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HEALTH CARE WORKERS WITH AIDS: DUTIES, RIGHTS, AND POTENTIAL TORT LIABILITY

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Since 1981, nearly 250,000 acquired immune deficiency syndrome (AIDS) cases have been diagnosed in the United States.¹ Of these infected individuals, the Centers for Disease Control know of 8,871 persons² that were health care workers.³ This number includes two hundred forty-three persons in the dental field, nine hundred three physicians, sixty-six surgeons, one hundred twenty paramedics, and one thousand nine hundred thirty-seven nurses.⁴ These numbers are likely to grow on all counts as the AIDS crisis matures, for an estimated one million Americans are infected with the human immunodeficiency virus (HIV) which causes AIDS.⁵

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1. CENTERS FOR DISEASE CONTROL, HIV/AIDS SURVEILLANCE REPORT 6 (Feb. 1993) (showing in Table 1 that as of December 1992, state and local health departments had reported to the Centers for Disease Control 244,939 AIDS cases among persons of all ages in the United States).
2. CENTERS FOR DISEASE CONTROL, FACTS ABOUT HIV/AIDS AND HEALTH-CARE WORKERS (Dec. 1992) ("Of the persons reported with AIDS in the United States through September 30, 1992, 8,871 had been employed in health care . . . represent[ing] 4.8% of the 184,163 AIDS cases . . . for whom occupational information was known.").
3. The Centers for Disease Control have defined health care workers as "persons, including students and trainees, whose activities involve contact with patients or with blood or other body fluids from patients in a health-care setting." *Recommendations for Prevention of HIV Transmission in Health-Care Settings*, 36 MORBIDITY & MORTALITY WKLY. REP. 1S, 3S (Supp. 1987). Morbidity & Mortality Weekly Report is a weekly publication of the Centers for Disease Control, a division of the U.S. Department of Health and Human Services.
4. CENTERS FOR DISEASE CONTROL, FACTS ABOUT HIV/AIDS AND HEALTH-CARE WORKERS (Dec. 1992) ("The type of job is known for 8,468 (96%) of the 8,871 reported health-care workers with AIDS. . . . Overall, 74% of the health-care workers with AIDS, including 660 physicians, 50 surgeons, 186 dental workers, 1,390 nurses, and 120 paramedics, are reported to have died.").
5. *Estimates of HIV Prevalence and Projected AIDS Cases: Summary of a Workshop, October 31 - November 1, 1989*, 39 MORBIDITY & MORTALITY WKLY. REP. 110, 110 (1990).

In 1983, the Centers for Disease Control published guidelines for health care workers and others in order to reduce the risk of HIV/AIDS transmission.⁶ Nevertheless, instances of transmission by health care workers have not dissipated and the disease itself has increased in epidemic proportions.⁷

The etiologic agent of AIDS, HIV, is communicable by blood transfers and sexual activity. On occasion, health care workers have contracted HIV via contact with blood in the workplace. To date, more than thirty-three health care workers have been infected by HIV while performing work related duties. Of them, twenty-eight have been infected through needle sticks, four through exposure of the eyes, nose, or mouth, and one through an open-skin wound.⁸

Likewise, HIV-infected physicians or nurses also have the capability of passing the disease to patients. In 1985, the Centers for Disease Control announced guidelines which spoke of this danger:

[A] risk of transmission of [HIV] from health care workers to patients would exist in situations where there is both (1) a high degree of trauma to the patient that would provide a portal of entry for the virus (e.g., during invasive procedures) and (2) access of blood or serous fluid from the infected health care worker to the open tissue of a patient, as would occur if the health care worker sustains a needle stick or scalpel injury during an invasive procedure.⁹

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6. *Acquired Immune Deficiency Syndrome (AIDS): Precautions for Health-Care Workers and Allied Professionals*, 32 MORBIDITY & MORTALITY WKLY. REP. 450, 450-52 (1983).
 7. "Epidemic" is most broadly defined as "an extensive outbreak or period of unusually high incidence of a disease in a community or area." BLAKISTON'S GOULD MEDICAL DICTIONARY 256 (4th ed. 1979). For a discussion of how AIDS grew to epidemic proportions, see RANDY SHILTS, *AND THE BAND PLAYED ON: POLITICS, PEOPLE AND THE AIDS EPIDEMIC* (1987).
 8. CENTERS FOR DISEASE CONTROL, HIV/AIDS SURVEILLANCE REPORT 19 (Feb. 1993) (Table 15 showing that as of December 1992 a total of thirty-three health-care workers with documented acquired AIDS/HIV infection and sixty-nine with possible occupational transmission); see also *Update: Human Immunodeficiency Virus Infections in Health-Care Workers Exposed to Blood of Infected Patients*, 36 MORBIDITY & MORTALITY WKLY. REP. 285, 285-88 (1987) (giving case histories of three health-care workers infected with HIV/AIDS in a workplace setting).
 9. *Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus in the Workplace*, 34 MORBIDITY & MORTALITY WKLY. REP. 686, 689-95 (1985), reprinted in CENTERS FOR DISEASE CONTROL, AIDS RECOMMENDATIONS AND GUIDELINES, NOVEMBER 1982-DECEMBER 1987, at 8 (1988).

This risk has materialized,¹⁰ and in response there have been increasing concerns about the rights and responsibilities of health care workers with AIDS.¹¹

This Article will examine whether an HIV-infected health care worker can be held liable in tort for infecting a patient with AIDS or causing a fear of such an infection. First, the Article discusses the ethical background against which the actions of health care workers in general, and physicians in particular, are judged. Next, the Article examines various theories of tort liability, including battery, misrepresentation, strict liability, and negligence. Included under the negligence analysis is a discussion of a physician's duty to disclose to the patient information concerning his or her HIV status and the countervailing confidentiality concerns that AIDS raises. Finally, the Article concludes with a discussion of whether a patient's fear of contracting AIDS from an HIV-positive physician may also be compensable under the theories of intentional and negligent infliction of emotional distress.

I. THEORETICAL ETHICS FOR A REAL PROBLEM

In 1988, the American Medical Association issued a policy statement declaring that "a physician who knows that he or she is seropositive [for HIV], should not engage in any activity that creates a risk of transmission of the disease to others."¹² In the same year, the State Medical Board of Ohio AIDS Committee went a step further in recommending that "any licensee infected with the AIDS virus *must* inform his/her professional colleagues . . . for the purpose of assessing the potential danger to patients being treated. . . . [A] seropositive physician shall not engage in any activity that creates a risk of transmission."¹³ These policy recommendations were issued

10. See, e.g., William F. Zorzi, Jr., & Jonathan Bor, *Baltimore Prison Dentist Dies of AIDS*, BALTIMORE SUN, May 23, 1991, at 1A.

11. The AIDS epidemic has already generated a number of cases dealing with blood transfusions. See, e.g., *Miles Labs., Inc. v. Doe*, 315 Md. 704, 556 A.2d 1107 (1989) (finding that blood and bloodproducts were not unreasonably dangerous products); see also *Doe v. Miles Labs., Inc.*, 927 F.2d 187 (4th Cir. 1991) (holding that a blood-clotting agent, "Koyne," was not an unreasonably dangerous product, and, therefore, manufacturers were not strictly liable to the patient who contracted AIDS).

12. Lawrence Gostin, *HIV-Infected Physicians and the Practice of Seriously Invasive Procedures*, HASTINGS CENTER REP., Jan./Feb. 1989, at 32 (citing American Medical Association, Report of the Council on Ethical and Judicial Affairs, *Ethical Issues Involved in the Growing AIDS Crisis*, 259 JAMA 1360, 1361 (1988)).

13. AIDS REFERENCE GUIDE: A SOURCE BOOK FOR PLANNERS AND DECISION MAKERS 2 (Michael E. Carbine & Michele Welsing, eds., 1988).

before there were any documented cases of health care workers infecting patients. Today, however, it is known that at least five patients have been infected by a Florida dentist.¹⁴

The problems, concerns, and timeliness of this issue are illustrated by the story of Dr. Victor J. Luckritz. Dr. Luckritz, the chief dentist at the Maryland Penitentiary, died of AIDS on May 7, 1991.¹⁵ Dr. Luckritz was accused of not wearing gloves while performing procedures on some of the prisoners he treated.¹⁶ It also was claimed that he worked with visible sores on his hands.¹⁷

Without considering the truth or falsity of the allegations against Dr. Luckritz, the situation illustrates the complexity of the issues involved. Did Dr. Luckritz have a duty to reveal his HIV status to his patients? Alternatively, did the dentist have a right to maintain his privacy with regard to this illness? Since prison populations

14. See *Possible Transmission of Human Immunodeficiency Virus to a Patient During an Invasive Dental Procedure*, 39 MORBIDITY & MORTALITY WKLY. REP. 489, 489-93 (1990) (reporting the possible transmission of HIV from an AIDS-infected dentist to his patient during an invasive dental procedure); *Update: Transmission of HIV to a Patient During an Invasive Dental Procedure - Florida*, 40 MORBIDITY & MORTALITY WKLY. REP. 21, 21-33 (1991) (reporting a follow-up investigation which identified four additional patients of the dentist who were infected with HIV).

One of the infected patients, Ms. Kimberly Bergalis, championed the patient's right to know of a health care worker's infection with AIDS. The Centers for Disease Control have faced a number of roadblocks in attempting to learn how these patients were infected by the Florida dentist, Dr. David Acer. See Donald C. Drake, *How Patients Got AIDS From Dentist Unresolved*, BALTIMORE SUN, June 22, 1991, at 1A (reporting on the difficulties of the Florida investigation as delivered in the findings of Mr. Harold Jaffe, chief investigator and epidemiologist at the Centers for Disease Control, at the Seventh International Conference on AIDS in Florence, Italy). All five "had undergone tooth extractions or root canal work-procedures involving sharp instruments that could cut tissue in the mouth, leaving it open to contamination with infected blood." *Id.* Dr. Acer also did not wear gloves while working until 1987. *Id.* However, in light of the recent Centers for Disease Control calculation that there is "only one chance in 42,000 of an infected surgeon giving the [AIDS] virus to a patient during an operation," one is lead to take a suspicious view of Dr. Acer's practices. *Id.*

In related stories, a Maryland dentist, Dr. Victor J. Luckritz, who treated 1,893 inmates in the Maryland Penitentiary between June 1988 and April 1990, died of AIDS on May 7, 1991. See *infra* notes 15-18 and accompanying text. Also, a Maryland breast cancer surgeon, Dr. Rudolph Almaraz, who treated over 1,800 patients since January 1984, died of AIDS on November 16, 1990. A number of lawsuits related to this case have been filed and will be discussed at length later in this article. See *infra* notes 132-44 and accompanying text.

15. See William F. Zorzi, Jr., & Jonathan Bor, *Baltimore Prison Dentist Dies of AIDS*, BALTIMORE SUN, May 23, 1991, at 1A; William F. Zorzi, Jr., & Jonathan Bor, *1,893 Prisoners Treated by Dentist Who Died of AIDS*, BALTIMORE SUN, May 30, 1991, at 1B.
16. See William F. Zorzi, Jr., & Jonathan Bor, *Baltimore Prison Dentist Dies of*

include individuals at high-risk for HIV infection,¹⁸ how easily can one prove causation under these circumstances? Further, should the invasiveness of the procedure determine the health care worker's right to privacy concerning this illness?

This Article proposes that there should be some form of tort liability for a health care worker who does not disclose his or her HIV positive status to a patient before performing "physically invasive"¹⁹ techniques. Infected health care workers, however, should not be denied the right to continue practicing in their field. Because AIDS is considered to be a handicap within the meaning of the Federal Rehabilitation Act of 1973,²⁰ it is believed that "[p]hysicians, then, have a right under federal [law] . . . not to be denied the right to practice medicine or to be reassigned to an administrative position unless there is a significant risk of HIV transmission."²¹

Thus there is a "need for balance between a physician's rights and a patient's safety."²² This balance is likely to be shaped by future Centers for Disease Control recommendations and by judicial decisions considering whether to assign liability to health care workers

AIDS, BALTIMORE SUN, May 23, 1991, at 1A; William F. Zorzi, Jr., & Jonathan Bor, *1,893 Prisoners Treated by Dentist Who Died of AIDS*, BALTIMORE SUN, May 30, 1991, at 1B.

17. See William F. Zorzi, Jr., & Jonathan Bor, *Baltimore Prison Dentist Dies of AIDS*, BALTIMORE SUN, May 23, 1991, at 1A; William F. Zorzi, Jr., & Jonathan Bor, *1,893 Prisoners Treated by Dentist Who Died of AIDS*, BALTIMORE SUN, May 30, 1991, at 1B.
18. Jonathan Bor, *Tracing Prisoners with AIDS from Dentist a Huge Task*, BALTIMORE SUN, May 24, 1991, at 1B (reporting on a 1988 study by the Johns Hopkins School of Hygiene and Public Health that found 8.1% of Maryland state prison inmates were infected with the HIV virus).
19. The Centers for Disease Control define "exposure-prone invasive procedures" as "procedures during which there is a recognized risk for percutaneous injury to the health care worker (HCW), and if such an injury occurs, the HCW's blood is likely to contact the patient's body cavity, subcutaneous tissues, and/or mucous membranes." *Process for Identifying Exposure-Prone Procedure*, 40 MORBIDITY & MORTALITY WKLY. REP. 565, 565 (1991).
20. See *Chalk v. Orange County Dep't of Educ.*, 832 F.2d 1158 (9th Cir. 1987) (although handicapped because of AIDS, plaintiff otherwise was qualified to perform his job under § 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, as amended); *Shuttleworth v. Broward County*, 639 F. Supp. 654 (S.D. Fla. 1986); see also *Harris v. Thigpen*, 941 F.2d 1495 (11th Cir. 1991) (teacher with AIDS determined to be handicapped but "otherwise qualified to perform his job" under § 504 of the Rehabilitation Act of 1973).

Similarly, HIV-infected health care workers are considered disabled under the Americans with Disabilities Act of 1990, made effective July 26, 1992, which prohibits employment discrimination based on a disability. See Americans with Disabilities Act of 1990, Pub. L. No. 101-336, 104 Stat. 327 (1990).

21. Gostin, *supra* note 12, at 37.

22. *Id.* at 37 (citing *Doe v. Cook County Hosp.*, No. 87 C 6888 (N.D. Ill. consent decree filed Feb. 21, 1988)).

who expose their patients to AIDS. The social policy which ultimately emerges should be one which places a premium on preserving human life and preventing all possibility of HIV transmission from health care worker to patient. At the same time, the dignity and quality of life of the infected health care worker who still wants to practice should be maintained and respected.

II. TORT LIABILITY

Tortious conduct can often give rise to different causes of action. Although one set of operative facts produces one distinct harm, a number of different legal theories may arise. Common causes of action arising out of tortious conduct are battery, misrepresentation, strict liability, negligence, infliction of emotional distress, and, in medical settings, lack of informed consent. Each of these causes of actions will be examined, with the conclusion that negligence is the most viable theory for a patient claiming infection from an HIV-infected health care worker.

A. Battery

Battery is the intentional touching of another person in an offensive and unauthorized manner.²³ Physicians have been held liable under a battery theory in situations where a doctor obtained consent to perform one procedure and instead performed a substantially different procedure.²⁴ Even when the consented-to operation was very similar to the actual operation that was performed, courts have concluded that a battery action was proper.²⁵

Liability under a battery theory may also obtain when an undisclosed potential complication results from medical treatment.²⁶ For instance, a battery action was sustained by an Ohio court when a physician failed to warn of the danger of radiation burns from therapy.²⁷ Similarly, a physician's failure to warn a patient that a spinal operation involved a risk of permanent paralysis was considered a battery in Pennsylvania.²⁸ By analogy, the argument may be made that the transmission of the AIDS virus from doctor to patient

23. RESTATEMENT (SECOND) OF TORTS § 18 (1965).

24. See, e.g., *Corn v. French*, 289 P.2d 173, 174 (Nev. 1955) (patient consented to exploratory surgery; doctor performed mastectomy); see also *Zoterell v. Repp*, 153 N.W. 692 (Mich. 1915) (consent given for hernia operation during which both ovaries were also removed).

25. See *Bailey v. Belinfante*, 218 S.E.2d 289 (Ga. Ct. App. 1975) (plaintiff brought action charging defendant dentist with battery and negligent extraction of all the plaintiff's teeth without consent).

26. *Cobbs v. Grant*, 502 P.2d 1, 7 (Cal. 1972).

27. *Belcher v. Carter*, 234 N.E.2d 311, 312 n.27 (Ohio Ct. App. 1967).

28. See *Gray v. Grunnagle*, 223 A.2d 663, 667 (Pa. 1966).

during an operative procedure, when there was no adequate warning, may also be a battery.

In instances of inadequate disclosure, most courts have held that liability is a result of negligence.²⁹ A number of significant consequences, however, result from relying on a negligence rather than a battery theory.³⁰ In those jurisdictions considering an informed consent action under a negligence theory, a doctor can assert the defense that the omitted disclosure was not required within his medical community.³¹ In comparison, expert opinion as to community standards is not a factor in a battery action; the plaintiff must merely prove an injurious touching absent informed consent.³² Another significant difference is that a doctor held liable for punitive damages under a battery count might not be covered by his malpractice insurance.³³ This is not true of an action in ordinary negligence, which arguably is the more appropriate theory of liability.

B. Misrepresentation

When a person misrepresents a fact to induce another individual to act in reliance upon it, the misrepresenting party is liable for any injury caused by the other's justifiable reliance.³⁴ Although this form of tort action is typically applied in a business setting or where some pecuniary loss is claimed, this is not always the case.³⁵ For instance, in *Kathleen K. v. Robert B.*,³⁶ a woman's lover failed to inform her that he was infected with the herpes virus. In fact, the plaintiff, Kathleen, claimed that Robert assured her that he was free of any venereal or other contagious diseases.³⁷ The California Court of Appeals held that the plaintiff's complaint stated a valid cause of action in fraud.³⁸

29. PAUL S. APPELBAUM ET AL., INFORMED CONSENT 118 (1987).

30. *Cobbs*, 502 P.2d at 8.

31. *Id.*

32. *Id.*

33. *Id.*

34. RESTATEMENT (SECOND) OF TORTS § 525 (1977). The elements of an action in misrepresentation, also known as fraud or deceit, are: (1) that a false representation was made; (2) the representation was known to be false or should have been known to be false; (3) the representation was made for the purpose of defrauding; (4) the person who was defrauded relied upon the misrepresentation in deciding his action and had a right to so rely; (5) the action taken by the person who was defrauded would not have been taken without the misrepresentation; and (6) the person suffered harm directly resulting from the misrepresentation. *Suburban Management v. Johnson*, 236 Md. 455, 460, 204 A.2d 326, 329 (1964).

35. *B.N. v. K.K.*, 312 Md. 135, 149, 538 A.2d 1175, 1182 (1988) (finding a cognizable cause of action for negligence and fraud when plaintiff alleged that she had a romantic relationship with a physician who knew he had herpes but did not divulge that information, and, as a result, she contracted the disease).

36. 198 Cal. Rptr. 273 (Ct. App. 1984).

37. *Id.* at 274.

38. *Id.* at 276 (holding that consent to sexual intercourse, regardless of whether

The *Restatement (Second) of Torts* also considers the passive concealment of facts leading to physical harm to constitute fraudulent misrepresentation.³⁹ The *Restatement* provides that "[o]ne who by a fraudulent misrepresentation or nondisclosure of a fact that it is his duty to disclose, causes physical harm to the person . . . of another who justifiably relies upon the misrepresentation, is subject to liability to the other."⁴⁰

In *B.N. v. K.K.*,⁴¹ Dr. K, a physician, and Ms. N, a nurse, were involved in an intimate relationship. Dr. K knew during the relationship that he had genital herpes, but he never revealed that fact to Ms. N.⁴² Ms. N ultimately was infected.⁴³ The Court of Appeals of Maryland found that the plaintiff had stated a valid cause of action for fraud.⁴⁴ The court observed that "concealment cannot be the basis of an action in deceit if there is no duty to speak, But if there is such a duty, the concealment can result in liability to the same extent that an actual denial of the existence of the fact would."⁴⁵ The defendant physician argued that he had no duty to speak and warn his lover because there was no marital or other confidential relationship between the parties.⁴⁶ The court, however, concluded that where a likelihood of physical harm exists, as it does with a communicable disease, "certain tort duties may arise under circumstances in which they otherwise would not."⁴⁷

Thus, if a duty to disclose an HIV-positive status is held to exist, then a valid argument can be made that a patient infected by a physician who failed to disclose an HIV-positive status has a cause of action for fraudulent misrepresentation. The failure to disclose will satisfy the false representation requirement. The fact that an AIDS carrier who is also a health care worker has special training in a particular health-related field arguably satisfies the requirement that the defrauding person knew or should have known of the falsity of his or her representation. In addition, the fact that an AIDS-carrying health care worker is likely to fail to disclose this status because of fear that patients will no longer desire the carrier's services

partners were married to each other, vitiated claim that partner fraudulently concealed the risk of infection with venereal disease).

39. RESTATEMENT (SECOND) OF TORTS §§ 554, 557A (1977). For instance, a spouse who fraudulently conceals from the other spouse a physical condition that makes cohabitation dangerous to the health of the other is liable in tort. *Id.* § 554.

40. *Id.* § 557A (emphasis added).

41. 312 Md. 135, 538 A.2d 1175 (1988).

42. *Id.* at 138, 538 A.2d at 1177.

43. *Id.*

44. *Id.*

45. *Id.* at 151, 538 A.2d at 1183.

46. *Id.*

47. *Id.* at 152, 538 A.2d at 1184.

is arguably evidence of an intent to defraud.⁴⁸ Finally, a patient who contracts AIDS from contact with an HIV-infected physician clearly satisfies the harm requirement for an action in fraudulent misrepresentation.

C. *Strict Liability in Tort*

Strict liability is an available cause of action for a person injured by a product deemed defective and unreasonably dangerous. The focus of this cause of action is not on the negligent conduct, but rather on the defective product itself. There is no basis for bringing an action against a health care worker under the *Restatement (Second) of Torts*, Section 402A, which addresses strict products liability.⁴⁹ The doctrine of strict liability is typically used for products⁵⁰ and recent attempts to apply the doctrine to services have been routinely rejected.⁵¹ In particular, when professional services are involved, courts have uniformly required that negligence be shown and have declined to impose strict liability.⁵² Therefore, actions brought under a strict liability theory for defective health care services will likely fail. Although strict liability "promotes the public interest in the protection of human life, health, and safety . . . [and] is an incentive

48. A recent Gallup Poll showed that eighty-six percent of those individuals surveyed believed that patients should be told if the health care worker caring for them has AIDS. Gostin, *supra* note 12, at 32 (citing *New AHA Guidelines Urge Universal AIDS Precautions*, 16 MED. STAFF NEWS 2 (1987)). It can be inferred, therefore, that many patients would choose not to be treated by a physician who has AIDS, and, furthermore, that some patients may interpret the nondisclosure of an HIV-positive status to mean that a physician does not, in fact, have AIDS.

49. RESTATEMENT (SECOND) OF TORTS § 402A (1965).

50. *See supra* note 11.

51. For a discussion of cases determining whether the doctrine of strict liability in tort, as applied in products liability cases, is applicable to a person or entity rendering medical services that are alleged to have resulted in injury to another, see, David B. Harrison, Annotation, *Application of Rule of Strict Liability in Tort to Person or Entity Rendering Medical Services*, 100 A.L.R.3d 1205 (1992).

52. *See, e.g.*, *Hoven v. Kelble*, 256 N.W.2d 379, 380 (Wis. 1977) (declining to impose the doctrine of strict liability to provider of professional medical services); *see also Pierson v. Sharp Memorial Hosp.*, 264 Cal. Rptr. 673, 676 (Ct. App. 1989) (holding that strict liability does not apply to latent defect in hospital room); *Podrat v. Codman-Shurtleff, Inc.*, 558 A.2d 895, 899 (Pa. Super. Ct. 1989) (finding hospital not strictly liable for patient's injury which occurred when a medical instrument broke during surgery as "its use was only incidental to the hospital's primary function of providing medical services"); *Black v. Gundersen Clinic*, 448 N.W.2d 247, 248 (Wis. Ct. App. 1989) (holding in part that strict liability does not apply to a physician's liability).

to safety,"⁵³ no precedent exists to extend the theory to HIV-infected health care workers.

D. Negligence

Negligence is the cause of action most likely to be successfully maintained against an HIV-infected health care worker. The traditional elements needed to sustain a suit in negligence are: (1) a duty, recognized by law, to conform to a certain standard of conduct for the protection of others against unreasonable risks; (2) a failure to conform to that standard of care - in other words, a breach of that duty; (3) a reasonably close causal connection between the conduct and the resulting injury; and (4) actual loss or damages to the person injured.⁵⁴ The application of each of these elements to the HIV-infected health care worker who treats patients will be discussed below.

1. Duty

A duty is a legally recognized obligation to conform to a certain standard of conduct towards another person.⁵⁵ A person has a duty to refrain from conduct when a reasonable person would know or should know that the conduct constitutes an unreasonable risk of harm to another.⁵⁶ With respect to medical malpractice, the first two elements of negligence (duty and breach) are defined by the medical standard of care owed by the health care worker to the patient; that is, "a duty to use that degree of care and skill which is expected of a reasonably competent practitioner in the same class to which he belongs, acting in the same or similar circumstances."⁵⁷ Thus, depending on the risk of transmission, a health care worker may have a duty to refrain from performing certain procedures, or at least a duty to warn the patient of the risks of infection before engaging in the medical procedure.

The central focus in determining whether a duty exists is the foreseeability of the risk that someone will be harmed by the health

53. *Hoven*, 256 N.W.2d at 391.

54. W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 30, at 164-65 (5th ed. 1984).

55. RESTATEMENT (SECOND) OF TORTS § 282 (1965).

56. *See, e.g.*, *McCance v. Lindau*, 63 Md. App. 504, 514, 492 A.2d 1352, 1358 (1985).

57. *Shilkret v. Annapolis Emergency Hosp.*, 276 Md. 187, 200, 349 A.2d 245, 253 (1975).

care worker's activity.⁵⁸ In a related situation, "it has been recognized by a number of courts that harm to a sexual partner is foreseeable when the defendant knows that he has a sexually transmitted disease."⁵⁹ In *B.N. v. K.K.*,⁶⁰ the Court of Appeals of Maryland stated that:

One who knows he or she has a highly infectious disease can readily foresee the danger that the disease may be communicated to others with whom the infected person comes into contact. As a consequence, the infected person has a duty to take reasonable precautions - whether by warning others or by avoiding contact with them - to avoid transmitting the disease.⁶¹

The ease of transmission of the illness thus becomes a factor. AIDS is a communicable disease and, although it is not "highly" infectious, it is readily transmissible via blood and other bodily fluids.⁶² To assess the foreseeability of harm as a result of various types of physician/patient contact, it is useful to discuss several recent studies examining AIDS transmission and operative risks. These studies indicate that following a percutaneous or mucous membrane exposure to a patient's HIV-infected blood, there is a risk in the range of 0.03 to 0.9 percent that a health care worker will contract AIDS.⁶³ There have been no actual studies to quantify the

58. See *Tarasoff v. Regents of Univ. of Cal.*, 551 P.2d 334, 342 (Cal. 1976); *Dillon v. Legg*, 441 P.2d 912, 921 (Cal. 1968). The Supreme Court of California analyzed foreseeability as follows:

[T]he Court will determine whether the accident and harm was reasonably foreseeable. Such reasonable foreseeability does not turn on whether the particular defendant as an individual would have in actuality foreseen the exact accident and loss; it contemplates that courts, on a case-to-case basis, analyzing all the circumstances, will decide what the ordinary man under such circumstances should reasonably have foreseen.

Dillon, 441 P.2d at 921.

59. Richard C. Schoenstein, *Standards of Conduct, Multiple Defendants, and Full Recovery of Damages in Tort Liability for the Transmission of Human Immunodeficiency Virus*, 18 HOFSTRA L. REV. 37, 52 (1989).

60. 312 Md. 135, 538 A.2d 1175 (1988).

61. *Id.* at 142, 538 A.2d at 1179.

62. See Edward N. Brandt, Jr., *Health Care Workers and AIDS*, 48 MD. L. REV. 1, 3 (1989).

63. Gostin, *supra* note 12, at 33 (citing CENTERS FOR DISEASE CONTROL, AIDS RECOMMENDATIONS AND GUIDELINES, NOVEMBER 1982-DECEMBER 1987 8 (1988)). See also Gerald H. Friedland & Robert S. Klein, *Transmission of the Human Immunodeficiency Virus*, 317 NEW ENG. J. MED. 1125, 1126-27 (1987); David K. Henderson et al., *Risk for Occupational Transmission of Human Immunodeficiency Virus Type 1 (HIV-1) Associated with Clinical Exposures*, 113 ANNALS OF INTERNAL MED. 740 (1990) (finding the risk for HIV transmission

risk in the other direction - from health care worker to patient.⁶⁴ "Physicians performing seriously invasive procedures, such as surgeons, have a potential to cut or puncture their skin with sharp surgical instruments, needles or bone fragments."⁶⁵ It has been estimated that a surgeon will cut a glove in one out of every four procedures⁶⁶ and will sustain a significant laceration in one out of every forty procedures.⁶⁷ Surgeons who cut themselves, however, do not necessarily expose the patient to their blood; even if they do, the volume of blood is usually quite small.⁶⁸ It is known that a small inoculum of contaminated blood is unlikely to transmit the virus,⁶⁹ but significant and prolonged contact with a patient's blood and organs⁷⁰ probably raises a surgical patient's chances of contracting AIDS to 1/130,000.⁷¹ The cumulative risk to surgical patients, though,

associated with a percutaneous exposure to blood from an HIV-infected patient was approximately .3% per exposure and the risk associated with occupational mucus membrane and cutaneous exposure were likely to be substantively smaller).

64. A number of studies have been performed which looked at HIV-infected surgeons and their patients. None of these studies have found any patients who were infected by the surgeons and, at the present date, there have been no reported cases of any HIV transmission from surgeon to patient. See Jeffrey J. Sacks, *AIDS in a Surgeon*, 313 *NEW ENG. J. MED.* 1017, 1017-18 (1985) (letter to the editor) (stating that as of Aug. 19, 1985 no cases of AIDS had been reported in over 400 patients operated on by a Florida surgeon who died of AIDS in 1983; of these patients, 20% had skin procedures, and 80% had endoscopic procedures); see also Francis P. Armstrong et al., *Investigation of a Health Care Worker with Symptomatic Human Immunodeficiency Virus Infection: An Epidemiologic Approach*, 152 *MILITARY MED.* 414, 414-18 (1987) (epidemiological investigation found that risk of HIV transmission to a surgical patient was essentially non-existent); Ban Mishu et al., *A Surgeon with AIDS: Lack of Evidence of Transmission to Patients*, 264 *JAMA* 467, 467 (1990) (stating that no episode of occupational HIV transmission from an infected health care worker to a patient has been documented); John D. Porter et al., *Management of Patients Treated by Surgeons with HIV Infection*, 335 *LANCET* 113, 113-14 (Jan. 13, 1990) (based on study of UK surgeon who died of AIDS in 1988 and a sampling of seventy-six of his patients tested, authors concluded that investigation supported limited previous evidence that during the course of surgery, HIV is not readily transmitted between surgeon and patient).
65. Gostin, *supra* note 12, at 33.
66. *Id.* (citing Peter J.E. Cruse & Rosemary Foord, *The Epidemiology of Wound Infection*, 60 *SURGICAL CLINICS OF N. AM.* 27, 35 (1980)).
67. *Id.* (citing Michael D. Hagen et al., *Routine Preoperative Screening for HIV: Does the Risk to the Surgeon Outweigh the Risk to the Patient?*, 259 *JAMA* 1357, 1357 (1988)).
68. *Id.*
69. *Id.* (citing Gerald H. Friedland & Robert S. Klein, *Transmission of the Human Immunodeficiency Virus*, 317 *NEW ENG. J. MED.* 1125, 1126-27 (1987)).
70. *Id.*
71. *Id.* However, another recent study found the risk could be even greater. In a study performed by David Bell of the Centers for Disease Control and reported

may be higher.⁷² The HIV-infected surgeon will likely perform numerous operations - and the risk that one of his patients will be infected is 1/1300 (assuming 100 operations) or 1/126 (assuming 500 operations).⁷³

Thus, there may exist, at a minimum, a duty for those health care workers who perform invasive procedures to disclose their infection to patients, if not a duty to avoid all intimate contact which may foreseeably lead to the transmission of AIDS. "The risk of transmission of HIV in the ordinary physician/patient relationship where exposure to large amounts of blood is unlikely is too remote to be foreseeable. . . . Nevertheless, the risks inherent in seriously invasive treatments may well reach the threshold where they become relevant to a rational assessment by the patient."⁷⁴

Ultimately, with respect to determining the existence of a duty, it is important to bear in mind that "legal duties are not discoverable facts of nature, but [are] merely conclusory expressions that, in cases of a particular type, liability should be imposed for damage done."⁷⁵ "[Duty] is not sacrosanct in itself, but [is] only an expression of the sum total of those considerations of policy which lead the law to say that a particular plaintiff is entitled to protection."⁷⁶ A strong argument can be made that, in certain health care situations, an HIV-infected health care worker has either a duty to refrain from performing given procedures or a duty to warn patients of the potential risk of HIV transmission.

2. Breach

The appropriate standard of conduct by which an individual's actions will be measured can be established by legislative enactment, administrative regulations or judicial decision.⁷⁷ Currently, no legislative enactments exist as to the proper conduct of health care workers with AIDS. However, guidelines to prevent HIV-positive health care workers from infecting their patients have been promulgated by the Centers for Disease Control.⁷⁸ These federal guidelines, although not

at the Seventh International AIDS Conference in Florence, Italy, the risk of transmission from an HIV-infected surgeon to a patient was determined to be 1/42,000. See Donald C. Drake, *How Patients Got AIDS from Dentist Unresolved*, BALTIMORE SUN, June 22, 1991, at 1A.

72. Gostin, *supra* note 12, at 33.

73. *Id.*

74. *Id.* at 34.

75. *Tarasoff v. Regents of Univ. of Cal.*, 551 P.2d 334, 342 (Cal. 1976).

76. KEETON, *supra* note 54, at 332-33.

77. Schoenstein, *supra* note 59, at 53.

78. See *Recommendations for Preventing Transmission of HIV and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures*, 40 MORBIDITY

binding, may be a basis for finding a breach of the standard of care in future negligence actions. In the opinion of one author, there should be "little doubt that a malpractice case would succeed if adequate infection control guidelines [have] not been followed and, as a result, HIV was transmitted to the patient."⁷⁹

It is only a matter of time before the proper standard of care is established. In the meantime, a statement from the American Medical Association provides fodder for those who ultimately will decide what constitutes a breach of a health care worker's duty of care:

a physician who knows that he or she has an infectious disease should not engage in any activity that creates a risk of transmission of the disease to others [P]atients are entitled to expect that their physicians will not increase their exposure to the risk of contracting an infectious disease, even minimally.⁸⁰

Which activities constitute at least a minimal risk remains to be determined.

3. Causation and Damages

The final two elements of an action in negligence apply with equal force to cases involving HIV-positive health care workers as they do to ordinary negligence cases. First, the defendant's conduct must be the cause in fact and the proximate cause of the injury. Presently, DNA studies allow for relatively accurate determinations of the source of the AIDS virus.⁸¹ Thus, whether the named health

& MORTALITY WKLY. REP. 1, 1-9 (Supp. RR-8 1991). These recommendations provide, *inter alia*, that all health care workers should adhere to universal precautions; that there is no basis to restrict HIV-infected health care workers from performing non-exposure prone invasive procedures; that health care workers performing exposure-prone procedures should know their HIV status; and that a health care worker who is HIV-positive should discontinue performing invasive procedures unless the prospective patient is notified and a review panel approves. *Id.*

Also, the American Medical Association has stated that "physicians who are HIV-positive have an ethical obligation not to engage in any professional activity which has an identifiable risk of transmission of the infection to the patient." AMERICAN MEDICAL ASSOCIATION, AMA STATEMENT ON HIV-INFECTED PHYSICIANS (1991). *But see* Lawrence K. Altman, *Medical Groups Resist Call For AIDS Guidelines*, BALTIMORE SUN, Aug. 30, 1991, at 1A (reporting that most medical groups at an AMA meeting found "that the risk of transmission from health care worker to patient was so low that compiling lists of high-risk procedures was worthless").

79. Gostin, *supra* note 12, at 34.

80. *Id.* (citing American Medical Association, Report of the Council on Ethical and Judicial Affairs, *Ethical Issues Involved in the Growing AIDS Crisis*, 259 JAMA 1360 (1988)).

81. See Andrea DeGorgey, *Note and Comment: The Advent of DNA Databanks - Implications for Information Privacy*, 16 AM. J.L. & MED. 381, 382 (1990).

care worker exposed the victim to AIDS can often be determined by chemical analysis of the viruses isolated in the infected party's blood.⁸² Second, the required damages from infection with AIDS are obvious. While the symptoms of AIDS are often slow to appear, the effects are devastating, costly, and in all cases, fatal.

E. The Duty to Disclose.

1. Negligence versus Confidentiality

The failure to disclose information in certain situations may be an act of negligence. Generally, "[a]n individual has no common law duty to warn innocent others of the existence of danger unless that individual is responsible for the creation of the danger."⁸³ A physician with AIDS, however, *is* responsible for the creation of the danger of infection, and, as a member of the medical profession, has a responsibility to prevent the spread of contagious diseases.⁸⁴ In addition, "[i]t generally is recognized that once a physician diagnoses a contagious disease it is the physician's duty to use reasonable care to advise members of the patient's immediate family of the existence of the disease and to warn them of its dangers."⁸⁵

It follows that a physician with a contagious disease should use reasonable care to advise his patients of his disease and the danger of exposure. The adequacy of a health care worker's conduct in failing to warn of the danger of transmission of AIDS "must be measured against the traditional negligence standard of the rendition of reasonable care under the circumstances."⁸⁶

"[D]ue care normally demands that the physician warn the patient of any risks to his well-being which contemplated therapy may involve."⁸⁷ Nonfulfillment of this obligation to disclose is a breach of duty which does not by itself, however, establish liability to the patient.⁸⁸ "An unrevealed risk that should have been made known must materialize, for otherwise the omission, however unpardonable, is legally without consequence."⁸⁹ In addition, there must

82. See DeGorgey, *supra* note 81, at 382.

83. Judith C. Ensor, *Doctor - Patient Confidentiality Versus Duty to Warn in the Context of AIDS Patients and their Partners*, 47 MD. L. REV. 675, 680 (1988).

84. Ensor, *supra* note 83, at 682.

85. *Id.* at 682-83 (citing *Hofmann v. Blackmon*, 241 So. 2d 752, 753 (Fla. Dist. Ct. App. 1970)).

86. *Tarasoff v. Regents of Univ. of Cal.*, 551 P.2d 334, 345 (Cal. 1976).

87. *Canterbury v. Spence*, 464 F.2d 772, 781 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

88. *Id.* at 790.

89. *Id.*

be a causal relationship between the failure to disclose and the resultant damage to the patient.⁹⁰

The requirement for disclosure of an HIV-positive status raises the issue of confidentiality. It has been argued that confidentiality concerns may mitigate, or be in opposition to, the duty to disclose. In *Tarasoff v. Regents of University of California*,⁹¹ a patient killed a certain young woman after informing his therapist of his intention to do so. The therapist did not reveal the conversation because of the confidential nature of the physician/patient relationship.⁹² The Court of Appeals of California found that a cause of action existed for failing to disclose this information to the victim.⁹³

Tarasoff has been regarded as persuasive in the analogous situation of a physician's duty to disclose his patient's HIV-positive status to the patient's sexual and needle-sharing partners.⁹⁴ Thus, in certain situations, confidentiality concerns are outweighed by matters of life and death.

Problems of confidentiality are not limited to those within the physician/patient relationship, but are a factor when anyone has AIDS — including health care workers. The stigma of AIDS makes the disclosure by a health care worker that he or she has the disease very likely to ruin their career. Thus, health care workers may be prevented from performing even those healing activities from which there is absolutely no risk of infection. This concern for the health care worker's career, in itself, however, cannot justify taking the ultimate decision away from the patient. Thus, the duty to disclose one's HIV status arguably is not outweighed by confidentiality concerns.

2. Disclosure Law in the Medical Setting - Informed Consent

A physician's duty to disclose information to patients about alternative treatments and the risks of therapy is often termed the

90. *Id.* Although courts agree that there must be this causal relationship, there is disagreement on whether an objective or subjective approach to determine causation should be applied. Under the objective standard, as applied in *Canterbury*, the causal link exists if a reasonable person in the patient's position who was adequately informed of all significant perils would have opted not to undergo the therapy. *Id.* at 791. Other courts, although probably in the minority, use a subjective standard for determining causation. That is, if the particular patient would not have consented to the treatment, after full disclosure, whether or not it is a reasonable choice, then the causal link exists. See *Arena v. Gingrich*, 733 P.2d 75, 76-78 (Or. Ct. App.), *aff'd*, 748 P.2d 547 (Or. 1987).

91. 551 P.2d 334 (Cal. 1976).

92. *Id.* at 340.

93. *Id.*

94. See *Ensor*, *supra* note 83, at 684-89.

doctrine of "informed consent."⁹⁵ This doctrine imposes on a physician the responsibility to warn the patient of any material risks or dangers inherent in *or collateral to* the therapy.⁹⁶ Included in this obligation is the duty to warn of the "risk of unfortunate consequences associated with such treatment."⁹⁷ The transmission of a communicable disease during physician/patient contact is assuredly an unfortunate consequence of treatment; although not inherent to therapy, it is a collateral result.

Judge Cardozo perhaps best described the essence of the informed consent doctrine almost eighty years ago when he stated: "[e]very human being . . . has a right to determine what shall be done with his own body."⁹⁸ "A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient."⁹⁹

In *Canterbury v. Spence*,¹⁰⁰ the United States Court of Appeals for the District of Columbia refined the modern standards for medical disclosure. In that case, a young man whose only symptom was back pain submitted to an operation without being informed of the risks of paralysis from the procedure.¹⁰¹ According to the physician's testimony, paralysis could be expected "somewhere in the nature of one percent" for that type of surgery.¹⁰² The doctor felt that informing the patient of that risk was "not good medical practice because it might deter patients from undergoing needed surgery and might produce adverse psychological reactions which could preclude the success of the operation."¹⁰³

The court, however, concluded that "the appropriate test is not what the physician . . . 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."¹⁰⁴ As the *Canterbury* court expressed: "To the physician,

95. *Canterbury v. Spence*, 464 F.2d 772, 780 n.15 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

96. *Sard v. Hardy*, 281 Md. 432, 439, 379 A.2d 1014, 1020 (1977).

97. *Id.*

98. *Schloendorff v. Society of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914), *overruled on other grounds by*, *Bing v. Thunig*, 143 N.E.2d 3 (N.Y. 1957).

99. *Salgo v. Leland Stanford, Jr., Univ. Bd. of Trustees*, 317 P.2d 170, 181 (Cal. 1957).

100. 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

101. *Id.* at 776.

102. *Id.* at 778.

103. *Id.*

104. *Sard v. Hardy*, 281 Md. 432, 442, 379 A.2d 1014, 1021 (1977) (citing *Canterbury v. Spence*, 464 F.2d 772, 785 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972)); *see also* *Fogal v. Genesee Hosp.*, 344 N.Y.S.2d 552, 559 (N.Y. App. Div. 1973).

whose training enables a self-satisfying evaluation, the answer may seem clear, but it is the prerogative of the patient, not the physician, to determine for himself the direction in which his interests seem to lie."¹⁰⁵ If the risk is not paralysis, but rather infection via the physician, it still would be the patient's decision to determine the importance of this risk and to decide whether or not to undergo the proposed treatment.

The risk of acquiring AIDS, even in invasive procedures, is less than the one percent risk of paralysis for the back operation described in *Canterbury*.¹⁰⁶ A physician need not disclose every potential risk to a patient no matter how small or remote.¹⁰⁷ What, then, is the scope of the data which must be revealed to a patient? "[T]he test for determining whether a particular peril must be divulged is its materiality to the patient's decision: all risks potentially affecting the decision must be unmasked."¹⁰⁸ "[A] risk is . . . material when a reasonable person . . . would be likely to attach significance to the risk . . . in deciding whether or not to forego the proposed therapy."¹⁰⁹

As previously stated, a large majority (86%) of individuals feel that a physician's infection with AIDS is something which should be disclosed to the patient.¹¹⁰ It follows that the risk of HIV transmission from physician to patient is a material one, as a person's decision would be affected by his doctor's HIV-positive status. Though the probability of harm is small, the degree of harm threatened by AIDS is great; even a very small chance of death may be material and deserving of disclosure.¹¹¹ Thus, although there is only a slight risk of HIV transmission from physician to patient, there may well be a duty to disclose this risk in all circumstances.

Causation is often a difficult element to prove in an informed consent claim. The issue is framed as whether the plaintiff would have chosen another alternative had the material risk been disclosed. It is easy for a patient or the next of kin to testify retrospectively that, where there was an adverse result, the patient would have opted for another alternative or would have foregone the procedure. Unless one can objectively conclude what a reasonably prudent person would have done under the same circumstances, the informed consent case

105. *Canterbury*, 464 F.2d at 781.

106. Gostin, *supra* note 12, at 33.

107. *Canterbury*, 464 F.2d at 786.

108. *Id.* at 786-87.

109. *Id.* at 787 (quoting John R. Waltz & Thomas W. Scheuneman, *Informed Consent to Therapy*, 64 NW. U. L. REV. 628, 640 (1970)).

110. See Gostin, *supra* note 12, at 32 (citing *New AHA Guidelines Urge Universal AIDS Precautions*, 16 MED. STAFF NEWS 2 (1987)).

111. *Canterbury*, 464 F.2d at 788.

will fail. But, in a case of transmission of AIDS from patient to health care worker, it appears that a fact-finder could easily come to the conclusion that, given the choice between having an operation performed by an HIV-infected physician and a non-infected physician, the patient would opt for the latter.

F. Infliction of Emotional Distress.

One who infects another with a disease or causes a fear of infection can be liable for the resulting emotional distress.¹¹² Thus, a health care worker who transmits HIV to a patient could potentially be responsible for the resulting emotional distress. Similarly, there may be a justifiable cause of action for emotional distress by those who are not even infected; a patient treated by an HIV-infected health care worker may suffer emotional distress caused by the fear of being infected.¹¹³ This is because HIV can remain undetected in the human body for up to 14 months.¹¹⁴ Thus, "a person exposed to HIV . . . may have a cause of action for his past fear during the 14-month interlude between the person's exposure to HIV and the person's discovery that he does not carry HIV."¹¹⁵

Damages for the infliction of emotional distress may be sought under theories of intentional tort or under a negligence count. In order for there to be a cause of action for the intentional infliction of emotional distress there must be intentional or reckless conduct which is extreme and outrageous and which causes severe emotional distress.¹¹⁶ It would be an unusual case where a health care worker would be successfully charged with this legal action. Hypothetically, if a physician or dentist were to operate without adequate protection and with open lesions, this action might be successful. There would be adequate intent, as the health care worker would be acting "recklessly in deliberate disregard of a high degree of probability that the emotional distress [would] follow."¹¹⁷ The characteristics of the illness would indicate the extreme and outrageous nature of the

112. John P. Darby, *Tort Liability for the Transmission of the AIDS Virus: Damages for Fear of AIDS and Prospective AIDS*, 45 WASH. & LEE L. REV. 185 (1988).

113. Darby, *supra* note 112, at 197.

114. Michael Specter, *AIDS Tests Can Fail to Detect Infection for More Than Year*, WASH. POST, Oct. 2, 1987, at A1. However, in 95% of those infected with HIV, antibody tests will give a positive result within six months of the transmission of the virus. C. Robert Horsburgh, Jr., et al., *Duration of Human Immunodeficiency Virus Infection Before Detection of Antibody*, LANCET, Sept. 16, 1989, at 637.

115. Darby, *supra* note 112, at 197.

116. RESTATEMENT (SECOND) OF TORTS § 46 (1965).

117. *B.N. v. K.K.*, 312 Md. 135, 144, 538 A.2d 1175, 1180 (1988) (citing *Harris v. Jones*, 281 Md. 560, 567, 380 A.2d 611, 614 (1977)).

health care worker's conduct.¹¹⁸ Thus, if severe emotional distress results from the health care worker's actions, there may be a justifiable claim for the intentional infliction of emotional distress. The occasions supporting this cause of action, however, will be exceedingly rare.

Claims for negligently inflicted emotional distress resulting from contacts by HIV-infected physicians are more likely to be successful. One limitation in these cases, however, is that most courts hold that a plaintiff cannot recover damages for mental distress in a negligence action without a physical injury.¹¹⁹ "Courts adhering to the physical injury requirement will not allow a plaintiff to recover damages for mental injury without objective physical evidence that the plaintiff has suffered an injury."¹²⁰

The courts, however, have substantially lowered the threshold requirement of physical injury.¹²¹ The plaintiff's physical harm does not necessarily have to result directly from the negligent party's physical contact or impact; indeed, physical harm resulting from the emotional stress which was caused by the contact will satisfy the physical injury requirement.¹²²

In *Plummer v. United States*,¹²³ prisoners sought to recover for their emotional distress caused by their exposure during incarceration to another prisoner with tuberculosis. The plaintiffs suffered no symptoms of the disease, but their bodies did harbor, in a dormant state, tubercle bacilli - the organisms which cause tuberculosis.¹²⁴ This "impact" of the bacteriologic agent, absent any symptoms, was considered an adequate physical injury.¹²⁵ Similarly, a patient who is infected with HIV will have been impacted; the infection alone comprises a sufficient physical injury to allow for recovery, but only if the other requirements for emotional distress are met.

118. *Id.*

119. KEETON, *supra* note 54, at 361. A small number of courts allow recovery for the negligent infliction of emotional distress standing alone, without any requirement that the plaintiff suffer physical injury or illness from the negligence. See *Molien v. Kaiser Found. Hosp.*, 616 P.2d 813 (Cal. 1980).

120. Darby, *supra* note 112, at 193 n.33 (citing *Payton v. Abbott Labs.*, 437 N.E.2d 171, 181 (Mass. 1982)).

121. See *Apostle v. Booth Newspapers, Inc.*, 572 F. Supp. 897, 901 (N.D. Mich. 1983) (finding that courts have been "very lenient" in requiring a definite and objective physical injury).

122. RESTATEMENT (SECOND) OF TORTS § 436(1) (1965); see *Vance v. Vance*, 286 Md. 490, 500, 408 A.2d 728, 733-34 (1979) (finding that in most jurisdictions "the term 'physical' is not used in its ordinary dictionary sense . . . [i]nstead, it is used to represent that the injury for which recovery is sought is capable of objective determination").

123. 580 F.2d 72 (3d Cir. 1978).

124. *Id.* at 73.

125. *Id.* at 76.

It is more difficult, however, to show physical injury when no actual infection with HIV has occurred during the health care worker/patient interaction but the patient, nevertheless, sues for fear of having acquired AIDS. In an analogous case, *Laxton v. Orkin Exterminating Company, Inc.*,¹²⁶ the plaintiff family's water supply was negligently contaminated with a carcinogen. One month after the plaintiffs became aware of the dangers of the exposure, test results proved that the chemical had no adverse effects on any member of the family.¹²⁷ Even though no one suffered physical damage from the exposure, the Tennessee Supreme Court concluded that drinking polluted water was sufficient injury to justify an award for mental anguish.¹²⁸

It can be argued that "[u]nder the court's analysis in *Laxton*, an uninfected person who was exposed to HIV should be able to recover for the fear of AIDS the person suffered before discovering that he did not carry HIV."¹²⁹ For those patients who are operated on by an HIV-infected physician, perhaps the surgical procedure itself would constitute the requisite physical impact or injury without the necessity of actual infection with the AIDS virus. This conclusion would be akin to finding a physical injury from mere contact with dangerous water alone, with no evidence that carcinogens had an impact on the plaintiffs.¹³⁰

Two recent opinions by Judge Joseph H. H. Kaplan of the Circuit Court of Baltimore City, however, are not in agreement with this reasoning.¹³¹ These unreported companion cases involved two law suits filed by patients who were afraid that they had contracted AIDS after undergoing surgery by a well-known Johns Hopkins breast cancer surgeon, Dr. Rudolph Almaraz, who later died of AIDS.¹³² The patients did not test positive for the virus, but sued for the "panic, horror, and fear" which ensued until the test results proved negative.¹³³

126. 639 S.W.2d 431 (Tenn. 1982).

127. *Id.* at 433.

128. *Id.* at 434.

129. Darby, *supra* note 112, at 199.

130. *Laxton*, 639 S.W.2d at 434.

131. Rossi v. Estate of Almaraz, No. 90344028, CL123396 (Balto. City Cir. Ct. May 23, 1991); Faya v. Estate of Almaraz, No. 90345011, CL123459 (Balto. City Cir. Ct. May 23, 1991).

132. Rossi, No. 90344028, CL123396, slip op. at 1; Faya, No. 90345011, CL123459, slip op. at 1.

133. See Liz Bowie, *Baltimore Judge Dismisses Suits on Fear of AIDS*, BALTIMORE SUN, May 24, 1991, at 1A; Raymond L. Sanchez, *Suits Based on AIDS Fear Dismissed: Judge Voids Claims Sparked by AIDS-Infected Surgeon*, BALTIMORE EVENING SUN, May 24, 1991, at A1.

In both cases, the patients underwent surgery at least one year before Dr. Almaraz's death.¹³⁴ After learning that their surgeon had died of AIDS, both patients were tested for HIV and the results proved negative.¹³⁵ Thus, for a very short period of time, both may have been in fear of having acquired HIV.

Judge Kaplan relied upon *Burk v. Sage Products, Inc.*,¹³⁶ in which a paramedic sued the manufacturer of a disposal device for used syringes.¹³⁷ The paramedic was stuck by a protruding needle but was unable to show that the needle was actually used on an AIDS patient.¹³⁸ The plaintiff subsequently proved to be uninfected with HIV and the *Burk* court ruled that he could not recover for his fear of exposure to AIDS.¹³⁹ The court concluded that "while injuries stemming from a fear of contracting illness after exposure to a disease-causing agent may present compensable damages, injuries stemming from fear of the initial exposure do not."¹⁴⁰

In the *Almaraz* cases, the court concluded that no recovery for fear of exposure to AIDS should be allowed since the plaintiffs were unable to allege sufficient facts to support their allegations that they were exposed to AIDS in the first place.¹⁴¹ The judge dismissed the cases on the rationale that no accident had happened during the surgeries that would lead the plaintiffs to believe the doctor's blood had entered their bodies.¹⁴²

In the absence of such a mishap, Judge Kaplan reasoned, actual exposure to AIDS was very unlikely. The court believed that, as a matter of law, there was not enough evidence on which a fact-finder could conclude that the plaintiffs had been exposed to the AIDS virus. The court reasoned that "the injury claimed by the plaintiff[s] is the fear that something that did not happen could have happened."¹⁴³

These cases can be distinguished from another Maryland case, *Bressler v. Hyatt Hotel Corp.*,¹⁴⁴ where the federal court indicated it

134. *Rossi*, No. 90344028, CL123396, slip op. at 1; *Faya*, No. 90345011, CL123459, slip op. at 1.

135. *Rossi*, No. 90344028, CL123396, slip op. at 1; *Faya*, No. 90345011, CL123459, slip op. at 1.

136. 747 F. Supp. 285 (E.D. Pa. 1990).

137. *Rossi*, No. 90344028, CL123396, slip op. at 6; *Faya*, No. 90345011, CL123459, slip op. at 6.

138. *Burk*, 747 F. Supp. at 287.

139. *Id.* at 288.

140. *Id.*

141. *Rossi*, No. 90344028, CL123396, slip op. at 9; *Faya*, No. 90345011, CL123459, slip op. at 8.

142. *Rossi*, No. 90344028, CL123396, slip op. at 9; *Faya*, No. 90345011, CL123459, slip op. at 9.

143. *Faya*, No. 90345011, CL123459, slip op. at 9.

144. No. 90-1071 (D. Md. Apr. 17, 1990).

would allow the jury to consider damages for the fear of contracting AIDS. The plaintiff in that case, a hotel guest, was stuck by a needle left in his bed. The previous night, the room had been used by a number of intravenous drug users. There the plaintiff learned of his potential exposure immediately, as it is well known that one of the most common ways for transmission of the HIV virus is through the used needle of an intravenous drug user. The plaintiff then was tested for the virus every ninety days for a year and postponed having a family with his wife during that time. Thus, a major distinction between *Almaraz* and *Bressler* would appear to be that in the *Almaraz* cases, a year passed by the time the plaintiffs became aware of the potential exposure to HIV; in *Bressler*, however, the plaintiff became aware of the potential exposure immediately and had to undergo a year of testing to determine the results.

Recovery by a patient for fear of exposure to AIDS, then, seems to require proof of contact with the infected physician's blood - a level of proof not likely to be sustainable by a patient in most operative situations. There must be proof of "impact" with the AIDS-causing agent (i.e., infected blood), and proof that there was an objective, reasonable basis for the fear of contracting AIDS.

The second requirement for recovery of damages for emotional distress, that the plaintiff's fear of the disease be reasonable,¹⁴⁵ has been analogized to situations where a defendant has exposed a plaintiff to a carcinogen.¹⁴⁶ In such a case, the United States Court of Appeals for the Fifth Circuit concluded that "a plaintiff is entitled to recover damages for serious mental distress arising from fear of developing cancer where his fear is reasonable and causally related to the defendant's negligence."¹⁴⁷ Further, "[w]hether the emotional distress which a plaintiff is alleged to have experienced is reasonable, is to be determined by the finder of fact."¹⁴⁸ It is worthwhile to note that a plaintiff's fear of a future disease may be reasonable even if the chance of developing the disease is low.¹⁴⁹

145. Darby, *supra* note 112, at 193.

146. *Id.* at 188.

147. Hagerty v. L & L Marine Servs., 788 F.2d 315, 318 (5th Cir. 1986).

148. Payton v. Abbott Labs., 437 N.E.2d 171, 181 (Mass. 1982).

149. See, e.g., Dartez v. Fibreboard Corp., 765 F.2d 456, 468 (5th Cir. 1985). A Maryland case comparable and instructive on this issue deals with recovery for fear of rabies after a dog bite. Buck v. Brady, 110 Md. 568, 73 A. 277 (1909). That case essentially held that recovery for fear of rabies was permissible where there was a reasonable basis for it - that is, where there was evidence that the biting dog was afflicted with hydrophobia. 110 Md. at 578, 73 A. at 277, 281. It was on the basis of that case that Judge Marshall A. Levin allowed recovery for fear of cancer in the recent asbestos cases. *In re* Baltimore City Personal Injury & Wrongful Death Asbestos Cases, Cain v. Eagle Picher Indus., Inc., Case Nos. 85056065 and 843139072 (Balto. City Cir. Ct. May 7, 1990) (memorandum opinion and order).

In the *Almaraz* cases, there was at most only a period of a few weeks from the patients' initial realization that their doctor had AIDS, until they were proved to be uninfected.¹⁵⁰ Because over one year had passed since the intimate physician/patient contact, the finding of their HIV- seronegativity put an end to any claim the patients may have had for fear of AIDS in the future.¹⁵¹ It can easily be concluded that it is not reasonable that either plaintiff suffered severe emotional distress in those few days before knowing of their favorable HIV test results.

In summary, if a negligence action against a physician for failure to disclose his HIV status is upheld, then recovery of damages for emotional distress should be allowed as well where there is objective evidence for the reasonableness of the fear. This undoubtedly should be the conclusion if the patient actually contracts AIDS and suffers the concomitant emotional pitfalls. Additionally, recovery for the fear of having been infected when no infection actually occurred may also be allowable for the severe emotional distress which results until an HIV test definitively proves that the fear is no longer reasonable.

III. CONCLUSION

AIDS is a terrible disease which currently has no cure. Unfortunately, there are no simple solutions for the legal problems it creates. As the epidemic matures, more and more situations like the ones discussed will occur and real answers need to be developed.

Health care workers who infect their patients with HIV need to be held accountable for their actions. This accountability is necessary if the interest of preserving life - the ultimate reason for health care - is to be furthered.¹⁵² The requirement for a warning as to the health

150. *Rossi v. Estate of Almaraz*, No. 90344028, CL123396 (Balto. City Cir. Ct. May 23, 1991); *Faya v. Estate of Almaraz*, No. 90345011, CL123459 (Balto. City Cir. Ct. May 23, 1991).

151. *See Darby*, *supra* note 112, at 197.

152. As a poignant reminder to this, consider the letter written (but never sent) by Kimberly Bergalis to an investigator with Florida's Department of Health and Rehabilitative Services. Ms. Bergalis was one of five patients infected by a Florida dentist, Dr. David Acer, during a routine dental procedure. The letter states:

AIDS has slowly destroyed me. Unless a cure is found, I will be another one of your statistics soon. Whom 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 who 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. You've ruined my life and my

care worker's HIV status can help bring about this end. This should only be done, however, where the purpose of preserving life can truly be facilitated. Thus, for example, a psychiatrist, a physical therapist, a pathologist, or an optometrist will likely never need to disclose their HIV status. Further, a radiologist, internist, or dermatologist may rarely perform invasive procedures, and thus, their duty to disclose may be limited. It is completely the opposite situation, however, for an endodontist, orthopedist, operating room nurse or general surgeon, as they may rarely perform non-invasive procedures. It is for them that the duty to disclose is most onerous, for this disclosure can be career-ending. Nevertheless, the failure to disclose may have catastrophic consequences for the patient - hence, disclosure in those cases where risk of HIV-transmission exists should be mandated and failure to disclose should be actionable.

IV. ADDENDUM

The Court of Appeals of Maryland decided the *Almaraz* cases on March 9, 1993.¹⁵³ The court of appeals concluded that the lower court decision dismissing these lawsuits before trial was incorrect. The court was "unable to say, as a matter of law, that Dr. Almaraz

family's.

I have lived to see my hair fall out, my body lose over 40 pounds, blisters on my sides. I've lived to go through nausea and vomiting, continual night sweats. . . . I have lived through the torturous acne that infested my face and neck - brought on by AZT. I have endured trips twice a week to Miami for three months only to receive painful IV injections. . . . I cried my heart out from the pain. . . . I lived to see white fungus grow all over the inside of my mouth, the back of my throat, my gums, and now my lips. I have it on my tongue. . . . Can you imagine what it's like to realize you're losing weight in your fingers and that your body may be using its muscles to try to survive. Or do you know what it's like to look at yourself in a full-length mirror before you shower - and you only see a skeleton? Do you know what I did? I slid to the floor and I cried. Now I shower with a blanket over the mirror. . . .

[A]ll is forgiven by me - there's no more hard feelings anymore. But I will never forget.

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

Florida AIDS Victim Infected by Dentist Vents Ire, BALTIMORE SUN, June 21, 1991, at 1A; Tim Golden, *Dental Patient Torn by AIDS Calls for Laws*, N.Y. TIMES, June 22, 1991, at L7. Ms. Bergalis' malpractice action against Dr. Acer was settled out of court for one million dollars. See *\$1 Million Is Awarded to Patient with AIDS*, N.Y. TIMES, Jan. 23, 1991, at A14. Ms. Bergalis died from AIDS on December 8, 1991, at the age of twenty-three. *Id.*

153. *Faya v. Almaraz*, 329 Md. 435, 620 A.2d 327 (1993) (deciding the appeals of *Rossi* and *Faya*).

owed no duty to the Appellants either to refrain from performing the surgery or to warn them of his condition."¹⁵⁴

The decision allows injured parties to recover only "for their fear and its physical manifestations which may have resulted from Almaraz's alleged negligence for the period constituting their reasonable window of anxiety — the period between which they learned of Almaraz's illness and received their HIV negative status."¹⁵⁵ Damages are therefore confined to injuries suffered during this "window of anxiety," after which "any lingering injuries, as a matter of law, are no longer related to fear that is reasonable."¹⁵⁶

This is essentially the same approach that Judge Garbis utilized in *Bressler*.¹⁵⁷ In the *Bressler* case, the reasonable window of anxiety was determined to be one year. In the *Almaraz* cases, however, since more than a year had passed since the exposure when the plaintiffs learned that Dr. Almaraz had been infected with HIV, the period of anxiety was limited to approximately one week¹⁵⁸ — the time from finding out about Dr. Almaraz's HIV status to the time test results could be available. The court of appeals thereby took a less restrictive approach than Judge Kaplan, but nevertheless imposed limitations along the lines suggested in *Bressler*.

154. *Id.* at 448, 620 A.2d at 333.

155. *Id.* at 455-56, 620 A.2d at 337. The "window of anxiety" appears to close once fear-relieving information becomes available or could have become available. *See id.* at 456 n.10, 620 A.2d at 337 n.10.

156. *Id.* at 459, 620 A.2d at 338-39.

157. *Bressler v. Hyatt Hotel Corp.*, No. 90-1071 (D. Md. Apr. 17, 1990).

158. Cathy Hinebaugh, *Distress Damages Recognized In AIDS Cases Against Doctors*, DAILY REC., Mar. 10, 1993, at 1, 7.