider important in deciding whether or not to undergo a particular course of treatment. Interestingly, the court observed that even if New Jersey were a "reasonable physician" disclosure state—basing risk disclosure on standards articulated by the profession—the court's decision would not be different. *Id.* at 1279 n.17.

19. *Id.* at 1283 (emphasis added).

20. See also *In re Milton S. Hershey Medical Ctr.*, 634 A.2d 159 (Pa. 1993) (upholding lower court decision to authorize notification of patients of an HIV-infected OB/GYN resident that the resident was involved in their surgery or obstetrical care when they were at the medical center; concluding that, regardless of small potential for HIV transmission, interests of patients outweigh those of physician). Cf. *Bradley v. University of Tex. M.D. Anderson Cancer Ctr.*, 3 F.3d 922 (5th Cir. 1993) (concluding that HIV-infected surgical technician could be reassigned to institution's purchasing department without violating federal laws governing discrimination on the basis of handicap; noting that technician was not "otherwise qualified" because his participation in surgery presented "cognizable risk of permanent duration with lethal consequences").

21. 620 A.2d 327 (Md. 1993).

22. *Id.* at 330.

23. *Id.* at 329.

knew himself to be HIV-positive, he performed a partial mastectomy and axillary dissection on Ms. Faya in 1988, followed by removal of an axillary hematoma in early 1989.<sup>24</sup> These surgeries were therapeutically successful.

In October of 1989, Dr. Almaraz was diagnosed with AIDS.<sup>25</sup> A month later, he surgically removed a benign lump from the breast of Perry Rossi.<sup>26</sup> This surgery also was successful.

Due to his illness, Dr. Almaraz gave up his medical practice in March of 1990 and died approximately eight months later.<sup>27</sup> It was at this time that Ms. Faya and Ms. Rossi learned of their surgeon's illness from local newspapers.<sup>28</sup> Each underwent HIV blood testing but neither showed evidence of seroconversion.<sup>29</sup> Nevertheless, both patients commenced litigation against the estate of Dr. Almaraz for compensatory and punitive damages.<sup>30</sup> Among other things, these lawsuits were based upon a lack of informed consent.<sup>31</sup>

The plaintiffs essentially complained that Dr. Almaraz acted wrongfully by virtue of failing to inform them of his illness prior to performing surgery.<sup>32</sup> The plaintiffs argued that they were placed at risk of exposure to HIV that might otherwise have been avoided.<sup>33</sup> If they had been properly informed, they could have refused consent to the invasive surgery. The plaintiffs claimed that they suffered from severe emotional distress and anxiety as a result of risk of exposure to HIV, as well as continued testing for the disease.<sup>34</sup>

The estate of Dr. Almaraz and the co-defendant hospital moved for dismissal on the basis that the plaintiffs failed to state a cause of action.<sup>35</sup> The trial court agreed and dismissed the claims, noting that "there [were] no reported cases of transmission of AIDS from a surgeon to a patient."<sup>36</sup> Moreover, the court stated that "such transmission is only a theoretical possibility when proper barrier techniques are employed . . ."<sup>37</sup> In the instant case, the plaintiffs did not allege that Dr. Almaraz negligently failed to use proper bar-

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24. *Id.*

25. *Id.*

26. *Faya*, 620 A.2d at 329.

27. *Id.*

28. *Id.*

29. *Id.*

30. *Id.*

31. *Faya*, 620 A.2d at 330.

32. *Id.*

33. *Id.*

34. *Id.*

35. *Id.*

36. *Faya*, 620 A.2d at 330.

37. *Id.*

rier techniques.<sup>38</sup> The trial judge also refused to accept the theory that recovery in such a case could be based on a fear of contracting AIDS when, at the time of litigation, the plaintiffs had not tested positive.<sup>39</sup>

The Maryland Court of Appeals issued a special writ to address what it considered to be an important and timely issue.<sup>40</sup> In doing so, the court noted that the concept of legal duty emanates from a responsibility to exercise due care to avoid unreasonable risk of harm to others.<sup>41</sup> The court found that regardless of the fact that there is an extremely low risk of HIV transmission in the types of surgeries performed, the risk to the patient may nevertheless be viewed as unreasonable.<sup>42</sup>

The Maryland High Court, in reversing the trial court's dismissal, stated that "we cannot say as a matter of law that no duty was imposed upon Dr. Almaraz to warn the [plaintiffs] of his infected condition or [to] refrain from operating upon them."<sup>43</sup> The court further found that the plaintiffs' fears of acquiring HIV infection, accompanied by headaches, inability to sleep, and physical and mental anguish in connection with repeated HIV testing, constituted legally compensable injuries.<sup>44</sup> The court upheld the legitimacy of a damages award for injury suffered during the period of time it would take to become relatively certain whether the plaintiffs had seroconverted.

The disclosure obligations of HIV-infected health professionals, as initially set forth in *Behringer* and subsequently refined in *Faya*, have established a predicate for potential liability in the context of failure to obtain a fully informed consent. These broad pronouncements were viewed favorably in a third significant case dealing with informed consent. In *Kerins v. Hartley*,<sup>45</sup> Jean Kerins had been experiencing severe abdominal pain and consulted a gynecologist. In November of 1986, she underwent surgery to remove a large uterine fibroid tumor.<sup>46</sup> The surgical procedure consisted of

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38. *Id.*

39. *Id.*

40. *Id.*

41. *Faya*, 620 A.2d at 333.

42. *Id.* at 336-37.

43. *Id.* at 334. The court noted that, under Maryland law, informed consent requires disclosure of risks that a reasonable person, in the patient's position, would consider significant in deciding whether or not to submit to a particular treatment. *Id.* at 334 n.6.

44. *Id.* at 338-39.

45. 21 Cal. Rptr. 2d 621 (Cal. Ct. App. 1993), *cert. granted*, 24 Cal. Rptr. 2d 236 (Cal. 1993). On February 24, 1994, this case was transferred in the Court of Appeal with directions to vacate its decision and to reconsider the case in light of *Potter v. Firestone Tire and Rubber Co.*, 863 P.2d 795 (Cal. 1993). *Kerins v. Hartley*, 868 P.2d 906 (Cal. 1994).

46. *Id.* at 623.



exploratory laparotomy, lysis of peritoneal adhesions, multiple myomectomies, reconstruction of the uterus, and repair of the broad ligament. Just prior to the surgery, the gynecologist had voluntarily undergone HIV testing.<sup>47</sup> Five days after the surgery in question, the doctor learned he was HIV-positive. Over the next year and a half he developed AIDS and, in April of 1988, his illness was announced during a television news broadcast that was seen by Ms. Kerins.<sup>48</sup> Within a day of the broadcast, Ms. Kerins underwent HIV testing.<sup>49</sup> She received negative test results approximately two weeks after the testing.

Despite the negative test results, Ms. Kerins subsequently initiated litigation against the gynecologist and his medical partners charging battery and seeking compensatory and punitive damages, including health care expenses, lost earnings, and severe emotional distress and mental anguish.<sup>50</sup> Among other things, the plaintiff's pleadings contended, and offered medical records to establish, that the gynecologist was suffering from AIDS or illnesses that were symptomatic of the disease at the time of the surgery in question.<sup>51</sup> Ms. Kerins also alleged that the doctor knew or reasonably should have known of his condition at the time of the surgery. Furthermore, the plaintiff's complaint specified that she went to the defendant gynecologist and his medical group "because she knew of their commitment to patient-involved decision-making and informed consent."<sup>52</sup> She specifically indicated that she expressed concern to her gynecologist about contracting AIDS from blood transfusions and, based upon his advice, stored some of her own blood for use if a transfusion became necessary during surgery.<sup>53</sup>

The plaintiff further alleged that, in a pre-surgery interview, she specifically asked the gynecologist "How is your health?"<sup>54</sup> He responded by answering "Well, I go to the gym regularly and I run every morning."<sup>55</sup> The plaintiff claimed that the gynecologist's response was deceitful, particularly in view of her expressed concern about contracting AIDS and the fact that he underwent HIV testing about the time of the plaintiff's surgery. Moreover, the surgical procedure performed by the gynecologist was classified as "exposure-prone" under applicable guidelines promulgated by the Centers for

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47. *Id.*

48. *Id.* at 631.

49. *Id.* at 627.

50. *Kerins*, 21 Cal. Rptr. 2d at 622.

51. *Id.*

52. *Id.* at 624.

53. *Id.*

54. *Id.*

55. *Kerins*, 21 Cal. Rptr. 2d at 624.

Disease Control and Prevention.<sup>56</sup> The defendants responded by denying that the aforesaid discussions with the plaintiff ever took place.

The trial court granted the defendants' motion for summary judgment, concluding that, as a matter of law, the plaintiff's fear of acquiring AIDS was unreasonable.<sup>57</sup> The court also held that there was no battery committed as a result of the gynecologist's alleged deceitful representations regarding his physical condition prior to surgery.<sup>58</sup> On appeal, the trial court's rulings on both issues were reversed. In the view of the appellate court, the plaintiff had established sufficient facts to set forth a cause of action for battery.<sup>59</sup> The court specifically stated the following:

Liberally construed, appellant's responsive pleadings established facts arguably supporting her claim that the question about Dr. Gordon's health was motivated by a fear of contracting AIDS, that her consent to the surgery was intended and understood to be expressly conditioned on taking precautions to avoid exposure to contagious diseases and the doctor's health, and further, that Dr. Gordon was aware of his HIV-positive status and the possible onset of symptoms of AIDS, and intentionally violated the "good health" condition because a contrary course of action would have jeopardized his ability to continue practicing surgical medicine. A legally cognizable cause of action for battery may rest on such facts.<sup>60</sup>

In recognizing the legitimacy of a cause of action for battery, the appellate court essentially created an obligation for physicians to respond truthfully to specific inquiries from patients regarding their HIV status.

The court also discussed the legitimacy of the plaintiff's claims for damages based upon fear of contracting AIDS. The court noted that the risk of HIV transmission, even in the context of an exposure-prone surgery, is minuscule. The court further recognized that a number of cases refused to allow recovery of damages for emotional distress in situations where the plaintiff had failed to plead or prove actual exposure to the AIDS virus or where the plaintiff was not likely to develop AIDS.<sup>61</sup> Nevertheless, the court

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56. *Id.* at 625 (citing Gostin, *CDC Guidelines on HIV or HBV-Positive Health Care Professionals Performing Exposure-Prone Invasive Procedures*, 19 *LAW, MED. & HEALTH CARE* 140 (1991)).

57. *Id.* at 625.

58. *Id.*

59. *Id.* at 627.

60. *Kerins*, 21 *Cal. Rptr. 2d* at 627 (emphasis added).

61. *See, e.g.*, *Burk v. Sage Products, Inc.*, 747 *F. Supp.* 285 (E.D. Pa. 1990) (allowing no cause of action where paramedic, who was stuck by needle on hospital floor where AIDS patient was being treated, tested negative and could not prove he was stuck by infected needle); *Doe v. Doe*, 519 *N.Y.S.2d* 595 (N.Y. 1987) (finding no cause of action by wife based on husband's failure to disclose homosexual relationship that placed him at high risk to develop AIDS, where husband tested negative); *Funeral Servs. by Gregory, Inc. v. Bluefield Community Hosp.*, 413 *S.E.2d* 79 (W. Va. 1991) (disapproving a cause of action by mor-

chose to follow the decision in *Faya v. Almaraz*, which recognized that the stress and anxiety related to fear of acquiring HIV infection constituted a basis for an award of damages during the period of time required to satisfactorily test for HIV seroconversion, i.e., approximately six months. The court stated as follows:

We agree with *Almaraz* that, whether or not a plaintiff can prove actual blood-to-blood exposure at the hands of AIDS- or HIV-infected surgical personnel, the fear of developing AIDS becomes unreasonable as a matter of law only after the plaintiff has had sufficient opportunity to determine with reasonable medical certainty that he or she has not been exposed and/or infected with the AIDS virus.<sup>62</sup>

Thus, in the opinion of the court, once the plaintiff receives negative results in the context of HIV testing for the recommended six month period of time, her emotional distress would become unreasonable as a matter of law and no longer compensable. Under the facts in *Faya*, however, the court was willing to recognize that the plaintiff could prove compensable emotional distress during the limited period of time when she reasonably believed she had been exposed to and could develop the AIDS virus.<sup>63</sup>

Several months after the California Appellate Court handed down its ruling in *Kerins*, the Minnesota Court of Appeals relied on both the *Faya* and *Kerins* cases to reach similar conclusions regarding the issues of informed consent, battery, and compensable emotional distress in the case of *K.A.C. v. Benson*.<sup>64</sup> There, the defendant, Dr. Phillip Benson, suffered from AIDS.<sup>65</sup> He was alleged to have performed invasive or exposure-prone procedures on a number of his patients at the same time he suffered from weeping exudative sores on his hands and arms, albeit while wearing single or double gloves.<sup>66</sup> At one point during his practice, he allegedly wrote a letter to a number of his patients, which contained the following language:

I am sending you this letter because there is a very minimal possibility that you were exposed to the AIDS virus through body fluids from this rash during certain medical procedures. At the time that I had this rash, I did not realize that there may have been any risk to you because I was wearing gloves. I am now aware that even with gloves, an

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tician and wife where hospital released body to funeral home without informing mortician that body was AIDS infected; mortician tested negative on four occasions).

62. *Kerins v. Hartley*, 21 Cal. Rptr. 2d 621, 632 (Cal. Ct. App. 1993).

63. *Id.* at 632. Cf. *Marriott v. Sedco Forex Int'l Resources, Ltd.*, 827 F. Supp. 59 (D. Mass. 1993) (recognizing a cause of action for recovery of damages to compensate for fear of contracting AIDS after plaintiffs were inoculated against Hepatitis virus with a vaccine that was found to contain the AIDS virus, but where they continuously tested negative for the virus).

64. No. C6-93-1203, 1993 Minn. App. LEXIS 1201 (Minn. Ct. App. Dec. 14, 1993), review granted, 1994 Minn. LEXIS 155 (Feb. 24, 1994).

65. *Id.* at \*13.

66. *Id.* at \*13.

extremely minimal risk existed.<sup>67</sup>

There were additional facts to suggest that the Minnesota Board of Medical Examiners had directed Dr. Benson not to perform invasive procedures after he developed the sores on his hands and arms and that he performed invasive gynecological procedures nonetheless.<sup>68</sup>

Numerous patients commenced litigation against Dr. Benson and other defendants, setting forth claims based upon intentional and negligent infliction of emotional distress, battery, negligent nondisclosure (breach of informed consent), and consumer fraud. The trial court granted summary judgment in favor of the defendants and appeal followed.<sup>69</sup>

The reviewing court reversed, finding that the defendant's alleged failure to follow the instructions of the Board of Medical Examiners could be found to constitute extreme and outrageous conduct resulting in severe emotional distress and, thus, raising issues of material fact.<sup>70</sup> The court also found that recovery for negligent infliction of emotional distress would be appropriate if the patients were in the zone of danger for contracting HIV, reasonably feared for their safety and, as a result, suffered emotional distress.<sup>71</sup> This in spite of the fact that the risk of HIV transmission is extremely low during surgery when proper barrier techniques are utilized and that here, the plaintiffs had not demonstrated actual exposure to the AIDS virus.

The court concluded that, by performing invasive or exposure-prone procedures on his patients while suffering from exudative dermatitis, the defendant raised a genuine issue of material fact regarding whether he placed his patients in the zone of danger of contracting HIV, thereby causing emotional distress. Of interest is the fact that the court accepted the pronouncements in *Kerins* and *Faya* when it concluded, as a matter of law, that "fear of exposure to HIV is reasonable only between when the patients learned of the possible exposure and when they received their negative test results."<sup>72</sup>

In addressing the battery claim, the court ruled that those plaintiffs who alleged that they questioned Dr. Benson or his colleagues regarding his or their health, or who expressed concern about the possibility of contracting AIDS, and who received either evasive or disingenuous assurances, had stated adequate facts to

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67. *Id.* at \*12.

68. *Id.* at \*5.

69. *K.A.C.*, Minn. App. LEXIS 1201, at \*1.

70. *Id.* at \*14.

71. *Id.* at \*6.

72. *Id.* at \*14.

withstand summary judgment on the claim for battery.<sup>73</sup> The court stated that, absent such express inquiry, there may not be a basis for a battery claim but a claim for negligent nondisclosure, or breach of informed consent may be present. In this regard, the court stated that a physician must disclose known risks of death or serious bodily harm as well as information typically provided by a skilled practitioner under similar circumstances. Evidence was submitted in the case that it is the standard of care in the medical community for physicians to inform patients that they are HIV positive prior to performing invasive procedures.<sup>74</sup>

Finally, the court addressed the question of whether the Minnesota Consumer Fraud Act was applicable under the facts of the case. The court stated that if it could be shown that Dr. Benson affirmatively misrepresented his condition to a patient with the intent that the patient rely on such representations to continue under his care, then a cause of action for consumer fraud would lie.<sup>75</sup>

## II. REGULATORY DEVELOPMENTS

At this writing, state courts in California, Maryland, Minnesota, and Pennsylvania have recognized that, under certain fact situations, HIV-infected physicians have an obligation to disclose their health status to patients. This disclosure is required either as an aspect of obtaining informed consent or in response to direct inquiry from patients. The pronouncements contained in this group of recent case decisions have been complemented by at least one state's regulations governing medical practice.

In May 1993, pursuant to Arkansas law, the Arkansas State Medical Board promulgated a regulation setting forth general requirements for minimizing the risk of transmission of Hepatitis B Virus (HBV) and HIV from practitioner to patient in the context of invasive or exposure-prone procedures.<sup>76</sup> This regulation sets forth standards regarding universal blood and body fluid precautions as well as percutaneous precautions. The regulation also prohibits certain conduct of a practitioner who is seropositive for HBV or HIV, or otherwise knows or reasonably should know that he or she

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73. *Id.* at \*17.

74. See also Barbara Gerbert et al., *Possible Health Care Professional-to-Patient HIV Transmission: Dentists' Reactions to a Centers for Disease Control Report*, 265 JAMA 1845 (1991) (noting that 74% of surveyed dentists believed that patients should be told if their dentist was HIV-infected); Patricia Marshall et al., *Patients' Fear of Contracting the Acquired Immunodeficiency Syndrome From Physicians*, 150 ARCH. INTERN. MED. 1501 (1990) (investigating patient concerns about HIV transmission from health professionals during routine treatment).

75. K.A.C., 1993 Minn. App. LEXIS 1201, at \*20.

76. See Regulation 16, Arkansas Medical Board, under authority of ARK. CODE ANN. § 17-93-409(7),(10) (Michie 1992).

carries and may transmit the virus. Such a practitioner shall not perform or directly participate in exposure-prone procedures without, among other things, obtaining the written and oral informed consent of the patient.

The regulation specifically requires the practitioner to affirmatively advise a patient, or a patient's authorized representative, that he or she has been diagnosed as seropositive for HBV or HIV. In addition, the practitioner must inform a patient of the risk of transmission of either virus during an exposure-prone procedure. This information must be personally communicated to the patient, and a written instrument must be signed by the patient, acknowledging that the practitioner complied with this disclosure obligation. A failure to comply with the regulation constitutes gross negligence that will subject the practitioner to a disciplinary hearing.

It is of interest to note that a regulation promulgated by the Arkansas State Board of Dental Examiners<sup>77</sup> differed from the regulation of the Arkansas State Medical Board in that it failed to require dentists to disclose HBV or HIV status to patients. It only required them to inform the State Board of Dental Examiners of their condition. Upon receiving such information, the Board would then establish, and appoint members to serve on, a review panel for the purpose of providing counseling, monitoring, and recommending restrictions, when appropriate, regarding the practices of an HIV- or HBV-seropositive practitioner. The inconsistency between these two regulations resulted in an expression of concern by state health officials who were asked to adopt a single set of guidelines for all practitioners.<sup>78</sup>

Should the disclosure requirements articulated by the Arkansas State Medical Board remain viable, they may constitute evidence of a standard of care in that state. Under appropriate circumstances, those requirements may give rise to a cause of action based on breach of informed consent or battery, which would likely be viewed by the Arkansas courts in a manner similar to that seen in the cases described above.

### III. CONCLUSION

Recent common law and regulatory developments throughout the country are beginning to raise a variety of questions regarding whether, and to what extent, HIV-infected health professionals may be obligated to inform patients of their condition prior to providing medical care and treatment. In Arkansas, California, Mary-

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77. Article XV, Arkansas State Board of Dental Examiners, under authority of ARK. CODE ANN. § 17-82-316(a)-(c), 17-82-406 (Michie 1992).

78. *AIDS Disclosure Decision*, AM. MED. NEWS, Nov. 8, 1993, at 2.

land, Minnesota, and Pennsylvania, such disclosure obligations appear to be a matter of record at this writing. In those states, it would appear that without regard for the extremely remote potential for transmission of the AIDS virus, health professionals are obligated to disclose their serological status to patients either as part of the informed consent interchange or in response to direct inquiry. A failure to do so may give rise to litigation and liability.

Only a few would have predicted that a common law and regulatory trend favoring disclosure of HIV status by health professionals would have developed so quickly in this country. The stage is now clearly set for a potential flurry of legal activity. It will be particularly important to carefully examine all new developments in state courts, legislatures, and regulatory agencies in an effort to seek additional guidance regarding evolving disclosure obligations in this complex and rapidly changing environment.