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“First, Do No Harm”

I. Introduction

On the evening of September 4, 1991, the Intensive Care Unit was well-lit, the floors were mopped clean under and around the curtained-off beds, and the scent of disinfectant pervaded. A good looking man in his mid-twenties was propped up against several pillows on one of the beds. His apparently healthy body, wired though it was with monitors, looked out of place in a hospital bed. A nurse approached, clad in her dress whites and armed with a needle. She smiled a greeting, which he returned.

“What have you got? Another needle for me?”

“Sorry. But, you know what they say — It’ll only hurt for a minute.”

Deftly, she lifted the patient’s arm, felt for a vein, swabbed the general area with alcohol-soaked cotton, and prepared the needle. She did it all very quickly, very practiced. Watching her curiously, he was surprised to note that her quick hands were bare. After all, he thought, gallons of blood must spill on the floors of the Intensive Care Unit each week. What about AIDS?¹

“No gloves? Aren’t you worried about AIDS? I would have thought you’d be wearing a suit of armor.” He laughed, confident that he really posed no threat to her.

She laughed back, and proceeded to insert the needle into his arm. “Oh, we wear them sometimes. I’m not worried with

1. Although the term “AIDS”, or Acquired Immune Deficiency Syndrome [hereinafter “AIDS”], has become almost a household word in the past decade, the more accurate name for the virus is the Human Immunodeficiency Virus [hereinafter “HIV”]. C. Everett Koop, *Surgeon General’s Report on Acquired Immune Deficiency Syndrome*, at 9, U.S. Public Health Service (1987)[hereinafter Koop]; see also LAURENCE MASS, *MEDICAL ANSWERS ABOUT AIDS 2-3* (1989)[hereinafter MASS]. HIV is the medical name given to a virus which attacks the white blood cells in the human blood and gradually breaks down the body’s immune system. *Id.* at 3. AIDS is but one of the stages of the breakdown of the immune system in a person infected with HIV. JOHN G. BARTLETT & ANN K. FINKBEINER, *THE GUIDE TO LIVING WITH HIV INFECTION 1-2* (1991)[hereinafter BARTLETT & FINKBEINER]. For a more complete discussion and definition of the progression of HIV and AIDS, see *infra* notes 12-43 and accompanying text.

you though. You know how it is. You can usually tell.”²

The nurse’s point is clear. Evidently, she believes that the AIDS virus is common only among drug-users and homosexuals and that, as a result, sanitary precautions like gloves are necessary only when dealing with these “high risk” people.³ Further, she is apparently under the impression that drug-users and homosexuals can easily be identified as they lie in hospital beds awaiting treatment. She is wrong on both counts.

The point that this true story makes with chilling clarity is that the nurse’s misconceptions about the AIDS virus, prevalent in the public at large, also exist among health care workers [hereinafter “HCWs”]. As a result, recommended infection control procedures are disregarded in many situations;⁴ gloves and other infection barriers remain, impotent, in the storage closet.

The risk of transmission from patient to HCW⁵ and from HCW to patient⁶ is real, even in today’s AIDS-conscious society. This unfortunate fact presents at least two very important, and

2. The above conversation actually took place on the date noted in a hospital in Newburgh, New York. The patient, who is the author’s brother, was under treatment in the Intensive Care Unit for heart palpitations.

3. “High risk” people are understood to be: (1) males or females who have had unprotected sexual contact since the mid-to-late 1970s with multiple male or female partners, *see infra* notes 36-37 and accompanying text; (2) males or females who have used or shared drug paraphernalia since the mid-to-late 1970s, *see infra* note 38 and accompanying text; (3) recipients of blood transfusions or blood products from donors who may be at risk, *see infra* notes 41-42 and accompanying text; (4) recipients of donor sperm or other donor tissues or organs from persons infected with HIV; (5) unborn children or breastfed children of women infected with HIV, *see infra* notes 39-40 and accompanying text. MASS, *supra* note 1, at 3-4, 7. The use of shared needles or blades for ritual scarring, acupuncture, tattooing, or piercing the skin will also put recipients at risk. *Id.*

4. *See infra* note 246 and accompanying text.

5. In the nine years after 1981, when the AIDS epidemic began, there were 19 documented cases of transmission from patient to health care worker. Dennis L. Breo, *The ‘Slippery Slope’: Handling HIV-infected Health Workers*, 264 JAMA 1464, 1464 (1990).

6. According to recent Center for Disease Control [hereinafter CDC] reports, several patients have been exposed to the fatal virus by their dentist, Dr. David Acer, a Florida man who recently died of AIDS. *See CDC, Possible Transmission of Human Immunodeficiency Virus to a Patient during an Invasive Dental Procedure*, 39 MORBIDITY & MORTALITY WKLY. REP. 489 (July 27, 1990); CDC, *Update: Transmission of HIV Infection During an Invasive Dental Procedure - Florida*, 40 MORBIDITY & MORTALITY WKLY. REP. 21 (Jan. 18, 1991). The painful story of one of the patients, Kimberly Bergalis, who was the first of Acer’s patients to have been diagnosed as HIV positive, has received much attention from the press and has added to the public outcry for legislative action in this arena. For a discussion of the Acer-Bergalis case, *see infra* notes 70-84 and accompanying text.

somewhat similar, questions. First, what can be done to minimize the risk of transmission of the virus from an infected patient to an unwary HCW? Second, what can be done to minimize the risk of transmission of the virus from an infected HCW to an unwary patient? The latter question is the subject of this Comment.⁷

Part II of this Comment will examine HIV, its relatively recent discovery, its modes of transmission, and its rapid rise to notoriety. This section will also discuss the impact that the communicable virus has begun to have in the health care setting, with a focus on the controversial practices of seropositive⁸ HCWs who perform invasive procedures.⁹ The tort concept of "informed consent" will be introduced, with a discussion of the types of risks for which the informed consent of a patient has traditionally been required by tort law.

Part II will also introduce the current guidelines advanced by the United States Public Health Service, Centers for Disease Control [hereinafter "CDC"] and will outline some of the most frequently cited criticisms of these guidelines. Finally, it will examine the most recent Congressional efforts to monitor the spread of HIV from HCW to patient and will briefly summarize the intent of this legislation, emphasizing the great polarization of views on this issue.

Part III of this Comment will attempt to synthesize the above considerations, to arrive at a legal and logical solution to the unsettled controversy of how best to minimize the risk of transmission from HIV-infected HCWs to their patients. Part

7. Although the former question is beyond the scope of this article, the author does not suggest that it is of less importance than the latter question. Many of the issues raised in this article will apply equally to both questions.

8. The word "seropositive" is used to describe a person who has tested positively for HIV. For descriptions of the tests most commonly used, see *infra*, notes 44-47 and accompanying text.

9. An invasive procedure is defined as a surgical entry into tissues, cavities, or organs or repair of major traumatic injuries associated with any of the following: 1) An operating or delivery room, emergency department, or outpatient setting, including both physicians' and dentists' offices; 2) cardiac catheterization and angiographic procedures; 3) a vaginal or caesarean delivery or other invasive obstetric procedure during which bleeding may occur; or 4) the manipulation, cutting, or removal of any oral or perioral tissues, including tooth structure, during which bleeding occurs. CDC, *Recommendations for Preventing Transmission of Human Immunodeficiency Virus, Hepatitis B Virus to patients during Exposure-Prone Invasive Procedures*, 266 JAMA 771, 771 (1991).

IV will conclude that HCWs who perform invasive procedures should be required by state law to undergo periodic testing for the virus and that those HCWs who test positively should be required to obtain their patients' informed consent before performing further invasive procedures. Although this solution may well be disagreeable and appear to be an overreaction to the relatively small minority of people it will adversely impact,¹⁰ this Comment will conclude that, where public health is concerned, the state and federal governments have little choice but to err on the side of caution.

II. Background

A. *The History of the Disease*

"There are no such things as incurables; there are only things for which man has not found a cure."

— Bernard M. Baruch¹¹

In 1981, five young homosexual men had the dubious honor of becoming the first reported cases of AIDS in the United States.¹² Ten years later, reduction of the incidence of AIDS ranks among the nation's top health priorities.¹³ The virus which causes AIDS is most commonly known as HIV.¹⁴ This virus at-

10. A mandatory testing and disclosure scheme will impact adversely on the practices of those HCWs who test positively for HIV, for many patients may choose to forego treatment or to go to another HCW rather than accept the risk of transmission.

11. Bernard M. Baruch in *INSTANT QUOTATION DICTIONARY* 87 (Donald O. Bolander et al. eds. 1972).

12. W. Meade Morgan & James W. Curran, *Acquired Immunodeficiency Syndrome: Current and Future Trends*, 101 *PUB. HEALTH REP.* 459, 459 (Sept./Oct. 1986) (citing *Pneumocystis Pneumonia — Los Angeles*, 30 *MORBIDITY & MORTALITY WKLY. REP.* 250 (June 5, 1981)). While the five Los Angeles AIDS patients were the first AIDS cases officially reported in the U.S., scientists are not certain that these were actually the earliest cases in the U.S. See W. Robert Lange, *Followup Study of Possible HIV Seropositivity Among Abusers of Parenteral Drugs in 1971 - 72*, 106 *PUB. HEALTH REP.* 451, 451 (July/Aug. 1991). Scientists have not ruled out the possibility that there were undetected cases in the U.S. prior to 1981. *Id.*

13. Lawrence O. Gostin, et al., *The Case Against Compulsory Casefinding in Controlling AIDS — Testing, Screening and Reporting*, 12 *AM. J.L. & MED.* 7, 7 n.1 (1986) (citing 15 *FDA DRUG BULL.* 26 (1985)) [hereinafter Gostin].

14. Scientists have also called the virus HTLV-III (Human T-Lymphotropic Virus Type III) and LAV (Lymphadenopathy Associated Virus). The three labels, HIV, HTLV-III, and LAV, all refer to the same virus. Koop, *supra* note 1, at 9; Gostin, *supra*

tacks the body's immune system by penetrating and breaking down certain white blood cells, the T-Lymphocytes.¹⁵

As a result of the breakdown, the body is unable to effectively fight other disease.¹⁶ The person is increasingly susceptible to infection by various protozoa, bacteria, fungi, and viruses which are ordinarily blocked by the immune system.¹⁷ The individual is thus faced with life-threatening illnesses, such as cancer, pneumonia, and meningitis.¹⁸ These illnesses are often referred to as "opportunistic diseases"¹⁹ because they use "the opportunity of lowered resistance to infect and destroy."²⁰ Opportunistic diseases are often a clear earmark of advanced seropositivity, because they are illnesses to which a healthy immune system would be resistant.²¹

note 13, n.5-6, at 8-9.

15. "Lymphocytes are the main functional cells of the lymphatic or immune system." MICHAEL H. ROSS & LYNN J. ROMRELL, *HISTOLOGY: A TEXT AND ATLAS* 190 (2d ed. 1989) (emphasis omitted)[hereinafter ROSS & ROMRELL]. The majority of the lymphocytes in blood or lymph have developed the capacity to recognize and respond to foreign antigen. *Id.* An antigen is defined as "any substance that the body regards as foreign or potentially dangerous and against which [the body] produces an antibody." *THE BANTAM MEDICAL DICTIONARY* 25 (Revised ed. 1990). An antibody is "a special kind of blood protein that is synthesized in lymphoid tissue in response to the presence of a particular antigen . . . [The antibody] circulates in the plasma to attack the antigen and render it harmless." *Id.* at 24. "All lymphocytes are involved in the phenomenon of immunological memory and are primed during their maturation to respond to a specific antigen." ROSS & ROMRELL, *supra* at 190 (emphasis omitted). The lymphocytes present in the body are split into two categories — "T-lymphocytes", or "T-cells", and "B-lymphocytes", or "B-cells." *Id.* The T-cells are likewise broken down into three fundamentally different types: (1) cytotoxic lymphocytes, (2) helper lymphocytes, and (3) suppressor lymphocytes. *Id.* These are necessary for, among other things: (1) recognition and destruction of other cells that have foreign antigens on their surfaces; (2) assistance and stimulation of B-cells and other T-cells in their response to antigens; and (3) suppression of the body's immune response to "self molecules," which are normally present in the body. *Id.* at 190-92. Each variation of the T-cell plays a specific, key role in the immune system. *Id.*

16. BARTLETT & FINKBEINER, *supra* note 1, at 62. "The diseases which invade a seropositive individual are caused by microbes to which everyone is exposed on a regular basis but which lack clout; usually a modest effort by the immune system is enough to defeat them. A suppressed immune system, however, is unable to fight off these infections." *Id.*

17. *Id.*

18. MASS, *supra* note 1, at 19-24.

19. KOOP, *supra* note 1, at 10.

20. *Id.* (emphasis in original).

21. Opportunistic diseases are sometimes also called *AIDS defining conditions*, because "someone with one [or more] of these conditions, by definition, has AIDS." BARTLETT & FINKBEINER, *supra* note 1, at 62.

After the virus enters the blood stream, the body recognizes the presence of an antigen²² and, in response, produces antibodies.²³ The antibodies, when detected by a blood test, point to the presence of HIV in the bloodstream.²⁴ Ironically, although the existence of antibodies marks the presence of the virus in the system, scientists have found that these antibodies do nothing to check the spread of the disease.²⁵ Thus, the immune system recruits and sends into battle an army of unarmed and incapacitated antibodies.²⁶ This impotent legion of antibodies is in place and identifiable anywhere from about three to twelve weeks after initial exposure to HIV.²⁷ During the early stages, for a period following exposure, most infected people are without apparent symptoms,²⁸ although they *are* able to pass the dis-

The two most common opportunistic diseases are *pneumocystis carinii* pneumonia (a fungal infection of the lung) and Kaposi's sarcoma (cancerous lesions of the skin, mucous membranes, internal organs and blood vessels). *Id.* at 62-64; MASS, *supra* note 1, at 19-20. Other, albeit less common, opportunistic infections include, but are not limited to: mycobacterium tuberculosis (pneumonia and systemic infection caused by bacteria); infections of the central nervous system, such as toxoplasmic encephalitis (a parasitic infection of the brain); non-Hodgkin's lymphomas (a cancer of the lymph tissues); herpes simplex infection (viral infections primarily of the mouth and the genitals). See BARTLETT & FINKBEINER, *supra* note 1, at 63-69; Harry Hollander & Mitchell H. Katz, *AIDS and Related Conditions*, in CURRENT MEDICAL DIAGNOSIS & TREATMENT 939, 942-48 (Steven A. Schroeder et al., eds. 30th ed. 1991) [hereinafter Hollander & Katz]; MASS, *supra* note 1 at 19-20 (1989). These infections are usually encountered in the later stages of HIV infection, when the patient is experiencing full-blown, or classic AIDS. BARTLETT & FINKBEINER, *supra* note 1, at 63-69; Hollander & Katz, *supra* at 942-48.

22. For a definition of "antigen" see *supra* note 15.

23. For a definition of "antibody" see *supra* note 15.

24. For a description of the tests used to identify these antibodies, see *infra* notes 44-47 and accompanying text.

25. MASS, *supra* note 1, at 16. "With most antibody tests, a positive result — antibodies have been detected — implies some immunity to the disease. This is apparently not the case with HIV antibody tests. This unusual circumstance has not yet been explained." *Id.*

26. Koop, *supra* note 1, at 27.

27. Michael J. Barry, et al., *Screening for HIV Infection: Risks, Benefits, and the Burden of Proof*, 14 LAW, MED. & HEALTH CARE 259, 261-62 (1986).

28. See Gostin, *supra* note 13, at 15 (citing Macklin & Friedland, *AIDS Research: The Ethics of Clinical Trials*, 14 LAW, MED. & HEALTH CARE 273-80 (1986)). The latency period between infection and manifestation of symptoms may be quite long — five or even ten years. Gostin, *supra* note 13, at 15 (citing Macklin & Friedland, *AIDS Research: The Ethics of Clinical Trials*, 14 LAW, MED. & HEALTH CARE 273, 278 (1986)); see also Tedd V. Ellerbrock et al., *Epidemiology of Women With AIDS in the United States, 1981 Through 1990: A Comparison With Heterosexual Men With AIDS*, 265 JAMA 2971, 2974 (1991) [hereinafter Ellerbrock].

ease on to others.²⁹

The severity and speed of progression of the disease vary from individual to individual.³⁰ The HIV positive person may remain asymptomatic for quite some time,³¹ may progress into the more advanced stages of AIDS-related complex [hereinafter "ARC"],³² or may develop full-blown AIDS.³³ Generally, once a

"Physicians have been tantalized by the puzzle of people with longstanding HIV infections who haven't developed symptoms." Jean Seligman & Mary Hager, *In Florence, a Meeting of Mysteries*, NEWSWEEK, July 1, 1991, at 56. According to Dr. Jay Levy, of the University of California, San Francisco, some individuals' immune systems naturally produce a substance which seems to temporarily halt the replication of the virus in the body. *Id.* This can result in a latency period which may last as long as a decade. *Id.*

29. See Gostin, *supra* note 13, at 8 n.3. "It is estimated that for every person who meets the CDC definition of AIDS, there are between 50 and 100 who have the [HIV] infection and are capable of transmitting it." Gostin, *supra* note 13, at 8 n.3. For the CDC definition of AIDS, see *infra* note 33.

30. Researchers are not certain that all HIV positive persons will eventually develop AIDS. See Hollander & Katz, *supra* note 21, at 948. However, studies of seropositive individuals, whose date of exposure is known, have shown that roughly 50 percent of untreated HIV positive people will progress into AIDS within ten years. *Id.* "When the [acquired immune deficiency] syndrome was [initially] found to be caused by [HIV], it became obvious that severe opportunistic infections . . . were at one end of a spectrum of disease, while healthy seropositive individuals were at the other end." *Id.*

31. Koop, *supra* note 1, at 11.

32. Koop, *supra* note 1, at 10-11. ARC, a condition caused by HIV, is manifest in a specific set of clinical symptoms, but is somewhat less severe than full-blown AIDS. MASS, *supra* note 1, at 9-10. ARC symptoms often include: loss of appetite, weight loss, fever, night sweats, skin rashes, diarrhea, fatigue, susceptibility to infection, and swollen lymph nodes. Koop, *supra* note 1, at 11. According to some researchers, the label "ARC" should be avoided, because it represents a broad group of patients whose symptoms are heterogeneous and whose clinical problems and prognoses are very different. Hollander & Katz, *supra* note 21, at 939. As a result, the label is not very descriptive or specific, and the term ARC is not officially recognized by the CDC in its surveillance and reporting system. MASS, *supra* note 1, at 9-10.

33. Although the name, AIDS, is used almost generically to describe the symptoms of the deadly HIV, AIDS actually refers to the very advanced stages of HIV progression. See BARTLETT & FINKBEINER, *supra* note 1, at 1-2. Broken into its parts, the name "acquired immune deficiency syndrome" is more meaningful: *Acquired* indicates that the virus is not inherited (as many diseases of immune deficiency are), but is *acquired* from outside the body. *Id.* *Immune Deficiency* refers to the weakened state of the body's essential immune system. *Id.* *Syndrome* indicates that the virus brings on a series of symptoms and complications, rather than just a single disease or condition. *Id.*

The CDC's 1987 classification is more technical. It "defines a variety of definitively or presumptively diagnosed opportunistic infections . . . as evidence of AIDS. The CDC criteria also specify AIDS diagnoses based upon documented weight loss, diarrhea, or dementia in a patient with positive HIV serology." Hollander & Katz, *supra* note 21, at 939.

person's illness has advanced to the classic AIDS stage, death is imminent,³⁴ because no cure has, as yet, been discovered.³⁵

The lapse of time is especially problematic, in light of the virus' modes of transmission. Transmission most often occurs during sexual activity,³⁶ especially anal intercourse.³⁷ Intrave-

Under the CDC definition, an AIDS case is "an instance of a disease, at least moderately predictive of a defect in cell-mediated immunity, occurring with HIV infection or no known cause for diminished resistance to that disease." Ellerbrock, *supra* note 28, at 2971.

"Increased use of the HIV antibody test and greater understanding of the spectrum of HIV-related diseases led to a revision of the case definition in 1987 that expanded the list of diseases indicative of AIDS and included some diseases diagnosed presumptively (i.e., without histological or laboratory confirmation)." *Id.*

34. One study focused on the incidence of AIDS in women and heterosexual men, and concluded that the two groups' average life-spans after the initial diagnosis of AIDS were not statistically different. Ellerbrock, *supra* note 28, at 2974. After studying the speed of progression of the disease in a group of 10,558 women and 26,362 heterosexual men (as reported to the CDC as of December 31, 1989), the researchers found that the median survival time from diagnosis to death for women was 9.8 months, and was 9.3 months for heterosexual men. *Id.*

35. MASS, *supra* note 1, at 24.

36. HIV is present in virtually all of the body fluids of an infected person, including his or her blood, semen, or vaginal secretions. Hollander & Katz, *supra* note 21, at 948. Transmission during sexual activity can occur when HIV in these bodily fluids enters the bloodstream through tiny, unseen tears in the lining of the vagina, rectum, or mouth. Koop, *supra* note 1, at 16. Female to male and, more commonly, male to female transmission does occur, but the "exact mechanisms" of this heterosexual transmission are the subject of continued study. MASS, *supra* note 1, at 6. Recent evidence that HIV may directly infect the inner lining cells of the vagina and cervix may explain male to female transmission during vaginal intercourse where there was no bleeding. *Id.* Similarly, female to male transmission may occur where the male urethral mucosa is exposed to infected female body fluids. MASS, *supra* note 1, at 6. The virus has also been detected in tears and saliva, but only in such small quantities that the risk of transmission from tears or saliva is considered exceedingly small; and to date there have been no recorded cases of infection through this route of transmission. Koop, *supra* note 1, at 25.

37. Hollander & Katz, *supra* note 21, at 948. Anal intercourse is considered to be the sexual act with the highest risk. *Id.* Unprotected anal intercourse is believed to be very risky because rectal tissue is easily torn, and as a result HIV infected sperm have direct access to the receptive partner's bloodstream. MASS, *supra* note 1, at 7. In addition, recent evidence suggests that HIV may *directly* infect the cells of the inner lining of the colon (including the anus and rectum). *Id.* Anal intercourse is likewise dangerous for the insertive partner, for transmission is believed possible where the male urethral mucosa is exposed to the contaminated blood or body fluids of an infected partner. *Id.* at 6. Increased numbers of sexual partners, receptive anal intercourse, and other sexual practices causing "rectal trauma" have been identified as high risk behaviors. See Warren Winkelstein, Jr. et al., *Sexual Practices and Risk of Infection by the Human Immunodeficiency Virus: The San Francisco Men's Health Study* 257 JAMA 321, 324-25 (1987).

nous [hereinafter "IV"] drug use is the second most common vehicle for transmission.³⁸ Furthermore, women who have been infected by the virus can pass it, in utero, to their unborn children³⁹ or to their infants, through breast milk.⁴⁰ In the early 1980s, blood transfusions also provided a route of transmission;⁴¹ but improved screening techniques have virtually eliminated this type of HIV transmission.⁴² Research has shown that the virus is not transmitted through respiratory vapors in the air, by insects, or by casual, non-sexual contact.⁴³

Several tests have been developed to identify the presence of HIV antibodies in the blood.⁴⁴ In the United States, the two most commonly used are the "ELISA" and the "Western Blot" tests.⁴⁵ Although there were initial concerns about the consis-

38. Hollander & Katz, *supra* note 21, at 939. Intravenous drug users comprise about 16 percent of the diagnosed cases of AIDS in the U.S. *Id.* Transmission through IV drug use occurs most often when a drug user "shoots up," injecting drugs directly into his or her bloodstream. *Id.*; Koop, *supra* note 1, at 19. A user may be infected when a previously used needle contains remnants of the HIV-contaminated blood of another user. Hollander & Katz, *supra* note 21, at 939; Koop, *supra* note 1, at 19. This problem is widespread in the drug using populations, especially in the nation's inner cities, because many users share needles and drug paraphernalia. Hollander & Katz, *supra* note 21, at 939; Koop, *supra* note 1, at 19.

39. Hollander & Katz, *supra* note 21, at 939. Roughly 30 to 50 percent of children born to seropositive mothers will contract HIV infection. *Id.*

40. See Gostin, *supra* note 13, at 22.

41. *Id.* at 15. It is estimated that two percent of reported AIDS cases resulted from infection by contaminated blood or blood products. *Id.* People who received transfusions prior to January 1985 may have encountered HIV contaminated supplies, because up until that time, blood screening techniques were inadequate to cull the bad blood from the good. Hollander & Katz, *supra* note 21, at 939.

42. Today, screening techniques are much more reliable and are considered to promise a very safe blood supply, with the risk of contracting HIV from a screened unit of blood estimated at one in one hundred thousand. Hollander & Katz, *supra* note 21, at 939; Koop, *supra* note 1, at 22.

43. Hollander & Katz, *supra* note 21, at 939; MASS, *supra* note 1, at 6-9.

44. MASS, *supra* note 1, at 14-16. The tests used to detect seropositivity do not actually isolate the virus; rather, the tests look for the presence (or absence) of antibodies which an infected body will produce in reaction to HIV. See also, CDC, *Update: Serologic Testing for Antibody to Human Immunodeficiency Virus*, 36 MORBIDITY & MORTALITY WKLY. REP. 833, 834 (1988); Schwartz, Dans & Kinosian, *Human Immunodeficiency Virus Test Evaluation, Performance and Use*, 259 JAMA 2574, 2574 (1988). See also Elaine M. Sloand et al., *HIV Testing; State of the Art*, 266 JAMA 2861 (1991) (discussing HIV antibody tests).

45. MASS, *supra* note 1, at 15-16. The ELISA is the enzyme-linked immunosorbent assay, also called enzyme immuno assay (EIA). This test indicates the level of HIV antibodies present in an individual's blood sample. *Id.* If the results of the first ELISA

tency and accuracy of these two tests,⁴⁶ it is now generally acknowledged that, when used in conjunction with one another, they are quite reliable.⁴⁷

The United States Department of Health and Human Services, through the CDC, has established the CDC AIDS Surveillance System in order to keep up to date on the AIDS crisis in the U.S. and its territories.⁴⁸ In each of the states, doctors who diagnose a case of AIDS must report it to their respective state health department.⁴⁹ A doctor's report may or may not give the

indicate seropositivity, further testing is generally performed to reduce the possibility of laboratory error. *Id.* Where further ELISA tests also demonstrate seropositivity, a Western blot test is usually conducted in order to confirm the ELISA results. *Id.* For a more detailed description of these tests, see *id.*; Barry, *supra* note 27, at 259-66; Gostin, *supra* note 13, at 13.

46. See, e.g., R. Bayer et al., *HIV Antibody Screening: An Ethical Framework for Evaluating Proposed Programs*, 256 JAMA 1768, 1769 (1986) [hereinafter Bayer]; Marwick, *Use of the Antibody Test May Provide More Answers*, 253 JAMA 1694, 1694-95, 1699 (1985) (discussing concerns that the tests would reflect false negatives or false positives, which would either foster a false sense of security or would unnecessarily alarm the individual tested).

47. Gostin, *supra* note 13, at 13. When used alone, without a supplemental test such as the Western Blot, the ELISA has proven "reasonably sensitive" (because it registers positive in a high proportion of patients with HIV) and "reasonably specific" (because it registers negative in a high proportion of healthy blood donors). *Id.* at 11. Specifically, the range of sensitivity of the ELISA has been reported at 93.4 to 99.6%, while the range of specificity has been reported at 98.6 to 99.6%. *Id.* at 11 n.14. "The current sequence of tests used to detect antibodies against HIV, when performed under well controlled conditions in good laboratories, yield both a sensitivity and specificity of greater than 99.8 percent." *Government of the Virgin Islands v. Roberts*, 756 F. Supp. 898, 900 (1991) (quoting *Report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic 80*, at 2 (June 1988)).

Because the ELISA is not always accurate and may show a false negative or a false positive, the National Institutes of Health Consensus Development Conference Statement on HIV Antibody Testing urges supplemental testing. Gostin, *supra* note 13, at 13. Additional testing should effectively eliminate the margin of error. *Id.* at 11.

However, despite the high reliability of the two tests when used together, they simply cannot detect the virus before the antibody levels have risen in the body in response to the antigen, HIV. Bayer, *supra* note 46, at 1769. The time lapse between exposure to HIV and detection in the bloodstream will vary with the individual, sometimes taking several weeks or even months. See *supra* notes 22-29 and accompanying text. This factor can sometimes cause a negative test result when the person actually has the disease in his or her system. Bayer, *supra* note 46, at 1769.

48. See Allison L. Greenspan, James W. Curran, *Communicating Surveillance, Epidemiologic, and Laboratory Information on HIV Infection and AIDS*, 106 PUB. HEALTH REPORTS 721, 724 (1991). The CDC AIDS Surveillance System covers the 50 states, the U.S. territories, and the District of Columbia. Ellerbrock, *supra* note 28, at 2971.

49. Ellerbrock, *supra* note 28, at 2971. "Laws requiring the reporting of communica-

patient's name and the probable origin of the disease, depending on the individual state's policy.⁵⁰ Some states statutorily require that doctors report positive HIV test results, while other states require only that cases that have advanced to AIDS or ARC be reported.⁵¹ The state health departments, in turn, report the numbers (without names and personal information) to the CDC, where the information is compiled.⁵² Because there are often time lapses between exposure and detection of HIV and much longer lapses between exposure and symptomatic manifestation and diagnosis of AIDS,⁵³ the statistics currently at our disposal most likely misrepresent the true numbers who are carrying the

ble diseases are among the oldest instruments in the armamentarium of public health. All states have them." Harold Edgar & Hazel Sandomire, *Medical Privacy Issues in the Age of AIDS: Legislative Options*, 16 AM. J.L. AND MED. 155, 164 (1990)[hereinafter Edgar and Sandomire]. The reports serve various state needs. *Id.* Most notably, the reports are useful for: (1) estimating the disease's incidence; (2) gathering information about the disease itself and its "natural history", which is used to understand the probable origins and cause of the disease and may also contribute to a prediction of the disease's future spread; and (3) contacting those who have been exposed, in the hopes of treatment, should it become available. *Id.*

50. *Id.* at 166. The reporting of names and other personal data has not gone without objection. *Id.* at 159. As one article noted, "[t]he principal battleground in American AIDS related legislation is the extent to which the confidentiality concerns of those infected with HIV should receive special legal protection as against the plausible needs of an array of actors . . . to know HIV-related information about them." *Id.*

51. *Id.* at 166-67 nn. 33-36 (citing ALA. CODE § 22-11A-14(a) (Supp. 1989); COLO. REV. STAT. §§ 25-4-1402, 1403 (1989) (requiring report of HIV positive test, AIDS or HIV related illness); FLA. STAT. ANN. § 381.609(2)(f)(5) (West Supp. 1989) (requiring report of HIV test result); IDAHO CODE § 39-606 (1989) (requiring report of those being treated for HIV, ARC, and AIDS, etc.); WIS. STAT. ANN. § 146.025 (7)(b)(3) (West 1989) (requiring report of presence of test result HTLV-III antibody); MICH. COMP. LAWS ANN. §333.5114(1) (West Supp. 1989) (requiring report of HIV infection); MD. HEALTH-GEN. CODE ANN. § 18-207 (Supp. 1989) (requiring report of HIV infection); MO. REV. STAT. § 191.653(3) (Supp. 1990) (requiring report of identity of any individual "confirmed to be infected with HIV."); ILL. ANN. STAT. ch. 111 ½, para. 7354 (Smith-Hurd Supp. 1989); FLA. STAT. ANN. § 384.25 (West 1989)(reporting cases of AIDS, ARC, and HIV positive test results, but reporting of the latter only if federal funding has been provided and after the health department has passed necessary regulations); KAN. STAT. ANN. § 65-6002 (1988) (requiring report of those who are suffering from or died of AIDS); CAL. HEALTH & SAFETY CODE § 1603.1(c) (West Supp. 1990) (reporting of transfusion associated AIDS); CAL. HEALTH & SAFETY CODE § 1603.1(d) (West Supp. 1990) (reporting of transfusion associated AIDS); *Id.* § 1603(1)(d) (requiring report of hospitalized confirmed AIDS and transfusion associated AIDS)); VA CODE ANN. § 32:1-36(c)(1988) (permitting report of cases); TENN. CODE ANN. §68-5-102(1989) (permitting report of suspected cases of AIDS).

52. Ellerbrock, *supra* note 28, at 2971-72.

53. See *supra* note 28 and accompanying text.

AIDS virus.⁵⁴

While homosexual and bisexual males⁵⁵ and IV drug users comprise the greatest percentage of people afflicted with HIV, these populations are by no means the only people at risk.⁵⁶ Anyone who comes into contact with the body fluids or blood of an infected person is also at risk of infection.⁵⁷ As the years pass, the virus is increasingly spreading⁵⁸ to women and the hetero-

54. BARTLETT & FINKBEINER, *supra* note 13, at 62. It is generally estimated that only about ten percent of the seropositive population currently has advanced to AIDS; it is only for that portion of seropositive people that we have true statistics. *Id.*

Since severe, clinical manifestations of HIV disease are required for the diagnosis of AIDS and the median time for progression from HIV infection to AIDS may be as long as 10 years, patients with AIDS represent only part of the HIV epidemic. Persons infected with HIV who are asymptomatic or have HIV-related symptoms not included in the AIDS case definition represent the other, much larger part of the epidemic. In 1989, an estimated 1 million persons were infected with HIV in the United States.

Ellerbrock, *supra* note 28, at 2974. (citations omitted).

The CDC, itself, is cognizant of the failings of its database. CDC, *HIV Infection Reporting — United States*, 262 JAMA 889, 890 (1989).

HIV infection reports that are now integral to public health programs in many states are not anticipated to be representative of all HIV-infected persons. Such reports represent only those persons within the infected population who are tested and reported at a given time. Testing and reporting may be influenced by factors other than the incidence and prevalence of AIDS, e.g., public awareness of risk factors, confidentiality concerns, and testing accessibility. While HIV infection reports complement other HIV/AIDS studies of HIV infection in a community, AIDS surveillance and the HIV family of surveys remain the basis for determining the current status and course of HIV infection in the United States.

Id. at 890. (citations omitted).

55. Hollander & Katz, *supra* note 21, at 939. In the U.S., homosexual and bisexual men make up 80 percent of the reported cases of AIDS. *Id.*

56. *Id.*

57. Hollander & Katz, *supra* note 21, at 939; *see supra* note 35 and accompanying text.

58. Hollander & Katz, *supra* note 21, at 939. It is estimated that there are about 1,000,000 people in the United States who are currently infected with HIV. *Id.* Although during the AIDS scare in the early eighties huge increases in the number of people with AIDS were predicted, fortunately the actual increase in the past ten years has been less than anticipated. *Id.* This may be attributable to the tremendous efforts toward increasing public awareness and education about the disease. *Id.* In San Francisco, for instance, transmission to "high risk" homosexual men has fallen to less than 1 percent annually since 1983. *Id.*

Despite these encouraging figures, the disease continues to take a terrible toll on our population. *Id.* Recent estimates put the number of living Americans with AIDS in 1991 at somewhere between 127,000 and 153,000. *Id.* The rate of increase is expected to be roughly 50,000 per year, with the greatest percent increase in inner city intravenous drug users, particularly blacks and Latinos. *Id.* While HIV is not known to infect one racial or

sexual population⁵⁹ and is also beginning to spread outward from the major metropolitan areas where it was originally concentrated.⁶⁰

Given the increasing numbers who have been infected with the virus, it is almost inevitable that the disease will rear its ugly head in every level of society and in every occupation and profession. The health care field is no exception.⁶¹ One study revealed that as of March 31, 1991, the number of diagnosed AIDS cases among HCWs in the United States was greater than 6,400.⁶² This number included 703 reported cases of diagnosed AIDS in physicians (including 47 in surgeons), 1,358 in nurses,

ethnic group over another, factors such as increased prevalence of high risk behaviors and decreased education and access to health care in certain geographical areas can cause disproportionate impact on racial or ethnic groups. Mass, *supra* note 1, at 5.

59. See Ellerbrock, *supra* note 28, at 2972. See also Gostin, *supra* note 13, at 22-23, nn. 63-64 (citing Fischl, Dickinson & Scott, *Evaluation of Heterosexual Partners, Children, and Household Contacts of Adults with AIDS*, 257 JAMA 640, 643-44 (1987); Whittington, Krauss, Lee & Nahmias, *The Prevalence of HTLV-III/LAV Antibodies in Heterosexuals*, 255 JAMA 1702, 1702-03 (1986); CDC, *Heterosexual Transmission of Human T-lymphotropic Virus Type III/Lymphadenopathy Associated Virus*, 34 MORBIDITY & MORTALITY WKLY. REPORT 561, 561-62 (1985)).

As of December 31, 1990, roughly 10 percent (a total of 15,493) of the 158,279 adults reported with AIDS in the United States were women. See Ellerbrock, *supra* note 28, at 2972. Between 1985 and 1990, the percentage of adult AIDS cases in women increased from 6.6% to 11.5%. *Id.* Likewise, the percentage of cases in heterosexual men also increased during that period. *Id.* See also Gostin, *supra* note 13, at 22-23, nn. 63-64 (citing Fischl, Dickinson & Scott, *Evaluation of Heterosexual Partners, Children, and Household Contacts of Adults with AIDS*, 257 JAMA 640 (1987); Whittington, Krauss, Lee & Nahmias, *The Prevalence of HTLV-III/LAV Antibodies in Heterosexuals*, 255 JAMA 1702 (1986); CDC, *Heterosexual Transmission of Human T-lymphotropic Virus Type III/Lymphadenopathy Associated Virus*, 34 MORBIDITY & MORTALITY WKLY. REPORT 561 (1985)).

60. Ellerbrock, *supra* note 28, at 2973. The virus has been found to be concentrated in certain geographical areas. Ellerbrock, *supra* note 28, at 2973. As of December 31, 1990, 70 percent (or 26,657) of the 38,103 cases of AIDS in heterosexual men were reported from the same ten reporting areas. Ellerbrock, *supra* note 28, at 2973. The highest cumulative incidence rates of AIDS cases in heterosexual men were as follows: Puerto Rico had the highest (224 per 100,000 adult male population), followed by New York (179 per 100,000), New Jersey (158 per 100,000), Washington, D.C. (154 per 100,000), and Florida (75 per 100,000). Ellerbrock, *supra* note 28, at 2973. New York had the largest number of both women (4,830) and heterosexual men (12,427) with AIDS. New Jersey had the second largest number of AIDS cases for these two groups (2,120 women and 4,782 heterosexual men). New Jersey was followed by Florida (1,923 women and 3,802 heterosexual men). Ellerbrock, *supra* note 28, at 2973.

61. Barbara Kantrowitz et al., *Doctors with AIDS*, NEWSWEEK, July 1, 1991, at 49, 50 [hereinafter Kantrowitz].

62. *Id.*

1,101 in health aids, 171 in dentists and dental hygienists, 319 in therapists, 116 in paramedics, and 941 in technicians.⁶³ These figures represent only those cases among HCWS where the HIV infection had advanced to (and been clinically diagnosed as) AIDS as of the date of the study.⁶⁴ It is also important to note that “[p]resumably, many times that number are infected with HIV, but have not yet developed clinical AIDS.”⁶⁵

B. *HIV in the Health Care Setting — The Growing Debate:*

“There are other Dr. Acers out there . . . his pocketbook meant more to him than his conscience.”⁶⁶

The presence of HIV infected HCWs in our nation’s health care facilities has begun to cause quite a stir in the public, the government, and the health care community, as each begins to consider the risks of transmission in the health care setting.⁶⁷ The question of the legal and ethical right of an infected HCW to continue practicing the “craft” without informing his⁶⁸ patients of his infection is at the core of this heated controversy. The focus has largely been on the HCW whose duties entail extensive invasive procedures.⁶⁹

63. *Id.*

64. *Id.*

65. Mark Barnes, *The HIV Infected Health Care Professional: Employment Policies and Public Health* 18:4 *LAW, MED. & HEALTH CARE* 311, 320 (Winter, 1990) (citations omitted). See also Kantrowitz, *supra* note 56, at 50. According to one article, an estimated 50,000 HCWs are currently infected with HIV. Jane Gross, *Many Doctors Infected With AIDS Don't Follow New U.S. Guidelines*, *N.Y. TIMES*, Aug. 18, 1991, at 20. This number was calculated using a “commonly used multiplier.” *Id.*

66. Words of Barbara Webb, patient of the late Dr. David J. Acer. Dr. Acer died of AIDS, but not before he transmitted HIV to five of his dental patients. Catherine Woodard, *State Affirms HIV Policy for Health-Care Workers*, *NEWSDAY* (Nassau, Suffolk), Oct. 9, 1991, at 17. For discussion of the Acer cases, see *infra* notes 70-84 and accompanying text.

67. Laurie Garrett, *Dentist's Lethal Legacy*, *NEWSDAY* (Nassau, Suffolk), August 18, 1991, at 4. “The Kimberly Bergalis impact has caused huge volumes of letters to members of Congress — enormous, unprecedented quantities,” said Carol Wolchok, a Washington lobbyist for the American Bar Association. “And most of it is just saying, ‘Do something. Do something about AIDS.’” *Id.*

68. The author’s use of the word “his” (rather than “hers”) is not intended to be limiting or sexist, but is in the interest of clarity.

69. See, e.g., *Only One Florida Dentist*, *THE WASHINGTON POST*, May 17, 1992, at C6.

The risk of transmission from HCW to patient during invasive procedures was driven home with the very recent and much publicized case of Kimberly Bergalis, a young Florida woman who contracted AIDS from her dentist, David Acer.⁷⁰ Hers was the first documented case of HCW-to-patient transmission of HIV.⁷¹ Soon after the news of Bergalis' diagnosis, it was announced that Dr. Acer had also infected four other patients.⁷² The Acer cases represent the realization of a latent fear; transmission of HIV in the health care setting has become not just a theoretical possibility, but a harsh reality.

This case presented a special dilemma for the health care community because both Dr. Acer and Ms. Bergalis recalled that Dr. Acer had worn gloves and a mask during the dental procedures.⁷³ It seemed to call into question the efficacy of the recommended infection barriers and thus brought an unwelcome note of mystery into the arena.⁷⁴ The health care community's response to this enigma has been varied.⁷⁵

Those who oppose restrictions on the practices of HIV positive HCWs have made much of the fact that, to date, Dr. Acer's

70. See *supra* note 5 and accompanying text. Bergalis' story has initiated what has been called "the explosive national controversy over AIDS-infected health-care workers." Kantowitz, *supra* note 61, at 49. Shortly after Bergalis was diagnosed with AIDS, she was questioned about the possible origins of her infection. Her case was puzzling to the authorities, because she did not fit in any of the known "risk groups" — she was a virgin, and she had never used IV drugs. Bergalis recalled that she had visited her dentist, David Acer, two years before to have her wisdom teeth extracted. Acer had been diagnosed with full-blown AIDS just three months before the dental procedure. Breo, *supra* note 6 at 1466.

Investigators were unable to obtain much information about Bergalis from Acer. State confidentiality laws prevented them from inquiring specifically about the patient, and Acer spoke only once to investigators before securing a lawyer and cutting off talks. The investigators were, however, able to glean some information from the dentist as to his general office practices. *Id.*

71. Elsa Brenner, *Volunteers of America Assisting in AIDS Care*, N.Y. TIMES, Dec. 29, 1991, at 10.

72. Kantowitz, *supra* note 61, at 50. These other patients are Barbara Webb, 66, of Palm City, Fla.; Richard Driskill, 32, of Indiantown, Fla.; Lisa Shoemaker, 35, who now lives in Michigan; and John Yecs, 35, of Stuart, Fla. See Laurie Garrett, *Dentist's Lethal Legacy*, NEWSDAY (Nassau, Suffolk), Aug. 18, 1991, at 4.

73. Barbara Gerbert et al., *Possible Health Care Professional-to-Patient HIV Transmission; Dentists' Reactions to a Centers for Disease Control Report*, 265 JAMA 1845, 1845 (1991).

74. *Id.* at 1845-46.

75. *Id.* at 1845.

patients are the only documented cases of doctor to patient transmission of HIV.⁷⁶ Apparently, some are skeptical of the CDC's report,⁷⁷ believing that the investigation into the Bergalis case was inadequate to support a conclusion that transmission occurred from HCW to patient.⁷⁸ One article, written for the *Journal of the American Medical Association*, reported the results of a survey in which dentists were questioned about their reactions to the CDC report on the Acer case.⁷⁹ Many of the dentists surveyed reported that they were not convinced that the CDC had investigated sufficiently.⁸⁰ In response to the dentists' skepticism, the article's authors commented, "This denial in itself is curious. The CDC had investigated the case for more than a year and took great care in preparing the report" The CDC's report relied upon DNA [deoxyribonucleic acid] analysis, which traced the patient's strain of the virus to the doctor.⁸¹

The article continued, "[T]he CDC stated that DNA assay revealed that the dentist's and patient's viral sequences displayed the extent of similarity expected for epidemiologically linked individuals. 'Unique patterns of nucleotide not found in any other virus isolate examined were shared between viral sequences found in the dentist and the patient.'"⁸² Summarizing the report, Gerald Myers, Ph.D., of the Los Alamos National Laboratory, concluded that the serologic evidence provided "very powerful" proof of a relationship between the two viral

76. See Sanford F. Kuvin, *AIDS Testing: Make it Mandatory*, NEWSDAY (Nassau, Suffolk), July 19, 1991, at 67.

77. See *supra* note 6.

78. Gerbert, *supra* note 73, at 1847.

79. *Id.* at 1846-48.

80. *Id.* at 1847.

81. *Id.* at 1847-48. The DNA analysis is accomplished through tests using PCR, or polymerase chain reaction. Garrett, *supra* note 67, at 4. PCR allows scientists to compare DNA, the genetic sequences, of viral samples to look for similarities. *Id.* The CDC used PCR analysis for the first time in the Bergalis case, and the analysis showed that Acer and Bergalis were infected with strains of HIV that vary genetically by only 1.2 percent. *Id.* This small variation is within the margin of error allowable for the tests, which led the CDC to conclude that the two strains of HIV were identical. *Id.* HIV is a rapidly mutating virus, and such close genetic matches between HIV strains have only been found where one individual directly infected the other. *Id.*

82. Gerbert, *supra* note 73, at 1847-48.

strains.⁸³ The CDC could not claim absolute certainty, given that conclusions in scientific studies usually rest upon "hypothesized relationships and probabilities"; but the authors said, "the CDC was as certain as it could ever be"⁸⁴

Since publication of the Acer cases, calls for reform have been made, most notably by Senator Jesse Helms of North Carolina,⁸⁵ and by Kimberly Bergalis herself.⁸⁶ These have been met with the heated criticism of activists who see many of the proposals as unreasoned overreactions, whose impact will be overly broad and whose aims are draconian.⁸⁷ Although such extreme measures⁸⁸ may be inappropriate, patients continue to be con-

83. *Id.* at 1848 (citations omitted).

84. *Id.*

85. In July, 1991, Senator Helms (R-N.C.) proposed that HCWs who, without informing their patients, continue to perform invasive procedures after they have AIDS be fined up to \$10,000 or be imprisoned for up to ten years, or both. See Martin Tolchin, *Senate Adopts Tough Measures on Health Workers with AIDS*, N.Y. TIMES, July 19, 1991, at A1; Jessie Mangliman, *Health Workers Denounce Helms Measure*, NEWSDAY (city ed.), July 20, 1991, at 14.

86. Philip J. Hilts, *AIDS Patient Urges Congress to Pass Testing Bill*, N.Y. TIMES, Sept. 27, 1991, at A12. Bergalis appeared before Congress on September 26, 1991 to plead for legislation to prevent a recurrence of her painful ordeal. *Id.* Visibly weakened by her illness, she addressed Congress for only fifteen seconds, stating, "AIDS is a terrible disease that we must take seriously. I didn't do anything wrong, but I'm being made to suffer like this. My life has been taken away. Please enact legislation so other patients and health care providers don't have to go through the hell that I have. Thank you." *Id.* Several months before, in April of 1991, Bergalis wrote a letter to the Florida health officials, portions of which ran as follows:

When I was diagnosed with AIDS in December of '89, I was only 21 years old. It was the shock of my life I was infected by Dr. Acer in 1987. My life has been sheer hell AIDS has slowly destroyed me. Unless a cure is found, I will be another one of your statistics soon

Who do I blame? Do I blame myself? I sure don't. I never used IV drugs, never slept with anyone and never had a blood transfusion. I blame Dr. Acer and every single one of you bastards. Anyone that *knew* Dr. Acer was infected and had full-blown AIDS and stood by not doing a damn thing about it. You are all just as guilty as he was

If laws are not formed to provide protection, then my suffering and death was in vain I'm dying guys. Goodbye.

Kantrowitz, *supra* note 61, at 52 (quoting letter by Kimberly Bergalis written April 6, 1991). Bergalis, 23, died on Sunday, December 8, 1991. *Kimberly Bergalis, 23; Got AIDS from Dentist*, CHI. TRIB., Dec. 9, at 91, at C6.

87. Mangliman, *supra* note 85, at 14. "What the [Helms bill] is doing is pandering to panic by using [a] jail sentence," said Kenneth Raskey, president of the Greater New York Hospital Association" Mangaliman, *supra* note 85, at 14.

88. See *supra* note 85.

cerned with the prospect of HCW to patient transmission.

C. *Informed Consent — A Tort Law Concept:*

A less imposing solution, which finds its support in long-standing tort law,⁸⁹ is rooted in the doctrine of informed consent.⁹⁰ While much of the medical community denies that obtaining the patient's informed consent is necessary,⁹¹ for some medical experts,⁹² most of the public,⁹³ and many of our nation's

89. See, e.g., *Karp v. Cooley*, 493 F.2d 408 (5th Cir. 1974), cert. denied, 419 U.S. 845 (1974). "Suits charging failure by a physician adequately to disclose the risks and alternatives of proposed treatment are not innovations in American law." *Id.* at 419. "The first buds of court decisions heralding this new medical duty" can be found in a 1957 California case. See *Scott v. Bradford*, 606 P.2d 554, 557 (Okla. 1979) (citing *Salgo v. Leland Stanford, Jr. Univ. Bd. of Trustees*, 317 P.2d 170 (Cal. App. 1957)).

90. "The doctrine imposes a duty on a physician or surgeon to inform a patient of his options and their attendant risks. If a physician breaches this duty, patient's consent is defective, and physician is responsible for the consequences." *Scott v. Bradford*, 606 P.2d at 557 (Okla. 1979). *Scott* noted, "This requirement, labeled 'informed consent,' is, legally speaking, as essential as a physician's care and skill in the performance of the therapy." *Id.* (emphasis in original).

91. For instance, a 1987 news article quoted the Surgeon General, C. Everett Koop, as saying that mandatory testing would be too expensive and ineffective and would subject AIDS victims "to discrimination that could jeopardize 'housing, jobs and friendships.'" *Sondra G. Boodman, Koop: Mandatory Tests Would Harm AIDS Fight*, THE WASHINGTON POST, May 2, 1987, at A3.

92. See *Kantrowitz*, *supra* note 61, at 54. That article quoted Dr. Sanford Kuvin, Vice Chairman of the National Foundation for Infectious Diseases in Washington, D.C., as saying:

The inherent right to know — for patient and doctors alike — always has to supersede confidentiality The doctor doesn't have to put up a signboard, but there has to be informed consent if he is going to do invasive procedures. 'First, do no harm' is the absolute bedrock of medicine. The Kimberly Bergalises of this world are avoidable.

Id.

93. Surveys of the American public have shown that employment policies for infected HCWs are of great import to most patients. One such survey showed that roughly 80% of the American public felt that HIV infected physicians have a duty to disclose their infection to their patients. Furthermore, almost 60% of the public would bar a surgeon with AIDS from practice, and over 50% would likewise exclude an infected dentist or dental hygienist. *Barnes*, *supra* note 9, at 311 (emphasis added) (citations omitted).

A Gallup poll, conducted for NEWSWEEK in June of 1991, estimated that 95% of the public felt that surgeons should be required to disclose their seropositivity to their patients, 94% felt that all physicians should have to disclose, 94% also felt all dentists should disclose, and 90% felt that all health care workers should have to inform their patients of seropositivity. *Kantrowitz*, *supra* note 61, at 51.

legislators,⁹⁴ this simple measure is the only logical, legal, and ethical solution.

The doctrine of informed consent is an outgrowth of the more basic doctrine of patient consent, "the universally recognized rule that a physician, treating a mentally competent adult under non-emergency circumstances, cannot properly undertake to perform surgery or administer other therapy without the prior consent of his patient."⁹⁵

Initially, courts recognized the need for a patient's voluntary consent prior to medical treatment because, as Judge Cardozo stated in the oft quoted New York Court of Appeals decision of *Schloendorff v. Society of New York Hospital*,⁹⁶ "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body."⁹⁷ The *Schloendorff* rationale focused on an individual's right to choose to undergo or forego a given treatment. Without an individual's authoriza-

94. See *infra* note 181 and accompanying text.

95. *Sard v. Hardy*, 379 A.2d 1014, 1019 (Md. 1977) (citing *Mohr v. Williams*, 104 N.W. 12, 15 (Minn. 1905); *McClees v. Cohen*, 148 A. 124, 127 (Md. 1930); *Powell, Consent to Operative Procedures*, 21 Md. L. REV. 189 (1961)).

While the duty to illicit a patient's informed consent has traditionally bound only physicians, the arguments that support its application to HIV-infected physicians extend equally to non-physician HCWs as well.

In some emergency situations, obtaining patient consent will be impracticable or impossible, and the law will recognize an exception to the consent requirement. See, e.g., *Dunham v. Wright*, 423 F.2d 940, 941-42 (3d Cir. 1970); *Sard*, 379 A.2d at 1022. "[T]he physician's duty to disclose is suspended where an emergency of such gravity and urgency exists that it is impractical to obtain the patient's consent." *Id.*

Other exceptions to the consent requirement have been recognized. As the *Sard* court put it, "We stress that a physician is not burdened with the duty of divulging all risks, but only those which are material . . . Even then, the physician retains a qualified privilege to withhold information on therapeutic grounds . . ." *Id.* Exceptions have been recognized in the following situations: (1) where the physician determines that candid disclosure would be detrimental to the patient's physical or psychological well-being; (2) where the patient is incapable of giving consent because of mental incapacity or infancy; (3) where the patient has requested that he not be told of risks; (4) where an emergency exists; (5) where the risk is known to the patient or is so obvious as to justify presumption of knowledge; (6) where there exists a relatively remote risk in performing a common procedure, but it is common knowledge that such inherent risk has only a low incidence; and (7) where the physician does not know of a risk and, in the exercise of ordinary care, he should not have been aware of it. *Id.* at 1022-23.

96. 211 N.Y. 125, 105 N.E. 92 (1914).

97. *Id.* at 129-30, 105 N.E. at 93; See *Sard*, 379 A.2d at 1019; *Karp v. Cooley*, 493 F.2d 408, 419 (5th Cir. 1974), cert. denied, 419 U.S. 845 (1974); *Dunham v. Wright*, 423 F.2d 940, 942, n.1 (3d Cir. 1970).

tion, or consent, a physician cannot give treatment.⁹⁸

Mohr v. Williams,⁹⁹ a 1905 Minnesota case, is also illustrative of the consent doctrine. In that case, the plaintiff, Anna Mohr, had consented to an operation on her right ear.¹⁰⁰ When, in the course of treatment, the physician determined that her left ear actually needed the treatment, he operated on the left ear instead.¹⁰¹ Despite the fact that the operation on the left ear was done with the proper degree of skill and care, the Minnesota court found for plaintiff Mohr, holding that the physician should have gotten plaintiff's consent for the work on the left ear.¹⁰² Express consent to the particular procedure was necessary.¹⁰³ Once consent is given, a physician is authorized, through a contractual theory, to "operate to the extent of the consent given, but no further."¹⁰⁴ Because the defendant physician had exceeded the bounds of his patient's consent, the physician was liable to his patient for wrongful assault and battery.¹⁰⁵

The phrase used in *Mohr* to limit authorized treatment "to the extent of the consent given, but no further"¹⁰⁶ raises questions about the scope of consent necessary to constitute valid authorization. What, exactly, has a patient consented to? Is his consent invalid if it is uninformed? If so, how much information does he need for the consent to be "informed" and, therefore, valid?

In answering these questions, courts have focused on the bottom-line notions that support the consent doctrine: patient autonomy, contractual obligations, and fiduciary principles.¹⁰⁷ Generally, courts will find valid consent only where disclosure has been made about the patient's options, risks, and the relative odds of success of the proposed treatment.¹⁰⁸ As the Court

98. *Schloendorff*, 211 N.Y. at 129-30, 105 N.E. at 93.

99. 104 N.W. 12 (Minn. 1905).

100. *Id.* at 13.

101. *Id.*

102. *Id.* at 14.

103. *Id.*

104. *Id.* at 15.

105. *Id.* at 16.

106. *Id.* at 15 (emphasis added).

107. See *infra* notes 97-98, 110-18 and accompanying text.

108. *Karp v. Cooley*, 493 F.2d 408, 419 (5th Cir. 1974) (citing *Scott v. Wilson*, 396 S.W.2d 532 (Tex. Civ. App. 1965), *aff'd*, 412 S.W.2d 299, 301 (Tex. 1967)). See also *Sard*,

of Appeals for the Fifth Circuit stated, "True consent to what happens to one's self is the informed exercise of choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each."¹⁰⁹ What has developed is the modern doctrine of informed consent.

In addition to the notions of individual autonomy, which underlie Cardozo's decision in *Schloendorff*, the doctrine of informed consent has been further justified by courts that focus on the "contractual" nature, or the "fiducial quality," of the physician-patient relationship.¹¹⁰ According to this line of reasoning, "the contract authorizing surgical procedure [does] not authorize operations 'involving risks and results not contemplated.'"¹¹¹ The Supreme Court of Pennsylvania discussed the contractual nature of the relationship in *Gray v. Grunnagle*,¹¹² where the court embraced the views asserted by Robert E. Powell in an article entitled, *Consent to Operative Procedures*.¹¹³ The court quoted Powell, as follows:

In order to understand the nature of consent it is necessary at the outset to have some understanding of the legal relationship between the physician and his patient. This relationship is essentially contractual in nature More often than not the contract is raised by implication from the dealings between the parties, and in a like manner the acts to be performed by the parties are impliedly defined In short, the surgeon must operate in accordance with the agreement made between the parties. Consent for the operation or treatment arises from the contract and is

379 A.2d at 1020.

If a patient's decision is to be a knowing and intelligent one, he must understand in addition to the risks of the suggested surgery, the possible results of the failure to chance it. A complete understanding of the consequences of foregoing the operation would seem necessarily to include a consideration of the alternative treatment for the patient's disease or condition.

Dunham v. Wright, 423 F.2d 940, 944 (3rd Cir. 1970) (footnote omitted).

109. *Karp*, 493 F.2d at 419 (footnote omitted). See also *Dunham*, 423 F.2d at 945 (citing *Gray v. Grunnagle*, 223 A.2d 663, 674 (Pa. 1966)).

110. *Sard*, 379 A.2d at 1019-1020 (citing *Miller v. Kennedy*, 522 P.2d 852, 860 (Wash. 1974), *aff'd per curiam*, 530 P.2d 334 (Wash. 1975); *Woods v. Brumlop*, 377 P.2d 520, 524 (N.M. 1962)).

111. *Dunham*, 423 F.2d at 944, n.6 (quoting *Wall v. Brim*, 138 F.2d 478, 481 (5th Cir. 1943)).

112. 223 A.2d 663, 669 (Pa. 1966).

113. 21 Md. L. Rev. 189 (1961).

given only in connection with what the parties understood was to be done¹¹⁴

In line with the reasoning in *Gray*, four years later the Federal Court of Appeals for the Third Circuit, concluded, "it is not the prerogative of the physician to keep secret and screen out any of the possible complications of surgery."¹¹⁵

Finally, the consent doctrine recognizes that most patients, untrained in the medical field, are not aware of the benefits and risks posed by various forms of treatment.¹¹⁶ In most cases, the patient relies on his physician for the information on which he bases his decision to undergo or forego treatment.¹¹⁷ "Because of the unequal distribution of knowledge between professionals on the one hand and patients . . . on the other, the principle of respect for autonomy entails that professionals have a prima facie obligation to disclose information, to ensure understanding and voluntariness, and to foster adequate decision making."¹¹⁸

The controversy about how much information is enough to support a valid patient consent has spawned two alternate standards for determining the proper scope of disclosure — the professional and the lay standards.¹¹⁹ The professional standard, the older of the two, allows the medical community to define the standards as to what information should be passed on to patients.¹²⁰ According to this view, the doctor's "duty to inform is akin to his standard of competence, that is, measured by the medical standards and customs in the community."¹²¹ This standard, therefore, "compels a physician to disclose facts which a reasonable medical practitioner in a similar community and of the same school or medical thought would have disclosed to his

114. *Gray*, 223 A.2d at 669 (quoting Powell, *supra* note 63, at 191) (footnote omitted in original).

115. *Dunham*, 423 F.2d at 944-45 (footnote omitted).

116. *See Sard*, 379 A.2d at 1020 (citing *Cobbs v. Grant*, 502 P.2d 1, 9 (Cal. 1972)).

117. *Id.*

118. TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 73 (3rd ed. 1989).

119. *See, e.g., Scott v. Bradford*, 606 P.2d 554, 557-59 (Okla. 1980) (comparing the two approaches).

120. *See, e.g., Small v. Gifford Memorial Hospital*, 349 A.2d 703, 705 (Vt. 1975); *Starnes v. Taylor*, 158 S.E.2d 339 (N.C. 1968); *Roberts v. Young*, 119 N.W.2d 627 (Mich. 1963); *Aiken v. Clary*, 396 S.W.2d 668 (Mo. 1965).

121. *Small*, 349 A.2d at 705.

patient regarding the proposed treatment."¹²² Under this view, in order to show a breach of the duty to disclose, a patient must produce expert medical testimony to show that a defendant doctor's disclosures did not conform with the accepted customs and practices of the local medical community.¹²³

The newer alternative, the lay standard,¹²⁴ does not focus on what the medical community deems appropriate disclosure; instead, its emphasis is on the level of disclosure which the patient would find necessary to his ability to make an intelligent choice.¹²⁵ Thus, the inquiry is into what information the doctor knew (or should have known) his patient, as a reasonable layperson, would want to know before making his decision.¹²⁶

Proponents of the professional standard argue that physicians cannot be held to a *lay* or *general* standard of care because a lay standard would mandate a broader scope of disclosure, and this would interfere with the "flexibility" a physician requires to best suit his patient's needs.¹²⁷ However, this older professional standard has met an increasing barrage of criticism.¹²⁸ Many courts have discarded the professional standard for the general or lay standard.¹²⁹ For example, in *Sard v. Hardy*,¹³⁰ the Mary-

122. *Karp*, 493 F.2d at 419 n.11.

123. See *Sard*, 379 A.2d at 1021; *Karp*, 493 F.2d at 420; *Small*, 349 A.2d at 705.

124. The lay standard has also been called the "reasonable person standard," because the "determination of informational needs is shifted from the physician to the patient . . ." BEAUCHAMP & CHILDRESS, *supra* note 118, at 89. Under this standard, the reference is "to a hypothetical reasonable person." *Id.*

125. See, e.g., *Scott v. Bradford*, 606 P.2d 554, 558 (Okla. 1980).

126. See, e.g., *Sard*, 379 A.2d at 1021-22; *Small*, 349 A.2d at 705; *Karp*, 493 F.2d at 419, n.11 (citing *Canterbury v. Spence*, 464 F.2d 772 (U.S. App. D.C. 1972), *cert. denied*, 409 U.S. 1064 (1972); *Riedinger v. Colburn*, 361 F. Supp. 1073, 1076-77 (D. Idaho 1973) (citing *Cobbs v. Grant*, 502 P.2d 1 (Cal. 1972)).

127. Compare *Ross v. Hodges*, 234 So. 2d 905, 909-910 (Miss. 1970) (discussing a surgeon's concern for the "best possible treatment" of illness, not preparation for "defense of a possible lawsuit") with *Butler v. Berkeley*, 213 S.E.2d 571, 581-82 (N.C. 1975) (emphasizing that the fear of lawsuit under lay standard would render the doctor unable to "give the best interest of his patient primary importance").

128. BEAUCHAMP & CHILDRESS, *supra* note 118, at 88. "Although many legal jurisdictions in the United States have retained the more traditional professional practice standard, the reasonable person standard [or lay standard] has gained acceptance in perhaps 60 percent of the states in the United States." *Id.*

129. *Sard*, 379 A.2d at 1021 (citing *Canterbury v. Spence*, 464 F.2d 772, 785 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972)); *Wilkinson v. Vesey*, 295 A.2d 676, 688 (R.I. 1972); *Miller v. Kennedy*, 522 P.2d 852 (Wash. 1974), *aff'd per curiam*, 530 P.2d 334 (1975); *Scaria v. St. Paul Fire & Marine Ins. Co.*, 227 N.W.2d at 653 (1974)). See also

land Court of Appeals joined what it called "an ever-expanding number of courts" that declined to accept the older view.¹³¹ In doing so, the court stated:

These decisions recognize that protection of the *patient's fundamental right of physical self-determination* — the very cornerstone of the informed consent doctrine — mandates that the scope of a physician's duty to disclose therapeutic risks and alternatives be governed by the patient's informational needs. Thus, the appropriate test is not what the physician in the exercise of his medical judgment thinks a patient should know before acquiescing in a proposed course of treatment; rather, the focus is on what data the patient requires in order to make an intelligent decision.¹³²

The professional standard has been criticized because it seems to contradict the basic notions of the consent doctrine — namely, the right of the individual patient to make his *own* choices about which risks he is willing to face.¹³³ For instance, the *Sard* court contended,

It is indeed questionable whether a professional standard of disclosure can be said to exist at all. But even where it may exist, it is apt to be so vague and nebulous as to endow the medical community with virtually absolute discretion in fixing the standard for adequate disclosure As the California Supreme Court stated in *Cobbs v. Grant*: "Unlimited discretion in the physician is irreconcilable with the basic right of the patient to make the

BEAUCHAMP & CHILDRESS, *supra* note 118, at 88.

130. 379 A.2d 1014 (Md. 1977).

131. *Id.* at 1021. One article focused on this new, "sharpened" concept of "informed consent":

Starting with the proposition that physicians must seek and secure the patient's consent before commencing treatment — a reflection of the fundamental ethical principle of autonomy — courts have inquired into the standards for determining whether consent was properly obtained. This inquiry has given rise to the rule in a number of state courts that the adequacy of consent should be determined from the viewpoint of the reasonable patient rather than from that of prevailing medical practice.

Sheila Jasanoff, *Biology and the Bill of Rights: Can Science Reframe the Constitution?*, 13 AM. J. L. AND MED. 249, 258 (1987) (citations omitted).

132. *Sard*, 379 A.2d at 1021.

133. BEAUCHAMP & CHILDRESS, *supra* note 118, at 88. "Perhaps the chief objection to the professional practice standard is that it can undermine the patient's right of autonomous choice, which is the primary function and justification of rules of informed consent." *Id.*

ultimate informed decision regarding the course of treatment to which he knowledgeably consents to be subjected."¹³⁴

The newer view, the lay standard, takes into account (and protects the patient from) what some courts have called a potential "conspiracy of silence" among the members of the medical community.¹³⁵ The courts have recognized the possibility that, unless it is held to a general standard of care, the medical community might be inclined to protect its own by testifying only to a very narrow scope of "customary" disclosure.¹³⁶ "Under that standard, earlier decisions seemed to perpetuate medical paternalism by giving the profession sweeping authority to decide unilaterally what is in the patient's best interests."¹³⁷ The consequence of the old rule is that many cases fail because plaintiffs often cannot present a prima facie case that the doctors deviated from medical custom.¹³⁸ "As a rule, it is . . . [criticized] because it lets the medical profession set its own standards for informing patients."¹³⁹

Even under the lay standard, questions remained as to exactly how much information was "enough" for the "reasonable" patient to make an "intelligent" decision. This, too, raised debate; but the consensus appears to be that an intelligent decision requires disclosure of all of the "material" facts.¹⁴⁰ "Materiality" has been variously defined by the courts.¹⁴¹ In all of the defini-

134. *Sard*, 379 A.2d at 1021 (quoting *Cobbs v. Grant*, 502 P.2d 1, 10 (Cal. Sup. Ct. 1972)).

135. See, e.g., *Cooper v. Roberts*, 286 A.2d 647, 650 (Pa. 1971).

136. E.g., *Wilkinson v. Vesey*, 295 A.2d 676, 687 (R.I. 1972) (discussing the reluctance of physician experts to jeopardize malpractice insurance when testifying).

137. *Scott*, 606 P.2d at 557.

138. *Small*, 349 A.2d at 705.

139. *Id.*

140. See, e.g., *Sard*, 379 A.2d 1014, 1022 (1977); *Small*, 349 A.2d 703, 706 (Vt. 1975); *Riedinger v. Colburn*, 361 F.Supp. 1073, 1076-77 (D. Idaho 1973); *Wilkinson v. Vesey*, 295 A.2d 676, 689 (R.I. 1972); *Cobbs v. Grant*, 502 P.2d 1, 11 (Ca. 1972); *Getchell v. Mansfield*, 489 P.2d 953, 956 (1971); See also *Waltz & Scheuneman, Informed Consent to Therapy*, 64 Nw. U.L. Rev. 628, 640 (1970) (concluding that the doctrine of informed consent will force the physician to behave as both a reasonable doctor and a reasonable man).

141. See, e.g., *Scott*, 606 P.2d at 558 ("What is reasonable disclosure in one instance may not be reasonable in another . . . [F]ull disclosure of all *material risks* incident to treatment must be made. *There is no bright line separating the material from the immaterial*; it is a question of fact. *A risk is material if it would be likely to affect patient's decision.*") (emphasis added).

tions, though, "materiality" is generally understood to mean information that a "physician knows or ought to know would be significant to a reasonable person in the patient's position in deciding whether or not to submit to a particular medical treatment."¹⁴² In other words, "when a reasonable person in the patient's position probably would attach significance to the specific risk in deciding on treatment, the risk is material and must be disclosed."¹⁴³ The general standard of reference is, therefore, one of *reasonableness*, and not of medical custom.¹⁴⁴

There are some courts, however, that have declined to embrace fully either of the two standards — professional or lay.¹⁴⁵ Rather, these courts have chosen to fashion a compromise approach, pulling something from each. For instance, in *Riedinger v. Colburn*,¹⁴⁶ a federal district court in Idaho analyzed and accepted the Supreme Court of California's approach to the scope of disclosure issue, as expressed in *Cobbs v. Grant*.¹⁴⁷ *Riedinger* explored what the California court had termed a "duty of reasonable disclosure."¹⁴⁸ The professional standard of care was considered too broad because "[t]he *Cobbs* court [recognized] the inherent impropriety in permitting the medical profession to make what may be a patient's non-medical decision . . ."¹⁴⁹ Yet, full disclosure of *every* conceivable risk — such as risks that would not threaten death or serious bodily harm — was likewise found to be impractical.¹⁵⁰

The solution the *Cobbs* court prescribed was as follows: where a complicated surgical process is to be performed, a doctor must, *at a minimum*, make his patient aware of any and all known risks which could potentially cause death or serious bodily harm.¹⁵¹ Beyond that minimum warning, a doctor has a duty to follow the community standards and reveal "such additional

142. *Sard*, 379 A.2d at 1022.

143. *Miller v. Kennedy*, 522 P.2d 852, 863 (Wash. 1974), *aff'd per curiam*, 530 P.2d 334 (Wash. 1975).

144. *Sard*, 379 A.2d at 1022 (1977).

145. *See supra* notes 117-123 and accompanying text.

146. 361 F. Supp. 1073 (D. Idaho 1973).

147. 502 P.2d 1 (Ca. 1972).

148. *Id.* at 10.

149. *Riedinger*, 361 F. Supp. at 1076.

150. *Id.* at 1076-77.

151. *Id.* at 1077.

information as a skilled practitioner of good standing would provide under similar circumstances."¹⁵² Essentially, then, the *Riedinger - Cobbs* solution is a hybrid, or an aggregate of the two more extreme views. Presumably, even under this compromise solution — the *Cobbs* hybrid formula — the risk of transmission of HIV would have to be disclosed to patients, given the current lack of a cure for the virus. It is a risk which could potentially cause death or serious bodily harm.

In a recent New Jersey case, *Estate of Behringer v. The Medical Center at Princeton*,¹⁵³ a Superior Court judge focused on the implications of the doctrine of informed consent for an HIV-infected HCW.¹⁵⁴ The judge upheld the actions of the Medical Center at Princeton, which suspended the surgical privileges of Dr. William Behringer, an ear, nose, and throat specialist who practiced at the Center until 1987, when he was found to have AIDS.¹⁵⁵ The judge wrote, "The ultimate risk to the patient is so absolute, so devastating, that it is untenable to argue against informed consent combined with a restriction on procedures which present 'any risk' to the patient."¹⁵⁶ He also noted, "If there is to be an ultimate arbiter of whether the patient is to be treated invasively by an AIDS-positive surgeon, the arbiter will be the *fully informed patient*."¹⁵⁷ *Behringer* evinces New Jersey's adherence to the lay standard in informed consent dilemmas.

D. Current CDC Guidelines and Recent Federal Legislative Efforts

With the July, 1990 CDC report of the Acer-Bergalis case,¹⁵⁸ the eyes and ears of the public and of the health care community were on the federal government — the former looking for quick and decisive reform that would prevent a recurrence, and the latter cringing with the apprehension of a legislative response that could potentially restrict the practices of individual HCWs. In turn, the federal government essentially turned *its*

152. *Id.* at 1076-77 (quoting *Cobbs*, 502 P.2d at 11).

153. 592 A.2d 1251 (N.J. 1991).

154. *Id.* at 1254.

155. *Id.* at 1283.

156. *Id.*

157. *Id.* (emphasis added).

158. See *supra* notes 6, 70-84 and accompanying text.

eyes and ears for guidance to its health experts in the CDC. In July 1991, the CDC promulgated guidelines,¹⁵⁹ which were quickly faced with the strong criticism of medical societies and interest groups.¹⁶⁰ The guidelines suggested the following: (1) that HCWs volunteer, on an individual basis, to be tested for HIV; (2) that the HCW who has volunteered and who subsequently learns he or she is seropositive must obtain the informed consent of his or her patients before performing certain invasive procedures; (3) that the seropositive HCW refrain from performing certain "exposure-prone" procedures; (4) that the states establish local medical advisory boards in health care facilities, whose function it would be to review, on a case by case basis, the practice, health, and capacity of individual HIV-positive health care employees and to assess what, if any, additional limitations should be placed on the HCW's patient contacts; and (5) that the medical and dental boards in the states compile a listing of the specific invasive procedures which, by their nature, are deemed to be "exposure prone," or pose a higher risk of HIV exposure to the patient.¹⁶¹ These riskier procedures would be off-limits to those HCWs who are aware of their seropositive status.¹⁶²

The significance of the July CDC guidelines was elevated, at least for a time, by Congressional legislation.¹⁶³ Congress voted into law a requirement that each of the 50 states adopt the CDC guidelines as state law or implement a "comparable" or "equivalent" plan (which would require the endorsement of the head of the CDC) if the state wishes to receive certain federal

159. CDC, *Recommendations for Preventing Transmission of Human Immunodeficiency Virus, Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures*, 266 JAMA 771, 774-76 (1991) [hereinafter *CDC Recommendations*]. The July guidelines are, however, currently under reformulation, due to the protests of organized medicine against the CDC's July guidelines. See Lawrence K. Altman, *U.S. Backs Off on Plan to Restrict Health Workers with AIDS Virus*, N.Y. TIMES, December 3, 1991, at A1; B.D. Colen, *Limits Dropped on HIV Doctors*, NEWSDAY (Nassau), December 5, 1991, at 145. As of the date of this writing, the new guidelines are still in draft and have not been publicly introduced. *Id.*

160. See Laurie Garrett, *Docs Confront Feds on AIDS Rules*, NEWSDAY (City), November 4, 1991, at 15. See also *infra* notes 169-173 and accompanying text.

161. CDC *Recommendations*, *supra* note 159, at 775.

162. *Id.*

163. § 633, "Treasury, Postal Service and General Government Appropriations Act, 1992," 102 P.L. 141, 1991 H.R. 2622, 105 Stat. 834, 102d Cong. (Oct. 28, 1991).

assistance.¹⁶⁴

This wording is somewhat vague, and has allowed for flexible interpretation.¹⁶⁵ Some states, urged by medical groups and AIDS activists, were quick to take advantage of this.¹⁶⁶ "Having failed to dissuade Congress from passing such legislation, AIDS activists and the nation's leading medical societies have shifted their hopes to narrowly defining 'exposure-prone procedures' and 'equivalent programs,' in the hopes that the law can be implemented with minimal restrictions on medical professionals."¹⁶⁷ For instance, as early as October 8, 1991, New York State announced its intention to refuse to draw up a list of "risk-prone" procedures, arguing that its plan for standard hygienic and safety precautions would suffice to control the spread of HIV.¹⁶⁸ Michigan and California followed suit, and other states were reported to be considering the New York plan.¹⁶⁹

What has resulted has been several months of battles and, eventually, compromise between officials at the CDC and representatives of organized medicine.¹⁷⁰ As of the date of this writing, the CDC, "overwhelmed" by the protests of organized medicine, is revamping its July guidelines.¹⁷¹ The CDC apparently intends to strike the requirement for lists of "exposure-

164. *Id.* Section 633 provides, in part: "[E]ach State Public Health Official shall, not later than one year after the date of enactment of this Act, certify to the Secretary of Health and Human Services that guidelines issued by the Centers for Disease Control, or guidelines which are *equivalent* to those promulgated by the Centers for Disease Control concerning recommendations for preventing the transmission of the human immunodeficiency virus and the hepatitis B virus during exposure prone invasive procedures, except for emergency situations when the patient's life or limb is in danger, have been instituted in the State." *Id.* (emphasis added).

165. See, e.g., Kevin Sack, *Albany Plans to Allow Surgery by Doctors With the AIDS Virus*, N.Y. TIMES, Oct. 9, 1991, at 1. "[T]he definition of equivalency was left vague, and apparently will be determined by the director of the Centers for Disease Control, said Jeffrey Levi, director of governmental affairs for the AIDS Action Council in Washington." *Id.*

166. See Garrett, *supra* note 160, at 15.

167. *Id.* at 15.

168. *Id.*

169. *Id.*

170. See *infra* notes 172-75.

171. Altman, *supra* note 148. The revised guidelines will have to be approved by Dr. Louis W. Sullivan, the Secretary of Health and Human Services, who had approved the July guidelines. *Id.*

prone" invasive procedures¹⁷² and focus, instead, upon case-by-case analysis of infected workers.¹⁷³ This new focus represents a weakening of the CDC's stance, which leaves the HIV-infected HCW relatively unscathed because it permits subjective application.¹⁷⁴ As one writer put it, "[a]fter coming under attack from most of organized medicine and the AIDS community, the [CDC] has reversed its position and decided to place *virtually no limitations* on the medical practice of HIV-infected health care professionals."¹⁷⁵

While the new guidelines, when formally announced, will most likely appease those who would leave unrestricted the HIV-infected HCW,¹⁷⁶ "[i]t is not immediately clear what effect, if any, the agency's action will have on legislative efforts to limit the practice of infected health workers."¹⁷⁷ Notably, Mr. Mike Franc, legislative counsel to Representative William Dannemeyer,¹⁷⁸ was reported as saying that the new version of the guidelines will be so vague that infected HCWs "can go ahead and do whatever they want."¹⁷⁹ According to Franc, the CDC's re-drafting will now "allow Mr. Dannemeyer and those who would support a mandatory testing approach to argue that what is needed is a system that is going to *guarantee* that those who are infected are accountable to their patients and the local panels."¹⁸⁰

Not surprisingly, on January 5, 1992, Mr. Dannemeyer and a number of his fellow representatives¹⁸¹ re-sponsored a bill to

172. See *supra* note 162 and accompanying text.

173. Altman, *supra* note 159; see also Colen, *supra* note 159, at 145.

174. Colen, *supra* note 159, at 145.

175. *Id.* (emphasis added).

176. For instance, Jeff Levi, Government Affairs Director of a Washington lobby group, the AIDS Action Council, was pleased with the CDC changes and was quoted as saying, "I think what it means is the CDC is finally letting science, rather than politics, drive their policy making." Colen, *supra* note 159, at 145.

177. Altman, *supra* note 159, at A1.

178. Representative Dannemeyer (R.-Cal.) is an advocate of mandatory testing for doctors. Colen, *supra* note 159. Dannemeyer is the sponsor of a bill currently before Congress, which addresses the risk of HIV transmission in the health care setting. For a more complete discussion of the bill, see *infra* notes 181-87 and accompanying text.

179. Colen, *supra* note 159.

180. *Id.* (emphasis added). See *infra* notes 181-87 and accompanying text.

181. Mr. Dannemeyer, for himself, Mr. Bliley, Mr. Holloway, Mr. Barton of Texas, Mr. Dornan of California, Mr. Inhofe, Mr. Lagomarsino, and Mr. Burton of Indiana,

be known as the "Kimberly Bergalis Patient and Health Provider Protection Act of 1991."¹⁸² The bill, portions of which are reproduced in the footnote below,¹⁸³ states as its purpose,

introduced the bill, which was referred to the Committee on Energy and Commerce. Additional Sponsors were: Mr. Rohrabacher, Mr. Lewis of Florida, Mr. Doolittle, Mr. Taylor of North Carolina, Mr. Myers of Indiana, Mr. Riggs, Mr. Hancock, Mr. Hyde, Mr. Fawell, Mr. Delay Mr. Arney, Mr. Herger, Mrs. Bentley, Mr. Cunningham, Mr. Packard, Mr. Duncan, Mr. Hunter, Mr. Dickinson, Mr. Fields, and Mr. Crane. H.R. 2788, 102d Cong., 1st Sess. (1991).

182. The bill, Version 2, as re-sponsored on January 5, 1992, is to be cited as the "Kimberly Bergalis Patient and Health Provider Protection Act of 1991." It was introduced originally on June 26, 1991 in the House of Representatives, 102d Cong., 1st Sess.

183. The following are excerpted portions of 1992 H.R. 2788, Version 2, dated January 5, 1992:

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

This Act may be cited as the "Kimberly Bergalis Patient and Health Provider Protection Act of 1991".

TITLE I-AMENDMENTS TO PUBLIC HEALTH SERVICE ACT REGARDING CERTAIN COMMUNICABLE DISEASES AMONG HEALTH CARE PROVIDERS AND PATIENTS

SEC. 101. ESTABLISHMENT IN TITLE XXVI IN PROGRAM FOR EARLY INTERVENTION SERVICES.

Subpart I of part C of title XXVI of the Public Health Service Act (42 U.S.C. 300ff-41 et seq.), as added by section 301(a) of Public Law 101-381 (104 Stat. 597), is amended by inserting after section 2648 the following new sections:

"SEC. 2648A. PROTECTION OF PATIENTS FROM HEALTH CARE PROVIDERS WITH CERTAIN COMMUNICABLE DISEASES.

"(a) LIST OF RELEVANT DISEASES AND MEDICAL PROCEDURES.-For purposes of the requirement established in subsection (b) regarding the receipt by a State of a grant under section 2641, the Secretary-

"(1) shall establish a list identifying each communicable disease that poses a risk to the public health (which list shall include HIV disease and hepatitis B, subject to subsection (d)(3));

"(2) in the case of each disease included on the list, shall specify (as a component of the list) the medical and dental procedures that a health care provider with such a disease should be prohibited from performing on the basis that performing the procedure on an individual would pose a risk of the transmission of the disease from the health care provider to the individual;

"(3) in the case of any medical or dental procedure specified for purposes of paragraph (2), shall specify (as a component of the list) the particular health professions and allied health professions whose practitioners perform the procedure;

"(4) in the case of a health care provider who performs any medical or dental procedure specified for purposes of paragraph (2), shall specify (as a component of the list) the frequency of testing for each of such diseases that the provider should undergo for purposes of protecting the public health . . .

"(b) REQUIREMENTS REGARDING PROTECTION FROM RELEVANT DISEASES.-Subject to subsection (f), for fiscal year 1992 and subsequent fiscal years, the Secretary may not make a grant under section 2641 to a State for a fiscal year unless-

To amend title XXVI of the Public Health Service Act to provide for the establishment of protections against certain communicable diseases for both health care providers and the patients of such providers, and to provide for certain forms of assistance for such providers and patients.¹⁸⁴

The portions of the bill which are highlighted represent the sponsors' hopes to establish a more uniform, "bright line" rule for dealing with HIV-infection in the health care setting.¹⁸⁵ While the bill is pending before the House Energy and Commerce Committee¹⁸⁶ and its future is as yet uncertain, it is surely representative of the "other side of the coin" — the argument that the CDC guidelines are not unduly restrictive, but in fact they are *not restrictive enough* to meet the threat.¹⁸⁷

"(1) in the case of any health care provider who performs any medical or dental procedure included on the list under subsection (a) (as in effect for the fiscal year)-

"(A) *the State requires that each such provider undergo testing for each disease with respect to which the procedure is so included; and*

"(B) *the State requires each such provider to undergo the testing as frequently as necessary to be in compliance with the applicable recommendation included on the list pursuant to paragraph (4) of such subsection;*

"(2) in the case of any health care provider determined through testing pursuant to paragraph (1) to have any such disease-

"(A) *the State prohibits the provider from performing the medical or dental procedure involved for the duration of the disease, except in circumstances in which the provider-*

"(i) *informs the patient involved that the provider has the disease;*

"(ii) *informs the patient of the risk posed by the disease in the context of the procedure; and*

"(iii) *obtains the written consent of the patient for the provider to perform the procedure notwithstanding such risk; . . .*

"(3) **HIV DISEASE AND HEPATITIS.**-*HIV disease and hepatitis B shall each be considered to be a communicable disease that poses a risk to the public health for purposes of the list required under subsection (a), as in effect for each of the fiscal years 1992 through 1994. . . .*

H.R. 2788, 102d Cong., 1st Sess. (1991) (emphasis added).

184. H.R. 2788, 102d Cong., 1st Sess. (1991).

185. See *supra* note 180 and accompanying text.

186. Referred to the House Energy and Commerce Committee on June 26, 1991. 137 Cong. Rec. H 5209. (Lexis Legis library; Billtracking file).

187. See *supra* notes 179-80 and accompanying text.

E. *The Polarization of Views*

Both the CDC's guidelines of July, 1991 and the legislative efforts since that date have taken their share of criticism.¹⁸⁸ Some critics deem the CDC's July guidelines and federal law overly intrusive and restrictive.¹⁸⁹ This view is generally championed by staunch civil libertarians and by much of the medical community. Their criticisms include the following: (1) that the CDC and the Congress are acting only to pacify an hysterical and uninformed public;¹⁹⁰ (2) that the seropositive HCWs should not be forced, in the name of public health, to disclose the small risk of infection since the Acer cases¹⁹¹ are the only documented cases of HCW to patient transmissions;¹⁹² (3) that restrictions on the practices of seropositive HCWs will discourage healthy HCWs from treating seropositive patients, for fear that they, too, will be infected and then lose their livelihoods;¹⁹³ (4) that attempts to restrict the rights of seropositive individuals are fueled only by long-standing contempt for homosexuals, who make up the great percentage of AIDS victims;¹⁹⁴ (5) that rigorous application of universal precautions¹⁹⁵ is the best solution to the risk of transmission of HIV in the health care setting;¹⁹⁶ and (6) that a mandatory testing scheme will be ineffective, since the potential time lapse between HIV infection and the appearance of the HIV antibodies could result in false negative test results, which would lull the infected worker into a false sense of security and thereby increase the risk to patients.¹⁹⁷

The contrasting view — that the guidelines and law are in-

188. See, e.g., Garrett, *supra* note 160 (discussing a November 4, 1991 meeting of representatives of the nation's medical and public health organizations, where federal guidelines were deemed "unworkable and overly restrictive").

189. *Id.* at 15.

190. See *infra* notes 205-09 and accompanying text.

191. See *supra* notes 6, 70-84 and accompanying text.

192. See *infra* note 223 and accompanying text.

193. See *infra* note 227 and accompanying text.

194. See *infra* notes 228-31 and accompanying text.

195. Universal precautions include infection control procedures such as appropriate hand washing, appropriate use and disposal of needles and other sharp instruments, including proper disinfectant and sterilization. CDC, *Recommendations*, *supra* note 159, at 774-76.

196. See *infra* note 240 and accompanying text.

197. See *infra* notes 252-53 and accompanying text.

sufficient to address the threat — is generally held by those who believe the potential of transmission is more real and serious than the health care community and civil rights activists would have us believe.¹⁹⁸ While recognizing that the July guidelines and the federal legislative efforts are steps in the right direction, these critics find: (1) that the CDC should not be inhibited by the admittedly small number of documented HCW to patient transmissions because the scientific reality of the risk is undeniable and transmission is likely to occur again;¹⁹⁹ (2) that, given the undeniable gaps in science's understanding of the HIV virus, the government should err on the side of caution, hoping for the best, but allowing for the worst;²⁰⁰ (3) that so-called "universal precautions" cannot realistically be universally applied and are, therefore, not the answer;²⁰¹ (4) that the interests of the few infected HCWs are *not* paramount to the state interest in public health and the individual patient's interest in making an informed decision about a risk that could prove to be deadly;²⁰² (5) that the medical community's denial of the risk of transmission is to be taken with a grain of salt, in light of the fact that an admission of risk would be counter to the interests and autonomy of the medical community;²⁰³ and (6) that the CDC's advocacy of voluntary testing is an idealistic, but unrealistic solution, as those individuals who know they are in a "high risk" category will be the least inclined to volunteer if restrictions are placed only on those who have tested positively.²⁰⁴

III. Analysis

A. *Proposals to Restrict: Hysteria or Reasoned Responses?*

Opponents to proposals to restrict the practices of seropositive HCWS or to require the patient's informed consent for invasive procedures²⁰⁵ argue that the public's fear of AIDS is irra-

198. See *infra* text accompanying notes 199-204.

199. See *infra* notes 213-14 and accompanying text.

200. See *infra* note 212 and accompanying text.

201. See *infra* notes 241-50 and accompanying text.

202. See *infra* notes 253-57 and accompanying text.

203. See *infra* notes 265-67 and accompanying text.

204. See *infra* note 235 and accompanying text.

205. See, e.g., Eileen Hansen & Tom Steel, *The Politics of Hysteria*, TEXAS LAWYERS 18 (October 28, 1991). "[E]nforced disclosure and notification of patients is not

tional and uneducated.²⁰⁶ These opponents argue that the significance the public would attach to the risk would therefore be disproportionate to the actual risk.²⁰⁷ They feel that, in addressing the HIV issues in health care, the legislatures and the CDC have been guided by public hysteria rather than medical knowledge.²⁰⁸ They believe the legislatures' various proposals to restrict practices or require consent have merely been unrealistic, unfounded attempts to satisfy the public's desire to see something done.²⁰⁹

The medical community has been studying AIDS since the early 1980's, when the first AIDS cases were identified and the so-called "hysteria" began.²¹⁰ Since that time, many advances have been made; but we are not yet out of the woods. There are at least two undisputed things the "experts" do know about HIV and AIDS: (1) the virus may spread where there is blood to blood or mucous membrane contact;²¹¹ and (2) there are still gaps in the scientific community's knowledge of the virus.²¹²

Given the gaps in understanding, charges that the CDC and legislative measures are unfounded and unrealistic are, themselves, unfounded and unrealistic. In a surgery room or a dentist's office, open cuts and spilled blood are commonplace; sharp instruments such as needles, probes, and scalpels are constantly in use on or inside the patient. It requires no special knowledge of science or of AIDS to note these things. The environment is often quite bloody and, especially in an emergency situation, quite hectic. Despite the careful precautions many or most of our hospitals require, gloved hands and masked faces are not al-

necessarily good medicine and, in fact, is generally just the opposite." *Id.*

206. *See id.* "[I]n the summer of 1990, science and reason gave way to panic over reports that a Florida dentist who has since died of AIDS may have infected some of his patients . . . [T]he CDC bowed to public pressure and the tremendous hysteria that has swept this country in the wake of the Florida case and issued new guidelines." *Id.*

207. *See id.* ("Because of the extremely small chance of transmitting the infection, it must be asked whether physicians and hospitals should unduly alarm their patients about a procedure that carries no significant life-threatening risk.")

208. *See id.* One article stated that measures to restrict infected HCWs' practices or to notify patients of their HCW's seropositivity are examples of laws which "bow[] to hysteria and [are] shaped by lawyers and insurers concerned primarily with liability." *Id.*

209. *Id.*

210. *See supra* note 12 and accompanying text.

211. *See supra* note 36 and accompanying text.

212. *See infra* note 217 and accompanying text.

ways impervious to slices or pricks by carelessly handled instruments.²¹³ The chances of blood to blood contact are actually quite realistic.²¹⁴

Opponents have also urged the government to back off the issue, citing the fact that the Acer cases are the only documented cases of HCW to patient transmission.²¹⁵ The government should not be so easily shaken. The low number of documented cases of this type of transmission, while probative of low risk, is not dispositive.²¹⁶ First, it is notable that there are a

213. See Porter, *Management of Patients Treated by Surgeon with HIV Infection*, 335 THE LANCET 113 (Jan. 13, 1990). "Potential risk of transmission of blood-borne infection may be assessed by the risk of glove damage during an operation and the risk of glove laceration depends on the duration of the operation and on whether the procedure involves 'mass wound closure' . . ." *Id.* See also Sanford F. Kuvin, *AIDS Testing: Make it Mandatory*, NEWSDAY, July 19, 1991, (Nassau), at 67. "The measures called for . . . wearing of gloves, masks, gowns and protective eyewear, plus improved infection control, will not guarantee safety in every case. Gloves leak, puncture and rip, and health-care workers will sometimes make careless mistakes." *Id.* For an interesting statistical inquiry into the frequency and various causes of glove tears and injuries caused sharps in the operating room, see James G. Wright et al., *Mechanisms of Glove Tears and Sharp Injuries Among Surgical Personnel*, 266 JAMA 1668 (1991).

214. See, e.g., Frank S. Rhame, *The HIV-Infected Surgeon*, 264 JAMA 507-508 (July 25, 1990). In his article, which was written before the publication of the Acer cases, Rhame noted, "No surgeon-to-patient HIV transmission has been reported, but it is an example of the collective denial that has afflicted past HIV-related deliberations to avoid vigorous consideration of the issue. Hepatitis B virus transmissions from surgeon to patient have occurred; it would be unexpected if HIV transmission does not also occur." *Id.* at 507 (citations omitted).

While Rhame did not anticipate a large number of exposures, he was quite willing to admit the potential risk, especially for invasive procedures. He continued, "Presumably, the exposure rate is strongly influenced by the type of procedure. Ophthalmic surgery should virtually never produce a surgeon-to-patient blood transfer. In contrast, the hepatitis B virus precedent would suggest that vaginal hysterectomy and pelvic surgery are the most hazardous. These procedures involve blind, ie, not directly visualized, by-feel manipulation of sharp instruments in patients' body cavities." *Id.* at 507.

As for appropriate methods of dealing with the HIV infected health care worker, Rhame referred to the policy of the University of Minnesota Hospital, where he worked. He explained, "Surgeons are required to determine their HIV status only if they are at an increased risk of HIV infection. They may undergo testing by whatever means they desire. If HIV infected, they are required to avoid performing surgery that requires blind, by-feel manipulation of sharp instruments. We believe that the probability of an HIV transmission during other types of surgery is so low that no other proscription is warranted." *Id.* at 508.

215. See *infra* note 223.

216. Said one doctor, "[Bergalis] was not the first case of HIV transmission from a health-care worker to a patient — it was the first documented one — using DNA high-technology sequencing tests that fingerprinted her blood with the dentist's." Kuvin,

small percentage of AIDS cases on record with the CDC as having unexplained origins.²¹⁷ While there is no reason to believe any or all of these enigmatic cases are attributable to HCW to patient transmission, it is significant that the medical community has not been able to understand or explain every reported case. Questions remain unanswered. Charges of hysteria and of unreasoned overreaction are misplaced in a research atmosphere that continues to be puzzled by its subject. As one article put it:

Public anxiety will not be alleviated by communications from authorities who suggest that the risk is so small that it is the same as "no" risk or that anyone who is frightened is merely hysterical. Neither will it be alleviated by messages that try to substitute one focus for another, e.g., scrutinizing the infection-control practices of dentists rather than their serological status. These messages appear to be designed to diminish fear, but they try to do so without acknowledging the validity of the fear. Experts must realize that health care professionals' and the public's fear of the acquired immunodeficiency syndrome is real, multifaceted, and quite complex Only a dialogue that respects and attempts to understand the nature of health care professionals' and the public's concerns about the acquired immunodeficiency syndrome will have the possibility of diminishing those concerns.²¹⁸

supra note 202.

217. See, e.g., Bayer, *supra* note 46, at 1768. As of 1986, an estimated 6.6% of the reported AIDS cases were people whose infection was of unknown origin. Bayer, *supra* note 46, at 1768.

218. The excerpt was taken from a reply (written by Barbara Gerbert, Ph.D, et al.) to a letter written by Frances Taylor, Md, MPH, of San Francisco, California. As evidenced by the excerpt, Gerbert and her co-writers were opposed to the way Ms. Taylor had addressed the issue of "public hysteria," implying that increased infection control was the simple solution. While the excerpt conveys the weight Gerbert felt should be accorded to the public's concern about AIDS, Gerbert did not conclude that the public outcry should be all-controlling. Rather, the reply emphasized that a balance had to be struck, weighing both the scientific statistics and the public's legitimate concerns. See Frances Taylor, *The Risk of Transmission of HIV From Health Care Professional to Patient*, 266 JAMA 1935-1936 (October 9, 1991) (citations omitted) (quote taken from comments written by Gerbert in reply to Frances Taylor's letter) [hereinafter, Gerbert Reply].

This point was further emphasized in a different article by Gerbert. The article was written in reply to a letter from Larry Gostin, of the American Society of Law and Medicine, in Boston, Massachusetts. See Larry Gostin, *Physicians and the Acquired Immunodeficiency Syndrome*, 264 JAMA 452-453 (July 25, 1990). In the response, Gerbert wrote:

The "common sense" that Dr Smith attributes to the public's opinion as reported

Furthermore, the actual significance of the low number of reported HCW to patient infections is also questionable. The virus has been known to remain asymptomatic, undetected and, in some cases, undetectable, for weeks, months, or even years.²¹⁹ This dormancy period is vital to the debate, when one considers that the virus only reared its ugly head about a decade ago.²²⁰ Theoretically, then, instances of HCW to patient transmissions may have occurred over the past decade which have yet to be discovered and documented. To make the matter even more interesting, one must consider that if these transmissions did occur, they might have involved people who have no reason to believe that they could have been exposed. This would be especially true of people who had been careful to avoid "high risk" behaviors²²¹ like unsafe sex, promiscuity, or IV drug use. Consequently, these unsuspecting people would be unlikely to be tested for the disease until they had some physical manifestation, and that could be years.²²²

Finally, although some have hung their hats on the low number of cases, arguing that the Acer incidents were a freak,²²³ the potential for infection in the future cannot truly be challenged. As one article noted, the fact that numerous investigations have not resulted in large numbers of transmissions is indeed encouraging; "[h]owever, similarities between the epidemiology of hepatitis B virus and HIV imply a theoretical

in our article is a dangerous guide for public policy Ongoing scientific evaluation of the hazards posed by HIV-infected health care workers should be the main basis of policy in this area Our purpose in publishing data on the concern some members of the public have about this issue was to demonstrate to physicians and policymakers that the public's perception of risk may differ from theirs and to remind them that in formulating policy about HIV-infected health care workers it is necessary to take into account the views of all stakeholders, including patients.

Id. at 453.

219. *See supra* notes 27-31 and accompanying text.

220. *See supra* note 12 and accompanying text.

221. *See supra* note 37 and accompanying text.

222. *See supra* note 28 and accompanying text.

223. *See, e.g.*, Lawrence K. Altman, *Medical Units Lag on AIDS Guidelines*, N.Y. TIMES, August 30, 1991, at A1. According to Dr. M. Roy Schwarz, a vice president of the American Medical Association, roughly 40 medical groups which gathered in Chicago in August of 1991 at an A.M.A. meeting concluded that "the Acer case is bizarre." *Id.* at A19.

risk of HIV transmission from infected HCWs to patients. Transmission of hepatitis B from surgeon to patient has been reported, and in one study an increased risk of transmission with high-risk operations was demonstrated."²²⁴

But we need not only look to scientists. Logic, too, tells us that the risk is real. We know enough about the disease to know that it passes blood to blood. We know enough about dentists, hospitals, and surgery to know there is a lot of blood on hand. We know enough about humans to know that mistakes are made — barriers are improperly made or placed; needles are carelessly capped; sharp instruments are clumsily handled; and infection is unknowingly passed. "[Lay people's] . . . conceptualization of risk is much richer than that of experts and reflects legitimate concerns that are typically omitted from expert risk assessments."²²⁵ As W. Shepherd Smith, Jr., president of Americans for a Sound AIDS Policy stated, "[P]eople in the AIDS community need to understand that a majority of Americans face their greatest risk of acquiring HIV only through blood transfusion and in the health-care setting The least likely mode of transmission overall is, in fact, the most likely mode of transmission for most people."²²⁶

Another objection to restriction proposals or the informed consent requirement runs as follows: seronegative doctors and dentists will refrain from treating seropositive patients, because they will not want to risk losing their livelihoods if they are in-

224. Porter, *supra* note 213, at 114. Hepatitis B is an inflammation of the liver which can cause liver cell damage or death. CHARLES B. CLAYMAN, THE AMERICAN MEDICAL ASSOCIATION HOME MEDICAL ENCYCLOPEDIA, VOL. 1, 532-33 (1989). The condition results from infection by a virus called Hepatitis type B. *Id.* at 533. The virus' modes of transmission are through blood, blood products, and sexual activity — "precisely the same mechanism by which HIV . . . is spread." *Id.* "In a proportion of [type B] cases, the virus persists for years after the initial infection and may lead to a chronic form of hepatitis . . . and eventually to liver cirrhosis and/or liver cancer." *Id.* Hepatitis B is far more infectious than HIV. Bayer, *supra* note 46, at 1772. However, a vaccination against viral hepatitis, type B, is currently available and is recommended to those at high risk of infection — a group which includes HCWs. Clayman, *supra* at 534. The Public Health Service regards hepatitis B as the "paradigm with regard to the transmission of HIV in the health care setting . . . and advises adoption of precautions in all health care settings where there is possible exposure to blood or body fluids." Gostin, *supra* note 13, at 38.

225. Gerbert Reply, *supra* note 218 (citations omitted).

226. Malcolm Gladwell, *Senate Vote Ordering AIDS Disclosure a Setback for Activists*, THE WASHINGTON POST, July 20, 1991, at A8.

fectured by an infected patient.²²⁷ Putting aside notions about the implications of the physicians' vocational oaths and duties to treat, the flaw in this suggestion is quite apparent. It can hardly be suggested that loss of livelihood would serve as a greater deterrent than loss of life. As it stands now, many dedicated doctors and dentists are willing to treat seropositive patients despite the risk of eventual infection and consequent loss of life. It would be strange if these same doctors and dentists would refuse to treat, based upon the unquestionably less severe risk of loss of earnings.

A further criticism of legislation and public outcry in this area comes from gay rights activists, who consider the public's attitudes and the legislative proposals a step backward in their fight against discrimination.²²⁸ Apparently, they fear the CDC guidelines, as drafted, will open the door for unchecked discrimination by hospital and health care administrators against their employees who test positively or who refuse to be tested.²²⁹ Given the high percentage of AIDS victims who are homosexual, many activists consider discrimination against people with AIDS

227. Elizabeth Rosenthal, *Angry Doctors Condemn Plans to Test Them for AIDS*, N.Y. TIMES, August 20, 1991, at C1.

228. Edgar & Sandomire, *supra* note 49, at 160. "The disease's early victims were predominantly gay men, a group collectively defined as deviant by the majority culture. Information that someone had AIDS necessarily revealed their sexual preferences." *Id.*

229. *See id.* Discussing this fear of inequitable treatment of individuals upon disclosure of their seropositivity, one article noted:

The HIV epidemic has made it clear that privacy, like voting, is a right that preserves other rights Secrecy and total anonymity are the only sure ways to protect infected persons against the possibility of state repressive schemes — the kinds of quarantines and tattoo programs mentioned casually in the popular press. Secrecy and anonymity are also the only plausible techniques to protect the sick from private acts of discrimination.

Edgar & Sandomire, *supra* note 49, at 160.

The same article continued, "The gay community rightly feared that disclosure would expose them to vicious private retaliatory actions and that the very existence of such information might facilitate later imposition of quarantines or other restraints." Edgar & Sandomire, *supra* note 49, at 165.

[W]e have plunged down a course where access to timely and appropriate health care will be seriously jeopardized by the potential loss of qualified workers who are unwilling to disclose their HIV status for fear of being discriminated against or fired. The shortage of health care workers is much more dangerous to public health than the remote possibility of HIV transmission by health care worker to patients.

Hansen & Steel, *supra* note 205, at 18.

to be just another means for society to oppress the gay community.²³⁰

In recent years, many people — homosexual and heterosexual — have fought to throw off the prejudice and discrimination based on sexual preference that is embedded in our culture.²³¹ There is no place for such discrimination in a society that strives for equality. And yet, the plight of the homosexual in America, however shameful, should not cause us to back down on a point of public health.

There are at least two flaws in allegations that illegal discrimination will result from efforts to implement a mandatory testing and plan. The first flaw is Constitutional in nature. It is clear that homosexuals make up a large percentage of HIV positive people,²³² and that as a result, legislative action mandating periodic HIV testing and requiring the informed consent of patients would affect more homosexual HCWs than heterosexual HCWs. The *result*, or *effect*, then, may appear to be discriminatory. However, under well established Constitutional jurisprudence, a discriminatory effect would not be fatal to the legislation, because the *intent* — protecting the public health — is not invidiously discriminatory.²³³ If the legislation is grounded in the legitimate interest of the state in protecting the public health, a seemingly discriminatory result should not defeat it.²³⁴

230. See Edgar and Sandomire, *supra* note 49, at n.13, where the author drew a comparison between today's private discrimination against homosexuals and the private injustices of the notorious McCarthy era: "In the McCarthy era . . . the civil liberties violations did not involve the state locking up putative communists, so much as exposing them so that private retaliation could do the work." *Id.*

231. For an interesting discussion of the historical and contemporary oppression of the homosexual community, see Leonard Orland & Sue L. Wise, *The AIDS Epidemic: A Constitutional Conundrum*, 14 HOFSTRA L. REV. 137 (1986).

232. See *supra* note 37 and accompanying text.

233. See *Washington v. Davis*, 426 U.S. 229 (1976), where the Supreme Court referred to "the basic equal protection principle that the invidious quality of a law claimed to be racially discriminatory must ultimately be traced to a racially discriminatory purpose." *Id.* at 240. The Court continued, "we have not held that a law, neutral on its face and serving ends otherwise within the power of government to pursue, is invalid under the Equal Protection Clause simply because it may affect a greater proportion of one race than of another." *Id.* at 242.

234. See, e.g., *Michael M. v. Superior Court*, 450 U.S. 464, 466-71 (1981); *Village of Arlington Heights v. Metropolitan Hous. Dev. Corp.*, 429 U.S. 252, 264-71 (1977) (holding that official action will not be unconstitutional solely because it results in a racially discriminatory impact).

A second flaw inherent in arguments citing the discriminatory impact of mandatory testing plans is more practical. The arguments against mandatory testing plans fail to recognize that state-mandated testing will actually prove to be less discriminatory in the long run than voluntary testing plans. The concept of voluntary testing, which the CDC currently endorses — both in its guidelines of July and in those being drafted at present — will prove to be quite ineffective and, in fact, counterproductive. The probable result of a voluntary scheme will be a decrease in the number of tests taken and an increase in private discriminatory employment practices.

First, there will be a decline in the number of tests taken because HCWs who know they are in “high risk” groups will be discouraged from testing, to avoid the “knowledge” of seropositivity and, thus, avoid the obligation to inform.²³⁵ If, on the other hand, testing is mandatory for all HCWs in certain lines of work, knowledge of seropositivity cannot be avoided. Second, the voluntary testing scheme will foster discriminatory employment practices; for employers who wish to avoid potential civil liability may conduct “witch hunts” if they suspect that certain of their employees are in “high risk” groups. In other words, only those employees whose private lives are known (or, worse yet, rumored) to put them in “high risk” categories will be pressured by their employers to get tested.²³⁶ Mandatory testing rules would eliminate this problem; the testing laws would not be applied discriminatorily, but would apply to all HCWs in defined lines of work.

Despite the questionable legitimacy of challenges of invidious discrimination, the cries of the activists have not gone unheard. The fact that the CDC backed down from its July guidelines and weakened the force of its recommendations for HIV-infected HCWs²³⁷ demonstrates the CDC’s attentiveness to

235. Sack, *supra* note 165, at B6.

236. For instance, refer to the article by Rhame, *supra* note 214, at 508, wherein the author referred to the policy at the University of Minnesota Hospital. To conform to the policy requirement at that facility, surgeons deemed to be in “high risk” categories were required to undergo testing. *Id.* Others were not. *Id.* It is this type of HIV testing program that will lead to unfair, unreasoned, and invidious discrimination based on sexual preference.

237. See *supra* notes 170-75 and accompanying text.

the objections of interest groups. For instance, one writer argued:

Bowing to homosexual groups and civil libertarians, the government and the public health community have resisted attempts to institute limited mandatory testing or, where such testing is done, notify persons who tested positive for the AIDS antibody. Their concerns seem to have less to do with public health considerations than with the fears of homosexuals — that their civil liberties will be violated.

Homosexuals come by their paranoia honestly. Disclosure that a person has AIDS is still tantamount to evidence of homosexuality. That could have severe repercussions — loss of job, housing or even custody of a child. Evidence of the AIDS antibody — often a precursor to the disease but not proof of the disease itself — could result in the cancellation of health insurance. Besides, sexual preference is a private matter. We are talking about the most personal of acts. . . . Personal privacy is not a trifling matter. And neither are the concerns of the homosexual community. But we all have our civil rights. Surely, the foremost is to life.²³⁸

Perhaps the government and the health care community have gone *too far* to pacify the rights activists. The pendulum has begun to swing, and the rights of the many may now be jeopardized by the rights of the few.

Other opponents of proposals to restrict practices or obtain consent have suggested that the better solution is to rigorously educate HCWs about infection barriers and to increase and improve the barriers that are presently in place.²³⁹ Thus, the theory runs, with universally applied precautions, direct HCW patient contact will be extremely limited, and exposure to blood will be eliminated.²⁴⁰

Unfortunately, universal safety precautions that, if meticulously enforced would minimize the risk of HIV transmission in

238. Richard Cohen, *Routine Tests for AIDS? Yes*, THE WASHINGTON POST, March 25, 1987, at A23.

239. See, e.g., Hansen & Steel, *supra* note 205.

240. See *id.* "Adherence to universal precautions virtually eliminates what is already an extremely low risk of transmitting HIV, Hepatitis B, and other blood-borne diseases from health care worker to patient." *Id.*

the health care setting, are often applied only sporadically.²⁴¹ In some cases, lapses in universal precautions are due to low funding, improper training, or emergency situations.²⁴² In other cases, the degree of precaution hinges on the individual HCW's flip-a-coin decision that a patient is "high risk" or on the HCW's decision regarding his own high risk category.²⁴³ Regrettably, when these HCWs are wrong, they are dead wrong.

The risk of viral transmission from HCW to patient, or vice versa, in these instances is escalated for two reasons. First, without the recommended barriers, an unsteady hand, an exposed instrument, or an uncapped needle is much more likely to result in transmission than when the barriers are in place. Second, this risk is compounded by the fact that the HCW's carelessness may be heightened by an irrational confidence based on his own ignorant estimation of the patient as being in a "low" or "no risk" category.

Added to these instances of potential exposure to the virus are the many unavoidable instances of barrier-free patient contact which are due to emergency circumstances.²⁴⁴ Almost inevitably, even the most conscientious HCW will be faced with a situation where a patient is in dire need of attention and the recommended precautionary equipment is unavailable, whether it be because of the unusual location of the patient or because of insufficient quantities or sizes of the necessary equipment.²⁴⁵ Most emergencies — particularly those in which a patient is losing blood — demand immediate care, care that must proceed with or without masks, gloves, and other protective equipment. Again, the risk of exposure to the virus is heightened because likelihood of blood contact is high and precautions are low.²⁴⁶

241. See, e.g., Service Employees International Union, AFL-CIO, CLC, Comments on Proposed Rule on Occupational Exposure to Bloodborne Pathogens, 1-2 (August 14, 1989) (unpublished memorandum).

242. See, e.g., *id.* at Table 5. Inadequate staffing, lack of equipment, lack of support from management, and lack of training were among the reasons most often cited as obstacles to use of personal protective equipment while exposed to blood-borne pathogens. *Id.*

243. See *supra* note 2 and accompanying text.

244. See Marsha F. Goldsmith, *Even 'In Perspective,' HIV Specter Haunts Health Care Workers Most*, 263 JAMA 2413, 2417, 2420 (1990).

245. See generally *id.* at 2417, 2420.

246. *Id.* In her article, Marsha Goldsmith talked about the great exposure to blood

Finally, even in those instances where recommended safety barriers are perfectly in place, personal equipment is available in sufficient quantities and sizes, and the procedures are meticulously followed, the risk of transmission is not fully eliminated.²⁴⁷ Albeit minute, the risk of infection in such a clearly utopian environment still exists and is realized through human error.²⁴⁸ Unfortunately, "[u]niversal precautions do not provide for universal safety."²⁴⁹ A carelessly handled sharp instrument could penetrate a barrier and mock the entire precautionary system.²⁵⁰ The Acer cases, discussed earlier, provide an example of

in emergency rooms. She quoted the director of Johns Hopkins' Emergency Medicine Residency Program as follows: "'When I talk about exposure, I really mean exposure,' he said, showing slides to illustrate his point." *Id.* Goldsmith continued, "In that setting [emergency rooms], a survey a few years ago of how well universal precautions were followed came up woefully short — only 44% of the time for minor interventions and 'an abysmal' 20% for major interventions." *See id.* (citing Gabor D. Kelen, M.D., et al., *Human Immunodeficiency Virus Infection in Emergency Department Patients, Epidemiology Clinical Presentation, and Risk to Health Care Workers: The Johns Hopkins Experience*, 262 JAMA 516-22 (1989)). Notably, a follow-up study was conducted some time later, and compliance levels had improved considerably. Goldsmith, *supra* note 244, at 2417.

Emergency room physicians cited various reasons for non-compliance. "Some said there wasn't enough time for them to don the many recommended articles of protective clothing, and others said it was just too cumbersome and interfered with their skill, or was uncomfortable." *Id.*

247. *See, e.g.*, Gerbert Reply, *supra* note 218, at 1935.

248. *Id.*

249. Kivin, *supra* note 213, at 67.

250. Gerbert Reply, *supra* note 218, at 1935. Referring to the call for increased attention to infection barriers, one article recognized that, with the publication of the Acer cases, "the risk of transmission in a health care setting has been demonstrated to be real, rather than merely the product of fear and hysteria on the part of the public and some health care workers . . ." *Id.* The article continued,

We applaud concern about infection control . . . [H]owever, implementation of universal precautions is neither "simple" nor "clear-cut." We have been monitoring dentists' use of infection control since the middle 1980s. It has improved considerably over the years but *will never be universal or foolproof*. Even the best infection control protocols cannot prevent accidents. Scientists, practitioners, and the public must be helped to understand that there will always be "some" risk of HIV transmission in dental offices. Calling it "very low" does not extinguish fears.

Id. (emphasis added) (citations omitted).

See also Goldsmith, *supra* note 244, at 2413. This article pointed out that "[e]ven in the extremely infection control-conscious environment of [San Francisco General Hospital], about half the needles discarded in special safety containers are found to be recapped — and a survey in The Johns Hopkins Emergency Department, among others, showed that half of all HIV-associated needle sticks involve recapped needles." *Id.*

Julie Gerberding, M.D., principal investigator of the AIDS/Health Care Work Study,

this "mockery."²⁵¹

Objectors to mandatory testing schemes have also argued that, due to the time lapses that may (and often do) occur between infection with HIV and manifestation of HIV antibodies, HCWs who have been infected may slip by undetected.²⁵² Theoretically, these infected HCWs would pose a greater risk, because they would be operating under a false sense of security, confident that they are seronegative.²⁵³

The answer to this criticism, however, is *not* to forego the whole testing scheme. Rather, the answer is to set up a regular, periodic testing system, whereby HCWs are tested at intervals. Although the latency period will inevitably allow some infected HCWs to remain undetected by the first HIV tests, seropositivity will eventually be discovered by subsequent testing. In any case, performing the tests and making as many people as possible aware of their HIV status is preferable to foregoing mandatory testing because a few may go undetected for a time. This "all or none" approach is unwarranted.

As for concerns of increased hazards to patients caused by an infected HCW's false sense of security, this is where the usefulness of universal precautions and infection barriers is most apparent. HIV is not the only communicable disease against which universal infection barriers are designed to protect.²⁵⁴ A negative showing on an HIV test — especially for an HCW who is aware of his or her "high risk" status — cannot be construed as license to disregard all requisite infection barriers. A mandatory HIV testing scheme and a system of infection barriers should be implemented *in tandem* to minimize the risks.

suggested that while the best response to the possibility of HIV infection remains primary prevention, it is not fool-proof. Gerberding stated, "I think some people still believe that we can reduce risks effectively by practicing good infection control across the board. Unfortunately, this is probably not going to be the case entirely." *Id.*

251. See *supra* notes 6, 70-84 and accompanying text.

252. See Kantrowitz, *supra* note 61, at 53-54.

253. *Id.*

254. For instance, universal precautions are also necessary to prevent Hepatitis B transmission. See CDC, *Recommendations for Preventing Transmission of Human Immunodeficiency Virus, Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures*, 266 JAMA 771, 774 (1991).

B. *The Acer Cases and Informed Consent*

Unfortunately for science, there was no "instant replay" video in the Acer cases. The play-by-play, showing just how Dr. Acer's strain of HIV infected his patients, will never be seen. Did transmission occur through a prick of a needle? a slice of an instrument through a glove? a contaminated, improperly cleaned instrument? a misapplied infection barrier? a properly applied, but ineffective infection barrier? Science will never know.

Unfortunately for a few of his patients, the transmission — whatever its vehicle — was deadly. In the final analysis, it hardly matters to Kimberly Bergalis and the others if the virus entered through a glove, a drill, or a needle. Their dentist knew he had AIDS. They were unaware of his condition. Months later, though, Dr. Acer's illness was a secret no longer. His illness was their own.

The patients who were infected by Dr. Acer probably visited his office with the same low-level anxiety that many people feel on their way to the dentist's chair. They worry about drills and probes. They worry about cavities and fillings. They worry about bleeding gums and open nerves. These are the risks and discomforts they probably anticipated. By coming to the office and opening wide their mouths, though, these patients accepted these risks. The patients did not, however, accept the risk — albeit minute — that, in addition to the temporary pain and numbness, they would be exposed to HIV. That risk was not accepted, nor was it even contemplated, because it was not disclosed.

Until science develops a vaccination or cure, infection with HIV most likely will eventually be lethal.²⁵⁵ The grave consequence of infection — regardless of the low likelihood of its occurrence — must surely play a part in the patient's right to be informed of the risk.²⁵⁶

The question of the patient's right to know and the physician's duty to disclose brings us back to the doctrine of informed consent.²⁵⁷ At least in those jurisdictions that hold physicians to a lay standard of care, disclosure of a risk is required where that

255. See *supra* note 35 and accompanying text.

256. See *supra* notes 140-57 and accompanying text.

257. See generally *supra* notes 89-157 and accompanying text.

risk is "material."²⁵⁸ As discussed earlier, "materiality" has been found where the risk is such that a "reasonable" physician knows (or should know) that his "reasonable" patient would attach some significance to the risk in making his intelligent decision to undergo or forego treatment.²⁵⁹

A glance at opinion polls²⁶⁰ will confirm what most people already know: AIDS is not a matter which the American public — which is essentially the pool of "reasonable" patients — treats lightly.²⁶¹ It is certainly a matter to which most patients would attach at least some significance. This is not surprising, of course, because AIDS is not a trifling matter; it is deadly. At least in those jurisdictions that have embraced the newer view, the lay standard,²⁶² disclosure of the material risk of HIV infection should be mandated.

In those jurisdictions that adhere to the older view, the professional standard of care,²⁶³ the doctrine would not require disclosure unless disclosure was customary in the medical community.²⁶⁴ Given that AIDS is a relatively new disease and that the percentage of seropositive physicians is relatively low (when compared to the number of healthy, seronegative physicians), the community really has not had to establish a standard of disclosure in this area. Unlike many other risks which are inherent in a specific *procedure*, this particular risk is inherent in a specific *health care worker*. Thus, in jurisdictions following the professional standard of care model, disclosure may not be the custom because the risk will not be universally encountered and considered by all physicians in the community.

As a result, the unfortunate potential for a "conspiracy of silence,"²⁶⁵ suggested by courts who have rejected the older view, is compounded by the fact that a standard may not exist at all. Along the lines of the conspiracy of silence objection, there is

258. See *supra* notes 140-43 and accompanying text.

259. See *supra* notes 140-43 and accompanying text.

260. See *supra* note 93.

261. See, e.g., Breo, *supra* note 5. "[D]ealing as it does with stigmatization, taboo behaviors, and certain death, AIDS clearly is perceived by the public as a different disease, requiring special precautions." *Id.* at 1464 (emphasis omitted).

262. See *supra* notes 124-44 and accompanying text.

263. See *supra* notes 120-23 and accompanying text.

264. See *supra* notes 122-23 and accompanying text.

265. See *supra* note 135 and accompanying text.

also the reality that many doctors and dentists would probably not be inclined to testify to a risk of transmission or a standard of disclosure, even if it did exist. To do so could only work to limit the rights and flexibility of the health care community, and it would invite legislative and judicial intervention. However cynical it may seem, the legislature might be better served by looking beyond the heated objections and denials of risk pro- pounded by the medical community, to see just how much the medical community has at stake.

"[We] must be concerned that the medical center decision- makers, while no doubt acting in good faith in the decision mak- ing process, are acting with the knowledge that their decisions may well affect their ultimate ability to practice their chosen profession."²⁶⁶ Perhaps the medical community's efforts to pac- ify the "hysterical" public should be taken with a grain of salt.

The recent federal proposal on this issue, H.R. 2788,²⁶⁷ is, perhaps, a subtle indication of legislative mistrust of the medical community's denial of risk. If adopted, the new law will hinge certain federal monies upon state compliance with federally im- posed guidelines.²⁶⁸ The proposed law would require the CDC to go further than it has and insist on mandatory periodic testing, rather than leaving it up to the discretion of the individual HCW.²⁶⁹ Those HCWs whose practice puts them in regular and inevitable contact with their patients' body cavities, blood, or mucous membranes would be tested periodically for exposure to the HIV virus.²⁷⁰ Upon a positive test result, these HCWs would be required to refrain from practice or to obtain their patients' informed consent before continuing to perform invasive procedures.²⁷¹

The states have the prerogative to enforce the mandatory testing scheme and to require informed consent for invasive pro-

266. *Estate of Behringer v. The Medical Center at Princeton*, 592 A.2d 1251, 1278 (N.J. 1991).

267. H.R. 2788, 102d Cong., 1st Sess. (1991). *See supra* note 183 and accompanying text.

268. H.R. 2788, 102d Cong., 1st Sess. (1991).

269. *Id.*

270. *Id.*

271. *Id.*

cedures, through the exercise of their police power.²⁷² The public health has long been held to be within the realm and control of the police powers.²⁷³ And the proposals to require testing and to illicit informed consent are reasonably tailored to meet the legitimate state interest in preserving the public health.

What is needed is a systematic schedule of HIV testing, mandated by the individual states and encouraged by the federal government through health care funding, for those HCWs who perform invasive procedures. These procedures should be uniformly defined and compiled in a list to ensure uniformity and to reduce the need for individual discretion. Where seropositivity is detected in an individual HCW, he should be required to report his seropositivity to those patients on whom he is to perform invasive procedures and to illicit their consent to further invasive treatment. Where seropositivity is *not* indicated by the tests, all HCWs should continue to implement the universal precautions currently in place, ever mindful of the potential for transmission of other communicable disease, of the possibility of a false negative test result, and of their own need for protection from any diseases the patient might transmit.

IV. Conclusion

HIV poses a unique dilemma in the health care setting, because it requires a balancing of delicate interests. However, the state and individual interests in preserving health cannot be subordinate to the individual HCW's interests in maintaining privacy and preserving livelihood. Said W. Shepherd Smith, president of Americans for a Sound AIDS/HIV Policy, a Wash-

272. The states' rights and duties with respect to the medical profession are clearly supported in American jurisprudence under the general rubric of state sovereignty, state "police power" and the public interest. *See, e.g.,* *Pierce v. New Hampshire*, 46 U.S. 504, 525 (1847) (referring to powers reserved to the states); *see also* *Louis Finocchiaro, Inc. v. Nebraska Liquor Control Comm'n*, 351 N.W.2d 701 (1984) (for proposition that police power is an attribute of state sovereignty).

273. *Barsky v. Board of Regents of N.Y.*, 347 U.S. 442 (1954). In *Barsky*, the Supreme Court noted,

It is elemental that a state has broad power to establish and enforce standards of conduct within its borders relative to the health of everyone there. It is a vital part of a state's police power. The state's discretion in that field extends naturally to the regulation of all professions concerned with health.

Id. at 449.

ington based group, "This does not seem sufficient to give the public what it is asking for, which is just more knowledge to base decisions on The public feels individuals have the right to know whether they will be exposed to a potentially fatal disease, regardless of the degree of risk."²⁷⁴

If the risk of transmission from HCW to patient is very low, then the public should be educated about the probabilities and about the medical community's diligent efforts to maintain universal infection control. This does not, however, mean that the existence of the risk should be denied, nor that an individual's decision whether to accept that risk should be made by a third party. The risk, however small, is certainly not insignificant; its realization could mean death. Denial and non-disclosure cannot be the way to enlightenment regarding this enigmatic virus.

As one court noted in embracing a broad scope of disclosure for informed consent, "Anglo-American law starts with the premise of thoroughgoing self-determination, each man considered to be his own master. This law does not permit a physician to substitute his judgment for that of the patient by any form of artifice."²⁷⁵ We must be ever-mindful of the value of individual physical self-determination when considering the very sensitive issues surrounding HIV-infected HCWs. In the final analysis, in order to better deal with the problem, we must be open about it. Anything less than openness is to return to medieval notions of paternalism or to more recent notions that there is a class of citizens who are somehow above the law and who know what is best for the "common man." Do we dare now, for the sake of political expediency or the desire not to imperil individual economic opportunities, abandon a precious principle of a democratic society — namely informed consent?

Susan E. Brown†

274. Sack, *supra* note 165, at B6.

275. Scott v. Bradford, 606 P.2d at 556 (Okla. 1979).

† To my father, Kenneth J. Brown, Jr., who has always been a steady source of inspiration and encouragement, and for whom I have immeasurable respect and affection.