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# Physicians with AIDS

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by Toni-Junell Herbert

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Acquired Immunodeficiency Syndrome (AIDS) is the illness that will probably go down in history as the epidemic of the twentieth century. There are court battles between people who contract the disease from a sexual partner and even between people who are exposed to the virus through sexual contact and have not yet developed the disease or related syndrome.<sup>1</sup> There are lawsuits by people who have become infected through blood transfusions or medical supplies.<sup>2</sup> There has not yet been a suit from a patient claiming he contracted AIDS from his attending physician. Will there be? Physicians have no special immunity from the disease; and to date there are approximately 469 physicians and 2,586 health care workers with the disease.<sup>3</sup> Physicians with AIDS pose a dilemma which involves their pursuit of their right to not be fired or lose their hospital employment privileges and their patients' rights to not risk exposure to a fatal disease without being informed of the risks.

Former Surgeon General C. Everett Koop has stated "that physicians with AIDS are going to present the medical profession with one of the twentieth century's major ethical problems."<sup>4</sup> Not only is there concern about the possibility of transmitting the virus, but there is also the problem of the cerebral dysfunction produced by AIDS and how such dysfunction may affect a physician's judgment and motor control.

The first cases of AIDS were reported to the Center for Disease Control (CDC) in the summer of 1981.<sup>5</sup> From then until December, 1987, there have been approximately 47,000 reported cases of AIDS in the United States. Of these cases, 58% of the patients have already died.<sup>6</sup> It is estimated that between one and two million individuals in the United States

are infected with HIV (human immunodeficiency virus)<sup>7</sup> and are at this time exhibiting no symptoms. Although the United States has the majority of reported cases, AIDS is a worldwide epidemic.<sup>8</sup>

## How the Disease Affects the Patient—Mentally and Physically

The etiologic agent of the acquired immunodeficiency syndrome is the human immunodeficiency virus (HIV). HIV has the ability to infect and eventually incapacitate the host's immune system which is responsible for protecting the body from foreign invasion. A defective immune system renders the host susceptible to "opportunistic" infections and neoplasms. The course of the immune defect is, at this time, progressive and irreversible.<sup>9</sup>

It is important to differentiate between "having AIDS" and being seropositive. This is a minor point, but one which shall become increasingly important as more people are found to be seropositive, yet remain symptomless (and thus without impairment) for an extended period of time.

People who have AIDS are susceptible to a number of diseases and opportunistic infections (e.g., cytomegalovirus, toxo-plasmosis and herpes simplex). These illnesses are caused by pathogens that are routinely found in the environment and which are not harmful to a person whose immune system is not compromised by the virus.<sup>10</sup>

Initial symptoms of AIDS include enlarged lymph nodes. Cells involved with host immune defense normally live in these lymph nodes. Such nodes or glands are found most frequently in the neck, groin and axilla. Other symptoms include anorexia, fatigue, fever, night sweats, diarrhea, weight loss, persistent coughs and various skin lesions. The

majority of AIDS patients develop a pneumonia caused by the protozoan *pneumocystis carinii*. In addition, approximately 37% of AIDS-infected persons develop a form of skin cancer called Kaposi's sarcoma. Kaposi's sarcoma is not strictly a skin cancer. The lesions typically involve endothelial cells<sup>11</sup> and fibroblasts,<sup>12</sup> thus causing damage to internal organs<sup>13</sup> in ten percent of the cases.

The incubation period for AIDS is estimated to be five or more years.<sup>14</sup> Thus, an individual exposed to the virus must live with the possibility of developing AIDS for an extended and potentially indefinite period of time.

AIDS not only affects the body's immune system, but it also has significant effects on the brain.<sup>15</sup> Individuals infected with HIV frequently suffer from AIDS dementia complex which is a neurological syndrome characterized by abnormalities in cognition, behavior and motor performance. This dementia is believed to result from the direct effect of the virus on the brain and not as a result of the opportunistic infections which develop.<sup>16</sup> The dementia usually arises as a complication in the late stages of AIDS.<sup>17</sup> Researchers surmise that the delayed development of the AIDS dementia complex, despite early exposure of the nervous system to the virus, indicates that although the virus is neurotrophic it is relatively nonpathogenic for the brain in the absence of immunosuppression.<sup>18</sup>

Important clinical features of the dementia are a slowing and a loss of precision in both cognitive ability and motor control. Patients have reported that, early in the disease, they must keep lists to carry out their normal activities. Complex, but formerly routine mental tasks, take longer and need to be consciously broken down into smaller component steps.<sup>19</sup>

The intellectual impairment eventually becomes more pervasive, affecting essentially all aspects of cognition. There is also a progressive slowing and decrease in the accuracy of performance.<sup>20</sup> Scientists have utilized specific neurological studies in an effort to document and follow the disease process to assist them in understanding the basis of the signs and symptoms.<sup>21</sup> These tests have demonstrated characteristic abnormalities produced by the dementia. They include difficulty with complex sequencing, impairment of fine and rapid motor movements and reduced verbal fluency. Other verbal abilities, including vocabulary and object naming, appear to be maintained even when the disease is relatively advanced.<sup>22</sup> An interesting discrepancy has been noted in some patients between their complaints of frequent forgetfulness and their relatively preserved performance on formal memory testing. The results of studies indicate that the neuropsychological impairments become most pronounced when some or all of the following demands are placed on the patient: performance under time pressure, problem solving, visual scanning, visual-motor integration and alternation between two or more performance rules or stimulus sets.<sup>23</sup>

Despite the studies discussing the effect of AIDS dementia, the epidemiology and clinical course of the dementia complex appear to be poorly defined. The estimates for the appearance of dementia are based on clinical and pathological studies.<sup>24</sup> Therefore, the frequency of this syndrome during each stage of the HIV infection is uncertain. However, it appears to be limited to the later stages of the AIDS illness.<sup>25</sup>

At present, there is no cure for AIDS although researchers are aggressively attempting to find one. One of the first conferences to highlight advances in AIDS chemotherapy was recently held at the University of Alabama Medical Center. A number of researchers presented promising findings. William Prusoff, the forefather of the azido amino-nucleoside analogs, including AZT (one of the first drugs to show potential benefit to AIDS patients), chronicled the development of antiviral agents used for AIDS therapy. Prusoff's recent research has led to the development of several potentially effective anti-AIDS agents which are currently in advanced preclinical trials.<sup>26</sup>

Another researcher at the conference, Jean Louis Imbach, Ph.D., Professor of Chemistry at the University of Montpel-

lier, France, explained how a class of drugs called alpha and alpha beta oligonucleotides prevent HIV from replicating. "Current drugs, such as AZT, bind to specific sites crucial for HIV multiplication. Compounds studied by Imbach bind to viral DNA base sequences that carry the genetic information of the virus and interrupt its life cycle."<sup>27</sup>

#### How AIDS is Transmitted

According to the United States Department of Health and Human Services, AIDS is transmitted through sexual contact, exposure to infected blood or blood products and perinatally from mother to baby. The HIV virus has been isolated in blood, semen, vaginal secretions, saliva, tears, cerebrospinal fluid, amniotic fluid and urine. However, epidemiological evidence indicates that only blood, semen, vaginal secretions and possibly breast milk are involved in the transmission of AIDS.<sup>28</sup>

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The virus is carried in the semen or vaginal fluids of infected individuals. It may be transmitted by sexual intercourse to males and females as a result of heterosexual, bisexual or homosexual contact.<sup>29</sup> The virus usually enters the body via the penis, vagina, rectum or mouth. Anal intercourse appears to be the riskiest form of sexual contact.<sup>30</sup> It was initially thought that the rectal mucosa was particularly susceptible to injury. However, it is not clear that this is the causative factor.<sup>31</sup>

Currently, the weight of evidence appears to indicate that AIDS is not contracted through everyday contact in the workplace or at home, by swimming in pools or from mosquito bites.<sup>32</sup> However, such a statement is not meant to indicate that the methods of transmission and infectivity of the AIDS virus are conclusively known by the medical or scientific community. In fact, there is contradictory research on the subject indicating just how difficult it is at this time to make any definitive statement.<sup>33</sup> The

AIDS virus is particularly susceptible to damage. One must use caution when comparing the AIDS virus to other blood borne infectious agents, since the AIDS virus has unique properties.<sup>34</sup>

Certain behaviors have been characterized by the United States Department of Health and Human Services as risky when performed with an infected person. Such behaviors include: sharing needles and syringes; anal sex, with or without a condom; vaginal or oral sex with someone who is involved in intravenous drug use or engages in anal sex; sex with a prostitute; and sex, without a condom, with an infected person.<sup>35</sup>

#### Current Guidelines to Prevent Transmission from Health Care Workers to Patients

The CDC has issued guidelines for prevention of HIV transmission in health care settings and during invasive procedures. These guidelines include recommendations that:

(1) blood and body fluid precautions be consistently used for all patients regardless of their blood-borne infection status. This extension has been referred to as "Universal Precautions" and these precautions are intended to prevent parenteral, mucous membrane, and non-intact skin exposures of HCWs (health care workers) to blood-borne pathogens. Body fluids to which these precautions apply include blood, other body fluids containing visible blood, semen and vaginal secretions, and cerebrospinal, synovial, pleural, peritoneal, pericardial and amniotic fluids. Protective barriers, such as gloves, gowns, masks and protective eyewear should be employed whenever there is a risk of exposure to blood or other body fluids to which universal precautions apply.

(2) care be taken to prevent injuries when using needles, scalpels and other sharp instruments.

(3) hands and other skin surfaces that are contaminated with blood or other body fluids to which universal precautions apply should be immediately and thoroughly washed.<sup>36</sup>

The above resolutions are evidence that the majority of the American Medical Association (AMA) recognizes that there is a problem and that there exists a potential for it to become compounded unless steps are taken. Substitute Resolution 6 asks that the problem of AIDS transmission from health care workers be addressed.

The AMA, in an effort to handle the potential problems resulting from health care workers with AIDS, has begun to devise guidelines for dealing with the situation. Report 7-I-88, generated in June 1988, is the result of Resolution 6,<sup>37</sup> "Disability for Physicians with Infectious Diseases," introduced by the Missouri delegation.<sup>38</sup> It was resolved that "the American Medical Association study the many and varied issues relating to physicians, resident physicians and medical students who become HIV or hepatitis B positive, particularly the issue of the availability of disability insurance...." It further calls for "the AMA to encourage insurers to pay appropriate disability income to potentially infectious physicians and other health care providers (hepatitis B or human immunodeficiency virus positive) who restrict or cease practice to minimize risk of infecting patients."

Resolution 183, contained in Substitute Resolution 6, calls for the "AMA to work with appropriate organizations to develop national policies that address the issue of the HIV-seropositive resident."<sup>39</sup> These policies should address: (1) discrimination; (2) confidentiality; (3) financial support, if training is discontinued; and (4) medical procedures that can be performed while undergoing specialty training."<sup>40</sup>

Resolution 187, also contained in Substitute Resolution 6, asks the "AMA to work with constituent state associations and specialty societies to review and recommend changes to disability policies for health care workers who must withdraw from all or part of their duties due to HIV-seropositivity and to develop guidelines that will assist health care workers in understanding and evaluating appropriate disability insurance policies."<sup>41</sup>

The final resolution, Resolution 200, contained in Substitute Resolution 6, requests the AMA "to adopt a policy that HIV-seropositivity should not be the sole reason for removal of a physician from the medical staff, to declare that HIV-positive physicians should be allowed to continue to practice medicine so long as they cannot transmit the virus, and to establish a policy for HIV-positive physicians whereby modification of medical staff privileges or dismissal should be based on whether that physician exposes patients to a risk of HIV infection."<sup>42</sup>

As of the summer of 1988, approximately 5.5% of the total number of AIDS cases in the United States had occurred in health care workers (HCW).<sup>43</sup> The median age for HCWs with AIDS is thirty-five years, similar to the general population. Of the HCWs with AIDS, 91.6% were males and the majority were white.

Ninety-five percent of the HCWs with AIDS could be classified into known transmission categories. The HCWs with AIDS were more likely to be homosexual or bisexual men and less likely to be intravenous drug abusers. However, they were also more likely to have an unknown risk factor.<sup>44</sup> Overall, 5.3% of the HCWs with AIDS had an undetermined risk factor compared to 2.8% for other AIDS patients. The reasons behind this are unknown, but could include a hesitancy on the part of HCWs with AIDS to report risk factors, or it could be a result of the occupational risk of HIV infection due to exposure to infected blood. Ten percent of all reported AIDS cases for which a risk could not be determined have been HCWs. This proportion has not changed with time.<sup>46</sup>

Although there are health care workers with HIV, there is currently no evidence of transmission of HIV from health care workers to patients.<sup>47</sup> One possible reason is that the concentration of HIV in the blood may be very low. However, the situation with HIV is similar to that of the hepatitis B virus (HBV).<sup>48</sup> It is useful to look at transmission of HBV from health care workers to patients because more is known about the transmission of HBV than HIV.

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Like HIV, HBV can be transmitted by both heterosexual and homosexual intercourse, by infected blood, and perinatally. Unlike HIV, HBV has been shown to be transmitted by saliva and from both patient to HCW and vice-versa.<sup>49</sup> There are three major risk factors associated with the transmission of HBV: male homosexuality; intravenous drug abuse; and heterosexual exposure. HBV is more infectious for humans than HIV, possibly because there is a much higher concentration of HBV ( $10^8$ /ml) than HIV ( $10^6$ /ml) in the blood.<sup>50</sup> The magnitude of HIV transmission, after a needlestick or an equivalent exposure, has been reported to be less than 1.0%, whereas there is a 19% to 24% risk of acquiring HBV following such exposure.<sup>51</sup> It is noteworthy that accidental needlestick transmission of HBV without concomitant transmission

of HIV with blood drawn from an AIDS patient has been reported.<sup>52</sup> Additionally, outbreaks of HBV associated with infected oral surgeons and dentists have been reported, thus demonstrating that transmission from an infected HCW to a patient does occur in the case of HBV.<sup>53</sup>

The latest report of the Board of Trustees of the AMA, taking into account the CDC guidelines, the incidence of HBV infection from HCWs to patients and the lack of definite information about transmission of HIV from HCWs to patients, states that "[s]o long as HIV-infected HCWs do not have any evidence of an illness that may compromise their ability to adequately and safely perform their medical duties, including invasive procedures, and so long as such HCWs adhere to current infectious disease control guidelines, they may continue with their professional practice."<sup>54</sup>

One suggestion would be to categorize physicians and HCWs in various stages of infection from AIDS. The smallest subset would contain physicians with mental impairments and AIDS symptoms. While no restrictions would be placed on the group (all physicians), it may be desirable to restrict seropositive (infectious) physicians from frequent direct patient contact, and the subset group may not be able to practice competent medicine at all due to mental deficiency.

#### Concerns and Rights of Physicians with AIDS

The primary conflict between the physician and patient or the physician and hospital is whether to allow the physician to continue in a medical capacity involving direct contact with patients. The physician has a financial as well as an emotional interest in continuing his job. The right of a physician to retain or acquire employment may depend on rights of nondiscrimination.<sup>55</sup> The physician can argue that AIDS, AIDS related complex (ARC),<sup>56</sup> or seropositivity does not impair performance on the job or place other employees or patients at risk. Discrimination based on health status is then unjustified. In addition, if it is determined that impairment or risk of infection exists, the physician may claim a right to alternative employment where there is no risk to others.

The hospital may attempt to claim that the fears of employees working in close contact with the infected physician could disrupt the smooth operation of the workplace. However, the United States Supreme Court has determined that such fears alone are not sufficient to justify the dismissal of such an individual.<sup>57</sup> The Court stated "society's accumulated myths and fears about disability

and disease are as handicapping as are the physical limitations that flow from actual impairment."<sup>58</sup>

Unless the physician informs the hospital, there is also the issue of confidentiality. Confidentiality of laboratory test results are often compromised by state statute or common law. The reasons behind this often involve the duty of an individual to warn of potential peril. Public health legislation frequently requires reporting of otherwise confidential information when contagious, infectious or sexually transmitted diseases are involved.<sup>59</sup> It is usually required that authorities protect such data from improper release. However, some cases of tracing may identify the party. In the case of AIDS, claims of confidentiality are reinforced by the argument that the premature release of seropositive results would deter members of high-risk populations from going through testing procedures. Yet physicians routinely submit to testing for tuberculosis and hepatitis B and readily acknowledge the wisdom behind the cessation of certain forms of patient contact.<sup>60</sup> However, tuberculosis is transmissible through saliva and may be transmitted by particulates in the air. Hepatitis B, as discussed earlier, has a different virulence than HIV.<sup>61</sup> Once again AIDS shows itself to be unique and difficult to deal with—on every level.

There are points at which the law mandates the disclosure of delicate and possibly harmful medical information. It is a principle of law that at some point disclosures are permissible breaches of confidentiality.<sup>62</sup> The Supreme Court of California summarized this principle when it observed that "[t]he protective privilege ends where the public peril begins."<sup>63</sup> It can be argued, though, that the protective duty owed to a third party, such as a patient, may be discharged by warning them of the source and nature of the danger.

The issue of AIDS and confidentiality frequently arises when health care workers feel the right and need to be notified of the status of patients with AIDS or ARC.<sup>64</sup> Members of the house staff<sup>65</sup> frequently argue that the fact that a patient is seropositive should be prominently displayed on the chart. However, within a hospital, the confidentiality of a medical chart is a contradiction in terms. Health care workers requesting such disclosure stress the severity of the illness and the "unknown" involved in transmission and infection.<sup>66</sup> Shouldn't the same standard apply to patients about to be treated by a physician seropositive for AIDS?

### Potential Causes of Action for Patients Treated by a Physician with AIDS

A patient who is treated by a physician with AIDS may have the following causes of action available to them: lack of informed consent; negligence; battery; fraudulent misrepresentation; or intentional infliction of emotional distress. These actions will be discussed along with pertinent defenses or limitations.

#### Informed Consent

A physician has a legal duty to disclose to a patient sufficient information to enable the patient to make an informed, intelligent choice whether to accept or reject a recommended procedure or treatment.<sup>67</sup> One of the elements of informed consent requires that a patient be informed of the known inherent risks which are material to an informed decision.<sup>68</sup> This element is tempered by the fact that a physician may refrain from informing a patient of certain information when he is reasonably certain the patient would develop anxiety which would be detrimental to the patient.<sup>69</sup> It may not be necessary for a patient to be informed that his physician has AIDS. Such knowledge, however, may be important in the patient's decision of whether to continue under the care and treatment of that physician.

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#### Negligence

The tort of negligence requires two elements: "1) a wrongful act or omission of a duty by the defendant; and 2) damage or loss to the plaintiff as a consequence of the defendant's wrongful act or omission."<sup>70</sup> A patient who contracts AIDS after exposure from an AIDS-infected physician may have a cause of action for negligence. But the patient must prove that the physician had a duty to disclose the condition or possibly a duty not to treat the patient. In addition to establishing a duty, the patient would have to demonstrate that the physician with AIDS was the proximate cause of the HIV infection.<sup>71</sup>

#### Battery

Battery is another cause of action which may be pursued by a patient treated by a physician with AIDS. Battery consists of the unpermitted application of trauma by an individual to the body of

another.<sup>72</sup> An accidental or inadvertent touching does not constitute battery.<sup>73</sup> Transmission of an infectious disease like AIDS would qualify as a harmful or offensive contact on the part of the defendant physician. The pain and emotional trauma of the disease would certainly establish the harm.<sup>74</sup> This element may be more difficult to establish by a patient who does not yet have the disease but who merely becomes aware of the potential harm when the physician's condition is revealed.

The plaintiff in a battery action must establish that the defendant intended to cause the unprivileged contact or transmission of the disease. It is the rare or nonexistent physician who intends to cause harm or the transmission of a deadly disease. However, it is possible that a court may infer the intent from the lack of disclosure by the physician with the infectious disease.<sup>75</sup> The physician who informs his patient that he has AIDS and obtains the patient's consent to treatment will be protected from a charge of battery. However, such consent will not insulate the physician from a suit for a lack of informed consent.<sup>76</sup>

#### Intentional and Negligent Misrepresentation

There are five elements which must be satisfied in an action for intentional misrepresentation by a physician. They are: 1) the physician makes a false representation of material fact to the plaintiff patient; 2) the falsity is known to the physician, or the misrepresentation is made with such reckless disregard for the truth as to be the equivalent of actual knowledge of its falsity; 3) the misrepresentation was made by the physician for the purpose of defrauding the patient; 4) the patient not only relied upon the misrepresentation but had a right to rely on it; and 5) the patient suffered damages as a direct result of their reliance upon the physician's misrepresentation.<sup>77</sup>

Normally a defendant in such actions is not liable for expressions of opinion, expectations, judgment or ordinary "puffing."<sup>78</sup> A false representation dealing with a matter which is peculiarly within the knowledge of the representer is actionable if the plaintiff relies upon the representation to his detriment.<sup>79</sup> A physician would have knowledge about the transmission of AIDS that a patient may not be able to verify. Considering the indefinite nature of certain aspects of AIDS, it is likely that a physician disclosing that he had AIDS, by discussing what he realistically expects the chances of transmission to be, would be able to defend an action of intentional misrepresentation.

A more likely situation would involve a patient suing for intentional misrepresentation by omission after discovering that the surgeon who removed his appendix had AIDS. In Maryland, a deliberate omission or concealment of material fact is actionable as an affirmative misstatement.<sup>80</sup> Maryland courts recognize that "fraud may consist in a suppression of the truth as well as in the assertion of a falsehood."<sup>81</sup> Normally there is no duty to disclose information that is not requested. However, confidential or special relationships impose an affirmative duty of full disclosure.<sup>82</sup> In addition to intentional misrepresentation by omission, a patient would also have the action of negligent misrepresentation by omission available to him.<sup>83</sup>

An alternative is an action for negligent misrepresentation. In contrast to actions for intentional misrepresentation, actions for negligent misrepresentation do not require that plaintiffs demonstrate that the defendant acted willfully.<sup>84</sup> Negligent representation actions evolved because plaintiffs were suffering damages, yet had no right of recovery.<sup>85</sup> Negligent misrepresentation requires the following elements: 1) the defendant owed a duty of care to the plaintiff; 2) the defendant made a false statement of material fact to the plaintiff; 3) the defendant intended that the plaintiff rely on the statement; and 4) the plaintiff sustained damages as a direct result of the defendant's negligent statement.<sup>86</sup> It is not required that the plaintiff prove that the defendant knew the statement was false when made, but merely that the statement was made negligently, without regard to whether it was true or not.<sup>87</sup>

### Intentional and Negligent Infliction of Emotional Distress

An action for intentional infliction of emotional distress requires the plaintiff patient to demonstrate that: 1) the defendant physician's conduct was intentional or reckless; 2) the physician's conduct was extreme and outrageous; 3) there was a causal connection between the physician's wrongful conduct and the emotional distress; and 4) the emotional distress was severe.<sup>88</sup> The long incubation period for AIDS (time after exposure to develop antibodies to the virus and the even longer period of latency before the disease manifests itself), is arguably a factor causing severe emotional distress. It is also a factor which may make it impossible for the plaintiff patient to prove the defendant physician actually was responsible for transmission of the virus. Be-

cause of this, some patients may argue the physician was responsible for negligent infliction of emotional distress.

The majority of courts which recognize this form of action limit liability to situations where the emotional harm is connected to an independently actionable tort or with a "contemporaneous or consequential physical injury."<sup>89</sup> This being the case, the patient would be more likely to bring an action based on one of the tort actions already discussed. An action for infliction of emotional distress would most likely be brought by an individual choosing to bring action based on their exposure to the disease (i.e., surgeon with AIDS cuts himself while removing the plaintiff's spleen). This avoids waiting to determine whether the virus actually manifests itself. Such a preemptive action would appear to avoid the problem of causation and proving that the physician actually transmitted the virus to the plaintiff.

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*"The long incubation period for AIDS...is arguably a factor causing severe emotional distress."*

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### Conclusion

Because AIDS is widely recognized as a fatal disease, there is concern about its possible transmission in health care settings from both patients and health care workers. Yet, only twenty-two cases of HIV infection were the result of transmission from infected patients to HCWs.<sup>90</sup> The majority of these cases were from accidental needlesticks. These facts must be tempered with the knowledge that not all the cases were the result of an accidental needlestick.<sup>91</sup> At this time, the AMA may take comfort in the statistic that although 5.5% of adult cases of AIDS have occurred in HCWs, there has not been a single case reported to date of any patient being infected by a HCW carrying the virus.<sup>92</sup> The AMA suggests that this may be because so few of the infected HCWs perform invasive procedures, and those that do are extraordinarily careful to avoid transmission of the virus.<sup>93</sup> It is interesting that the AMA, in suggesting

the above reasons, fails to mention the most obvious—the delay in testing positive for exposure to the virus (as of June 1, 1989 the time for incubation of the virus prior to testing positive is said to be one to three years) and the five to ten year delay known to exist before developing the AIDS disease.

### Endnotes

<sup>1</sup>People, February 17, 1989, at 254B3.

<sup>2</sup>Williams, *Blood Transfusions and AIDS: A Legal Perspective*, 32 Med. Trial Tech. Q. 267 (1986); Burda, *News at Deadline*, Hospitals, Aug. 20, 1987 at 18.

<sup>3</sup>J. Ring, *Report I: The Board of Trustees of the American Medical Association*, CDC Reports (1988). Not all of the physicians have remained in practice. Some physicians removed themselves from practice so as to avoid any problems.

<sup>4</sup>See, e.g., Droste, *Medical Staff*, Hospitals, Dec. 5, 1986, at 61-62. See also, Cherskov, *M.D. with Aids; Scenario Poses Policy Questions*, Med. Staff, Apr. 5, 1987, at 68-69 (a Cook County hospital reported a suit filed by a physician who was suspended from practice due to having AIDS); Burda, *News at Deadline*, Hospitals, Aug. 20, 1987 at 18 (discussing Cook County physician's lawsuit seeking \$1 million in damages and the right to practice without restrictions).

<sup>5</sup>Fauci, *The Human Immunodeficiency Virus; Infectivity and Mechanisms of Pathogenesis*, 239 Science 617-22 (1988).

<sup>6</sup>Centers for Disease Control, AIDS Weekly Surveillance Rep.-U.S., Nov. 30, 1987.

<sup>7</sup>HIV is the etiologic agent of the acquired immunodeficiency syndrome.

<sup>8</sup>Fauci, *supra* note 5.

<sup>9</sup>Fauci, *Acquired Immunodeficiency Syndrome: Epidemiologic, Clinical, Immunologic, and Therapeutic Considerations*, 100 Annals of Internal Med. 92-106 (1984).

<sup>10</sup>Roberts, *Treatment of Opportunistic Infections in Patients with Acquired Immunodeficiency Syndrome in The Acquired Immune Deficiency Syndrome and Infections of Homosexual Men* 314 (1986).

<sup>11</sup>Endothelial cells are cells which line the cavities of the heart, blood and lymph vessels, as well as other cavities of the body.

<sup>12</sup>Fibroblasts are a type of connective tissue cell.

<sup>13</sup>An organ of the digestive, respiratory, urogenital and endocrine systems, the spleen, the heart and great vessels.

<sup>14</sup>Ring, *supra* note 3.

<sup>15</sup>Wiley, et al., *Cellular Localization of*

- Human Immunodeficiency Virus Infection Within the Brain of Acquired Immune Deficiency Syndrome Patients*, 83 Proc. Nat'l. Acad. Sci. U.S.A. 7089 (1986); Stoler, et al., *Human T-Cell Lymphotropic Virus Type III Infection of Central Nervous System*, 256 J. Am. Med. A. 2360 (1986); Gyorkey, et al., *Human Immunodeficiency Virus in Brain Biopsies of Patients With AIDS and Progressive Encephalopathy*, 155 J. Infect. Dis. 870 (1988); Price, et al., *The Brain in AIDS: Central Nervous System HIV-1 Infection and AIDS Dementia Complex*, 239 Science 586-92 (1988).
- <sup>16</sup>Price, *supra* note 15.
- <sup>17</sup>Navia, et al., *The AIDS Dementia Complex: I. Clinical Features*, 19 Ann. Neurology 517 (1986).
- <sup>18</sup>Price, *supra* note 15.
- <sup>19</sup>Price, *supra* note 15 at 587.
- <sup>20</sup>Price, *supra* note 15.
- <sup>21</sup>Tross, et al., *AIDS: Proceedings of Third International Conference on AIDS*, June 1-5, 1987, Wash. D.C. (in press).
- <sup>22</sup>*Id.*
- <sup>23</sup>Ornitz, *AIDS: Proceedings of Third International Conference on AIDS*, June 5, 1987, Wash., D.C. at 189 (in press).
- <sup>24</sup>Price, *supra* note 15.
- <sup>25</sup>Price, *supra* note 15.
- <sup>26</sup>Diasio, *Advances in Chemotherapy of AIDS*, 1 UAB Insight (1989).
- <sup>27</sup>*Id.*
- <sup>28</sup>*Morbidity and Mortality Weekly Report* (Supplement), Vol. 36 MMWR (Supplement) 1987.
- <sup>29</sup>*Understanding AIDS: A Message from the Surgeon General*, HHS 88-8408.
- <sup>30</sup>Curran, et al., *The Epidemiology of AIDS: Current Status and Future Prospects*, 229 Science 1352 (1985).
- <sup>31</sup>Curran, 259 Sci. Am. 72 (1988). ("Syphilis and genital herpes as well as other cases of genital or anal ulcers have been associated with HIV infection. It is supposed that the damage done to the genital skin and mucous membranes by these infections may facilitate HIV acquisition or transmission").
- <sup>32</sup>Fauci, *supra* note 5.
- <sup>33</sup>O'Connor, *AIDS: The Alarming Reality* pp. 19-25 (4th Ed. 1988) (citing studies which document researchers and health care workers infected with the AIDS virus). Gianelli, *Researcher in AIDS Lab Infected with HIV*, American Medical News, p.2 (September 18, 1987); CDC, 36 MMWR 285-88 (May 22, 1987); Wahn, et al., *Horizontal Transmission of HIV Infection Between Two Siblings*, Lancet p. 694 (1986); Pahwa, et al., *Spectrum of Human T-cell Lymphotropic Virus Type III in Children*, 2299-2305, (1986); Salahirdin, et al., *HTLV-III in Symptom-free Seronegative Persons*, Lancet 1418-1420 (1984).
- <sup>34</sup>Resnik, et al., *Stability and Inactivation of HTLV-III/LAV Under Clinical and Laboratory Environments*, 255 J. Am. Med. A. 1887-91 (1986).
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- <sup>36</sup>Richardson, et al., *Biosafety in Microbiological and Biomedical Laboratories*, United States Department of Health and Human Services, Public Health Service HHS CDC 84-8395.
- <sup>37</sup>Ring, *supra* note 3.
- <sup>38</sup>Obtained from American Medical Association National Office in Chicago, Illinois.
- <sup>39</sup>Physician undergoing post-graduate clinical training.
- <sup>40</sup>Ring, *supra* note 3.
- <sup>41</sup>Ring, *supra* note 3.
- <sup>42</sup>No. 5 DRGs For Rural Hospitals (Reference Committee A) at 442.
- <sup>43</sup>*Acquired Immunodeficiency Syndrome and Human Immunodeficiency Virus Infection Among Health Care Workers*, 37 MMWR 229-39 (1988).
- <sup>44</sup>*Id.*
- <sup>45</sup>Ring, *supra* note 3.
- <sup>46</sup>Ring, *supra* note 3.
- <sup>47</sup>Ring, *supra* note 3.
- <sup>48</sup>Both illnesses are transmitted via blood products and bodily fluids.
- <sup>49</sup>Ring, *supra* note 3.
- <sup>50</sup>Werner, *Hepatitis B Immune Globulin for Accidental Exposures Among Medical Personnel: Final Report of a Multicenter Controlled Trial*, 138 J. Infect. Dis 625 (1978).
- <sup>51</sup>*Id.*
- <sup>52</sup>Gerberding, et al., *Transmission of Hepatitis B Without Transmission of AIDS by Needlestick*, 312 New England J. Med. 56 (1985).
- <sup>53</sup>Shaw, et al., *Lethal Outbreak of Hepatitis B in a Dental Practice*, 255 J. Am. Med. A. 3260-64 (1986); Kane, et al., *Transmission of HBV from Dental Personnel to Patients*, 110 J. Am. Dental A. 634 (1985).
- <sup>54</sup>Ring, *supra* note 3.
- <sup>55</sup>Murphy, *Protecting Employees with AIDS: Using Title VII to Meet an Urgent Need*, 7 Rev. Litigation 357 (1988).
- <sup>56</sup>Aids related complex occurs in individuals who are infected with the virus, who are symptomatic, but do not fulfill the criteria for the full-blown disease. It is estimated that 25% of patients with ARC develop the full-blown disease within three years. Braunwald, et al., *Harrison's Principles of Internal Medicine*, p. 1394, McGraw-Hill, 1987.
- <sup>57</sup>*School Bd. of Nassau County v. Arline*, 480 U.S. 273 (1987).
- <sup>58</sup>*Id.*
- <sup>59</sup>H. Dalton and S. Burris, *AIDS and the Law: A Guide for the Public* at 47-65 (1987).
- <sup>60</sup>These diseases are readily transmissible and once discovered they are amenable to treatment.
- <sup>61</sup>Virulence is the quality of being poisonous, the disease evoking power of a microorganism in a given host. It is the ability to cause disease.
- <sup>62</sup>*Whalen v. Roe*, 429 U.S. 589 (1977).
- <sup>63</sup>*Tarasoff v. Regents of the Univ. of Calif.*, 17 Cal. 3rd 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976).
- <sup>64</sup>Johnson, *AIDS Economic, Social Impact Heightens Concern*, 261 J. Am. Med. A. 17 (1989).
- <sup>65</sup>Physicians accorded the privilege of admitting patients to the hospital.
- <sup>66</sup>In reality the physicians are acknowledging that they are not always following "Universal Precautions" (guidelines set out by the Centers for Disease Control). However, when they know a patient has AIDS, they follow the guidelines more closely.
- <sup>67</sup>*Sard v. Hardy*, 281 Md. 432, 379 A.2d 1014 (1977).
- <sup>68</sup>*Cobbs v. Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972).
- <sup>69</sup>Lecture by Dr. I. Bianco, Law and Medicine, University of Baltimore (Spring 1989).
- <sup>70</sup>*Telak v. Maszczenski*, 248 Md. 476, 237 A.2d 434 (1968); *Acker, Menrall & Condit Co. v. McGaw*, 106 Md. 536, 68 A. 17 (1907).
- <sup>71</sup>See *Peterson v. Underwood*, 258 Md. 9, 264 A.2d 851 (1970); *Mayor of Baltimore v. Seidel*, 44 Md. App. 465, 409 A.2d 747 (1980).
- <sup>72</sup>Gilbert, *Maryland Tort Law Handbook*, § 3.1 (1986).
- <sup>73</sup>*Steinman v. Baltimore Antiseptic Steam Laundry Co.*, 109 Md. 62, 71 A. 517 (1908).
- <sup>74</sup>Leonard Karp and Dr. Cheryl Karp, *Sexual Domestic Torts - Transmission of Contagious Diseases*, 1 American Journal of Family Law No. 4 at 412 (1987).
- <sup>75</sup>*State v. Lanford*, 29 Del. 594, 102 A. 63, 64 (1917).
- <sup>76</sup>Dr. Bianco classroom communication, Law and Medicine, University of Baltimore (Spring 1988).
- <sup>77</sup>James & Gray, *Misrepresentation-Part I*, 37 Md. L. Rev. 286 (1977); James & Gray, *Misrepresentation Part II*, 37 Md. L. Rev. 488 (1978); Gilbert, *supra* note 72 at § 17.1
- <sup>78</sup>Puffing is an expression of opinion not

made as a representation of fact. It is an exaggeration by a person concerning the quality of goods or services (usually not considered to be a legally binding promise). *Gulf Oil Corp. v. Federal Trade Commission*, 150 F.2d 106, 109 (1945).<sup>79</sup>*Buschman v. Codd*, 52 Md. 202, 208 (1879).

<sup>80</sup>Gilbert, *supra* note 72 at § 17.3

<sup>81</sup>*Schnader v. Brooks*, 150 Md.52, 132 A. 381 (1926).

<sup>82</sup>See, Comment, *Maryland and Common Law Remedies for Misrepresentation in Securities Actions*, 13 U. Balt. L. Rev. 574, 581-83 (1984).

<sup>83</sup>*Leonard v. Sav-A Stop Servs., Inc.*, 289 Md. 204, 213, 424 A.2d 336, 340 (1981).

<sup>84</sup>*Virginia Dare Stores, Inc. v. Schuman*, 175 Md. 287, 1 A.2d 897 (1938); *Martens Chevrolet, Inc. v. Seney*, 292 Md. 328, 439 A.2d 534 (1982).

<sup>85</sup>*Virginia Dare Stores, Inc.*, 175 Md. 287, 1 A.2d 897 (1938).

<sup>86</sup>*Martens Chevrolet Inc.*, 292 Md. 328, 439 A.2d. 534 (1982).

<sup>87</sup>*Id.*

<sup>88</sup>Restatement (Second) of Torts § 46.1 (1977); *Harris v. Jones*, 281 Md. 560, 380 A.2d 611 (1977).

<sup>89</sup>See, Comment, *Negligent Infliction of Emotional Distress: Developments in the Law*, 14 U. Balt. L. Rev. 135 (1984). See generally, Keeton & Prosser, *On The Law of Torts*, § 54 (5th ed. 1984).

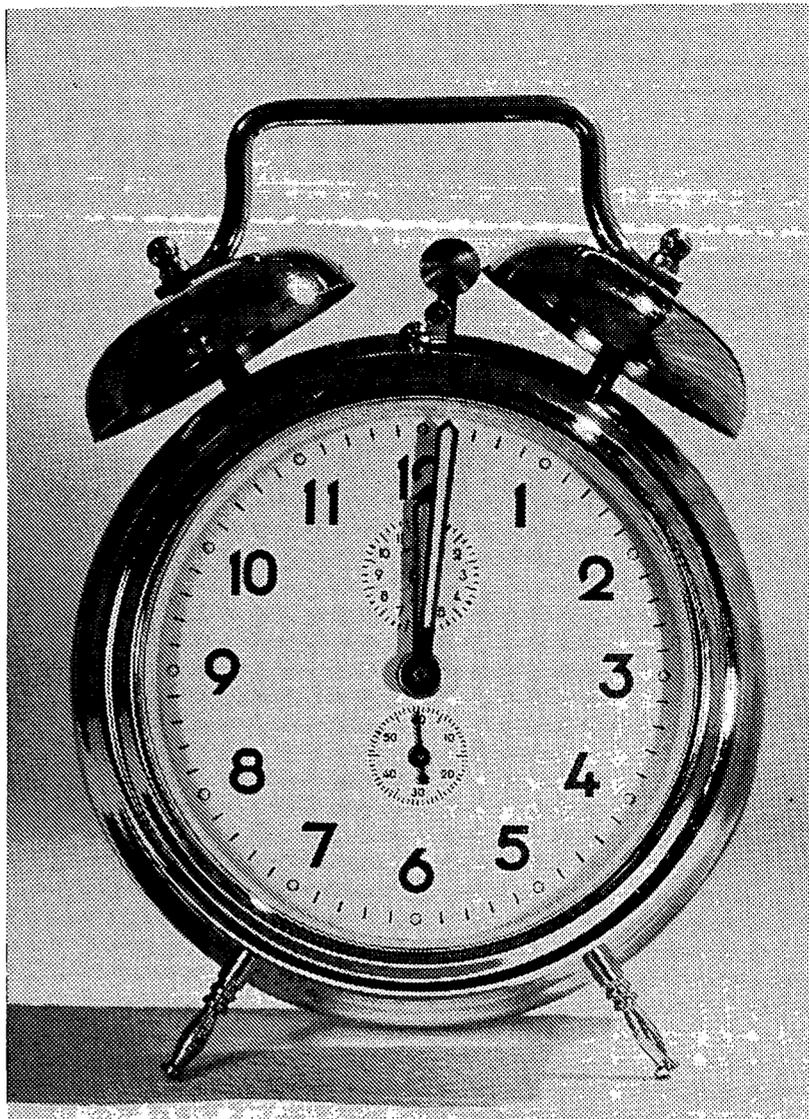
<sup>90</sup>CDC: *Update: Acquired Immunodeficiency Syndrome and Human Immunodeficiency Syndrome and Human Immunodeficiency Virus Infection Among Health Care Workers*, 37 MMWR 229 (1988).

<sup>91</sup>*Id.*

<sup>92</sup>Ring, *supra* note 3.

<sup>93</sup>*Id.*

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