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SYMPOSIUM DIALOGUE

SYMPOSIUM: JOB RESTRICTIONS AND DISCLOSURE REQUIREMENTS FOR HIV-INFECTED HEALTH CARE PROFESSIONALS: WHOSE PRIVACY IS IT ANYWAY?

SYMPOSIUM DIALOGUE

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I. INTRODUCTION

PROFESSOR LEONARD:[1] Welcome on behalf of the *New York Law School Law Review* and the cosponsoring committees from the Association of the Bar of the City of New York, the Ad Hoc Committee on AIDS, the Committee on Health Law, and the Committee on Legal Issues Affecting People With Disabilities. As moderator, I will introduce the issue of the rights that HIV-infected health care workers have, or should have, as a matter of law and public policy, and then pose to the panel the difficulties associated with the attainment of those rights. I will pose a hypothetical to the panel, ask each panel member to respond, and then open the debate up to the members of the panel as well as the audience.

The focus of this symposium is HIV-infected health care workers and, more particularly, the health care workers whose regular work involves direct patient contact, and, thus, the possibility of blood exposure. Federal courts have been churning out decisions on this subject.[2] In

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1. Arthur Leonard is Professor of Law, New York Law School, founding co-chair of the Special Committee on Lesbians and Gay Men in the Legal Profession of the Association of the Bar of the City of New York, and founding and continuing member of the Association Committee on AIDS and the Law.

2. *See, e.g.*, Doe v. Attorney Gen., 814 F. Supp. 844 (N.D. Cal. 1992), *rev'd* 62 F.3d 1424 (9th Cir. 1995), *cert. granted, judgment vacated and remanded sub nom.* Reno v. Doe, 116 S. Ct. 2543 (1996), *aff'd sub. nom.* Doe v. Attorney Gen. 95 F.3d

addition, law reviews have been churning out commentary and articles over the past three years.[3] Two recent articles that appear in the

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29 (9th Cir. 1996); Doe v. University of Md. Med. Sys. Corp., 50 F.3d 1261 (4th Cir. 1995) (holding that a physician posed a significant risk to patients that could not be eliminated by reasonable accommodation and, thus, was not an otherwise qualified individual with a disability who could seek protection from the Rehabilitation Act or the Americans with Disabilities Act); Bradley v. University of Tex. M.D. Anderson Cancer Ctr., 3 F.3d 922 (5th Cir. 1993) (holding that a surgical technician was not "otherwise qualified" to continue employment within meaning of the Rehabilitation Act); Leckelt v. Board of Comm'rs, 909 F.2d 820 (5th Cir. 1990) (holding that a licensed practical nurse who refused to provide hospital with the results of his HIV test, after the hospital heard rumors that he was infected, was not "otherwise qualified" for protection under the Rehabilitation Act); Mauro v. Borgess Med. Ctr., 886 F. Supp. 1349 (W.D. Mich. 1995) (granting summary judgment against a HIV-infected surgical technician who claimed that his layoff violated, inter alia, the Americans with Disabilities Act); Scoles v. Mercy Health Corp., 887 F. Supp. 765 (E.D. Pa. 1994) (granting partial summary judgment to a hospital regarding a surgeon who was prohibited from performing surgery without a patient's consent, given patient's knowledge of physician's HIV status); Doe v. Washington Univ., 780 F. Supp. 628 (E.D. Mo. 1991) (holding that an HIV positive dental student was not "otherwise qualified" within the meaning of the Rehabilitation Act, and, therefore, the dental student could not collect damages due to his dismissal from school).

3. *See, e.g.*, Patricia M. Bailey, *"Significant Risk" Concept Justifies Practice Restrictions of an HIV-Infected Surgeon*, 40 VILL. L. REV. 687 (1995) (discussing, in depth, *Scoles v. Mercy Health Corp.*, 887 F. Supp. 765 (E.D. Pa. 1994), including the case's repercussions regarding HIV-infected health care workers, as well as analyzing the standards used to determine what constitutes a "significant risk" under both the Rehabilitation Act and the Americans with Disabilities Act); Becky J. Belke, Kerins v. Hartley*: A Patient's Silent Cry for Mandatory Disclosure by HIV-Positive Physicians*, 25 SW. U. L. REV. 205 (1995) (discussing a "fear of Aids" case and whether or not disclosure of HIV status by HIV-infected physicians should be mandatory); Christine Huebner, *Mandatory Testing of Health-Care Workers for AIDS: When Positive Results Lead to Negative Consequences*, 37 N.Y.L. SCH. L. REV. 339 (1992) (discussing the growing concern regarding HIV-infected health care workers, their privacy rights and the issue of whether mandatory testing of such physicians is discriminatory); Theodore R. LeBlang, *Obligations of HIV-Infected Health Professionals to Inform Patients of Their Serological Status: Evolving Theories of Liabilities*, 27 J. MARSHALL L. REV. 317 (1994) (discussing the rights of patients to know the serological status of their physician or other health professional, emphasizing the duty of HIV-infected health care professionals to disclose their status to their patients); Mary K. Logan, *Who's Afraid of Whom? Courts Require HIV-Infected Doctors to Obtain Informed Consent of Patients*, 44 DEPAUL L. REV. 483 (1995); Philip L. McIntosh, *When the Surgeon Has HIV: What to Tell Patients About the Risk of Exposure and the Risk of Transmission*, 44 U. KAN. L. REV. 315 (1996) (discussing the legal aspects of the dilemma regarding the HIV-infected health care workers by looking at the risks of HIV transmission, how the Americans with Disabilities Act relates to such workers, and to the doctrine of informed consent).

University of Kansas Law Review[4] and in the *Archives of Family Medicine*[5] take opposite positions on the issues we are discussing at this Symposium. This issue remains unsettled in the law and still requires considerable debate. The purpose of this symposium is to further the debate and contribute to the resolution of some of these problems.

The first official reports of Acquired Immune Deficiency Syndrome ("AIDS") appeared in 1981 in a U.S. Public Health Service publication entitled *Morbidity and Mortality Weekly Report.*[6] By the end of 1982, public health officials began to believe that AIDS was caused by an infectious agent that could be transmitted from one person to another, and that AIDS causes a collapse of the infected person's immune system, which normally functions to fight off a variety of infections.[7] Health officials determined this by monitoring reports about strange cancers and pneumonia appearing in gay men, intravenous (IV) drug users, Haitians, hemophiliacs, and children. These infections, found in people with AIDS, only manifest themselves if the immune system fails, and are therefore called "opportunistic" infections because they seize upon the opportunity of an unguarded body to take root. Doctors were baffled by these early cases of AIDS because the infections, which arose in people who otherwise seemed healthy, did not respond to typical medical treatments.

The conclusion that AIDS was a blood-borne infectious agent, at a time when no one had actually isolated such an agent, was drawn through the use of epidemiology.[8] Epidemiology is a scientific method based on observation and investigation that attempts to trace patterns of occurrence to find common characteristics and behaviors among people who experience a particular medical condition. Then, epidemiologists attempt to relate those patterns to already existing knowledge about how diseases are caused and spread. Early in the history of AIDS, epidemiologists noticed that the disease seemed to be appearing in particular groups of

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4. *See* McIntosh, *supra* note 3.

5. Scott Burris, *Human Immunodeficiency Virus-Infected Health Care Workers*, 5 ARCHIVES OF FAM. MED. 102 (1996).

6. *See* Centers for Disease Control, U.S. Dep't of Health & Human Servs., *Kaposi's Sarcoma and Pneumocystitis Pneumonia Among Homosexual Men--New York City and California*, 30 MORBIDITY & MORTALITY WKLY. REP. 305 (1981).

7. *See* Rosemary Ffrench et al., *How HIV Produces Immune Deficiency*, 164 MED. J. AUSTL. 166 (1996); Jonathan W.M. Gold, M.D., *Infectious Complications*, 9 CLINICS CHEST MED. 377 (1988); Clifford D. May, *McKinney Dies of Illness Tied to AIDS*, N.Y. TIMES, May 8, 1987, at B1 (stating that in 1982 scientists knew AIDS could be transmitted through blood).

8. *See* Arthur S. Leonard, *AIDS, Employment and Unemployment*, 49 OHIO ST. L.J. 929, 930 (1988) (noting that by investigating the behavior of persons ill from AIDS, epidemiologists concluded the existence of blood-borne infectious agent).

people, characterized by particular behaviors.[9] Through epidemiology, HIV was found to occur in the same group as hepatitis (another blood-borne disease). Accordingly, epidemiologists theorized that AIDS was associated with, and perhaps caused by, a blood-borne infectious agent that was not casually communicable and, therefore, it would not be transmitted from one person to another by touching, sharing food, or breathing on each other.[10] Based on the theory that AIDS was caused by a blood-borne infectious agent, epidemiologists predicted that cases would surface among blood transfusion recipients. These initial theories were born out by further study; case reports mounted; and diagnoses of AIDS among transfusion recipients started to surface.[11] By 1983, scientists in France and the United States had succeeded in isolating a virus, subsequently named human immunodeficiency virus (HIV), in the blood of AIDS patients.[12] There remains some controversy about whether HIV is the sole cause of AIDS, or whether other factors are necessary for it actually to produce disease.[13] However, it is now generally accepted that HIV infection is a precursor to the development of AIDS.

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9. *See* Centers for Disease Control, U.S. Dep't of Health & Human Servs., *Human Immunodeficiency Virus Infection in the United States: A Review of Current Knowledge*, 36 MORBIDITY & MORTALITY WKLY. REP. 1 (1987).

10. *See* Centers for Disease Control, U.S. Dep't of Health & Human Servs., *Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/Lymphadenophy-Associated Virus in the Workplace*, 34 MORBIDITY & MORTALITY WKLY. REP. 682 (1985).

11. *See* Steven Kleinman & Karen Secord, *Risk of Human Immunodeficiency Virus (HIV) Transmission by Anti-HIV Negative Blood Estimated Using the Look Back Methodology*, 28 TRANSFUSION 499 (1988); *see also* Michael J. Miller, *Strict Liability, Negligence and the Standard of Care for Transfusion-Transmitted Disease*, 36 ARIZ. L. REV. 473, 479-80 & nn.50-52 (1994) (estimating 90 cases of HIV transmission through blood transfusions per year).

12. *See* Robert C. Gallo et al., *Frequent Detection and Isolation of Cytopathic Retroviruses (HTLV-III) from Patients with AIDS and at Risk for AIDS*, 224 SCIENCE 500 (1984); Mikulas Popovic et al., *Detection, Isolation, and Continuous Production of Cytopathic Retroviruses (HTLV-III) From Patients With AIDS and Pre-AIDS*, 224 SCIENCE 497 (1984).

13. *See, e.g.*, *The Netherlands: Dissidents Challenge Basic Principles of AIDS Research*, AIDS WKLY., May 25, 1992, at 5-6 (questioning whether AIDS even actually exists); Mandana Shahvari, *AfrAIDS: Fear of AIDS as a Cause of Action*, 67 TEMP. L. REV. 769, 774-75 (1994) (discussing the view of a small number of scientists that AIDS is not caused by a single agent).

AIDS is frequently described as an invariably fatal disease, especially by the popular press.[14] However, new treatments for both immunodeficiency and various opportunistic infections have become available, and, consequently, some people with HIV are living longer and are in better health than was common when the epidemic first arose. Some doctors believe that even if a cure is not found, HIV will ultimately become a manageable medical condition with which people could live in otherwise reasonably good health for substantial periods of time.[15]

On the basis of the epidemiological studies and what is known about blood-borne viruses, it appears that HIV can be spread through the direct exchange of infected bodily fluids in a quantity sufficient for a viable infection to start.[16] In other words, direct exposure to the blood of an infected person is necessary, but not always sufficient, to transmit HIV. Also, exposure to infected blood from outside the body of an infected person can spread HIV. HIV transmission has occurred through blood transfusions and through the use of medications made from blood products, such as clotting medication used by hemophiliacs.[17] It was clear that transfused blood was a risk even before we had screening tests available to protect the blood supply from contamination. Shared hypodermic needles, which are likely to have blood on them from a prior user, also remain a major source of HIV transmission.[18] A large proportion of AIDS cases are associated with sexual intercourse with an infected person; therefore, it is clear that semen, which contains blood

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14. *See, e.g.*, Laurie Goodstein, *I Can be Fully Myself—Gay and Christian*, WASH. POST, Sept. 29, 1996, at A1 (referring to AIDS as a fatal plague); Binaya Guruacharya, *Price of Freedom: AIDS Virus/HIV Rises in Nepal as "Sold" Women Return*, HOUSTON CHRON., July 17, 1994, at 22 (calling AIDS "fatal"); Gina Kolata, *AIDS Patients Seek Solace in Suicide but Many Risk Added Pain in Failure*, N.Y. TIMES, June 14, 1994, at C1 (calling AIDS "debilitating and ultimately fatal").

15. *See* Lawrence K. Altman, *Landmark Studies Change Outlook of AIDS Treatment*, N.Y. TIMES, July 14, 1996, at 5.

16. *See* Alix R. Rubin, *HIV Positive, Employment Negative? HIV Discrimination Among Health Care Workers in the United States and France*, 17 COMP. LAB. L.J. 398, 404 (1996) (listing specific bodily fluids which transmit HIV, and noting that the larger the concentration of such fluids, the greater the risk of transmission).

17. *See* Jon Cohen, *Duesberg and Critics Agree: Hemophilia Is the Best Test*, 266 SCIENCE 1645, 1645 (1994).

18. *See* State v. Gamberella, 633 So. 2d 595, 599 (La. Ct. App. 1993) (stating that "the two most common forms of transmission of the virus are sexual activity and sharing needles"); *see also* Richard E. Chaisson, M.D., et al., *Cocaine Use and HIV Infection in Intravenous Drug Users in San Francisco*, 261 JAMA 561 (1989) (explaining the connection between HIV infection and cocaine injection due to frequency of injection and large amounts of blood drawn into the needle).

particles, can transmit HIV.[19] Studies show that anal intercourse presents the highest risk of sexual transmission, while oral intercourse is believed to present the lowest risk of sexual transmission.[20]

It is also clear, from reported and investigated cases, that a person who is exposed to infected blood from splashing, splattering, or spilling can become infected if enough of that blood finds an entry into the exposed person's bloodstream through an open wound.[21] That is what helps to explain the rare case where an emergency worker, for example, contracts HIV from exposure to an accident victim's blood. In light of the large number of health care workers and emergency workers who may be exposed to patient blood, the rarity of such cases suggest that it is not an easy method of transmission.

It is unlikely that HIV infection can be spread through exposure to the saliva, sweat, or tears of an infected person despite the trace amounts of the virus that might be found in those fluids.[22] If HIV were easily spread in this manner, the epidemiology of the disease would be entirely different, and there would be a significant number of cases that are only explainable through casual contact with infected people. Such cases have not materialized in an epidemic that has existed for more than fifteen years.

There are also cases of mothers transmitting to fetuses and babies.[23] This usually occurs during the birth process, when a baby may be exposed directly to the mother's blood stream without the protection of the

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19. *See* Council on Scientific Affairs, *The Acquired Immunodeficiency Syndrome; Commentary (Council Report)*, 252 JAMA 2037, 2037 (1984) (stating that more than 70% of AIDS patients are homosexual or bisexual males and that sexual intercourse is the most common mode of transmission within this population).

20. *See* Roger Detels et al., *Sexual Activity, Condom Use, and HIV-1 Seroconversion, in* AIDS AND SEX: AN INTEGRATED BIOMEDICAL AND BIOBEHAVIORAL APPROACH 13, 15-17 (Bruce Voeller et al. eds., 1990) (explaining that receptive anal intercourse is considerably more risky than oral sex, but that in the late 1980s, one case of transmission through oral sex was reported); *Update: Revised Safer Sex Guidelines Released*, AIDS WKLY., Aug. 29, 1994, at 9.

21. *See* Larry Gostin, *Hospitals, Health Care Professionals, and AIDS: The "Right to Know" the Health Status of Professionals and Patients*, 48 MD. L. REV. 12, 17 (1989).

22. *See* Paul M. Anderson, *Cautious Defense: Should I Be Afraid to Guard You? (Mandatory AIDS Testing in Professional Team Sports)*, 5 MARQ. SPORTS L.J. 279, 285-86, 308 n.162 (1995) (discussing the World Health Organization's Consensus Statement that HIV is not transmissible through saliva, sweat or tears).

23. *See* Michael A. Grizzi, *Compelled Antiviral Treatment of HIV Positive Pregnant Women*, 5 UCLA WOMEN'S L.J. 473, 479-80 nn. 24-25 (1995) (discussing three methods of HIV transmission unique to mother and child: in utero, at delivery, and through breast feeding).

placenta.[24] Another suspected source of the infection is breast milk.[25] These risks to babies have given rise to an entirely separate public policy debate about HIV testing for newborn infants and pregnant women.[26]

The issue of HIV-infected health care workers and their rights has hovered under the surface of the AIDS policy debate throughout the 1980s.[27] However, with two main events as its impetus, it became a major issue in the late 1980s. First, in the legal arena, there was a lawsuit brought by Kevin Leckelt, a licensed practical nurse who worked in a Louisiana hospital.[28] Leckelt was discharged when he refused to provide HIV test results to his employer who demanded them after Leckelt's roommate died from AIDS in 1986.[29] He claimed that his discharge from the hospital was a violation of laws protecting people with disabilities from unjustified employment discrimination.[30] He specifically claimed that his discharge was a violation of the federal government's Rehabilitation Act of 1973,[31] as well as a Louisiana statute[32] protecting handicapped persons.[33] In 1990, the Fifth Circuit Court of Appeals rejected Leckelt's claim.[34]

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24. *See id.* at 479-80.

25. *See id.* at 479.

26. *See* John M. Naber & David R. Johnson, *Mandatory HIV Testing Issues In State Newborn Screening Programs*, 7 J.L. & HEALTH 55, 55 (1992-1993); Suzanne M. Malloy, *Mandatory HIV Screening of Newborns: A Proposition Whose Time Has Not Yet Come*, 45 AM. U. L. REV. 1185, 1190-1214 (1996).

27. *See* Lorynn A. Cone, *AIDS and HIV Infection in the Workplace*, 13 MENTAL & PHYSICAL DISABILITY L. REP. 70 (1989) (proposing, inter alia, a policy for dealing with AIDS and HIV infection in the work place); Sev S. Fluss & Dineke Zeegers, *AIDS, HIV, and Health Care Workers: Some International Legislative Perspectives*, 48 MD. L. REV. 77, 88-91 (1989) (surveying the international legislative response to AIDS and HIV infection); Arthur S. Leonard, *Law, Social Policy, and Contagious Disease: A Symposium on Acquired Immune Deficiency Syndrome (AIDS)*, 14 HOFSTRA L. REV. 11 (1985) (discussing the legal theories and workplace legal issues raised by the AIDS phenomenon).

28. *See* Leckelt v. Board of Comm'rs, 714 F. Supp. 1377 (E.D. La. 1989), *aff'd*, 909 F.2d 820 (5th Cir. 1990).

29. *See id.* at 1383-84.

30. *See id.* at 1385.

31. *See id.* at 1378 (referring to the Rehabilitation Act of 1973, 29 U.S.C. § 794 (1994)).

32. *See id.* at 1379 (referring to the Louisiana Civil Rights for Handicapped Persons Act, LA. REV. STAT. ANN. §§ 46:2251, 46:2254 (West 1982)).

33. *See id.* at 1385.

34. *See* Leckelt v. Board of Comm'rs, 909 F.2d 820, 821 (5th Cir. 1990).

In 1987, while Leckelt's case was pending, the United States Supreme Court ruled in *School Board v. Arline*,[35] that under section 504 of the Rehabilitation Act, a person with a contagious condition, who was otherwise able to work, would be protected from discrimination unless his or her condition presented a significant risk of harm to others in the workplace.[36] Leckelt's attorneys argued that under that standard, the hospital did not have a right to know about his HIV status.[37] The court disagreed.[38]

At about the same time that the Fifth Circuit was ruling in Leckelt's case, a Florida dentist, Dr. David Acer, died from AIDS, and several of his patients came forward to reveal that they were infected with HIV.[39] The Center for Disease Control and Prevention (CDC) conducted studies and determined that a similar, perhaps identical, strain of HIV had infected both Dr. Acer and perhaps as many as five of his patients.[40] Although the CDC could not definitively establish how the patients and Dr. Acer had been infected with the same strain of HIV, the most plausible explanation was that he transmitted the virus to some or all of his patients while rendering dental care.[41]

Thereafter, by the end of 1990, Dr. William Roper, who was then the director of the CDC, revealed to the press that top federal public health officials were considering proposals to require routine HIV testing of surgeons and other health care workers who perform invasive procedures, that is, procedures that involve going into the body of the patient in some way.[42]

Another event that occurred in 1990, and which is very important to this debate, was the final deliberations on, and the enactment of, the

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35. 480 U.S. 273 (1987).

36. *See id.* at 284-89.

37. *See Leckelt*, 909 F.2d at 829.

38. *See id.* at 833.

39. *See* Don Colburn, *Odds of HIV Transmission from Doctor to Patient: Low*, WASH. POST, Oct. 8, 1991, at 5.

40. *See* Centers for Disease Control, U.S. Dep't of Health & Human Servs., *Possible Transmission of Human Immunodificiancy Virus to A Patient During an Invasive Dental Procedure*, 39 MORBIDITY & MORTALITY WKLY. REP. 489 (1990).

41. *See id.* at 491.

42. *See* Thomas E. Margolis, Note, *Health Care Workers and AIDS*, 13 J. LEGAL MED. 357, 369-73 (1992) (noting that several lawmakers responded to the public fear of HIV transmission from health care workers to patients by proposing the "Bergalis Bill," which, among other things, would have required health care workers who perform invasive procedures to undergo HIV testing and disclose their status to their patients prior to an invasive procedure).

Americans With Disabilities Act (ADA).[43] Reacting to the particular problems posed by infectious diseases as revealed in the *Arline* decision, Congress made clear in the ADA's legislative history that people with contagious transmissible conditions would be covered by the statute if those conditions met the definition of a "disability,"[44] but they would not be considered qualified for protection from discrimination if their condition presented a direct threat to others that could not be eliminated through reasonable accommodation.[45]

In 1991, in reaction to the Acer incident—and reportedly due to direct pressure from key members of Congress following hearings at which one of Dr. Acer's patients, Kimberly Bergalis, had testified—the CDC issued guidelines.[46] The CDC recommended requiring HIV-infected health care

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43. 42 U.S.C. §§ 12101-12213 (1994).

44. *See id.* § 12102. The ADA defines "disability" as: "(A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment." *Id.*

45. The ADA prohibits discrimination against an otherwise qualified individual with a disability. *See id.* § 12112. "No covered entity shall discriminate against a qualified individual with a disability because of the disability of such individual . . . ." *Id.* However, an individual is not otherwise qualified if that individual poses a significant risk to the health or safety of others by virtue of the disability that cannot be eliminated by reasonable accommodation. *See id.* § 12113(a)-(b). An individual is not qualified if that individual poses a direct threat to the health or safety of other individuals in the workplace. *See id.* A "direct threat" is defined as a significant risk to the health or safety of others that cannot be eliminated by reasonable accommodation. *See id* § 12111(3).

Several courts have held that an HIV-infected health care worker is not an otherwise qualified individual with a disability where the health care worker poses a significant risk to patients that cannot be eliminated by reasonable accommodation. *See, e.g.*, Doe v. University of Md. Med. Sys. Corp., 50 F.3d 1261 (4th Cir. 1995) (finding that a neurosurgical resident's HIV-infection could not be reasonably accommodated, despite no documented case of surgeon-to-patient transmission, because some measure of risk will always exist in the type of activities in which the surgeon was engaged); Bradley v. University of Tex. M.D. Anderson Cancer Ctr., 3 F.3d 922 (5th Cir. 1993) (finding that a hospital could not make reasonable accommodation to eliminate the risk connected with the essential functions of a surgical assistant because surgery involves inevitable accidents); *see also* R. Bradley Prewitt, Comment, *The "Direct Threat" Approach to the HIV-Positive Health Care Employee Under the ADA,* 62 MISS. L.J. 719, 726-27 (1993).

46. *See* Centers for Disease Control, U.S. Dep't of Health and Human Servs., *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 (1991). The CDC guidelines consisted of recommendations such as wearing gloves during procedures that were likely to generate splashes of blood and procedures to prevent injuries caused by needles. *See id.* at 5; *see*

workers to disclose their HIV status to patients before performing what were called "exposure-prone invasive procedures."[47] The guidelines, although not legally binding, have assumed great significance whenever courts have had to consider these issues.[48] This responds to the Supreme Court's statement in *Arline* that in evaluating workplace risks, courts should normally defer to the reasonable medical judgments of public health officials.[49] At the time the CDC made this recommendation, there was no consensus in the medical community as to which procedures were "exposure-prone invasive procedures" largely because discussion was entirely theoretical. The only reported cases of patients contracting HIV from a health care worker were the cluster of patients treated by Dr. Acer.[50] Since that day, there has not been a confirmed case of any other infected health care worker transmitting HIV to a patient while performing a medical procedure.[51] There have been numerous cases of surgeons who have AIDS and whose patients have been studied to determine

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also Barbara Matthews Anderson, *"First Do No Harm . . . ": Can Restrictions on HIV-Infected Health Care Workers Be Justified?*, 33 SANTA CLARA L. REV. 603, 613-17 (1993) (outlining the aforementioned 1991 CDC guidelines).

47. Centers For Disease Control, *supra* note 46, at 5 (urging that expert review panels establish guidelines under which HIV-infected health care workers may perform invasive procedures, including requiring notifying prospective patients of the HIV-infected health care worker's seropositivity); *see also* Margolis, *supra* note 42, at 391.

48. *See, e.g.*, Abbott v. Bragdon, 912 F. Supp. 580, 590-91 (D. Me. 1995) (commenting that a dentist has complete control over the reduction of his risk of infection from an HIV-infected patient by following the CDC recommended precautions); Estate of Behringer v. Medical Ctr., 592 A.2d 1251 (N.J. Super. Ct. Law Div. 1991) (recognizing CDC guidelines as supportive of a hospital's restriction of surgical privileges for an AIDS-infected surgeon).

49. *See* School Bd. v. Arline, 480 U.S. 273, 288 (1987).

50. *See* Centers for Disease Control, U.S. Dep't of Health & Human Servs., *Update: Transmission of HIV Infection During an Invasive Dental Procedure in Florida*, 40 MORBIDITY & MORTALITY WKLY. REP. 21, 27 (1991).

51. *See* Centers for Disease Control, U.S. Dep't of Health & Human Servs., *Update: Investigations of Persons Treated by HIV-Infected Health-Care Workers—United States*, 42 MORBIDITY & MORTALITY WKLY. REP. 329, 329 (1993) (reporting that an HIV-infected dentist in Florida is the only case in which HIV transmission from an infected healthcare worker to patients has been documented); Richard N. Danila et al., *A Look-Back Investigation of Patients of an HIV-Infected Physician*, 325 NEW ENG. J. MED. 1406, 1408-10 (1991) (reporting several studies of HIV-infected health care workers finding no transmission of HIV from HIV-infected surgeons and health care workers to patients other than from Dr. Acer).

whether any of them were infected.[52] These studies have now examined thousands of patients and there have been no confirmed cases of transmission.[53]

The CDC has also calculated the odds of transmission, based on what was known in 1991 about the transmissibility of HIV in the other direction, that is, from patients to health care workers.[54] They have produced numbers representing a range of risk. For any single procedure performed by an HIV-infected health care worker, the CDC estimates the risk that a patient will contract HIV to be between 1 in 42,000 and 1 in 420,000.[55] Of course, during a career, a health care worker will perform hundreds and thousands of procedures, so the risk mounts that transmission may occur. After issuing its guidelines, the CDC asked the various specialty medical associations to produce lists of "exposure-prone invasive procedures" that could be used to guide hospital administrators in deciding how to deal with HIV-infected health care workers.[56] After some internal debate, the medical profession refused to cooperate with the production of such lists on any sort of formal basis.[57]

With this background, the issue is now framed for our discussion this afternoon, although I expect some of our panelists may have different perspectives on some of my introductory exposition. But the basic questions we are facing here are: What is the risk? Who should bear the risk of HIV transmission in the health care setting? How has the balance been struck in existing law, by Congress, by the courts, and by the medical profession? How should the balance be struck?

II. HYPOTHETICAL CASE

Consider the following hypothetical: Doctor Martin Stone is a respected surgeon at a major metropolitan hospital. Doctor Stone has a good reputation in the community and among the hospital staff as a careful and conscientious professional. While performing a surgical procedure on an emergency patient brought in from an auto accident, Dr. Stone was

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52. *See* Crispian Scully, M.D., & Stephen R. Porter, *Can HIV be Transmitted from Dental Personnel to Patients by Dentistry?*, 175 BRIT. DENTAL J. 381, 381 (1993) (citing a study of 19,000 patients treated by 57 HIV-infected health care workers where no patient was infected due to the treatment, excluding the dental practice of Dr. Acer).

53. *See id.*

54. *See* Bernard Lo, M.D., & Robert Steinbrook, M.D., *Health Care Workers with the Human Immunodeficiency Virus: The Next Steps*, 267 JAMA 1100, 1100 (1992).

55. *Id.*

56. *See* Centers for Disease Control, *supra* note 46, at 5.

57. *See* Lo & Steinbrook, *supra* note 54, at 1102.

exposed to large amounts of blood. When the patient regained consciousness in the recovery room after surgery, he informed the nurse that everyone should be careful with his blood because he is HIV-positive. The nurse relayed this information to Dr. Stone, who then immediately obtained HIV testing and took a dose of AZT as a precautionary measure. Doctor Stone tested negative. However, four weeks later, after repeated testing, he tested positive, and was subsequently confirmed positive.

III. DR. NORTON SPRITZ[58]

I now turn to Dr. Norton Spritz, who is an administrator in a major hospital in New York City, a doctor, and a lawyer. Dr. Stone has kept this information confidential thus far, but has come to you, the chief of medical services, for advice on how to proceed. From the viewpoint of someone in your position at a large metropolitan hospital, how would you respond to his situation?

DR. NORTON SPRITZ: Before I get to the fundamental question, I want to present the medical background surrounding a case such as this. First, this is an exceedingly rare method for transmission of the HIV virus. The CDC estimates that there are approximately forty to fifty documented episodes of transmission from patients to health care workers.[59] A majority of those, probably about thirty, are from punctures by hollow needles.[60] Hollow needles are needles that go into syringes that contain blood, and there is a real transfer of blood into the health care worker under the surface of the protected skin. That is thought to be the crucial step.[61] The HIV virus cannot penetrate through

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58. Dr. Spritz is Chief of the Medical Service at the New York Veterans Administration Medical Center and Professor of Medicine at New York University Medical Center. He is also presently Attending Physician at Tisch Hospital, New York, Visiting Physician in Medicine at Bellevue Hospital, New York, and an Adjunct Associate at The Hastings Center, New York.

59. *See* CENTERS FOR DISEASE CONTROL, U.S. DEP'T OF HEALTH & HUMAN SERVS., HIV/AIDS SURVEILLANCE REPORT 21 tbl.21 (reporting that through December 1995, the CDC had received reports of 49 health care workers in the United States with documented occupationally acquired HIV infection and 102 with possible occupationally acquired HIV infection).

60. *See* Centers for Disease Control, U.S. Dep't of Health & Human Servs., *Case-Control Study of HIV Seroconversion in Health-Care Workers After Percutaneous Exposure to HIV-Infected Blood—France, United Kingdom and United States, January 1988-August 1994*, 44 MORBIDITY & MORTALITY WKLY. REP. 929, 929 (1995) (reporting 29 health care workers were exposed to HIV by hollow needle-stick injuries).

61. *See* Julie L. Gerberding & William P. Schecter, *Surgery and AIDS: Reducing the Risk*, 265 JAMA 1572 (1991).

normal skin or through normal mucous membranes such as those in the mouth.[62] The kinds of needles that are used in surgery, mostly for sewing skin, are not hollow but filled needles; and there are very few, if any, documented instances in which the HIV virus was transmitted by accidental sticking with those needles.[63] Therefore, the fact that Dr. Stone developed an HIV infection, is an extremely rare occurrence, and we have every reason to assume this is how he contracted HIV.

Second, I would like to touch on AZT prophylaxis—an anti-viral drug therapy—because, although whether it works is primarily a medical issue, I think it also has important legal and ethical ramifications, because it concerns whether people can limit their risk if they know they have been exposed. Therefore, I think that whether AZT prophylaxis treatment actually works is important when we consider the confidentiality rights of patients and the rights of health care workers exposed to those patients.

AZT prophylaxis has never been, and can never be, subject to standard therapeutic testing.[64] The occurrence rate of the disease is so small that it is impossible to put together a test control and treated group. This is because both groups, no matter how large they are, are probably not going to have any HIV conversions. However, the CDC recently looked at all the data on health care workers exposed by needle-sticks throughout the United States, Great Britain, and France.[65] They considered cases where health care workers were exposed to HIV from patients.[66] From that study—and there are problems with that kind of study—it was quite convincing that AZT was protective.[67] Its use

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62. *See* R.J. Simonds & Martha F. Rogers, *HIV Prevention - Bringing the Message Home*, 329 NEW ENG. J. MED. 1883, 1884 (1993) (reporting that after more than 1100 mucous-membrane exposures to HIV among health care workers, only one seroconversion occurred).

63. *Cf.* Centers for Disease Control, *supra* note 60, at 929 (estimating the risk of HIV transmission to a health care worker after percutaneous exposure to be 0.3%).

64. *See* Lawrence O. Gostin et al., *HIV Testing, Counseling, and Prophylaxis After Sexual Assault*, 271 JAMA 1436, 1438 (1994); *see also* Rebecca Voelker, *Federal Ruling Reins in Liberal HIV Testing Law, Consensus Still Lacking on Controversial Issue*, 270 JAMA 2530 (1993) (reporting that post-exposure prophylaxis with AZT has not been shown to prevent infection with any certainty).

65. *See* Centers for Disease Control, *supra* note 60, at 929-33 (summarizing the results of a retrospective case-control study conducted by the CDC in collaboration with French and British public health authorities).

66. *See id.*

67. *See id.* at 929, 933; *see also* Sabine K. Loes, *A Controlled Trial of Zidovudine in Primary Human Immunodeficiency Virus Infection*, 333 NEW ENG. J. MED. 408 (1995) (finding a possible reduction in acute symptoms, preservation of immune function, and improvement of the long-term prognosis, if zidovudine treatment is given early during

became standard. In our hospital, our house staff who stick themselves regularly with needles, either from patients they know are HIV-positive, or patients they do not know are not HIV-positive, generally take AZT. The situation has become more complicated because patients who are on AZT prophylaxis may have a strain of the HIV virus that is resistant to AZT. Therefore, the debate is whether we should be using a more modern combination of drugs in these prophylactic studies. I mention that because it is an important aspect of this case.

Another important aspect that is more directed to the ethical concern of what are Dr. Stone's rights, as well as what are the rights of the institution and society, is that it is unusual to detect who has been infected at the very beginning of his or her HIV infection.

It is known that Dr. Stone probably has at least eight years of good health from when the initial infection was dated.[68] During this HIV-positive period, his CD count will be normal and he will not have any opportunistic infections. The main issue concerning Dr. Stone is that during that long period of time, although he will most likely remain productive, he is also capable of transmitting the virus. If his ability to practice his profession is limited, he pays a larger price than a patient who is already sick and has a short life expectancy when this disease is first discovered. Therefore, the decision in this matter has potential to deprive Dr. Stone of a great deal of productive activity. There have been patients who are HIV-positive for twenty years yet do not contract AIDS. For the first time, it is being said that people who have HIV, even if they live a normal life expectancy, may never develop AIDS.[69] The survival rate of people with AIDS used to average ten or eleven months. Now, it is not unusual for patients who have bona fide CDC-definable AIDS to live for four to seven years after the diagnosis. So Dr. Stone, who is a presumably young person, may face a decade or more of productive life. Accordingly, restrictions of breach of confidentiality have severe and prolonged implications.

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primary infection with HIV). *But see* J.I. Tokars et al., *Surveillance of HIV Infection and Zidovudine Use Among Health Care Workers After Occupational Exposure to HIV-Infected Blood*, 118 ANN. INTERN. MED. 913 (1993) (stating that documented failures of post-exposure zidovudine prophylaxis indicate that if zidovudine is protective, any protection afforded is not absolute).

68. *See* Ruth L. Berkelman, *Epidemiology of Human Immunodeficiency Virus Infection and Acquired Immunodeficiency Syndrome,* 86 AM. J. MED. 761, 761 (1989) (noting that after the initial HIV infection there is an average incubation period of approximately eight years during which time the person may remain asymptomatic).

69. *See HIV Discoverer Reassessing View of AIDS,* AIDS WKLY., May 4, 1992, at 5; *see also* Jesse Green, *Flirting With Suicide,* N.Y. TIMES, Sept. 15, 1996, §6 (Magazine), at 40 (describing how a new treatment involving protease inhibitors has made HIV a more manageable disease).

The primary public responsibility of a physician who deals with an HIV-positive patient is to identify what people are clearly at risk. I, as chief of medical services, would have the absolute responsibility to protect those whom he could infect, including his patients. Even though he is a physician and should know what he is doing, I have a responsibility to make Dr. Stone understand who in his world are at a risk of infection. If there are people who may have already acquired HIV from him, his clear responsibility is to inform them. However, we need not get into that because that is not what we are talking about today. There is a very clear responsibility for physicians, both ethically, and in New York State, legally, to protect known sexual partners.[70] If he had a regular sexual partner, and he told me that he was not informing this partner and continuing to have unprotected sex, I feel I would have a responsibility to inform that third party.

Now, the real underlying factual basis for the policy questions that we face in this case is his ability to transmit to patients. As Professor Leonard pointed out, with the possible exception of Dr. Acer, there has not been a documented instance of transmission from health care personnel to patients.[71] Let us examine what that data means. Nineteen thousand patients operated on by known HIV-positive surgeons were studied.[72] As would be expected in a group of nineteen thousand people, some were found to be HIV-positive. However, a logical conclusion could not be made in any of the cases that the transmission occurred from their surgeon during surgery.[73] So I think it's very important to define the two kinds of information on which we make policy decisions. There is a kind of mechanistic hypothetical information from which you can construct a scenario by which the virus can be transferred from a surgeon to a patient. For example, surgeons cut their fingers, they bleed, and they bleed into an open cavity. I would not have been surprised if, of these nineteen thousand people tested, there were some cases transmitted during surgery. If I faced Dr. Stone's case ten years ago, I would have to say we would have made the decision on the basis of probable risk because we did not

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70. *See* N.Y. PUB. HEALTH § 2782(4) (McKinney 1993) (stating that physicians, under certain circumstances, may disclose certain confidential HIV information when the physician reasonably believes disclosure is medically appropriate and when there is a significant risk of infection); *see also* Larry O. Gostin, *Public Health Strategies for Confronting AIDS: Legislative and Regulatory Policy in the United States,* 261 JAMA 1621, 1628 (1989) (citing American Medial Association policy that failure to warn a third party in immediate danger can result in liability).

71. *See supra* notes 50-53 and accompanying text.

72. *See* Scully & Porter, *supra* note 52, at 381.

73. *Id.* at 381 (finding that 92 patients were found to be HIV-infected, but the evidence did not support transmission from health care workers).

have the data. But now we do have data. If you have nineteen thousand cases and have not detected an instance of such transmission, I believe there are firm scientific and legal grounds to say that this is not a mechanism by which this disease is transmitted. I am not saying that if you test another million you will not find a case. However, I do think that we can say that surgery is not a mechanism by which virus is transmitted from one person to another. I believe that this fact is the crux of this case. The patients on whom Dr Stone operates are not at any risk that we can define.

The CDC was immensely criticized for coming up with their figures for risk.[74] Consider the question of what the chance is that the next child born is going to have blue hair. This cannot be predicted because there is no historical basis for such predictions. Accordingly, the CDC has come up with predictions for which there is no historical basis. I believe the CDC faced a lot of political pressure to come up with some defined risk. Congressmen were not comfortable with the idea of saying they cannot find any risk at all. Therefore, I don't think we should use the CDC's 42,000 to 1 or 420,000 to 1 figures in our analysis of a patient's risk in this case. On that basis, I believe that if there is no demonstrable risk, there is no responsibility. I have no responsibility to report Dr. Stone to anyone and breach his confidentiality.

There are, however, two problems with my decision. One is that surgeons transmit hepatitis B, and now it's well-documented that surgeons transmit hepatitis C, to patients during surgery.[75] These are very similar pathogens to HIV blood-borne virus pathogens. The outbreaks generally occur where a single surgeon transmits hepatitis to a group of patients. If not for the nineteen thousand negatives, this would be very strong evidence, by analogy, that HIV could be transmitted from health care worker to patient, and that there is a definable risk. Although I do not know how to explain the difference, virologists have a lot of explanations

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74. *See* Norman Daniels, *HIV-Infected Professionals, Patient Rights, and the 'Switching Dilemma'*, 267 JAMA 1368, 1369 (1992) (acknowledging the controversial assumptions and important uncertainties surrounding the CDC estimates); Lo & Steinbrook, *supra* note 54, at 1100 (noting the limitations of the model used by the CDC to calculate risk of transmission).

75. *See* Centers for Disease Control, *supra* note 46, at 2 (citing published reports of 20 clusters in which a total of over 300 patients were infected with Hepatitis B virus after treatment by a healthcare worker); Juan I. Esteban et al., *Transmission of Hepatitis C Virus by a Cardiac Surgeon,* 334 NEW ENG. J. MED. 555, 555 (1996) (reporting that a surgeon possibly transmitted Hepatitis C to five of his patients during open-heart surgery); Ludwig A. Lettau et al., *Transmission of Hepatitis B with Resultant Restriction of Surgical Practice*, 255 JAMA 934 (1986) (finding five patients developed a hepatitis subtype matching that of a obstetric-gynecologic surgeon who performed surgery on the patients).

for why HIV is so difficult to transmit compared to other similar blood-borne viruses.[76]

The second problem with my decision that Dr. Stone is entitled to confidentiality is the issue of informed consent. The issue is whether Dr. Stone's patients have a right to know. It's undoubtedly true that many of his patients would choose not to be operated on by him, in spite of all my eloquence about why there is no risk. Many of us in this audience, and perhaps myself to be honest with you, would at the very least worry about being operated on by an HIV-infected surgeon. In terms of informed consent, we don't require patients to be bright, or smart, or brilliant, or to view things the way we do. We have to give them the information they need, and then they can make any decision to accept or reject treatment. We have patients who don't want to have urgently needed spinal surgery because their grandfather didn't walk after something that happened twenty-five years ago. It is not in the patient's best interest to make that decision, but it is his or her decision, and it controls. So one could argue that even though we can say that statistically there is no risk of contracting HIV, if the patient thinks there is a risk and would refuse medical treatment from an HIV-positive doctor, the information must be supplied to the patient in an honest, informed consent process. The *Arline* case deals with this fundamental issue.[77] The Court determined, although in a somewhat different context, that an imagined danger is not reason enough to compromise the interests of people with disabilities.[78] I think that this defines the ethical issue presented here and that the Court's decision shapes one's duty to Dr. Stone. So I would maintain that on the basis of an inability to really define "appreciable risk," I have no responsibility to report Dr. Stone to anyone else in the hospital. If he asked me if he has a moral responsibility to reveal his status to patients or hospital officials, I would say no.

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76. *See, e.g.*, Julie Louise Gerberding, *Drug Therapy: Management of Occupational Exposure to Blood-Borne Viruses*, 332 NEW ENG. J. MED. 444 (1995) (discussing the risk of transmission for Hepatitis B, Hepatitis C, and HIV); Lawrence A. Kingsley et al., *Sexual Transmission Efficiency of Hepatitis B Virus and Human Immunodeficiency Virus Among Homosexual Men*, 264 JAMA 230 (1990) (reporting on the transmission efficiency of Hepatitis B and Human Immunodeficiency Virus Type 1 by a prospective study of homosexual men); Ban Mishu & William Schaffner, *HIV-Infected Surgeons and Dentists: Looking Back and Looking Forward*, 269 JAMA 1843 (1993) (recognizing that HIV is less likely to be transmitted through blood-borne contact than Hepatitis B Virus).

77. *See* School Bd. v. Arline, 480 U.S. 273 (1987) (holding that the basic factors to be considered in determining whether a person handicapped by a contagious disease is "otherwise qualified" under the Rehabilitation Act are the nature of the risk, the duration of the risk, the severity of the risk, and the probability that the disease will be transmitted).

78. *See id.* at 285.

IV. KATHRYN MEYER[79]

PROFESSOR LEONARD: It is clear from the reported cases on HIV-infected health care workers that a lot of people would say that he does have a responsibility.[80] For the sake of the hypothetical discussion, assume that Dr. Stone has authorized Dr. Spritz to tell the president of the hospital that he is HIV-positive, provided that Dr. Spritz is assured by the president of the hospital that the information will only be used for internal hospital decision-making purposes. The president of the hospital contacts the general counsel of the hospital for a legal opinion. For this we have the general counsel of Beth Israel Medical Center in New York City, Kathryn Meyer. Ms. Meyer was also the first Chair of the New York City Bar Association's Ad Hoc Committee on AIDS, and she currently lectures on medical ethics.

The president has just learned that a respected surgeon on the hospital staff has tested HIV-positive as a result of exposure to a patient's blood; a possible, but unusual occurrence. The president received the recommendation of the chief of medical services, which is what we have just heard from Dr. Spritz. Now, the president wants a legal opinion as to whether the hospital should take any steps to restrict the practice of this surgeon, or whether the surgeon's status should be revealed to anyone else. The president also wants to know what the hospital's legal exposure may be and the potential impact on the hospital's malpractice coverage, if they later get sued by patients. Ms. Meyer, what advice might you give?

MS. KATHRYN MEYER: After I got over my amazement that a physician, who was only HIV-positive and not afflicted with active AIDS, voluntarily came forward to tell us, I would have several concerns.

On the one hand, I would be concerned about the liability implications and what we need to do to protect ourselves from the vanishingly small risk that Dr. Spritz has described. On the other hand, the hospital would want to take great care not to act in a manner that would jeopardize the chances of other doctors coming forward. I don't want to see Dr. Stone

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79. Kathryn Meyer is Senior Vice President for Legal Affairs at Beth Israel Medical Center, New York, Adjunct Associate Professor, Brooklyn Law School, and Assistant Clinical Professor, Albert Einstein College of Medicine. She is also Chair of the Committee on Health Law of the Association of the Bar of the City of New York and a member of the New York State Task Force on Life and the Law.

80. *See generally* Barbara Gerbert et al., *Physicians and Acquired Immunodeficiency Syndrome: What Patients Think About Human Immunodeficiency Virus in Medical Practice*, 262 JAMA 1969, 1971 (1989) (reporting that 80% of patient-respondents believed physicians infected with HIV should inform their patients of their HIV status).

punished for having actually confided in us. Also, I would be very concerned about the fact that he contracted it from a patient. When the word gets out that a physician has contracted HIV from a patient, there could be devastating morale implications for the institution. If the hospital serves a large HIV-infected population, you have to be very concerned on that level.

The first thing I would do is send him to my infection control coordinator for evaluation. I would want to know what kind of procedures the doctor performs and what we can do to further lessen the negligible risk of transmission by such a surgeon. You've said he's a surgeon. There are many kinds of surgeons. Does he do "blind suturing," a procedure in which he stitches with a needle in a cavity where he cannot see what he is doing? If he does, can we substitute needles? There is a whole movement to make surgery even safer by using techniques, such as blunt needles or newly devised gloves that have reinforced tips. Can he triple-glove? The infection control person would examine everything the doctor does in the various procedures he performs and tell me what can be done to lessen the risk of transmission. There may be a few procedures that he should no longer perform. Perhaps there would be one or two procedures where the possibility of a blood exposure could not be eliminated. My guess is there would be very few, and that the infection control coordinator would be able to devise a plan that we could work out with Dr. Stone, whereby he would be able to keep practicing with only some very minor restrictions.

PROFESSOR LEONARD: Do you think that the hospital has any legal obligation to inform patients that a surgeon, who may be operating on them, is HIV-positive?

MS. MEYER: I think I have to answer that question no. I have a practical reason for not wanting to tell them. I am not really worried about the suit from the person who gets HIV. We are not going to have that because no one is going to get HIV. Rather, it is the suit from the patient who develops AIDS-phobia because the patient has been told he or she might get HIV. In fact, New York recognizes that possibility.[81] The moment I start down the road of informing people, they will get anxious and will sue me because I made them anxious.

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81. *See* Johnson v. New York, 37 N.Y.2d 378 (1975) (holding that plaintiff could recover for emotional harm where there was objective physical manifestations of emotional harm resulting from the defendant's negligent misinformation about the death of the plaintiff's mother); Schulman v. Prudential Ins. Co., 640 N.Y.S.2d 112 (App. Div. 1996) (holding that a patient could maintain action for negligent infliction of emotional distress as a result of erroneous reporting of his or her HIV-positive status).

Leaving that aside, I think the issue is whether it is safe for Dr. Stone to practice. If infection control decides that it is safe, I do not understand the role of informed consent. We would be asking patients to make a decision based on information that we have decided has no relevance. Clearly, the result of informed consent, even though the hospital has decided that he can practice, will be that he cannot practice. This risk is not the kind of risk that has historically been included in informed consent. Informed consent is about risks that are inherent in the procedure, not about risks that the surgeon brings to the procedure. For example, we do not tell patients that a surgeon has never done a procedure before, that he does not know what he is doing, or that he has an alcohol problem. Maybe we should disclose such information, but the question of disclosure is typical of the inappropriate focus on AIDS. The answer is no, I would not bring in informed consent.

PROFESSOR LEONARD: To further complicate the hypothetical, suppose that several years later, Dr. Stone develops AIDS and becomes disabled to the degree that he is no longer able to practice. He develops symptoms, the word spreads in the community, and people whom Dr. Stone operated on in recent years develop a terrible, blinding, and paralyzing fear that they may contract AIDS. They all test negative, but until they get those test results, they suffer severe emotional distress. Moreover, the former patients of Dr. Stone sue the hospital because the hospital let an HIV-infected surgeon perform surgery on them without disclosing his condition. Will the hospital's malpractice coverage pay for the defense of those lawsuits?

MS. MEYER: Absolutely. First of all, if the insurance carrier ever wants to write insurance in New York again, it cannot disclaim them. The carrier can only disclaim if there is a material risk that was not disclosed.[82] This situation is the exact reason the hospital maintains insurance.

PROFESSOR LEONARD: Do you think the hospital would win those lawsuits?

MS. MEYER: Although it is difficult to know the chances of success in emotional distress cases, I think the hospital would win those lawsuits. The patients would be required to show some sort of negligence. However, I would not let the fear of this liability affect my decision concerning Dr. Stone at this point. The situation that I find harder, and

82. *See* N.Y. INS. LAW § 3105(b) (McKinney 1985) ("No misrepresentation shall avoid any contract . . . unless such misrepresentation was material.").

that your hypothetical does not quite raise, is suppose he came to us after he had been practicing for six or seven years, and he was starting to become seriously ill. At that point, there is a question of whether the hospital has an obligation to look back at ourselves and our people to see if any patients have been exposed. This would be especially true if he can remember an incident when, in fact, he did have a terrible bleed into a patient cavity.

I would suggest that we let him continue practicing, but possibly with some modifications. There might be some procedures he could not do as determined by the hospital's infection control people. Ultimately, that is a very tough question for the hospital.

V. PROFESSOR MICHAEL CLOSEN[83]

PROFESSOR LEONARD: Suppose this problem presents itself, and it is an issue on which you have not really done much work. However, you know that there is an alumnus and current faculty member of your law school, in the same city, who has published and lectured extensively on AIDS-related legal issues. Professor Michael Closen, what is the law on this and what should the hospital do?

PROFESSOR CLOSEN: Well, I come with the bias of being plaintiffs' attorney in a class action case against a dental student and a dental school in Chicago, Illinois.[84] It was filed on behalf of approximately 125 patients who were treated by an HIV-infected dental student who did not tell those patients of his HIV status prior to treating them. I can assure you, from that personal experience as counsel for those patients, that the news of possible HIV exposure has a devastating effect on many of these individuals. Some people have suffered severe emotional distress, and some have changed or discontinued their sex lives. In almost all cases, these patients are getting tested for HIV over long periods of time and discontinuing sexual relations on the advice of medical doctors. I am concerned that other presenters on the panel seem to have incorrectly placed the interests of the institution, the hospital, and the surgeon, above the interests of the patients. Certainly, the patient is the principal in this principal/agent relationship, and, in turn, the physician and the hospital are the fiduciaries of the patients. The medical profession has suffered over time from being stereotyped as arrogant and putting its views of things above that of the lowly patient (who cannot possibly be as

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83. Michael Closen is a Professor of Law at John Marshall Law School where he has been a member of the faculty since 1976.

84. *See* Doe v. Northwestern Univ., No. 93 L 8847 (Cir. Ct., Cook County, Ill.) *appeal docketed,* No. 96-067 (Ill. App. Ct. filed Mar. 31, 1995).

capable as they are of making reasoned decisions). The present discussion sounds as though it approaches ratifying that sentiment.

The first matter is probably the most important. Is there an actual risk of HIV transmission from surgeon or dentist to patient? My distinguished colleagues conclude that they believe there is no documented case of such transmission, and, therefore, the answer is no. In "look-back" studies of some nineteen thousand people, we have not found any cases. Therefore, my opponents argue that there is no risk. They have said that the danger is so insignificant as to be "irrelevant." I would differ in that view for a number of reasons. A very important one, admitted by both of my colleagues, is that we have a number of documented instances of viral hepatitis being transmitted by surgeons and dentists to patients.

Second, as an attorney, I certainly give some weight to the view of lawyers and judges. I think that, with some regularity, they are reasonable individuals who think fully about the matters that they confront. In every single case in which a state or federal court has decided the question of whether a hospital or clinic could restrict the practice activities of an HIV-infected health care professional who performs invasive procedures, the court has held that an HIV-positive health care professional poses a significant risk to his or her patients.[85] I realize fully that these results have been in the context of employment discrimination cases, under the Federal Rehabilitation Act or the ADA, and, therefore, certainly did not involve tort transmission settings. However, there must be twenty-five or thirty state and federal judges who have held, in written opinions, that these HIV-infected health care professionals do pose a significant risk to their patients.[86]

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85. *See, e.g.*, Doe v. University of Md. Med. Sys. Corp., 50 F.3d 1261 (4th Cir. 1995) (holding that an HIV-positive physician posed significant risk to a patient that could not be eliminated by reasonable accommodation); Bradley v. University of Tex. M.D. Anderson Cancer Ctr., 3 F.3d 922 (5th Cir. 1993) (holding that an HIV-infected surgical technician was not "otherwise qualified" to continue his employment because there was some risk of transmitting the virus); Mauro v. Borgess Med. Ctr., 886 F. Supp. 1349 (W.D. Mich. 1995) (holding that a surgical technician infected with HIV posed significant risk to health of patients); Scoles v. Mercy Health Corp., 887 F. Supp. 765 (E.D. Pa. 1994) (finding that an orthopedic surgeon infected with HIV posed a significant risk to patients); Doe v. Washington Univ., 780 F. Supp. 628, 633-34 (E.D. Mo. 1991) (stating that there is a risk of transmission of HIV from an infected dental worker to a patient); Leckelt v. Board of Comm'rs, 714 F. Supp. 1377, 1387, 1392 (E.D. La. 1989) (finding that a licensed practical nurse, if HIV-infected, posed risk of transmission to patients during invasive procedures); *In re* Hershey Med. Ctr., 595 A.2d 1290, 1296 (Pa. Super. Ct. 1991), *aff'd*, 634 A.2d 159 (Pa. 1993); Estate of Behringer v. Medical Ctr., 592 A.2d 1251 (N.J. Super. Ct. Law Div. 1991).

86. *See* cases cited *supra* note 85.

Third, we know that HIV is transmitted by blood-to-blood contact between patients and health care professionals through accidental needle-sticks in surgical situations.[87] It is also known that, in the intravenous drug situation, about one-third of the people in the United States who have HIV were infected from sharing intravenous drugs by way of blood contaminated syringes.[88] Thus, in operating theaters where there could be accidents that cause blood-to-blood exposure by way of needles and scalpels, there seems to be a genuine risk of HIV transmission from surgeons and dentists to patients. I am not convinced the simple lack of evidence of a case of accidental transmission from surgeon or dentist to patient is proof of the nonexistence of this risk.

There are a couple of reasons for my doubts. First, if eighteen months ago, this panel had convened over whether HIV can be transmitted by bite, Dr. Spritz and Ms. Meyers and others would have been able to sit here and say that in ten or twelve years of the HIV epidemic, there had never been a documented case of HIV transmission by bite. Yet very recently, there appears to have been a documented case of HIV transmission by bite.[89]

Second, the other problem with the lack of proof of HIV transmission in an operating room or in a dental office is that it is almost impossible to prove the exposure incident in the first place. Who will speak up and declare that there has been an exposure incident? It is not going to be the patient, for the patient is sedated under the knife. He or she is probably unconscious or incapable of observing or knowing of any exposure. So if the patients are not going to speak up, who is going to speak up? Is the surgeon or dentist going to admit that he or she has possibly caused an HIV transmission knowing the liability implications of such transmission?

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87. *See* Ruthanne Marcus, *Surveillance of Health Care Workers Exposed to Blood from Patients Infected with the Human Immunodeficiency Virus*, 319 NEW ENG. J. MED. 1118, 1120 (1988) (citing three health care workers who had no other risk factors for HIV infection, all with needle-stick exposures, tested positive for the HIV antibody); Eric Oksenhendler et al., *HIV Infection with Seroconversion After a Superficial Needlestick Injury to the Finger*, 315 NEW ENG. J. MED. 582 (1986) (noting a case where a nurse tested positive for the HIV antibody after receiving a superficial self-inflicted needle-stick injury).

88. *See* Centers for Disease Control, U.S. Dep't of Health & Human Servs., *Syringe Exchange Programs—United States, 1994-1995*, 44 MORBIDITY & MORTALITY WKLY. REP. 684, 684 (1995) (citing CDC statistics that 35.5% of the cases of AIDS reported to the CDC were associated with injecting-drug use).

89. *See* L. Vidmar et al., *Transmission of HIV-1 by Human Bite*, 347 LANCET 1762 (1996) (reporting that a 53 year-old man bitten by HIV-positive neighbor subsequently tested HIV positive); *see also* Morrison v. State, 673 So. 2d 953 (Fla. Dist. Ct. App. 1996) (reporting that a 90-year-old who was bitten during a robbery was later diagnosed HIV-positive).

Even though the medical profession is a noble profession, there are numbers of documented instances of health care professionals who have sustained those kinds of injuries and have not reported them.[90]

Recently, there was a case in Illinois involving a health care professional who sustained a needle-stick injury and proceeded to use the contaminated syringe to draw blood from a patient.[91] This incident was not disclosed for two months.[92] Such incidents occasionally happen. It is in their own interest for health care professionals not to disclose. Furthermore, we cannot expect that the subordinates in the operating room will report an exposure incident. The surgical assistants, dental assistants, nurses and others are undoubtedly disinclined to inform on their employers, the surgeons or the dentists.

With all the blood present in a body cavity, it is impossible to know whose blood is whose. Quite often the dentists and the surgeons do not even realize, until they unglove, that they have sustained an injury. If a surgeon touches a piece of broken bone, he or she cannot be sure a cut was sustained without pulling out his or her hand. The same is true with needles.

Additionally, unless the plaintiff is ideal—a young person who is a virgin—he or she would likely have multiple risk factors for HIV transmission. Many adult Americans have had sex, many have shared intravenous syringes, undergone blood transfusions, or undergone surgical or dental procedures. For many people, we would not be able to declare that there was no other risk factor, aside from the health care worker, for HIV transmission.

Finally, the CDC and many of the professional medical associations including the American Medical Association (AMA), the American Dental Association, and the American Nurses Association (ANA), are concerned with the incident after the fact. Everyone gets concerned at the point once there is an exposure incident involving either the patient or the health care professional. They run out and do testing on both sides and sometimes begin prophylactic AZT treatments. If they are concerned post-incident, why are they not concerned before an exposure incident? All of those

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90. *See* B.H. Hamory, *Underreporting of Needlestick Injuries in a University Hospital*, 11 AM. J. INFECTION CONTROL 174, 174 (1983) (reporting that 40% of needlestick injuries within the previous three months and 75% of needlestick injuries in the previous year had not been reported); D. Tandberg et al., *Under-Reporting of Contaminated Needlestick Injuries in Emergency Health Care Workers*, 20 ANNALS EMERGENCY MED. 66 (1991).

91. *See* Doe v. Surgicare of Joliet, Inc., 643 N.E.2d 1200 (Ill. App. Ct. 1994).

92. *See id.* at 1205 (Barry, J., dissenting) (noting that the defendant never offered any explanation for the two month period that lapsed prior to notifying the plaintiffs that there may possibly have been exposure to HIV during her surgery).

organizations have issued policy statements over the years declaring that there is a risk of HIV transmission in trauma settings, especially risk-prone, low visibility surgical settings.[93] It seems to me that for us to say that we will not pay attention to the computer and statistical models simply because we do not have cases, is closing our eyes to a genuine risk and a great deal of evidence that many reasonable people have considered.

PROFESSOR LEONARD: What is your advice to Ms. Meyer on what the hospital should do?

PROFESSOR CLOSEN: There is no question that one of two things needs to be done. At the very minimum, the surgeon's patients should be advised about his HIV condition in advance of performance of a surgical procedure by him. The fiduciary duty of surgeons and dentists, if there is a real risk of HIV transmission, is to tell the patient of the avoidable risk. It is not like the inherent risk of anesthesia; rather, it is something the patient could avoid.

More importantly, in my opinion, is that if there is a real risk of HIV transmission, the surgeon should desist completely from any kind of practice that involves such a danger. Certainly, with eight to ten years of professional life expectancy, as Dr. Spritz points out, the surgeon could do something very productive and worthwhile in a number of other ways.

Additionally, the American public overwhelmingly (eighty to ninety percent) say they want to know if their surgeons and dentists have HIV-AIDS.[94] And, a large number of them would choose not to be treated by HIV-infected surgeons and dentists.[95] That is telling. How often do we get eighty, ninety, or more, percent of the American public to agree on anything? To get that many people to agree on this issue strikes me as somewhat relevant and important.

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93. *See, e.g.*, Centers for Disease Control, *supra* note 46, at 1 (discussing the risk of HIV transmission during invasive procedures). *See generally* Lo & Steinbrook, *supra* note 54 (reporting that the American Dental Association and American Nurses Association recognize that a risk of transmitting HIV infection to patients exists); *When the Healer is HIV-Positive*, N.Y. NEWSDAY, Jan. 22, 1991, at 40 (reporting that both the American Medical Association and the American Dental Association have recommended that doctors and dentists who have the AIDS virus should either tell their patients of that fact or stop performing invasive medical procedures).

94. *See* Gerbert et al., *supra* note 80.

95. *See* Jerry Carroll, *In the Doctor's Hands: Florida AIDS Case Has People Nervous*, S.F. CHRON., July 18, 1991, at D4 (explaining that a Gallup poll conducted in the early 1990s showed that 65% of those polled, if told that their doctor or dentist was HIV-positive, would switch to another doctor or dentist).

I would be inclined, if there is a genuine risk, to restrict this surgeon from surgical practice. He can do other kinds of medical related activities at this and other hospitals but not surgery. If the hospital refuses to go that far, at a minimum, his patients should be advised in advance of surgical procedures.

Certainly, if individuals have AIDS-phobia—an unreasonable fear of contracting HIV—they should have no cause of action. However, a number of these individuals can, and do, have a reasonable fear of having been exposed to HIV and should have a cause of action for emotional suffering. I feel very badly in asserting the position I have taken, because I have many friends in the medical community and a number of them have HIV. But life is not fair. If Dr. Stone had lost his hand by reaching down too close to his lawnmower, and was unable to perform surgery any longer, he would be disqualified. If he lost his vision, became epileptic, or was an alcoholic, and the hospital knew it, Ms. Meyer and her colleagues would do something about that. Here they know it. This is an easy case. The tough cases are about all the HIV-infected surgeons and dentists who have not fortuitously learned of their condition and continue to perform invasive procedures on unsuspecting patients.

VI. MARC ELOVITZ[96]

PROFESSOR LEONARD: Dr. Stone also got a bit of advice from Dr. Spritz. Dr. Spritz told him that he probably should consult a lawyer about what his rights are. Marc Elovitz has litigated AIDS issues, and is probably one of the most qualified people to provide Dr. Stone with some advice about his legal rights in the situation. So, what would you say if Dr. Stone contacted you, Mr. Elovitz?

MR. ELOVITZ: One of the piles of work that I have is messages from HIV-infected health care workers around the country who contact their local ACLU office because they do not know to whom else to turn. The journey for those HIV-infected health care workers who have relied on our federal laws has not been a successful one. There has only been one case that has been successful.[97] The rest have not.[98]

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96. Marc Elovitz was Staff Counsel for the American Civil Liberties Union's AIDS Project, 1993-1996. He has been a member of the AIDS Committee of the Association of the Bar of the City of New York since 1993.

97. As of the date of the Symposium, *Doe v. Attorney General* was remanded to the circuit court from the Supreme Court after the Ninth Circuit had reversed the district court's decision for the defendant. However, on remand, although the Ninth Circuit did find that the plaintiff's handicap was entitled to federal protection, the court affirmed the district court's judgment in favor of the defendant on other grounds. *See* Doe v.

When someone asks me what their legal rights are, I tell them that section 504 of the Rehabilitation Act of 1973[99] and the ADA[100] say that an HIV-infected health care worker should not be forced to disclose his or her status and should not be restricted in his or her duties more than any other health care worker. That is what the law says to me. Unfortunately, many courts have said otherwise, relying on the notion that HIV infection poses a significant risk of harm.

The tide of bad court decisions does not stop me, and I try to convince those HIV-infected health care workers, who are interested in fighting this incredibly important battle, not to let those cases stop them. In the courts it has been, and will continue to be, an uphill battle. But if we look to the science of HIV transmission, as we heard from Dr. Spritz and Ms. Meyer, the justification for these decisions is not there.

This is a situation where we are fighting fear itself. In order to oppose equal treatment of HIV-infected health care workers, one must contend that although the cases of doctor to patient transmission have not happened (and we have had over fifteen years of opportunity for such cases to surface), they still might, and because they might, then that is a sound basis in the law to restrict people's careers.

Attorney Gen., 814 F. Supp. 844 (N.D. Cal. 1992), *rev'd* 62 F.3d 1424 (9th Cir. 1995), *cert. granted, judgment vacated and remanded sub nom.* Reno v. Doe, 116 S. Ct. 2543 (1996), *aff'd sub nom.* Doe v. Attorney Gen., 95 F.3d 29 (9th Cir. 1996).

98. *See e.g.*, Doe v. University of Md. Med. Sys. Corp., 50 F.3d 1261 (4th Cir. 1995) (holding that a physician posed a significant risk to patients that could not be eliminated by reasonable accommodation and thus, was not an otherwise qualified individual with a disability who could seek protection from the Rehabilitation Act or the ADA); Bradley v. University of Tex. MD Anderson Cancer Ctr., 3 F.3d 922 (5th Cir. 1993) *cert. denied*, 510 U.S. 1119 (1994) (holding that a surgical technician was not "otherwise qualified" to continue employment within the meaning of the Rehabilitation Act); Leckelt v. Board of Comm'rs, 909 F.2d 820 (5th Cir. 1990) (holding that a licensed practical nurse who refused to provide hospital with the results of his HIV test, after hearing rumors that he was infected, was not "otherwise qualified" for protection under the Rehabilitation Act); Scoles v. Mercy Health Corp., 887 F. Supp. 765 (D. Pa. 1994) (holding that an HIV-positive doctor was not "otherwise qualified" as required for the surgeon to be protected under the Rehabilitation Act and that the surgeon posed a "direct threat" to the health of his patients and, therefore, the hospital did not violate the ADA by prohibiting performance of surgery without the patient's informed consent).

99. 29 U.S.C. § 701-797b (1994). Section 504 of the Rehabilitation Act of 1973 states that "[n]o otherwise qualified individual with a disability . . . shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance . . . ." *Id.* § 794(a) (1994).

100. Equal Opportunities for Individuals with Disabilities (Americans with Disabilities Act of 1990), 42 U.S.C. §§ 12101-12213 (1994).

Make no mistake, we are not talking about an inconvenience to someone's career, nor are we talking about moving from one job title to another. If someone has spent his career training to be a surgeon, and has been a surgeon, he cannot then become a radiologist or an anesthesiologist without years of retraining. This raises numerous questions. Who will pay for this training? Who will provide health insurance during this time? Who will pay back all that the doctor has invested in the practice he would be forced to abandon? How will these doctors explain the radical and costly abandonment of their specialties without it becoming apparent that they were forced out based on their HIV status? But there is also a broader picture. If doctors with HIV are restricted from their practice, who will treat people with HIV? If we are trying to send the important message that it is safe and important for doctors to treat people with HIV, then what message is sent to doctors with HIV-infected patients? Some have suggested that HIV-infected doctors can treat HIV-infected patients. But again, what message does this send?

I think that the basic answer to Dr. Stone is quite simple when it comes down to it. I would tell Dr. Stone that he is entitled under the law to continue with his practice, subject to neutral rules of infection control and procedure. Indeed, I would encourage Dr. Stone to take a stand against the widespread and unjustified discrimination against HIV-infected health care workers.

PROFESSOR LEONARD: Do you think that you would have any responsibility to tell his patients, before he performs surgery, that he is HIV-infected?

MR. ELOVITZ: The effect of such a disclosure is quite clear; the public opinion polls are devastating. Eighty to ninety percent of people do not want to be treated by an HIV-infected health care worker.[101] More than fifty percent do not even want to be treated by a doctor who treats patients with HIV even though not HIV-infected himself.[102] The effect of mandatory disclosure would be to destroy the doctor's practice. As a side note on the use of public opinion polls, if you take the *Arline* case, I believe a poll would indicate that a high percentage of parents in this country would not want their child to be taught by a teacher with tuberculosis. Yet the Supreme Court had the wisdom to hold that public

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101. *See* Gallup Poll, NEWSWEEK, June 24, 1991, at 49 (finding that only 15% of the people polled would allow surgery to be performed on them by an HIV-positive doctor, and even those would require stringent protective measures for any treatment).

102. *See* Gerbert et al., *supra* note 80, at 1969 (finding that more than half of those who had seen a physician in the past five years said they would change physicians if they knew their physician was treating people with HIV).

opinion does not govern when disfavored medical conditions present themselves.[103]

VII. PANELIST DISCUSSION

PROFESSOR LEONARD: We have heard from each of the panelists. Now, I would like to give them a chance to react to each other's comments before we open it up to questions and comments from the audience. First, Dr. Spritz, do you have any reaction to what the other panelists have said?

DR. SPRITZ: I would like to raise an issue with Michael Closen. You describe the serious consequences of revealing the HIV status of the physician. Such consequences make me even more reluctant to advocate disclosure, and it probably will have the same effect on others. Don't you think that the fact that the cases go the way they do—and if doctors were required to reveal to all their patients, even though there is no documented risk—tends to add to the silence about people not publicizing the HIV status of a health care worker?

PROFESSOR CLOSEN: It may well have that secondary effect. As between patient and surgeon or dentist, the surgeon or dentist is the professional here. The professional duty is on the health care provider to make that disclosure. After all, health care professionals enter this field by choice. They know they are constantly on the front lines whether it is Legionnaires Disease or HIV. Tragic as it is, some individuals become infected and must move on to do something else.

MS. MEYER: I think that's missing the point that Dr. Spritz was making. Let's say everyone's goal is to protect patients. To the extent you punish physicians with HIV for disclosing, they are not going to come forward. At least Dr. Stone has given us the opportunity to work with him and to look into procedures and things that might make his practice safer. Your position leads to the mandatory testing of health care workers.

I also take issue with your statement that the professionals are only interested in these incidents after the fact. I think the point I made is that there is a lot of research going on to prevent exposures in the first place through improving technology and improving the way procedures are done. I think that issue is being addressed very aggressively.

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103. *See* School Bd. v. Arline, 480 U.S. 273, 277 (1987) (holding that the dismissal of a teacher solely because of her susceptibility to tuberculosis violated the Rehabilitation Act of 1973).

Finally, this is one of those rare occasions when I am actually glad I live in New York. The New York State Department of Health has taken the position that health care providers do not have to inform patients about their HIV status.[104]

PROFESSOR LEONARD: To the extent we have referred to statutes or laws, they have been primarily federal. It should be noted that almost every state has a civil rights act that covers handicap or disability,[105] and most of them lend themselves to the interpretation that Marc Elovitz put forward. Of course, under most of them, it is likely that the judges will adopt the interpretation that the federal courts have adopted regarding significant risk. In the cases we have so far under the Rehabilitation Act or the ADA, it should be kept in mind that there is state law as well as federal law to consider.

MR. ELOVITZ: I would just add one thing to what Ms. Meyer was saying earlier in regard to referring the individual doctor to the head of infection control. This referral, from my perspective, is problematic because, anytime the circle of people who are informed about the doctor's HIV status grows, there is an increasing danger to that doctor's career. Given that, I wonder why there are not broader rules of infection control to protect against transmission of a range of viruses such as HIV, Hepatitis Type B virus (HBV), and Hepatitis Type C virus (HCV), that should apply to everyone and be strictly enforced by the hospital.

PROFESSOR LEONARD: One of the problems is that the medical community, when asked to do so by the CDC, refused to come up with lists of infection-prone invasive procedures.[106] As a result, it leaves everyone in the position of doing ad hoc decision-making in each institution.

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104. *See* NEW YORK STATE DEP'T OF HEALTH, POLICY STATEMENT AND GUIDELINES TO PREVENT TRANSMISSION OF HIV AND HEPATITIS B THROUGH MEDICAL/DENTAL PROCEDURES (1992); *see also* Lawrence K. Altman, *New York Won't Tell Doctors With AIDS to Inform Patients*, N.Y. TIMES, Jan. 19, 1991, at A1.

105. *See, e.g.*, N.Y. CIVIL RIGHTS LAW § 40-c (McKinney 1996); CAL. CIVIL CODE § 51 (West 1995); 715 ILL. COMP. STAT. ANN. 5/1-102 (West 1996); MICH. COMP. LAWS § 37.1202 (1996); *see also* Arthur S. Leonard, *Employment Discrimination Against Persons with AIDS*, 10 U. DAYTON L. REV. 681, 689-96 (1984) (discussing the handicap discrimination laws and their applicability to AIDS).

106. *See generally* Sidney D. Watson, *Eliminating Fear Through Comparative Risk: Docs, AIDS and the Anti-Discrimination Ideal*, 40 BUFF. L. REV. 739, 762 (1992) (discussing widespread opposition by many medical organizations to CDC recommendations to identify exposure prone procedures).

MS. MEYER: Ideally, I think that should happen, and I think, in fact, it does happen. The work that is going on does not just concentrate on HIV-infected physicians. The infection control people are generally trying to make procedures safer.[107] But, frankly, wearing my hat as the general counsel, and wanting to do what is necessary to protect the institution, I would want that extra sign-off of institutional review.

The New York State guidelines call for case-by-case review to determine a physician's fitness to practice.[108] In this case, Dr. Stone is newly infected and healthy. Other times, people are very far along, and there may be other reasons why they should not be practicing. So I would do such a review as a risk management measure.

DR. SPRITZ: I have a comment about the fact that the profession did not come up with a list of adverse procedures. I participated in that nonactivity and I honestly believe we are on pretty solid ground. If you want the words "high risk" to have any meaning that we can all accept, then "high risk" cannot mean something that has never been shown to produce risk. How can you say that the operation is a "high risk" when nineteen thousand instances do not show that anything bad happens? To me, that is a definition of "low risk" or "no risk," rather than "high risk." Although it may not be risk-free, it is not going to qualify as a "high risk" activity like certain sexual practices or intravenous drug use. Medical procedures performed by HIV-infected health care workers were just not in those categories, or else it would have appeared. I don't see how we could have called these procedures "high risk" by any rational definition of that term. That was the position that the medical establishment took, and I think that is the right position.

PROFESSOR LEONARD: I would like to clarify some of the terminology being used. In the *Arline* case—where the Supreme Court was interpreting the Rehabilitation Act, which was, in effect, prior to the Americans With Disabilities Act—the Supreme Court used the term "significant risk."[109] In the Americans With Disabilities Act, Congress used the term "direct threat."[110] One proposal before Congress was to overrule the *Arline* case, as part of amendments to the Rehabilitation Act,[111] in which other proposals were to codify the *Arline* case.[112]

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107. *See* Centers for Disease Control, *supra* note 46 (promoting adherence to universal precautions such as proper disinfection and sterilization).

108. *See* NEW YORK STATE DEP'T OF HEALTH, *supra* note 104, at 2-3.

109. *See* School Bd. v. Arline, 480 U.S. 273, 287 (1987).

110. *See* 42 U.S.C. § 12113(b) (1994).

111. *See* 133 CONG. REC. S9724-29 (1987) (statement of Sen. Armstrong).

The compromise that was worked out in Congress was to use the phrase "direct threat." Under that compromise, someone who had a disabling condition, which was theoretically contagious, would be protected from discrimination if their condition did not present a "direct threat." What "direct threat" means is up to the courts to decide. Thus far, the courts, with one exception, have interpreted "direct threat" to mean "quantifiable risk."[113] The exception, as Marc Elovitz pointed out, is a case that has been successful in the Ninth Circuit up to this point but is still being litigated by the ACLU.[114] Now, I would like to open it up to members of the audience to participate.

VIII. DISCUSSION WITH AUDIENCE

MR. CHARLES WERTHEIMER: Professor Closen, do you not think that a probable consequence of mandatory disclosure will be a reluctance on the part of medical professionals to get tested for HIV, and, therefore, in actuality, defeat what you propose?

PROFESSOR CLOSEN: That may very well be the psychological effect that mandatory testing will have on the health care workers, but one thing we have to remember is that the CDC, AMA and American Dental Association have said that there is an obligation on the part of health care professionals to know their HIV status, and, if they are HIV-positive, to make a disclosure to a review committee that would consider his or her area of practice and other relevant circumstances.[115] A health care professional cannot abide by that guideline without having been tested. Overwhelmingly, health care professionals are not getting tested.

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112. *See* 134 CONG. REC. S2860-62 (1988) (statement of Sen. Harkin).

113. *See, e.g.*, Scoles v. Mercy Health Corp., 887 F. Supp. 765, 770 (D. Pa. 1994); Estate of Behringer v. Medical Ctr., 592 A.2d 1251, 1280 (N.J. Super. Ct. Law Div. 1991).

114. *See* Doe v. Attorney Gen., 814 F. Supp. 844 (N.D. Cal. 1992), *rev'd* 62 F.3d 1424 (9th Cir. 1995), *cert. granted, judgment vacated and remanded sub nom.* Reno v. Doe, 116 S. Ct. 2543 (1996), *aff'd sub nom.* Doe v. Attorney Gen., 95 F.3d 29 (9th Cir. 1996).

115. *See* Lawrence K. Altman, *U.S. Drafts Guidelines for Doctors with AIDS*, N.Y. TIMES, Apr. 5, 1991, at D18; B.D. Colen, *Guidelines for Infected Doctors*, N.Y. NEWSDAY, Apr. 6, 1991, at 9 (reporting the American Medical Association and the American Dental Association policy calling on physicians and dentists to determine their HIV status); B.D. Colen, *Probe of HIV Cases Backed*, N.Y. NEWSDAY, Oct. 14, 1992, at 16 (citing the CDC guidelines that require health care workers to learn their own HIV status).

Although I will raise the ire of some others in the audience, who I have not already troubled, I think perhaps we can limit mandatory testing to those surgeons and dentists who perform exposure-prone procedures. I am not talking about the doctor, such as in *Doe v. Attorney General*,[116] who was simply giving physical exams to FBI agents in California.[117] Although he was touching them, he was not doing invasive procedures.[118] So that is the only case that is the exception.

It seems to me that mandatory HIV testing is needed among surgeons who do exposure-prone surgical procedures and also for dentists and dental students. Anyone going to a dental office knows that dentists constantly engage in low-vision activity. They have four or five fingers and a number of instruments in the patient's mouth. It is a low visibility situation where traumas to the hands of dentists are commonplace.

MS. MEYER: Do you also support mandatory HIV testing of patients that are about to undergo surgical procedures?

PROFESSOR CLOSEN: Absolutely not. Remember that the professional here is the health care provider. The patients—unless they have elective, cosmetic kinds of surgical settings—are there due to necessity. Most often, they do not choose to be the patients and do not want to be there having surgery. Patients should all be treated as presumptively HIV-positive, and universal precautions should be used to protect the health care professionals against HIV transmission. But, I do not see this as a reciprocal obligation setting at all.

DR. SPRITZ: One of the problems with compulsory testing of surgeons is the frequency of that testing. As soon as the test comes back, you are off, by your definition, on another cycle of risk. How often should surgeons be tested?

PROFESSOR CLOSEN: All of us have expressed a concern about the safety of patients, and the first concern ought to be their protection. If we tested surgeons, dentists, and dental students, who do exposure-prone activities, a sizeable number of HIV-positive health care professionals will be identified, especially if we do appropriate repeat testing to confirm the positive status. That positive status never changes. I would not argue that we need monthly or weekly testing. These are very capable adults who, knowing about HIV, do not frequently seroconvert. Perhaps annual

116. *Doe*, 814 F. Supp. 844.

117. *See id.* at 846.

118. *See id.*

retesting would be best. Although I recognize that no system will be perfectly safe, I would argue for regular repeated testing.

MS. MEYER: You are talking about an enormous expenditure of resources, financial and administrative, for a nonexistent risk. I find it mind-boggling that you wish to expend such resources at a time when there are not enough resources currently available to take care of the basic health care needs of people in this country. I think it is an incredibly inappropriate use of the resources that are available.

MR. NATHAN COBURN: To clarify Ms. Meyer's point, Dr. Spritz, in your opinion, does the spilling of infected blood into a patient's open cavity pose absolutely no risk of HIV infection?

DR. SPRITZ: I think that in a biological world there is no such thing as no risk. If you exposed four million patients in this way, I cannot say the disease would not ever be transmitted. I can say that, among the nineteen thousand cases studied, blood exposure as you described must have occurred several times, yet there was still no transmission of infection. So at least on the basis of this experience, transmission is rare and may never occur.

MR. COBURN: Then you concede that it could possibly be one in four million; therefore, this is not an instance of "nonexistent risk."

DR. SPRITZ: There is no way to eliminate the possibility of risk; statistics just do not permit that. In fact, to be fair, if you have nineteen thousand negatives, and the real risk—the kind of risk that we do not know but exists out there—is 1 in 10,000, and we test nineteen thousand individuals a couple of times, you won't find that 1 in 10,000. There are only going to be two people in the nineteen thousand based on real risk of 1 in 10,000, and you may miss both of them. It is only a statistical estimate. It could be zero; it could be 1 in 4,000,000; it could be 1 in 10,000. Almost certainly, it is not one in a hundred. There is a very small likelihood that you have missed all the people in the nineteen thousand. That is the way you have to think about biological questions. There is no reason to think that the person who is 1001 would not be positive.

However, I do not think you can make policy and discriminate against people because of something you have not demonstrated to be within the possibility of happening. The risk of dying from being hit by lightning in New York is clearly greater than this risk of transmission. We use statistical methods, and I think they are very powerful. When answering a biological question, it would be very uncommon to come out with such strong data that it really did not happen in nineteen thousand times, if it

really did. Very rare events are likely to be picked up in nineteen thousand cases.

MR. COBURN: My only other comment goes to Ms. Meyer. You named the economics as a reason for not following through with profession-wide HIV testing. The U.S. Armed Forces has established, through force-wide testing, that testing could be done for less than four dollars per test.[119] How do you respond to that?

MS. MEYER: The U.S. Armed Forces has a little more money than we do these days. It is not just dollars; it is institutional resources, in terms of time, focus, and what is number one on our agenda. Also, I cannot imagine what would happen with our medical staff if we voluntarily tried to implement mandatory testing of physicians. Our doors would close because the doctors would walk. If it is state law, it is another matter, but it will not happen voluntarily.

MR. MARK LEFFLER: I have two questions. First, Professor Closen, I think that the American Dental Association would probably disagree with you that dentistry is a "low visibility" profession. But, assuming it is, you make it seem so easy for a health care practitioner to just change professions. You also expect them to do this when he or she is not disabled with AIDS, but when they have merely contracted HIV. The disability insurance company will say you are not disabled, so you may continue to practice. The fact that you do not have a viable practice anymore is not the insurance company's concern. How would you suggest dealing with the economics of that very real problem?

PROFESSOR CLOSEN: I do not want to suggest that it is easy to just pick up and move from brain surgery to radiology, or from dentistry to some other practice. Disability law perpetuates a very complicated situation. We have many inconsistencies between what the law and courts say and what insurance companies may argue on the other side. There will be devastating effects on some health care professionals who reveal that they are HIV-positive. But, again, I harken back to the position that the health care professional's primary obligation is to his or her patient. The first instinct should not be to protect one's professional practice because that is not the noble mind-set that the profession should have.

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119. *See* Authur E. Brown & Donald S. Burke, *Cost of HIV Testing in the U.S. Army (Correspondence)*, 332 N. ENG. J. MED. 963 (1995) (reporting the cost of testing each active-duty soldier and applicant to the military was $2.43 in 1994).

MR. ELOVITZ: Typically, people are forced to abandon their livelihoods and learn a new profession when there is a good reason for it. Professor Closen has used examples in some of his publications, such as a sports star getting old and a surgeon or pianist whose hand is lopped off by a lawn mower.[120] I have not seen the justification for the HIV-infected health care worker discussed here. If you have ten years of productive life remaining, completing an entirely new residency, which is grueling work and costs a lot of money, is not possible. You already have debts from the past, such as those from the practice you were forced to abandon. Not to mention the likelihood that you cannot get disability insurance benefits if you are not disabled, and that no one will hire you. There is also a tremendous stigma having to do with being HIV-infected as a health care worker. I find it wholly impractical.

MR. LEFFLER: Ms. Meyer, you mentioned earlier that informed consent typically serves the purpose of discussing the risks of the operation and not the risks that the surgeon brings to the operating room. How can you justify that when there are routine publications of morbidity and mortality rates from procedures performed by, for example, cardiovascular surgeons, and it is perfectly appropriate for a patient to ask the surgeon how many of these procedures he or she has performed. If it is not the surgeon who is the consideration, and only the surgery, why are those appropriate things to discuss?

MS. MEYER: Well, informed consent does not currently include mortality and morbidity rates or the number of times a surgeon has performed a particular procedure. The rates may be published, but it is not part of standard informed consent. Maybe it should be because at least those risks are relevant and material. HIV, however, is not material.

Beyond that, I really worry about the informed consent trap. Let's assume here for a moment that there is a material risk. Informed consent lets you pass the risk off to the patient and let the patient worry. We could draw up a consent form that says "we did not clean the operating rooms," and half the patients would just sign it. Informed consent does not really promote the safety of patients.

MS. DENISE WASHINGTON: Professor Closen, if you go out and test all the surgeons, what would you do about the liability when some tests return false-positive? The surgeons are now in the position to sue the

120. *See, e.g.*, Michael L. Closen, *Mandatory Disclosure of HIV Blood Test Results to the Individuals Tested: A Matter of Personal Choice Neglected*, 22 LOY. U. CHI. L.J. 445, 454-455 (1991); Michael L. Closen, *When a Doctor Has AIDS*, NAT'L L.J., Sept. 9, 1991, at 15.

hospital. My other concern, and this relates to some of the medical information coming out now, is that even if you test positive for HIV, you may never develop AIDS. So what is the harm? And, even if you do transmit the virus, there is still a possibility that there is no harm. What about the liabilities in that instance?

PROFESSOR CLOSEN: Let me first address the question about the emotional turmoil that people would suffer if they get a false-positive result. I am constantly amazed at the number of people who come into my office, sit down, and say, "I have HIV; I need a will," or "I need some help with employment." I then ask how they know they have HIV. Each says, "I had an HIV test and the doctor told me." I then ask whether both the ELISA[121] and Western Blot Series[122] tests (the proper protocol) were administered. Usually, the patients do not know. I then ask the individual whether they have gotten a second opinion, or whether they have gone to another laboratory to get a second test result. Of course, an HIV-positive result is one of the most important test results a person will receive in his or her life.

DR. SPRITZ: I would like to comment on that. I agree with you that some patients consider themselves HIV-positive whether or not they have had careful testing. Let's say the test is better than most tests, and only one in a thousand people, who don't have HIV, test positive. That is a very low false-positive rate, and I think it is about right for HIV testing. There are certain known situations where people might have false-positives that are transient. Now, if you test all surgeons—a low-risk, high economic group—their real rate is probably 1 in 1000; whereas the rate for the whole country is 1 in 250.[123] That means, if you get a surgeon

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121. ELISA (Enzyme-linked immunosorbent assay) is "a sensitive method for serodiagnosis of specific infectious disease." STEDMAN'S MEDICAL DICTIONARY 143 (25th ed. 1990); *see also* Elaine M. Sloand, M.D., et al., *HIV Testing: State of the Art*, 266 JAMA 2861 (1991) (describing the general application of ELISA and Western Blot tests).

122. Western Blot Series is "a procedure in which proteins separated by electrophorese in polyacrylamide gels are transferred (blotted) onto nitrocellulose or nylon membranes and identified by specific complexing with antibodies that are either pre- or post-tagged with a labeled secondary protein." STEDMAN'S MEDICAL DICTIONARY, *supra* note 121, at 66; *see also* Wayne R. Cohen, *An Economic Analysis of the Issues Surrounding AIDS in the Workplace: In the Long Run, the Path of Truth and Reason Cannot be Diverted*, 41 AM. U. L. REV. 1199, 1210 (1992) (explaining that the Western Blot is a more sophisticated test than the ELISA and is most often used to confirm repetitive positive ELISA results).

123. *See* Keith Berndtson, *Mandatory HIV Testing and the Character of Medicine*, SECOND OPINION, Jan. 1994, at 28.

who is positive, he has a fifty percent chance of being HIV-infected and a fifty percent chance of being false-positive. One of the principles of screening in medicine is that when you are screening for very low prevalence, the screening is inadequate because the false-positives start to equal the real positives. If you tested in a population where one in a thousand was the false-positive, but the real occurrence rate was ten percent, that one in a thousand would be washed out. Very few of the positive people would not have AIDS. Therefore, a big problem you are going to have with annual screening of all surgeons is deciding who is really positive and who is really negative. Considerable damage is done during that process of determining false positives.

PROFESSOR CLOSEN: But doesn't the repeat testing (Elisa followed by Western Blot at another laboratory) virtually eliminate the concern about false-positives?

DR. SPRITZ: Not necessarily. There are false-positives that are repeatedly false. Today, we find people who test positive, but we cannot find the virus even with the most complex molecular biologic techniques, so we do not think they are infected. We believe that these individuals have made antibodies to something similar to the HIV and we cannot detect the difference. We also detect people who have AIDS, but they test negative. So we have to look again at the whole false-positive issue. It gets tremendously important in the screening of the low prevalence population. I think there are big biological issues, almost as big as the ethical issues.

MR. ELI LEVINE: I have a twofold question directed to everyone except Professor Closen. The first is, do the rest of you disregard, or easily dismiss, Professor Closen's statistics that ninety percent of Americans would like to be informed if their doctors are HIV-infected? Second, if there are ten percent of people who would continue to see a doctor who is HIV-infected, would that not assist with the statistics that show that there was no risk involved? If those people went to the HIV-infected doctor and were not infected, would not that help define the statistics in favor of what you support?

MR. ELOVITZ: There are plenty of people in this country who are going to HIV-positive health care workers. I do not think we have a problem that we need to limit that to ten percent. I think earlier I addressed the public opinion issue that ninety percent of people would not want their kids being taught by a teacher who had tuberculosis.[124] The

124. *See supra* notes 101-03 and accompanying text.

Supreme Court recognized our country's commitment to the rights of people with disabilities.[125] It is not an abstract commitment. The implications of adopting a weak standard of "significant risk" for the lives of people with disabilities are tremendous. If we can all imagine a way in which HIV can be transmitted in surgery, despite infection control procedure, and justify widespread and devastating discrimination on this basis, then we can imagine a way in which a person in a wheelchair in this room would be a risk to all of us if there were a fire, because they would block the doorway and we would be trapped. We could, therefore, justify excluding all people using wheelchairs from attending this symposium. Those arguments were made twenty years ago, but they were rejected because the risk is too remote and the harm too severe. There is no reason not to do the same in the case of HIV-infected health care workers.

PROFESSOR LEONARD: I think one of the great documents in recent American history is Justice Brennan's opinion for the court in the *Arline* case.[126] In that opinion, he says that perhaps in all of recorded history, there is nothing that has terrified people as much as infectious diseases.[127] But, we cannot let the fact that people are terrified by diseases substitute for science when making our policy decisions about how to treat people with infectious diseases. That is the point I would make. Ninety percent of the public is absolutely terrified at the prospect of having a surgeon who is HIV-positive.[128] But, can we make our public policy decisions on that basis if we believe that the risk of transmission from an HIV-positive health care worker is negligible at best?

MS. JAYNE SOUTH: Ms. Meyer, the hypothetical posed earlier was of a surgeon who had just contracted HIV. Let us say it is eight to ten years later, and he has AIDS. At what point would you consider removing that surgeon from practice if there was minimal risk?

MS. MEYER: Well, again, I would have him closely monitored by the physicians with the expertise. They would be looking for signs of AIDS dementia as well as certain skin lesions that could be a problem for patients. His health also becomes an issue for him, not just the hospital.

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125. *See* School Bd. v. Arline, 480 U.S. 273 (1987).

126. *Id.* at 274-89.

127. *See id.* at 284 (stating that "[f]ew aspects of a handicap give rise to the same level of public fear and misapprehension as contagiousness").

128. *See* Gerbert et al., *supra* note 80.

He is going to be very concerned about being exposed to some of the infectious agents that he may find in the operating room.

Frankly, when people get to that stage of the illness, we usually try to work out an accommodation to enable them to maintain an income, such as possibly working shorter hours. Being a surgeon is physically extremely strenuous, and it involves many hours on your feet. Therefore, there will be a decrease in responsibilities in the best interest of the physician.

DR. SPRITZ: While I think that question is very reasonable, I also think it illustrates the disproportionate fear of AIDS that exists today. Your biggest risks from impaired physicians is not at all AIDS-related. These risks are from physicians who get old and senile or have Parkinson's disease. There are also physicians who drink or use drugs. I doubt that in real terms our physician with AIDS has a place among the real risks to patients from impaired physicians.

MR. HENRY MITTENDORF: With regard to deciding there was really no risk, what kind of privilege does this give the hospital doctor, in the year 1998, when a patient comes in with a very clear case and points to his only possible risk: that he was operated on by that doctor. And, the patient may not know at that time and may be seeking discovery. Will the hospital or the doctor be able to exert any privilege, at that time, based on this very low-risk factor?

PROFESSOR LEONARD: To refuse to reveal?

MR. MITTENDORF: Or use it as a defense.

MR. ELOVITZ: I'm going to say no. It's quite clear that they do not have an obligation to reveal that.

MS. MEYER: What if a subpoena goes out for the physician's medical record? That is the question; is the record going to be produced?

MR. ELOVITZ: My position would be that it is irrelevant information because of the lack of demonstrated risk.

MS. FIA PORTER: Mr. Elovitz, I believe you stated that you would advise Dr. Stone that he had no prospective responsibility to inform his patients. What if he came to you and stated that he believed he had exposed one of his patients? What would your advice be?

MR. ELOVITZ: I would be very interested to know why he thought the exposure had occurred.

MS. PORTER: Let us say he was performing surgery, blind suturing as Ms. Meyer suggested, and he felt that his blood had been spilled into the body cavity of his patient.

MR. ELOVITZ: Well, one of the interesting things here is that I think there is often an assumption that blood-to-blood contact equals transmission. But, it is quite clear that you can have contact without transmission of the virus.[129]

If a doctor has a concern about transmission, I would consider the specifics of the situation described and simultaneously consult the research that has been done on HIV-infected health care workers. The fact that research shows no transmission says to me that this concern is likely to be invalid. If that doctor looks at that research and agrees with what Professor Closen said, and wants to go and inform his patients and sacrifice his career because he feels that it is scientifically justified, then that is his decision. But I do not see the numbers.

MS. JEAN JOYCE: Ms. Meyer, you have discussed steps that hospitals could take to evaluate the types of procedures that physicians are involved in and decide whether the risk of transmission would be too great to perform those certain procedures. If an HIV-positive surgeon is highly skilled in a difficult or rare surgical procedure, should the surgeon's potential benefit to patients in need of such procedures be weighed against the risk of transmission?

MS. MEYER: There will be many factors that come into play in such a decision. I suppose that one factor might be that this person has a unique skill, which could not possibly be duplicated elsewhere.

DR. SPRITZ: When that question comes up, we think of the New York context. With seven medical schools and twenty hospitals, for every chest surgeon who is HIV-positive, there are twenty who are not. Where this issue really comes up, and it has, is in small communities where there is one vascular surgeon. The elimination of that person, has much greater health consequences in the community setting than it would in a city like New York or Chicago.

MS. ARIELA REBACK: Suppose I am a patient who is going to undergo elective surgery, and I say to my physician, when discussing informed consent, "could you assure me that you or any members of your group that are going to operate on me are not HIV-infected?" How does

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129. *See* Rubin, *supra* note 16, at 404 (stating that, "the higher the concentration [of virus in the blood], the greater the chance of transmission").

that change the scenario as far as the requirements to disclose, or the requirements of medical malpractice insurance? I would think it would change the scenario. Do you agree?

PROFESSOR LEONARD: I think the context here would be probably more in the tort realm if the surgeon lied to the patient when the surgeon knew, or had reason to know, he was positive. How does the panel respond to whether a surgeon has any legal duty, whether in the realm of tort law or other law, to answer that question honestly when a surgeon does know that he or she is, or may be, HIV-positive?

MS. MEYER: Clearly, I do not think he can lie. The question is whether there is a response that can be given that is not a lie. Something along the lines of, "I do not discuss my HIV status. If you want a surgeon who does, you will have to go to someone else." Again, the surgeon should provide an explanation as to why it is not relevant. Clearly, it is a problem if he lies.

MR. ELOVITZ: A response that seeks to educate the patient about the lack of risk, as suggested, seems to me to be the most appropriate, while using that opportunity to dispel some fear.

PROFESSOR LEONARD: Is it likely that any patient who asks that question, and receives an evasive answer, will immediately assume that the doctor is HIV-positive?

MS. MEYER: One way you could deal with that is to have a standard policy that nobody gives out their HIV status. In that case, the answer would be that the hospital's policy is that doctors and other health care workers do not disclose HIV status. This provides the health care workers with some protection.

PROFESSOR CLOSEN: My interpretation is that if the CDC policy carries any weight, under CDC policy, surgeons are supposed to know their HIV status.[130] It would seem to me that, as a professional, a surgeon, if asked by a patient, should have an obligation to answer honestly, because the standard of care is determined by such factors as statutes, regulations, and the guidelines of institutions like the CDC.

MR. ELOVITZ: The CDC issues all sorts of guidelines that do not have the force of law and are not followed by people. Keep in mind that

130. Centers for Disease Control, *supra* note 46, at 5.

these issues are not simple, and that the CDC was subject to tremendous political pressure around the drafting of these guidelines.

MS. MEYER: Also, on a legal matter, the New York State Department of Health guidelines are flatly inconsistent with the CDC guidelines. The New York State Department of Health says you are not required to disclose your HIV status.[131] So I think in New York you have a more complicated standard of care than you do in the rest of the country.

PROFESSOR CLOSEN: We are not aided by state legislatures. In Illinois, there is no statute affirmatively setting out an obligation to know one's HIV status or disclose it to a patient. But, there is a statute that says if there has been an exposure of a patient to a health care professional, where the health professional is later found to have HIV, there is an obligation to give notice retroactively.[132] Illinois will look back and inform patients who "may" have been exposed to an HIV-infected health care professional.[133] So we have this strange statutory complex in Illinois, where we do not do it on the front end, but do it on the back end.

PROFESSOR LEONARD: I would just add that there is a case my torts class studied this fall that involved a physician who was asked by a patient whether there was any problem with the physician's health that the patient should know about.[134] The physician said "no," that he was fine and in good health.[135] The physician considered himself to be in good health because he did not have any kind of disabling condition at that moment.[136] Only later was it discovered that the physician was HIV-positive.[137] The patient learned that the physician had died from AIDS from a television news broadcast.[138] There was an emotional

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131. *See* NEW YORK STATE DEP'T OF HEALTH, *supra* note 104, at 2, 5.

132. *See* Illinois Sexually Transmissible Disease Control Act, 410 ILL. COMP. STAT. ANN. 325/5.5 (West 1991).

133. *See id.* §5.5 (b), (c).

134. *See* Kerins v. Hartley, 33 Cal. Rptr. 2d. 172, 175 (Ct. App. 1994).

135. *See id.* at 175-76 (stating that the physician told patient he went to the gym regularly and jogged every morning).

136. *See id.* at 174.

137. *See id.*

138. *See id.* at 175.

distress lawsuit in which the issue was whether the physician had lied to the patient.[139]

My position would be that, at that time he made the representation to the patient, the physician believed he was in good health, and the fact that he was HIV-positive was not relevant to any risk presented to the patient.

MR. DAVID MOSS: I have two questions; the first is for Dr. Spritz. You were saying that out of the nineteen thousand cases, there were not any individuals who were identified as having contracted HIV from the infected doctors. You fail to mention the five or six cases which might have been related to Dr. Acer. Why do you discount those?

DR. SPRITZ: Well, I do not discount them. Today's discussion focuses on a thoracic surgeon. I do not know what to do with Dr. Acer. I cannot find any logical biological explanation about how one dentist transmits to six people, while no other dentist transmits to one person. I do not have a biological explanation for that. In policy terms, however, I do not think that we can lean on what must be an exceedingly aberrant event. Also, as more information comes in, there is more reason to think that these people were not all infected by Dr. Acer. Certainly, as to Kimberly Bergalis, there is now considerable doubt about her practices and her risks of contracting HIV from other sources.[140] Dr. Acer's virus turned out not to be uncommon in Florida, which is where he practiced. It is possible that the HIV types seen in his patients represent a random aggregation. Also, six HIV-positive people is not aberrant for what would just be a background prevalence of HIV in that community. I believe as time goes on, and we fail to find any corroborative evidence, that we should not use that single instance as a strong basis for policy.

MR. MOSS: However, even if we acknowledge that there is no material risk of transmission of HIV from doctor to patient, given the prevalence of AIDS-phobia in the community-at-large, isn't there a material risk that when patients subsequently learn that their surgeon was HIV-positive that they will then go through the three to nine months of hell that Professor Closen's clients have gone through?

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139. *See id.* at 179 (discussing the third cause of action, whether the physician intentionally misrepresented the patient's foreseeable risk of contracting AIDS to secure her business).

140. *See* Jeffery W. Cavender, *AIDS in the Health Care Setting: The Congressional Response to the Kimberly Bergalis Case*, 26 GA. L. REV. 539, 540 (1992) (stating that the CDC refused to entirely exclude the possibility of infection from another source).

MR. ELOVITZ: Plaintiffs are routinely thrown out of court for having what they consider to be serious concerns over, not just three to nine months but, years of distress about risks of cancers from environmental exposure.[141] The basis has to be a reasonable fear.[142] Therefore, to say that you can accept that the risk is remote, and then still allow an emotional distress recovery, doesn't seem consistent.

DR. SPRITZ: I would say that you have got the wrong defendants from the point of view of that question. The real villains are the physicians who are fanning this inordinate fear by telling patients they must continue to abstain from sexual relations long after testing would have shown conversion, had Dr. Acer, in fact, infected them.

PROFESSOR CLOSEN: In these cases, what happens is that after the discovery of the infected dental student or surgeon, the institution sent a letter to all the patients. The letter stated that it was important to their health that they seek HIV testing. So the villain in that situation was the hospital, clinic, or dental school that sent a letter that reasonably interpreted said, "you have been exposed to HIV" and served to severely scare people. In fairness to doctors, the doctors have not recommended desisting from sex for the rest of these people's lives but periodic testing for up to twelve months. The patients draw the conclusion that if they are being tested they might have HIV, and they do not want to spread HIV to their partners or create children who may have HIV. Accordingly, the letter often caused patients to change their lives.

MR. DOUGLAS CARDONI: My first question is a clarification from Dr. Spritz on his data that he is using. Specifically, is the zero in nineteen thousand figure from HIV-infected doctors operating correct?

DR. SPRITZ: Yes. These are a group of eight or so known HIV-positive physicians who performed major surgery.

MR. CARDONI: So that is nineteen thousand operations, not nineteen thousand times they cut themselves.

DR. SPRITZ: Nineteen thousand operations.

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141. *See* Leaf River Forest Prods. v. Ferguson, 662 So. 2d 648 (Miss. 1995) (stating that absent medical evidence of possible or probable future illness, landowners could not recover emotional distress damages due to fear of cancer from paper mill's alleged release of dioxin into a river).

142. *See id.* at 650 (stating that emotional distress claims must be supported by scientific evidence showing there is a rational basis for the fear).

MR. CARDONI: I would think it is pretty safe to say that most doctors do not cut themselves in operations.

MS. MEYER: No. I don't think that is safe to say.

DR. SPRITZ: The data from surgeons is that, during the course of almost any surgery that lasts more than two hours, there is at least some blood inside the glove from the surgeon.[143] So it seems very common that blood is around. Nineteen thousand still stands.

MR. CARDONI: What would you term as a "substantial risk?" Would it be 1 in 19,000, 10 in 19,000? What would it be? Because, obviously, the probability is very low, but the harm involved is obviously immeasurable.

DR. SPRITZ: I think that is a very good question and a very difficult question. I consider myself to be very lucky that it came out to 0 in 19,000. If instead it were 1 in 19,000, I think I would take pretty much the same position, but with less clear conviction, because that kind of risk is small compared to other kinds of risks. I think we are lucky, biologically and medically, and also legally, that we have such a hard piece of data. It is uncommon in answering complex biological questions to have data of this power. It really means that it must be very difficult to transmit the virus under those circumstances.

IX. CONCLUSION

PROFESSOR LEONARD: So, in summation, it is clear that we have a basic difference of opinion as to whether the risks that have been described are significant enough to justify restricting HIV-infected health care workers. We should bear in mind, as we go away from this Symposium, that the federal courts are virtually unanimous that the risk is significant enough in cases involving health care workers who perform invasive procedures. If you look at the scholarship on the subject, the articles published and listed in the bibliography in the back of the materials, the clear majority of those who have published on the issue think it is not significant enough, but there is significant dissent.

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143. *See* Joel Neugarten, Note, *The Americans with Disabilities Act: Magic Bullet or Band-Aid for Patients and Health Care Workers Infected with the Human Immunodeficiency Virus?*, 57 BROOK. L. REV. 1277, 1296-98 nn.84 (1992) (discussing the incidence of percutaneous injuries during surgery); *see also* McIntosh, *supra* note 3, at 326-28 (discussing that percutaneous injuries present the greatest risk to the patient during surgery and that the degree of risk is increased with the length of the procedure).

Professor Closen is not alone. There are several published articles by independent scholars from different parts of the country taking the same position.[144] So this is an issue as to which there is significant disagreement. I do not know that we have settled it in anyone's mind today, but I hope that we shed some light on it and brought arguments together that will help you make up your mind.

144. *See, e.g.*, 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 (1992); Becky J. Belke, Note, Kerins v. Hartley: *A Patient's Silent Cry for Mandatory Disclosure by HIV-Positive Physicians*, 25 SW. U. L. REV. 205 (1995); Karen C. Lieberman & Arthur R. Derse, M.D., *HIV-Positive Health Care Workers and the Obligation to Disclose*, 13 J. LEGAL MED. 333 (1992).

SYMPOSIUM BIBLIOGRAPHY

Anderson, Barbara Matthews. "'First Do No Harm. . .': Can Restrictions on HIV-Infected Health Care Workers Be Justified?" *Santa Clara Law Review* 33 (1993): 603-50.

Atkins, Patricia S. (note). "The Constitutional Implications of Mandatory AIDS Testing in the Health Care Industry." *Southwestern University Law Review* 17 (1988): 787-822.

Bailey, Patricia M. "'Significant Risk' Concept Justifies Practice Restrictions of an HIV-Infected Surgeon." *Villanova Law Review* 40 (1995): 687-722.

Barnes, Mark, Nicholas A. Rango, Gary R. Burke and Linda Chiarello. "The HIV-Infected Health Care Professional: Employment Policies and Public Health." *Law, Medicine & Health Care* 18 (winter 1990): 311-30.

Barney, Jane H. (comment). "A Health Care Worker's Duty to Undergo Routine Testing for HIV/AIDS and to Disclose Positive Results to Patients." *Louisiana Law Review* 52 (March 1992): 933-70.

Becker, Jr., Arthur J. (comment). "The Competing Interests of HIV Disclosure for Infected Health Care Workers: The Judicial and Legislative Responses." *Dickinson Law Review* 97 (summer 1993): 777-802.

Belke, Becky J. "Kerins v. Hartley: A Patient's Silent Cry for Mandatory Disclosure by HIV-Positive Physicians." *Southwestern University Law Review* 25 (1995): 205-22.

Benesch, Katherine. "AIDS and the ADA in the Health Care Workplace." *The Brief* vol. 23 no. 3 (spring 1994).

Bobinski, Mary Anne. "Risk and Rationality: The Centers for Disease Control and the Regulation of HIV-Infected Health Care Workers." *Saint Louis University Law Journal* 36 (winter 1991): 213-307.

Brandt, Jr., Edward N. "Health Care Workers and AIDS." *Maryland Law Review* 48 (1989): 1-11.

Brennan, Troyen A. "Occupational Transmission of HIV: An Ethical and Legal Challenge." In *AIDS and the Health Care System.* New Haven: Yale University Press, 1990.

Brennan, Troyen A. "Patients and Health Care Workers." In *AIDS Law Today: A New Guide for the Public*. New Haven: Yale University Press, 1993.

Brinkley, Dean P. (comment). "Health Care Worker's Legal Duty to Disclose HIV-Positive Status to Patients Before Performing Invasive Procedures." *Tulsa Law Journal* 29 (winter 1993): 429-48.

Burris, Scott. "Human Immunodeficiency Virus-Infected Health Care Workers." *Archives of Family Medicine* 5 (February 1996): 102-06.

Caldwell, Stacey Turner (casenote). "Discrimination or Protection of the Public: An Examination of Estate of Behringer v. Medical Center at Princeton." *George Mason University Law Review* 14 (winter 1991): 469-98.

Cavender, Jeffery W. (note). "AIDS in the Health Care Setting: The Congressional Response to the Kimberly Bergalis Case." *Georgia Law Review* 26 (winter 1992): 539-99.

Closen, Michael, L. "A Call for Mandatory HIV Testing and Restriction of Certain Health Care Professionals." *Saint Louis University Public Law Review* 9 (1990): 421-38.

DeVille, Kenneth A. "Nothing to Fear But Fear Itself: HIV-Infected Physicians and the Law of Informed Consent." *Journal of Law, Medicine & Ethics* vol. 22 (summer 1994).

DiMaggio, Susan L. (note). "State Regulations and the HIV-Positive Health Care Professional: A Response to a Problem That Does Not Exist." *American Journal of Law & Medicine* 19 (1993): 497-522.

Eisenstadt, Steven. "The HIV Infected Health Care Worker: The New AIDS Scapegoat." *Rutgers Law Review* 44 (winter 1992): 301-33.

Feldblum, Chai R. "A Response to Gostin, 'The HIV-Infected Health Care Professional: Public Policy, Discrimination, and Patient Safety.'" *Law, Medicine & Health Care* 19 (spring/summer 1991): 134-39.

Fluss, Sev S. and Dineke Zeegers. "AIDS, HIV, and Health Care Workers: Some International Legislative Perspectives." *Maryland Law Review* 48 (1989): 77-92.

Frankel, Lois J. "Commentary: AIDS Testing of Health Care Workers." *Nova Law Review* 16 (spring 1992): 1161-69.

Gerner, Carol J. "AIDS in the Healthcare Workplace: Rights and Responsibilities." *Annals of Health Law* 1 (1992): 119-37.

Giovingo, Wendy Elaine Williams (casenote). "Bradley v. University of Texas M.D. Anderson Cancer Center: HIV and the Rehabilitation Act in the Surgical Setting." *Loyola Law Review* 40 (summer 1994): 379-89.

Gostin, Larry. "CDC Guidelines on HIV or HBV-Positive Health Care Professionals Performing Exposure-Prone Invasive Procedures." *Law, Medicine & Health Care* 19 (spring/summer 1991): 140-43.

Gostin, Larry. "HIV-Infected Physicians and the Practice of Seriously Invasive Procedures." *Hastings Center Report* 19, no. 1 (January/February 1989): 32-39.

Gostin, Larry. "The HIV-Infected Health Care Professional: Public Policy, Discrimination and Patient Safety." *Law, Medicine & Health Care* 18 (winter 1990): 303-10.

Hard, Vallori K. (comment). "Mandatory Disclosure of AIDS Status by Health Care Workers." *Western State University Law Review* 21 (fall 1993): 295-319.

Hermann, Donald H. J. "Commentary: A Call for Authoritative CDC Guidelines for HIV-Infected Health Care Workers." *Journal of Law, Medicine & Ethics* vol. 22 (summer 1994).

Herz, Jennifer (comment). "Physicians With AIDS: A Proposal for Efficient Disclosure." *University of Chicago Law Review* 59 (spring 1992): 749-78.

Holzhauer, James D. "AIDS Testing in the Health Care Setting." *Issues in Law & Medicine* 4 (winter 1988): 345-57.

Isaacman, Scott H. "The Other Side of the Coin: HIV-Infected Health Care Workers." *Saint Louis University Public Law Review* 9 (1990): 439-94.

Johnson, Mark D. (comment). "HIV Testing of Health Care Workers: Conflict Between the Common Law and the Centers for Disease Control." *The American University Law Review* 42 (winter 1993): 479-541.

Keyes, Gordon G. "Health-Care Professionals with AIDS: The Risk of Transmission Balanced Against the Interests of Professionals and

Institutions." *Journal of College and University Law* 16 (spring 1990): 589-621.

LeBlang, Theodore R. "Obligations of HIV-Infected Health Professionals to Inform Patients of Their Serological Status: Evolving Theories of Liability." *John Marshall Law Review* 27 (winter 1994): 317-30.

Lieberman, Karen C. and Arthur R. Derse, M.D. "HIV-Positive Health Care Workers and the Obligation to Disclose: Do Patients Have the Right to Know." *Journal of Legal Medicine* 13 (September 1992): 333-56.

Logan, Mary K. "Who's Afraid of Whom? Courts Require HIV-Infected Doctors to Obtain Informed Consent of Patients." *DePaul Law Review* 44 (winter 1995): 483-511.

Lunde, R.N., Janice K. "Informed Consent and the HIV-Positive Physician." *Medical Trial Technique Quarterly* 38 (1991): 186-204.

Margolis, Thomas E. (commentary). "Health Care Workers and AIDS: HIV Transmission in the Health Care Envirorment." *Journal of Legal Medicine* 13 (September 1992): 357-96.

Mayfield, Eleanor. "Protecting Patients and Professionals from Blood-Borne Disease." *FDA Consumer* vol. 27, no. 3 (April 1993).

McIntosh, Phillip L. "When the Surgeon Has HIV: What to Tell Patients About the Risk of Exposure and the Risk of Transmission." *University of Kansas Law Review* 44 (February 1996): 315-64.

McNeil, Donald J. and Laurie A. Spieler. "Mandatory Testing of Hospital Employees Exposed to the AIDS Virus: Need to Know or Unwarranted Invasion of Privacy." *Loyola University Law Journal* 21 (summer 1990): 1039-74.

Mitchell, Sandra L. "Employment Issues Facing HIV-Infected Health Care Workers." *Journal of Pharmacy & Law* 3 (1994): 5-27.

Neugarten, Joel (note). "The Americans With Disabilities Act: Magic Bullet or Band-Aid for Patients and Health Care Workers Infected with The Human Immunodeficiency Virus?" *Brooklyn Law Review* 57 (winter 1992): 1277-1342.

Nissenbaum, Gary D. "Employers' and Physicians' Duties to Tell Third Parties." *New Jersey Lawyer* no. 126 (January/February 1989): 44-46.

Prewitt, R. Bradley (comment). "The 'Direct Threat' Approach to the HIV-Positive Health Care Employee Under the ADA." *Mississippi Law Journal* 62 (spring 1993): 719-42.

Reid, Brenda S. "HIV in the Health Care Workplace: Challenges Involving HIV-Infected Employees and Physicians." *Whittier Law Review* 14 (1993): 24-32.

Richardson, Eric N. and Salvatore J. Russo, eds. "Calming AIDS Phobia: Legal Implications of the Low Risk of Transmitting HIV in the Health Care Setting." *University of Michigan Journal of Law Reform* 28 (summer 1995): 733-98.

Rothenberg, Karen H. et al. "The AIDS Project: Creating a Public Health Policy—Rights and Obligations of Health Care Workers." *Maryland Law Review* 48 (1989): 93-211.

Rubin, Alix R. "HIV Positive, Employment Negative? HIV Discrimination Among Health Care Workers in the United States and France." *Comparative Labor Law Journal* 17 (winter 1996): 398-443.

Schaper, Reed E. "HIV in the Health Care Workplace: Challenges Involving HIV-Infected Employees and Physicians." *Whittier Law Review* 14 (1993): 33-40.

Schiff, Matthew B. "AIDS and the Health Care Worker: Tort and Workers' Compensation Liability." *Gonzaga Law Review* 29 (1993/94): 331-58.

Stanton, Wm. Clark. "HIV in the Health Care Workplace: Challenges Involving HIV-Infected Employees and Physicians." *Whittier Law Review* 14 (1993): 15-23.

Stukes, Anne Whitford. "Doe v. University of Maryland Medical Corporation: Should Doctors With AIDS Continue to Practice?" *North Carolina Law Review* 74 (September 1996): 2013-35.

Tomlinson, Diane A. (note). "Physicians With AIDS and Their Duty to Patients." *Florida Law Review* 43 (July 1991): 561-82.

Watson, Sidney D. "Eliminating Fear Through Comparative Risk: Docs, AIDS and the Anti-Discrimination Ideal." *Buffalo Law Review* 40 (fall 1992): 739-807.