# Ethical Problems for Physicians Raised by AIDS and HIV Infection: Conflicting Legal Obligations of Confidentiality and Disclosure

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## INTRODUCTION

Considering the rising incidence of human immunodeficiency virus (HIV) infection and its symptoms,[1] including acquired immune deficiency syndrome (AIDS), it was natural that ethical problems and associated commentary would proliferate.[2] Unfortunately, however, the commentary has not sufficiently examined the problems that physicians and health-care workers can experience in attempting to reconcile their legal, ethical, and public-health responsibilities in treating HIV-infected patients.[3]

Physicians can encounter problems of unexpected dimensions both in the duty to treat and in the extraordinary sensitivity of information about the HIV status of patients and others in the health-care setting.

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[1] By 1992, the United States will have seen 365,000 cases of AIDS, 263,000 cumulative deaths, 80,000 new cases in one year, and 66,000 deaths in one year. Centers for Disease Control, *Quarterly Report to the Domestic Policy Council on the Prevalence and Rate of Spread of HIV and AIDS — United States*, 260 J. A.M.A. 1845 (1988).

[2] *See, e.g.*, Sherer, Book Review, 260 J. A.M.A. 1301 (1988) (reviewing AIDS: PRINCIPLES, PRACTICES, AND POLITICS (I. Corless & M. Pittman-Lindeman 1988)) (wondering when saturation will be reached in public debate on AIDS).

[3] *See, e.g.*, Richardson, Lochner, McGuigan & Levine, *Physician Attitudes and Experience Regarding the Care of Patients with Acquired Immunodeficiency Syndrome (AIDS) and Related Disorders (ARC)*, 25 MED. CARE 675 (1987). Surveys show wide variation among hospitals and physicians in their use of the HIV antibody test and the confidentiality of AIDS-related records. *See, e.g.*, Henry, Willenbring & Crossley, *Human Immunodeficiency Virus Antibody Testing: A Description of Practices and Policies at U.S. Infectious Disease-Teaching Hospitals and Minnesota Hospitals*, 259 J. A.M.A. 1819 (1988).



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Physicians and their attorneys should examine developing public policy with great concern.[4] Both federal and state activities affect physician use of AIDS-related information.

The purpose of this Article is to describe the operative medical facts, to identify the areas in which substantial legal issues arise, and to propose a traditional public-health framework in which to resolve competing policies and interests. The Article concludes that AIDS-related ethical problems are not unprecedented but are part of the larger context of medical ethics. Physicians and hospitals treating HIV-infected patients ought not to face any increase in civil liability or other penalties already applicable.

## I. Treatment and Care of Patients with AIDS and HIV Infection

A recent survey shows that twenty-five percent of young physicians would not voluntarily treat AIDS patients.[5] Some physicians have stated publicly that they do not intend to evaluate or to treat HIV-infected patients, and a limited survey of surgeons showed widespread support for refusing to treat such patients.[6] A vigorous response in the medical literature condemns stigmatizing AIDS patients and exhorts physicians to fulfill the ethical obligation to treat HIV-infected patients.[7] By contrast, the *legal* obligation to provide treatment depends

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[4] Many states specifically regulate physician duties of confidentiality and disclosure of AIDS-related medical information about patients. *See, e.g.*, *infra* notes 125-30; *see also* Faden & Kass, *Health Insurance and AIDS: The Status of State Regulatory Activity*, 78 Am. J. Pub. Health 437 (1988).

[5] Link, Feingold, Charap, Freeman & Shelou, *Concerns of Medical and Pediatric House Officers About Acquiring AIDS from Their Patients*, 78 Am. J. Pub. Health 455 (1988); Rogers, *Caring for the Patients with AIDS*, 259 J. A.M.A. 1368 (1988).

[6] *See* Kim & Perfect, *To Help the Sick: An Historical Essay Concerning the Refusal to Care for Patients with AIDS*, 84 Am. J. Med. 135, 136 (1988) (citing Clark, Huck & Quade, *Doctors Fear AIDS, Too*, Newsweek, Aug. 3, 1987, at 58-59).

[7] Kelly, Lawrence, Smith, Hood & Cook, *Stigmatization of AIDS Patients by Physicians*, 77 Am. J. Pub. Health 789 (1987); Kim & Perfect, *supra* note 6; Link, Feingold, Charap, Freeman & Shelou, *supra* note 5; Rogers, *supra* note 5; Walters, *Ethical Issues in the Prevention and Treatment of HIV Infection and AIDS*, 239 Science 597 (1988). The American Medical Association (AMA) Council on Ethical and Judicial Affairs has categorically stated:

> A physician may not ethically refuse to treat a patient whose condition is within the physician's current realm of competence solely because the patient is seropositive. Persons who are seropositive should not be subjected to discrimination based on fear or prejudice. . . . Physicians are dedicated to providing competent medical service with compassion and respect for

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on many varying circumstances.

### A. *The Physician-Patient Relationship*

Office practitioners treating HIV-infected patients have relative autonomy in the absence of an institutional setting. They also can have difficulties in resolving ethical problems and in discharging their public-health responsibilities. The first question they may face is whether to enter a physician-patient relationship.

Physicians have no special legal obligations to nonpatients.[8] Although courts seem "quick to establish a physician-patient relationship," the law imposes no duty on physicians to take a prospective patient.[9] The decision whether to treat is "more a matter of conscience than of legal

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> human dignity. . . . Physicians who are unable to provide the services required by AIDS patients should make referrals to those physicians or facilities equipped to provide such services.

Council on Ethical and Judicial Affairs, American Med. Ass'n, *Ethical Issues Involved in the Growing AIDS Crisis*, 259 J. A.M.A. 1360, 1361 (1988) [hereafter *Ethical Issues*]; *see also* American Pub. Health Ass'n, *Irrational Response to the Fear of the Spread of the Virus that Causes AIDS*, 78 AM. J. PUB. HEALTH 188 (1988); Health & Pub. Policy Comm., American College of Physicians and the Infectious Diseases Soc'y of Am., *Position Paper: Acquired Immunodeficiency Syndrome*, 104 ANNALS INTERNAL MED. 575, 576 (1986).

[8] *But see infra* notes 186-96 (physician liability to nonpatients for failure to warn).

[9] Vogt, *Physician-Patient Relationship*, in AMERICAN COLLEGE OF LEGAL MEDICINE, LEGAL MEDICINE 189 (1988); *see* O'Neill v. Montefiore Hosp., 11 A.D.2d 132, 202 N.Y.S.2d 436 (1960) (appointment by telephone to treat blind woman created duty when woman appeared for treatment); Hamil v. Bashline, 236 Pa. Super. 267, 305 A.2d 57 (1973) (telephone call constituted advice and treatment). *But see* Fabian v. Matzko, 344 A.2d 569 (Pa. 1975) (telephone call insufficient to create relationship). Parties have not litigated whether refusing services to HIV-infected persons is grounds for a licensing authority to discipline physicians. *See* Dickens, *Legal Rights and Duties in the AIDS Epidemic*, 239 SCIENCE 580 (1988). "Physicians are free to choose their patients and are not obligated to treat anyone with whom they have no special relationship." Vogt, *supra*, at 189; *see also* Oliver v. Brock, 342 So. 2d 1 (Ala. 1977) (finding no obligation to practice); Hiser v. Randolph, 126 Ariz. 608, 617 P.2d 774 (1980) (holding that physician may refuse to treat patient); Pearson v. Norman, 106 Colo. 396, 106 P.2d 361 (1940); Childers v. Frye, 201 N.C. 42, 158 S.E. 744 (1931); Duke Sanitarium v. Wearn, 159 Okla. 1, 13 P.2d 183 (1932) (holding that license to practice does not require physician to accept all comers); Childes v. Weiss, 440 S.W.2d 104 (Tex. Ct. App. 1969) (holding that physicians may arbitrarily refuse care to nonpatient); Hoover v. Williamson, 236 Md. 250, 203 A.2d 861 (1964) (finding no duty to nonpatient unless physician assumes to act); *cf.* Coss v. Spaulding, 41 Utah 447, 126 P. 468 (1912) (holding that physician-patient relationship created when physician employed by third party only for examination purposes but gratuitously advised patient).

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or professional liability."[10] Thus, a physician may refuse to treat an AIDS patient.[11] A physician may also qualify and limit the physician-patient relationship.[12]

Unlike physicians, hospitals have a duty to provide at least emergency care.[13] As public accommodations, hospitals may be prohibited from discriminating on the basis of handicap. Clinical trials and other drug-testing activities can bring HIV patients into contact with physicians in hospitals. A physician-patient relationship with a clinical professor who has seen a patient may arise if the patient had a reasonable expectation that the professor's role included treatment.[14] Third parties, such as employers, sometimes engage physicians to examine patients only for diagnosis. When examinations are not therapeutic, no physician-patient relationship arises.[15] Physicians must not exceed the scope of their employment, however, for any advice (let alone treatment) that they render is likely to create a physician-patient relationship.[16] Third party payment, by an insurer or health maintenance organization, does not affect the physician-patient relationship.[17]

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[10] Kim & Perfect, *supra* note 6, at 135.

[11] *See Physician Can't Be Held Liable for Refusing to Treat AIDS Patient*, 57 U.S.L.W. 2121 (1988).

[12] The physician "may limit his engagement to treat a patient to one particular treatment or procedure, and may limit his availability to certain times or places." Vogt, *supra* note 9, at 189. *See generally* Osborne v. Frazor, 58 Tenn. App. 15, 425 S.W. 2d 768 (1968) (stating that relationship may be general or limited by its terms); Sendjar v. Gonzalez, 520 S.W.2d 478 (Tex. Ct. App. 1975) (holding that physician had right to refuse hospital calls).

[13] Vogt, *supra* note 9, at 191 ("to the extent that hospital facilities . . . allow"). *See generally Hiser*, 126 Ariz. 608, 617 P.2d 774 (holding that assenting regulations of hospital altered physician's right to refuse to treat patient); Guerro v. Copper Queen Hosp., 112 Ariz. 104, 537 P.2d 1329 (1975) (licensing and health regulations justify imposition of duty to treat in hospital); Wilmington Gen. Hosp. v. Manlove, 54 Del. 15, 174 A.2d 135 (1961) (finding public reliance on hospitals to render emergency care).

[14] Vogt, *supra* note 9, at 190; *see* Smart v. Kansas City, 208 Mo. 162, 105 S.W. 709 (1907) (finding physician-patient relationship created when clinical professor examined patient with patient's knowledge, consent, and belief that purpose was for treatment); *cf.* Rainer v. Grossman, 31 Cal. App. 3d 539, 107 Cal. Rptr. 469 (1973) (finding no physician-client relationship when lecturing professor only gave advice in response to question); Rogers v. Horvath, 65 Mich. App. 644, 237 N.W.2d 595 (1975) (no physician-patient relationship when examination not conducted for patient's benefit).

[15] Vogt, *supra* note 9.

[16] *See generally* Keene v. Wiggins, 69 Cal. App. 3d 308, 138 Cal. Rptr. 3 (1977) (holding that voluntary care, treatment, or attempt to benefit worker establishes duty to worker).

[17] *See* Vogt, *supra* note 9, at 191.

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Controlling legal principles are not as rigorous as the medical profession's ethical principles.[18] In the case of treatment for AIDS and HIV infection the major medical societies unanimously recognize an ethical duty to provide necessary treatment to persons notwithstanding infectious condition.[19]

### *B. The Duty to Refer*

The physician who cannot or will not provide treatment to a particular patient must refer the patient to another physician or health-care provider.[20] Failure to exercise reasonable care in making such a referral may result in liability for abandonment.[21]

Statutes limit the discretion of hospitals and physicians to refer patients.[22] Economic factors affect the ability of health-care providers to treat patients with AIDS and HIV infection; therefore, state statutes dealing with the referral of indigent patients[23] will become increasingly important. When a physician-patient relationship has been established the physician must obtain the patient's consent to transfer; if the patient fails to consent, the physician must counsel the patient about the risks of not being transferred.[24] Referral may be ethically required if a special-purpose institution or other source of care is available that is clearly more suitable to the patient's financial or other requirements.[25]

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[18] *See, e.g.*, *Ethical Issues*, *supra* note 7; Health & Pub. Policy Comm., American College of Physicians & the Infectious Diseases Soc'y of Am., *The Acquired Immunodeficiency Syndrome (AIDS) and Infection with the Human Immunodeficiency Virus (HIV)*, 158 J. INFECT. DIS. 273 (1988).

[19] *See, e.g.*, *Ethical Issues*, *supra* note 7, at 1360 (stating that physicians may not ethically refuse to treat patient solely on account of HIV infection); Health & Pub. Policy Comm., *supra* note 18, at 275 (stating that denying appropriate care to patients is unethical).

[20] *Ethical Issues*, *supra* note 7, at 1361; Vogt, *supra* note 9, at 189.

[21] *See* Vogt, *supra* note 9, at 189.

[22] *See, e.g.*, CAL. HEALTH & SAFETY CODE § 1451 (West 1979) (allowing transfer of patient provided that alternative was of same level of care).

[23] *See, e.g.*, *id.* (allowing transfer of indigent patients to facilities providing treatment not available in the transferring facility).

[24] *See* Cotton, *The Impact of AIDS on the Medical Care System*, 260 J. A.M.A. 519, 523 (1988) (arguing that special centers for AIDS treatment may be necessary).

[25] *Id.*

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### *C. Particular Problems in AIDS and HIV Treatment*

Ethical problems are a daily presence in a medical practice.[26] Accordingly, many ethical issues that physicians face in caring for AIDS patients are not unique to the disease. In cases of AIDS, however, certain issues are likely to appear with greater frequency or complexity.

Some AIDS-related ethical problems are unique, have a unique scope, or arise more frequently than in other diseases. For example, a doctor's decision not to prescribe a certain drug may appear to the patient as a refusal to treat.[27] A guardianship issue may arise when a homosexual AIDS patient wants his partner to make decisions for him because the partner cannot make these decisions unless legally designated.[28] Confidentiality issues that are specifically related to the patient's sexual orientation complicate this problem.[29]

Some ethical problems are particularly associated with AIDS because they are rooted in public and private attitudes about how the disease is transmitted.[30] Ethical problems in the treatment of AIDS and HIV are also associated with negative attitudes toward homosexuals.[31]

Like other patients who require life-sustaining treatment, many AIDS patients might be mentally incompetent to participate in the decision whether to use mechanical ventilation and cardiopulmonary re-

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[26] *See* Connelly & DalleMura, *Ethical Problems in the Medical Office*, 260 J. A.M.A. 812 (1988) (identifying ethical conflicts affecting 30% of patients and 21% of office visits, including costs of care (11.1%), psychological factors that influence preferences (9.6%), competence and capacity to choose (7.1%), refusal of treatment (6.4%), informed consent (5.7%), and confidentiality (3.2%)).

[27] *See* Cotton, *supra* note 24, at 521 (stating that patients pressure physicians to prescribe drugs with which physicians have neither experience nor means to evaluate).

[28] *See* Steinbrook, Lo, Tirpack, Dilley & Volderding, *Ethical Dilemmas in Caring for Patients with the Acquired Immunodeficiency Syndrome*, 103 ANNALS INTERNAL MED. 787 (1985) [hereafter *Ethical Dilemmas*]; *see also* Steinbrook & Lo, *Decision Making for Incompetent Patients by Designated Proxy*, 310 NEW ENG. J. MED. 1598 (1984).

[29] *See* Cotton, *supra* note 24, at 521 (stating that a physician commonly conceals AIDS diagnosis from a patient's family who is unaware that the patient is gay, with the consequence that when the patient is no longer competent, the physician must refer to the family, rather than to the patient's life partner, questions of appropriate terminal care).

[30] For example, surgeons and others who perform invasive procedures on persons who are intravenous drug abusers will "consciously or unconsciously ask whether it is fair for them to risk acquiring a fatal infection to save the life of someone who probably will return to drug abuse after hospital discharge." *Id.* at 521.

[31] *Id.* at 523 (discussing prejudices in the health care system to treating gay and bisexual men).

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suscitation (CPR).[32] Physicians may withhold or withdraw mechanical ventilation and CPR in cases of long-term care for the elderly and terminally ill.[33] Some commentators argue that leaving the decision to withhold CPR to the health-care team promotes rational allocation of resources and that the patient or patient's surrogate should be consulted only in the event of disagreement among the health-care team.[34] The economics of health care for patients with AIDS will require difficult and far-reaching decisions about the application of various life-sustaining techniques.[35]

Another ethical issue may arise when the physician, rather than the patient, has an HIV infection.[36] In this case the physician may have the obligation *not* to provide treatment, at least in the performance of surgery and other invasive procedures.[37] The conflict between the physi-

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[32] *See Ethical Dilemmas*, *supra* note 28; *see also* Price, Bren, Sidtis, Scheck & Cleary, *The Brain in AIDS: Central Nervous System HIV-1 Infection and AIDS Dementia Complex*, 239 SCIENCE 586 (1988).

[33] *See generally In re* Quinlan, 70 N.J. 10, 355 A.2d 647 (1976); Ball, *Withholding Treatment: A Legal Perspective*, 32 J. AM. GERIATRIC SOC'Y 530 (1984); Murphy, *Do-Not-Resuscitate Orders: Time for Reappraisal in Long Term Care Institutions*, 260 J. A.M.A. 2098 (1988). *But see In re* O'Connor, 72 N.Y.2d 517, 531 N.E.2d 607, 534 N.Y.S.2d 886 (1988) (holding that artificial life support treatment cannot be withheld from incompetent patient absent clear and convincing evidence of patient's firm and settled commitment, made while competent, to decline such treatment); *cf.* Gray v. Romeo, 697 F. Supp. 580 (D.R.I. 1988) (holding that individual has right grounded in fourteenth amendment's due process clause to refuse life-sustaining treatment, including nutrition and hydration through feeding tube).

[34] Murphy, *supra* note 33, at 2100.

[35] Cotton, *supra* note 24, at 522 (stating that if AIDS therapies become partially effective, competition for scarce intensive care unit beds will increase, posing allocation issues).

[36] In 1988, 46 states had reported cases of health-care workers with AIDS. *See* Centers for Disease Control, *AIDS and HIV Update: Acquired Immunodeficiency Syndrome and Human Immunodeficiency Virus Infection Among Health Care Workers*, 259 J. A.M.A. 2817, 2817 (1988).

[37] *See Ethical Issues*, *supra* note 7, at 1361. *But see* Updegrove, *Ethical Issues in the AIDS Crisis: The HIV-Positive Practitioner*, 260 J. A.M.A. 790, 790 (1988) (criticizing AMA's position as "extremely vague"). *See generally* Centers for Disease Control, *Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus During Invasive Procedures*, 35 MMWR 221 (1986) [hereafter *Preventing Transmission*]. The physician's legal liability for transmitting an infectious disease to a patient as a result of failing to warn the patient of the condition was recognized long ago in the common law. *See, e.g.*, Piper v. Menifee, 51 Ky. 465 (12 B. Mon. 1851) (physician liable for failure to warn patient that physician had smallpox); *see also infra* note 182 and accompanying text (discussing confidentiality issues associated with HIV-positive health-care workers).

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cian's right of privacy, on the one hand, and countervailing duties to patients and public-health considerations, on the other, is apparent.[38]

Even under the best of circumstances, treating patients with serious chronic or terminal illness involves a significant degree of physician stress.[39] The problem of "burn-out" among physicians and health-care workers treating AIDS patients is necessarily related to ethical and legal problems. Health-care workers experience "significant anxiety" over occupational safety and health issues raised by the HIV epidemic.[40] Physicians who specialize in the treatment of sexually transmitted disease "have been relegated historically to second-class status within the profession."[41] In a few years in some urban hospitals one-fourth or more of all medical beds will be required for patients with AIDS.[42] Meanwhile a growing crisis exists in the national shortage of hospital nurses.[43] Increased AIDS-related health needs means an increased need for workers.[44] Subjecting health-care workers to the threat of increased penalties and civil liability in connection with the treatment of HIV patients could deter physicians and others from meeting that need.

### D. *Traditional Public-Health Responses to Epidemics of Infectious Disease*

Although some important problems are unique to AIDS and HIV infection, the fundamental issues involved have a parallel in recent American history. Physicians were reluctant to treat patients with syphilis and gonorrhea during the epidemic of venereal disease in the first half of this century, before the discovery of penicillin as a cure in 1943.[45] Many other aspects of the present epidemic, including the com-

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[38] *See* Doe v. County of Cook, No. 87 C 6888 (N.D. Ill., consent decree entered Feb. 4, 1988) (allowing plaintiff physician with AIDS to practice medicine at defendant hospital provided he complies with applicable CDC guidelines, follows appropriate hospital policies regarding the monitoring of employees with AIDS, and wears two sets of gloves for certain procedures and examinations).

[39] *See* McCue, *The Effects of Stress on Physicians and Their Medical Practice*, 306 NEW ENG. J. MED. 458 (1982).

[40] Cotton, *supra* note 24, at 520.

[41] *Id.*

[42] *Id.* at 522.

[43] *See* Aiken & Mullinax, *The Nurse Shortage: Myth or Reality?*, 317 N. ENG. J. MED. 641 (1987); Iglehart, *Problems Facing the Nursing Profession*, 317 N. ENG. J. MED. 646 (1987).

[44] Cotton, *supra* note 24, at 519.

[45] A. BRANDT, NO MAGIC BULLET 132 (1987).

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plex moral overtones and debate over education and public-health response, also have a historical basis.[46]

Of course, the epidemic of sexually transmitted disease in the earlier part of this century occurred before civil rights laws such as the Vocational Rehabilitation Act.[47] These civil rights protections, however, do not mean that the relevant ethical problems should be singled out for legislation by states, much less by the federal government. If anything, the civil rights protections that are already recognized for patients with infectious disease are factors militating *against* legislation that would increase the burdens under which health care professionals are already operating.

### *E. State Regulation of the Medical Profession*

The standard of care for physicians and other health-care providers is a matter of state law.[48] State legislatures, courts, and licensing boards deal with the conduct of health-care providers.

State medical-licensing boards have jurisdiction over confidentiality and other ethical standards.[49] State medical-licensing boards may disci-

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[46] *Id.*

[47] Pub. L. No. 95-602, § 119, § 16(d)(2), 92 Stat. 2982, 2987 (1978) (codified as amended at 29 U.S.C. § 794 (Supp. IV 1986) (protecting persons suffering from infectious diseases against discrimination); *see* School Bd. of Nassau County v. Arline, 480 U.S. 273 (1987); Ray v. School Dist. of DeSoto County, 666 F. Supp. 1524 (M.D. Fla. 1987); Thomas v. Atascadero Unified School Dist., 662 F. Supp. 376 (C.D. Cal. 1987); District 27 Community School Bd. v. Board of Educ., 130 Misc. 2d 398, 502 N.Y.S.2d 325 (Sup. Ct. 1986); Leonards, *AIDS and Employment Law Revisited*, 14 HOFSTRA L. REV. 11 (1985); *cf.* New York State Ass'n of Retarded Children v. Carey, 612 F.2d 644, 650 (2d Cir. 1979).

[48] In California, for example, the hospital and its personnel are under a duty to exercise that degree of care, skill and diligence required under the circumstances. 6 B. WITKIN, SUMMARY OF CAL. LAW, Torts § 750, at 87-88, § 801, at 153-54 (9th ed. 1988), *see* Wood v. Samaritan Inst., 26 Cal. 2d 847, 851, 161 P.2d 556, 558 (1945); Gin Non Louie v. Chinese Hosp. Ass'n, 249 Cal. App. 2d 774, 789, 57 Cal. Rptr. 906, 916 (1967); McDonald v. Foster Mem. Hosp., 170 Cal. App. 2d 85, 95, 338 P.2d 607, 612 (1959); Ericson v. Petersen, 116 Cal. App. 2d 106, 110, 253 P.2d 99, 101 (1953); Gray v. Carter, 100 Cal. App. 2d 642, 644, 224 P.2d 28, 29 (1950); Thomas v. Seaside Mem. Hosp., 80 Cal. App. 2d 841, 847, 183 P.2d 288, 292 (1947); Valentin v. La Societe Francaise, 76 Cal. App. 2d 1, 4, 172 P.2d 359, 361 (1946).

[49] Hawker v. New York, 170 U.S. 189, 191 (1898) (recognizing state's power to promulgate standards of behavior and ethics). *See generally* Brun v. Lazzell, 172 Md. 314, 191 A.2d 240 (1937) (disciplinary action against dentist); Raymond v. Board of Registration in Medicine, 387 Mass. 708, 443 N.E.2d 391 (1982) (holding possession of unregistered machine guns immoral); Yurick v. Community Bd. of Osteopathic Examination, 43 Pa. Commw. 248, 402 A.2d 290 (1979) (disciplinary action based on

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pline physicians for breaches of ethical obligations.[50] Boards typically begin disciplinary procedures before filing formal charges, which protects the privacy of the complaining party because the public has no access to dismissed complaints.[51] Also, most hospitals have internal mechanisms for addressing ethical problems.[52] Regulation of the medical profession is thus "a matter of exclusive statewide concern, to the extent that it enters an area fully occupied or preempted by general state law."[53]

## II. STATE PRIVACY RIGHTS IN MEDICAL RECORDS AND CORRESPONDING ETHICAL OBLIGATIONS OF PHYSICIANS

### A. *Background*

Since the Code of Hammurabi, physicians have been under ethical, moral, or professional obligations of confidentiality and privacy.[54] The privacy of the physician-patient relationship is recognized today in the Principles of Medical Ethics, which have been codified in many state codes of professional conduct.[55] Disclosure that is necessary for purposes of diagnosis and treatment or for other valid public-health rea-

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criminal conviction).

[50] Hyams, Sanbar & Warner, *Professional Practice Regulation*, in AMERICAN COLLEGE OF LEGAL MEDICINE, LEGAL MEDICINE 85 (1988).

[51] *Id.* at 86; *see In re* Board of Medical Review Investigation, 463 A.2d 1373 (R.I. 1983) (holding that pertinent confidentiality of health care information act did not prevent subpoena of physician's records of patient treatment during investigation). *See generally* Gill v. Mercy Hosp., 199 Cal. App. 3d 889, 295 Cal. Rptr. 304 (1988), *cert. denied*, 109 S. Ct. 227 (1988); State v. Civil Serv. Employees Ass'n, 104 Misc. 2d 1086, 430 N.Y.S.2d 510 (1980) (disciplinary proceedings against employee of mental health facility based on allegations of patient abuse).

[52] *See, e.g.*, Brennan, *Ethics Committees and Decisions to Limit Care: The Experience at the Massachusetts General Hospital*, 260 J. A.M.A. 803 (1988); LaPuma, Stocking, Silverstein, DiMartini & Siegler, *An Ethics Consultation Service in a Teaching Hospital: Utilization and Evaluation*, 260 J. A.M.A. 808 (1988). Courts have recognized the importance of internal hospital reviews.

[53] Northern Cal. Psychiatric Soc'y v. City of Berkeley, 178 Cal. App. 3d 90, 106, 223 Cal. Rptr. 609, 615-16 (1986) (holding municipal ordinance regulating electroshock treatment pre-empted by state law).

[54] Hirsch, Smith, Bisbing, Shemonsky & Wachsman, *Disclosure About Patients*, in AMERICAN COLLEGE OF LEGAL MEDICINE, LEGAL MEDICINE 208 (1988) [hereafter *Disclosure About Patients*]; *id.* at 209 (quoting Hippocratic Oath on preserving patient secrets); *see also* Petrillo v. Syntex Laboratories, 148 Ill. App. 3d 581, 499 N.E.2d 952 (1986), *cert. denied*, 107 S. Ct. 3232 (1987).

[55] *See Disclosure About Patients*, *supra* note 54 (quoting Principle IV's obligation of physicians to protect patients' confidences).

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sons is not an invasion of privacy.[56]

Much of the concern over the confidentiality of AIDS-related medical records applies to all medical records. An important source of this concern is the relationship between health care providers and third parties such as employers and insurance companies. Many insurance companies require as a condition for reimbursement that the patient waive privacy in respect to factors such as age, occupation, physical condition, health history, and avocations.[57] Also contributing to this concern are computerized information processing capabilities for storing, retrieving, and communicating medical records. For example, the Medicine Information Bureau, a nonprofit clearinghouse owned by insurance companies, operates a centralized patient-medical-record data base.[58]

Also, many persons must have access to confidential medical information about a patient. The patient's health-care team in a typical hospital consists of attending physicians, designated residents, specifically assigned nurses, technicians, ward clerks, social services staff, medical records staff, and patient advocates.[59] Their access to confidential medical information about patients has traditionally been unquestioned.[60] On the other hand, membership on the team is not automatic and does not extend to special consultants, students, or chaplains.[61]

Finally, the dramatic increase in private damage actions against physicians[62] inevitably involves litigation discovery affecting patient records.

These factors combined have subjected physicians to conflicting pres-

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[56] *See, e.g.*, People v. Florendo, 95 Ill. 2d 155, 447 N.E.2d 282 (1983) (holding that grand jury subpoena seeking disclosure of abortion facility's patient identification cards, thereby disclosing names, did not request confidential medical records, even though disclosure inevitably associated patients with treatment received); Koudsi v. Hennepin County Medical Center, 317 N.W.2d 705 (Minn. 1982) (holding that disclosure of patient's discharge and fact that she had given birth did not involve "medical records"); *cf.* Moore v. St. John's Episcopal Hosp., 89 A.D.2d 618, 452 N.Y.S.2d 669 (1982) (holding that plaintiff entitled to production of nonmedical information from defendant hospital).

[57] *Disclosure About Patients*, *supra* note 54, at 209; *see also* Henry v. Lewis, 102 A.D.2d 430, 478 N.Y.S.2d 263 (1984) (holding that a disclosure form authorizing insurer to release or obtain any information that might be necessary to determine benefits not a waiver of physician-patient privilege).

[58] *Disclosure About Patients*, *supra* note 54, at 209.

[59] *Id.* at 208.

[60] *But see* Doe v. Shasta Gen. Hosp., No. 92236 (Superior Court of Calif., Shasta County, order overruling defendants' demurrer entered January 20, 1988), discussed *infra* note 130 and accompanying text.

[61] *Disclosure About Patients*, *supra* note 54, at 208.

[62] *See generally* Abraham, *Medical Liability Reform*, 260 J. A.M.A. 68 (1988).

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sures to disclose and to withhold medical information.[63] State-law civil-damage actions penalize the physician for an erroneous choice. The wisdom of augmenting such liability by federal or state confidentiality standards addressed specifically to HIV-related information may seriously be questioned.

## B. Constitutional Privacy Interests

The advent of drug testing by employers,[64] the shifting political and judicial coalitions on abortion, and growing medical-records data-processing capabilities have combined to bring the constitutional issue of privacy to the forefront. The United States Supreme Court has recognized a constitutional right to make sensitive reproductive-health-care decisions without unwarranted government intrusion.[65] The federal courts have defined the scope of privacy on a "case-by-case method, balancing the individual's right to confidentiality against the governmental interest in limited disclosure."[66] To qualify for constitutional protection the subjective expectation of privacy must be reasonable.[67]

States seeking medical records about minors, particularly in the area of abortion, have tested the limits of privacy. The Court has afforded minors, like other persons, a constitutional right of privacy that protects private information about their sexual experience and medical condition.[68] Although the right is not absolute and does not automatically

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[63] *Disclosure About Patients*, *supra* note 54, at 209.

[64] *See* National Treasury Employees Union v. Von Raab, 57 U.S.L.W. 4338 (1989); Skinner v. Railway Labor Executives Ass'n, 57 U.S.L.W. 4324 (1989); Harmon v. Thornburgh, 690 F. Supp. 65 (D.D.C. 1988).

[65] Akron v. Akron Center for Reproductive Health, 462 U.S. 416, 426-27 (1983); Carey v. Population Serv. Int'l, 431 U.S. 678 (1977); Eisenstadt v. Baird, 405 U.S. 438 (1972); Loving v. Virginia, 388 U.S. 1 (1967); Griswold v. Connecticut, 381 U.S. 479 (1965).

[66] Woods v. White, 689 F. Supp. 874, 876 (W.D. Wis. 1988); *see also* United States v. Westinghouse Elec. Corp., 638 F.2d 570 (3d Cir. 1980) (holding that employee's medical records, which may contain intimate facts of a personal nature, are within the ambit of materials entitled to privacy protection, but government's interest in monitoring health hazards in the workplace outweighed the intrusion on employee's right to confidentiality). *But see* Plowman v. United States Army, 698 F. Supp. 627, 631-35 (E.D. Va. 1988) (holding that no controlling authority confirms extension of constitutional privacy right to HIV-related medical information).

[67] *See* California v. Greenwood, 108 S. Ct. 1625 (1988) (holding warrantless seizure of trash left for collection outside the curtilage of a residence not unconstitutional invasion of privacy).

[68] *Carey*, 431 U.S. at 693 (1977) (plurality opinion); Planned Parenthood v. Danforth, 428 U.S. 52, 74 (1976); People v. Stockton Pregnancy Control Medical Clinic,

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extend to all consenting sexual behavior,[69] states may infringe on the right only by the least-restrictive alternative necessary to further a compelling state interest.[70]

State constitutions may provide patients and others with even greater protection than the federal constitution. The California Supreme Court has declared its state constitutional right of privacy to be much broader than the privacy rights guaranteed by the federal constitution.[71]

### C. *State Law Privacy and Confidentiality of Medical Records*

By the end of the nineteenth century, the physician's duty of confidentiality was widely codified in state statutes.[72] State courts show much independence in their approach to the confidentiality of medical records.[73]

A confidentiality-of-medical-information statute may generally require patient consent for disclosure of medical records.[74] Other statutes may specifically protect medical records involved in areas such as adoption,[75] alcohol and drug abuse treatment,[76] child abuse,[77] freedom of in-

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203 Cal. App. 3d 225, 249 Cal. Rptr. 762 (1988).

[69] Bowers v. Hardwick, 478 U.S. 186 (1986); *cf.* Geever v. Illinois, 122 Ill. 2d 313, 522 N.E.2d 1200 (1988) (holding that state statute criminalizing knowing possession of child pornography did not impermissibly infringe first amendment), *appeal dismissed*, 109 S. Ct. 299 (1988).

[70] *See* Committee to Defend Reproductive Rights v. Myers, 29 Cal. 3d 252, 625 P.2d 779, 172 Cal. Rptr. 866 (1981) (Tobriner, J.).

[71] *See Myers*, 29 Cal. 3d at 262-63, 625 P.2d at 784; 172 Cal. Rptr. at 871; City of Santa Barbara v. Adamson, 27 Cal. 3d 123, 130 n.3, 610 P.2d 436, 440 n.3, 164 Cal. Rptr. 539, 543 n.3 (1980); *accord* Planned Parenthood Affiliates v. Van de Kamp, 181 Cal. App. 3d 245, 277, 226 Cal. Rptr. 361, 378 (1986).

[72] A. BRANDT, *supra* note 45, at 17. By 1900, a majority of states prohibited a physician's testimony in legal proceedings without the patient's consent. *Id.* at 215 n.47.

[73] *See, e.g.*, Walston v. Axelrod, 107 Misc. 2d 563, 435 N.Y.S.2d 493 (Sup. Ct. 1980) (allowing health commission to obtain X-rays without patient's knowledge).

[74] *See, e.g.*, CAL. CIV. CODE § 56.10(a) (West Supp. 1989); *see also* Inabnit v. Berkson, 199 Cal. App. 3d 1230, 245 Cal. Rptr. 525 (1988).

[75] *See* Shipman v. Division of Social Servs., 442 A.2d 101 (Del. Fam. Ct. 1981) (holding that confidentiality of adoptive parents' medical records subject to countervailing requirement of disclosure when they placed their physical, emotional, and mental condition in issue by opposing agency's petition for termination of parental rights).

[76] *See, e.g.*, Danielson v. Superior Court, 157 Ariz. 41, 754 P.2d 1145 (Ct. App. 1988) (holding that voluntary release of alcohol treatment center records by physician, who was a former patient, pursuant to medical board's investigation of physician did not constitute a waiver of physician-patient privilege); *cf.* 42 U.S.C. § 290ee-3(f)

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formation,[78] grand jury proceedings,[79] health and life insurance,[80] hospital corporate records,[81] medical board disciplinary proceedings,[82] mental health institutions,[83] psychotherapy,[84] workers' compensation,[85] and un-

(Supp. IV 1986); 42 C.F.R. § 2.14 (breach of patient confidentiality by federal drug rehabilitation program may result in criminal fine of $500 for first offense and $5,000 for subsequent offenses.). *But cf.* Logan v. District of Columbia, 447 F. Supp. 1328 (D.D.C. 1978) (finding no civil liability for breach of federal regulations).

[77] *See, e.g.*, CAL. PENAL CODE § 11,166 (West Supp. 1989) (requiring health practitioners to report suspicions of child abuse); *see also* People v. Stockton Pregnancy Control Medical Clinic, 203 Cal. App. 3d 225, 241-42, 249 Cal. Rptr. 762, 770 (1988) (holding that reporting requirement in Penal Code does not violate federal or state privacy rights); *cf.* Planned Parenthood Affiliates v. Van de Kamp, 181 Cal. App. 3d 245, 247, 226 Cal. Rptr. 361, 363 (1986) (holding that Penal Code does not require professional to report instances of consensual sexual activity with other minor of similar age).

[78] Richmond County Hosp. Auth. v. Southeastern Newspapers Corp., 252 Ga. 19, 311 S.E.2d 806 (1984); Head v. Colloton, 331 N.W.2d 870 (Iowa 1983) (holding that confidential medical records of potential bone marrow donor could not be obtained from registry at state hospital under state public records law); State *ex rel.* Stephan v. Harder, 230 Kan. 573, 641 P.2d 366 (1982) (construing public records act to impose duty on agency to delete confidential and nondisclosable information from that which may disclosed in response to request for disclosure); Minnesota Med. Ass'n v. State, 274 N.W.2d 84 (Minn. 1978) (payments to medical assistance vendors); Short v. Board of Managers of Nassau County Med. Center, 57 N.Y.2d 399, 442 N.E.2d 1235, 456 N.Y.S.2d 724 (1982); Miller v. New York State Dep't of Health, 91 A.D.2d 975, 457 N.Y.S.2d 564 (1983) (exempting "intra-agency" materials from disclosure); Cleveland Newspapers, Inc. v. Bradley County Mem. Hosp. Bd. of Directors, 621 S.W.2d 763, 767 (Tenn. App. 1981) (requiring disclosure of hospital payroll records).

[79] *See, e.g.*, Doe v. People, 116 Misc. 2d 626, 455 N.Y.S.2d 945 (Sup. Ct. 1982).

[80] *See* Wash. Post, Nov. 30, 1988, at A-1, col. 1.

[81] *See* Texarkana Mem. Hosp. v. Jones, 551 S.W.2d 33 (Texas 1977) (holding minutes of meetings of hospital groups statutorily exempt from disclosure).

[82] *In re* Board of Medical Review Investigation, 463 A.2d 1373 (R.I. 1983); *cf.* Hyman v. Jewish Chronic Disease Hosp., 15 N.Y.2d 317, 206 N.E.2d 338, 258 N.Y.S.2d 397 (1965) (holding hospital's board of directors entitled to disclosure of confidential patient information).

[83] CAL. WELF. & INST. CODE § 5328 (West Supp. 1989) (making treatment records confidential). *See generally* People v. Gardner, 151 Cal. App. 3d 134, 198 Cal. Rptr. 452 (1984); *In re* S.W., 79 Cal. App. 3d 719, 721, 145 Cal. Rptr. 143, 144 (1978) (holding that statute imposes greater confidentiality than evidence code privileges); County of Riverside v. Superior Court, 42 Cal. App. 3d 478, 116 Cal. Rptr. 886 (1974) (protecting records in connection with patient's license to practice from disclosure to board).

[84] CAL. EVID. CODE § 1014 (West Supp. 1989) (patient-psychotherapist privilege); *see, e.g.*, Inabnit v. Berkson, 199 Cal. App. 3d 1230, 1238-39, 245 Cal. Rptr. 525, 530-31 (1988).

[85] CAL. LAB. CODE § 6412 (West Supp. 1989) (making workers' compensation medical records confidential).

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employment insurance.[86] Whether a statute prohibits disclosure in a particular instance is a "matter of interpretation of that statute as applied to the case in which disclosure is sought."[87]

Collecting and retaining personal records by an institution under state jurisdiction is enough to raise an invasion of privacy issue, which some states recognize as a cause of action.[88] The same conduct may also form part of a claim for the intentional or negligent infliction of emotional distress.[89]

Whether the state recognizes an action for violation of privacy, the physician-patient relationship includes a covenant of confidence and trust that can be the basis for a damage action.[90] Duties under existing state law, therefore, are adequate to enforce the patient's privacy rights without subjecting physicians to penalties under new state or federal requirements.

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[86] *See, e.g.*, CAL. UNEMP. INS. CODE § 2714 (West Supp. 1989) (making medical records of Department of Vocational Rehabilitation confidential). *See generally* Rogers v. St. Jude Hosp., 252 Cal. App. 2d. 496, 60 Cal. Rptr. 528 (1967).

[87] Richards v. Superior Court, 258 Cal. App. 2d 635, 638, 65 Cal. Rptr. 917, 920 (1968) (emphasis omitted).

[88] White v. Davis, 13 Cal. 3d 757, 533 P.2d 222, 120 Cal. Rptr. 94 (1975); *see also* Porten v. University of San Francisco, 64 Cal. App. 3d 825, 134 Cal. Rptr. 839 (1976) (holding that limited disclosure of private information stated a prima facie case of invasion of privacy).

[89] In California, for example, the "overbroad collection and retention of unnecessary personal information by government interests" or "the improper use of information properly obtained for a specific purpose" and a subsequent "disclosure of it to some third party" establish an action in tort. *See* Bowden v. Spiegal, 96 Cal. App. 2d 793, 216 P.2d 571 (1950); Alcorn v. Anbro Eng'g, 2 Cal. 3d 493, 468 P.2d 216, 86 Cal. Rptr. 88 (1970); Davidson v. City of Westminster, 32 Cal. 3d 197, 185 Cal. Rptr. 252 (1982). Wrongful discharge cases refine emotional distress theory. *See, e.g.*, Kelly v. Schlumberger Technology Corp., 849 F.2d 41 (1st Cir. 1988) (holding employer liable for negligent infliction of emotional distress); Cole v. Fair Oaks Fire Protection Dist., 43 Cal. 3d 148, 729 P.2d 743, 233 Cal. Rptr. 308 (1987) (standard for prima facie case of negligent infliction less than for intentional infliction.); Duerkson v. Trans-Am. Title, 189 Cal. App. 3d 647, 234 Cal. Rptr. 521 (1987); Rulon-Miller v. IBM, 162 Cal. App. 3d 241, 208 Cal. Rptr. 524 (1984) (requiring "outrageous behavior" for intentional infliction).

[90] Anderson v. Strong Mem. Hosp., 140 Misc. 2d, 770, 531 N.Y.S.2d 735 (Sup. Ct. 1988); *accord* Crocker v. Synpol, Inc., 732 S.W.2d 429 (Tex. Ct. App. 1987) (reversing summary judgment for defendant physician because genuine issue of material fact existed on breach of physician-patient privilege).

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### D. *Use of Medical Records in Court Proceedings Distinguished*

The "physician-patient privilege"[91] frequently bars the use of evidence from confidential medical records or testimony by a patient's physician in court proceedings.[92] The privilege protects the privacy of patients' records and prevents compelling a defendant physician to give opinion testimony to establish the negligence of a codefendant physician.[93] Although no such privilege existed at common law,[94] thirty-four states and the District of Columbia have included it in confidentiality statutes.[95] Six states do not recognize the privilege.[96] Although the statutes "vary in scope and application and many contain significant exceptions,"[97] they generally require: (1) a physician-patient relationship; (2) information acquired as a result of the relationship; and (3) the need and propriety of the information to enable the physician to properly treat the patient.[98] Whether the patient has waived the privilege is a frequent issue.[99]

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[91] *See, e.g.*, CAL. EVID. CODE §§ 990-1007 (West 1966 & Supp. 1989).

[92] Court proceedings are different from grand jury proceedings, in which a patient's privacy interests are subordinate to the powers of the grand jury. *See, e.g.*, Doe v. People, 116 Misc. 2d 626, 455 N.Y.S.2d 945 (Sup. Ct. 1982); *cf.* People v. Florendo, 95 Ill. 2d 155, 447 N.E.2d 282 (1983) (holding that names of patients did not constitute confidential information for purposes of grand jury subpoena).

[93] *See* Evans v. Otis Elevator Co., 403 Pa. 13, 168 A.2d 573 (1961); *accord* Jistarri v. Nappi, 549 A.2d 210 (Pa. Super. Ct. 1988). Some jurisdictions, however, hold that a plaintiff may question a defendant physician regarding matters that require the expression of medical opinion. *E.g.*, McDermott v. Manhattan Eye, Ear & Throat Hosp., 15 N.Y.2d 20, 203 N.E.2d 469, 255 N.Y.S.2d 65 (1964).

[94] In an early case it was stated:

> If a surgeon was voluntarily to reveal these secrets, to be sure, he would be guilty of a breach of honor, and of great indiscretion; but to give that information to a court of justice, which by the law of the land he is bound to do, will never be imputed to him as any indiscretion whatever.

Duchess of Kingston's Case, 20 How. St. Trials 355 (1776) (concerning testimony of physician in bigamy trial that patient told him of previous marriage); *see Disclosure About Patients*, *supra* note 54, at 211 n.20; *see also* Coralluzzo v. Fass, 450 So. 2d 858 (Fla. 1984); Khajezadeh, *Patient Confidentiality Statutes in Medicare & Medicaid Fraud Investigations*, 13 AM. J.L. & MED. 105, 113 (1988).

[95] *See* Aranoff & Hirsch, *Confidential Communications Between Physician and Patient in Judicial and Administrative Proceedings*, 29 MED. TRIAL TECH. Q. 331 (1983).

[96] These states are Florida, Illinois, Maryland, Massachusetts, Rhode Island, and South Carolina. Khajezadeh, *supra* note 94, at 114 n.56.

[97] *Id.* at 114 n.57.

[98] Aranoff & Hirsch, *supra* note 95, at 333-34; *see* E. HAYT, MEDICOLEGAL ASPECTS OF HOSPITAL RECORDS 82 (2d ed. 1977).

[99] *E.g.*, State v. Boss, 490 A.2d 34 (R.I. 1985) (holding that defendant waived privi-

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Whether HIV-antibody test results are protected by the physician-patient privilege is an issue in cases of transfusion-associated infection when the recipient seeks discovery of the identity of the blood or tissue donor.[100] The Colorado Supreme Court recently held that a donor's identity was not discoverable.[101] The court strictly construed the physician-patient privilege as a statutory creation and held that the privilege "does not include communications with medical technicians"[102] and that the privilege therefore did not apply because the interviewing technician was not a physician or nurse. Nevertheless, the court was concerned about the possibility that the disclosure of blood donors' identities would deter future blood donations, and the court decided that the donor's privacy right outweighed the plaintiff's right to compensation and the public interest in assuring such compensation.[103]

In a variety of circumstances falling short of a court order, a physician may be asked to divulge confidential information in connection with a court proceeding. For example, the attorney of the patient's adversary may informally seek, in connection with a court proceeding, information about the patient from the latter's physician.[104] Although

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lege of confidentiality of medical records by testifying to physical and mental condition in reckless driving prosecution); *accord* State v. Soney, 177 N.J. Super. 47, 424 A.2d 1182 (1980). *But cf.* Pacheco v. Ortiz, 11 Ohio Misc. 2d 1, 463 N.E.2d 670 (1983) (holding that deposition of plaintiff taken by defendant discussing health and hospital records was not a waiver of treating hospital records); *see also* Hamilton v. Verdow, 207 Md. 544, 414 A.2d 914 (1980).

[100] *See, e.g.*, Rasmussen v. South Florida Blood Serv., 500 So. 2d 533 (Fla. 1987) (holding that names and addresses of blood donors not discoverable). *But cf.* Tarrant County Hosp. Dist. v. Hughes, 734 S.W.2d 675 (Tex. Ct. App. 1987), *cert. denied*, 108 S. Ct. 1027 (1988) (ordering hospital to disclose identities and addresses of blood donors); *see also* Kirkendall v. Harbor Ins., 698 F. Supp. 768 (1988) (dismissing action against blood bank for negligent screening of blood donors and negligent failure to test blood for HIV); Krygier v. Airweld, Inc., 137 Misc. 2d 306, 520 N.Y.S.2d 475 (Sup. Ct. 1987) (ordering blood center to produce donation records without revealing names and addresses of donors).

[101] Belle Bonfils Mem. Blood Center v. Denver Dist. Court, 763 P.2d 1003 (Colo. 1988). Other courts have similarly provided limited discovery against hospitals when information is sought about patients. *See, e.g.*, Moore v. St. John's Episcopal Hosp., 89 A.D.2d 618, 452 N.Y.S.2d 669 (1982) (holding plaintiff entitled to nonmedical information about patient).

[102] *Belle Bonfils*, 763 P.2d 1009 (Colo. 1988).

[103] *Id. But see* Mason v. Regional Med. Center of Hopkins County, 121 F.R.D. 300 (W.D. Ky. 1988) (holding that the blood donor must appear for deposition because constitution does not create generalized right of privacy).

[104] The Federal Rules of Civil Procedure does not address this issue. *See* FED. R. CIV. P. 26(a); *id.* 26(b)(4)(A); *see also Disclosure About Patients*, *supra* note 54.

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informal discovery is useful, the physician is clearly entitled to assert the physician-patient privilege in opposing it.[105] For some information, the "physician may be *obligated* to assert the privilege, and ex parte contacts by adverse counsel may be a basis for legal and ethical action against both the attorney and the physician."[106] Whether the physician is obligated to assert the patient's privacy depends on whether the state recognizes the privilege[107] and the degree of compulsion accompanying the request for information.[108]

## III. The Sensitivity of AIDS-Related Medical Information

A physician who knows that his or her patient has HIV antibodies faces important issues, particularly when the patient does not yet have symptoms of disease. On one hand, the physician must maintain the physician-patient relationship confidential and so must not disclose the patient's condition to others. On the other hand, the patient could threaten to infect a third person, such as a spouse or lover whom the patient explicitly or implicitly intends not to inform of his condition. Also, hospital workers such as nurses arguably are at foreseeable risk of infection and thus have an interest in knowing a patient's HIV status.

Alternatively, the physician may learn that another health-care worker has an HIV infection. The physician may reasonably believe that the other health care worker threatens a particular patient with infection. Although the physician may owe the other health-care

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[105] Osterman v. Ehrenworth, 106 N.J. Super. 515, 521-22, 256 A.2d 123, 127 (1969).

[106] *Disclosure About Patients, supra* note 54, at 215; *see also* Jordan v. Sinai Hosp. of Detroit, 171 Mich. App. 328, 429 N.W.2d 891 (1988) (holding that physician's fiduciary duties to patient bars defense from conducting ex parte interviews with plaintiff's treating physicians).

[107] For example, some states such as Alaska and Delaware allow ex parte interviews. *See* Langdon v. Champion, 745 P.2d 1371 (Alaska 1987); Green v. Bloodsworth, 501 A.2d 1257 (Del. Super. Ct. 1985).

[108] *See generally* Roberts v. Superior Court of Butte County, 9 Cal. 3d 330, 508 P.2d 309, 107 Cal. Rptr. 309 (1973). In Inabnit v. Berkson, 199 Cal. App. 3d 1230, 245 Cal. Rptr. 525 (1988), the court of appeals relied on Cal. Civ. Code § 56.10(b)(3) (Deering 1988) (compelling physician to disclose in response to subpoena or discovery), in affirming summary judgment to a psychiatrist who was sued by his patient for disclosing confidential records about the patient in response to a subpoena. The court also found that the plaintiff had waived the privilege by failing to timely raise it. *But cf.* Pacheco v. Ortiz, 11 Ohio Misc. 2d 1, 463 N.E.2d 670 (1983) (holding that hospital records may not be released without consent or waiver even though subpoena duces tecum properly served on record custodian).

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worker no ethical duty of confidentiality, a confidentiality statute may nonetheless prohibit the physician from disclosing the risk of infection to the patient.[109] Exigencies of this nature lend truth to the aphorism that "a little knowledge is a dangerous thing." A physician may hesitate to check a patient's or coworker's HIV status even when knowing would be medically appropriate.

### A. *Civil Rights vs. Public Health*

The conflict between confidentiality and disclosure is at the root of the public debate over the AIDS crisis. The conflict arises from the fear of discrimination and from other adverse consequences that a person may suffer when a seropositive condition is disclosed.[110] These consequences may result from irrational fears and prejudices in the community that can lead to unwarranted limitations on a patient's access to employment, insurance, and housing. To that extent, AIDS is appropriately viewed as a "civil-rights issue."[111]

Labeling AIDS a civil-rights issue, however, obscures the fact that HIV infection has many of the characteristics of other blood-borne and sexually transmitted infectious diseases. To formulate a coherent policy on confidentiality and disclosure of AIDS-related medical records requires recognizing that AIDS is, above all, a public-health issue.[112]

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[109] One bill presently pending in the U.S. House of Representatives, H. 3701, could significantly restrict the physician's privilege to disclose information about the HIV status of other individuals in the hospital notwithstanding the physician's judgment that the disclosure was medically indicated.

[110] The disclosure of a male patient's sexual orientation to his own spouse appears to be a problem of unexpected dimensions. In one study, 6 of 16 men who had homosexual exposures reported that they were married at the time of the interview, and two others had previously been married. Michael, Laumann, Gagnon & Smith, *Number of Sex Partners and Potential Risk of Sexual Exposure to Human Immunodeficiency Virus*, 260 J. A.M.A. 2020 (1988).

[111] In particular, persons suffering from AIDS and HIV infection are entitled to the civil rights protections extended to handicapped individuals pursuant to the Rehabilitation Act of 1973, Pub. L. No. 93-112, § 504, 87 Stat. 355, 394 (1973) (codified as amended at 29 U.S.C. § 794 (Supp. IV 1986)). *See* School Bd. of Nassau County v. Arline, 480 U.S. 273 (1987) (holding that Rehabilitation Act extends to persons suffering impairments from infectious disease); Thomas v. Atascadero Unified School Dist., 662 F. Supp. 376 (C.D. Cal. 1987) (holding that HIV infection a protected handicap); *accord* Ray v. School Dist. of DeSoto County, 666 F. Supp. 1524 (M.D. Fla. 1987); *see also* District 27 Community School Bd. v. Board of Educ., 130 Misc. 2d 398, 502 N.Y.S.2d 325 (Sup. Ct. 1986). State human rights statutes also protect handicapped persons. *See, e.g.*, MASS. GEN. LAWS ch. 151B, § 4 (West 1982 & Supp 1988); FLA. STAT. ANN. § 760.10 (West 1986).

[112] *See* Eickoff, *Hospital Policies on HIV Antibody Testing*, 259 J. A.M.A. 1861

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In general, the epidemic of syphilis and gonorrhea in the United States before the discovery of penicillin has been neglected as an analogue for studying public-health options in responding to the AIDS crisis.[113] Many of the medical issues during those years were the same as today, such as uncertainty over the true prevalence of infection,[114] the reluctance to diagnose,[115] and concern about the duty to inform.[116] Moreover, the focus of public-policy debate during the syphilis epidemic was largely the same as it is today. For example, there was heated opposition to public-health efforts in the area of education and prevention from "critics who suggested that the anti-venereal emphasis should be on sexual morals."[117] Some doctors contended that reporting venereal disease lacked benefits and would "ultimately hinder the control of these diseases."[118] The Chicago program of widespread, routine syphilis testing in the late 1930s, however, was effective in reducing that city's infection rate to the lowest of major cities.[119]

### B. *State Reporting Requirements*

State public-health law may require a physician to disclose his or her patient's HIV infection. All states require that physicians report specified "listed" or "notifiable" diseases to public health departments.[120] AIDS is universally notifiable.[121] Therefore, a physician must make a threshold determination whether the patient's condition meets the case definition of AIDS.[122] For example, AIDS-related complex (ARC) is

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(1988).

[113] *See generally* A. BRANDT, *supra* note 45.

[114] A committee of the New York County Medical Society estimated in 1901 that up to 80% of men in New York City had been infected at one time or another with gonorrhea and that it was the most prevalent of all diseases in the adult male population. *Id.* at 12. The admission rate for syphilis in the Army in 1909 was nearly 200 per 1000 men. *Id.* at 13. However, critics charged that "fanatics and moralists inflated . . . [the] disease statistics to generate publicity and fuel the public's fears." *Id.* at 13.

[115] Doctors frequently ascribed syphilis-related deaths to other causes. *Id.* at 10.

[116] *See id.* at 16 (stating that physicians cooperated with their male patients in concealing venereal infection, even failing to inform the patient of the diagnosis, often at the risk of promoting infection of the patient's spouse).

[117] *Id.* at 164.

[118] *Id.* at 43.

[119] *Id.* at 152.

[120] Dickens, *supra* note 9, at 581.

[121] *Id.*

[122] *See* Centers for Disease Control, *Revision of the Centers for Disease Control's Surveillance Case Definition for Acquired Immunodeficiency Syndrome*, 36 MMWR 15 (1987).

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not a "listed" disease in most states. Some states, such as Minnesota, however, have general provisions that require the reporting of any "case," "condition," or "carrier state" relating to a listed disease, including AIDS.[123] For reporting purposes, then, physicians must know if the state public-health law requires reporting positive HIV-antibody tests. A growing number of states specifically require such reporting.[124]

### C. *Maintaining the Confidentiality of AIDS-Related Medical Records*

Because a patient's positive HIV status has enormous sensitivity, the confidentiality of AIDS-related medical records must strictly be guarded. A hospital and physician may face civil liability for breaching physician-patient confidentiality through disclosing an AIDS patient's identity.[125] The argument that the mere fact of a patient's illness is not per se a "medical record,"[126] is apparently untested in any case involving HIV infection or AIDS.

The need for confidentiality protection, particularly of the patient's identity, may be less when the patient suffers from advanced AIDS and is hospitalized because of an AIDS-related condition. In such cases, the patient's condition cannot reasonably be concealed from nurses and hospital staff and, to that extent, does not present a confidentiality problem.[127] A more difficult problem arises when the patient has no obvious manifestations of HIV infection.

One of the most controversial issues concerning AIDS and HIV infection is the need for strict confidentiality legislation for HIV test re-

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[123] MINN. STAT. ANN. §§ 144.4171-.4186 (West 1989).

[124] Dickens, *supra* note 9, at 581; *see also* Judson & Vernon, *The Impact of AIDS on State and Local Health Departments: Issues and a Few Answers*, 78 AM. J. PUB. HEALTH 387 (1988).

[125] *See* Anderson v. Strong Mem. Hosp., 140 Misc. 2d 770, 531 N.Y.S.2d 735 (Sup. Ct. 1988) (release of photograph showing patient in silhouette taken from back angle to illustrate article on AIDS).

[126] *See* Koudsi v. Hennepin County Med. Center, 317 N.W.2d 705 (Minn. 1982); *accord* People v. Florendo, 95 Ill. 2d 155, 447 N.E.2d 282 (1983) (grand jury subpoena requesting disclosure of photocopies of patients' identification cards, thereby disclosing names, did not request confidential medical records of patients, notwithstanding assertion that, since center rendered only abortion-related services, disclosure would inevitably associate patients with treatment provided).

[127] *But see Anderson*, 140 Misc. 2d 770, 531 N.Y.S.2d 735 (plaintiff's allegations that hospital, physician and nurse used photograph showing patient in silhouette taken from back angle to illustrate article on AIDS stated cause of action for breach of physician-patient privilege).

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sults. A California example[128] provides civil and criminal liability for any person who negligently or willfully "discloses results of a blood test to detect antibodies to [HIV] to *any* third party, in a manner which identifies or provides identifying characteristics of the person to whom the test results apply."[129] Until 1989 legislation,[130] California law thus appeared to prohibit a physician from sharing HIV-antibody test results with hospital personnel.

### D. *Physician Use of the HIV Antibody Test*

Given the conflicting demands for disclosure and confidentiality of HIV-antibody test results, a physician may hesitate to test a patient for HIV antibodies because of potential liability. Unfortunately, minimizing a physician's liability exposure by avoiding testing may be inconsistent with the patient's interests and is directly contrary to sound public-health policy.[131]

Medical literature extensively discusses when HIV testing is appropriate.[132] Most medical commentators recommend against routine, widespread HIV-antibody testing except for carefully selected high-risk populations, and then only when accompanied by pretest and posttest counseling.[133] This apparent consensus, however, has masked a

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[128] CAL. HEALTH & SAFETY CODE §§ 199.20-.28 (West Supp. 1989) (mandating blood testing and confidentiality to protect public health); *id.* §§ 199.30-.40 ("Acquired Immune Deficiency Syndrome Research Confidentiality Act").

[129] *Id.* § 199.21(a) (emphasis added).

[130] *Id.* § 199. 215 (allowing physician to disclose test results for treatment purposes).

[131] Failing to provide diagnostic testing, leading to an erroneous diagnosis, can also be an actionable breach of duty owed to the patient. *See* Lynch v. Bay Ridge Obstetrical & Gynecological Assocs., 72 N.Y.2d 632, 532 N.E.2d 1239, 536 N.Y.S.2d 11 (1988) (holding that negligent failure to give pregnancy test before advising woman that she was not pregnant and prescribing drug that could cause congenital defects in child led woman to choose abortion after learning of pregnancy, stating action to recover damages for physical and emotional injuries).

[132] *See, e.g.*, Bayer, Levine & Wolf, *HIV Antibody Screening: An Ethical Framework for Evaluating Proposed Programs*, 256 J. A.M.A. 1768 (1986); Douglas, Harper & Polk, *HIV Positivity: The Psychosocial Impact of Donor Notification*, (presented at the Third International Conference on AIDS, Washington, D.C., June 1, 1987); Hagen, Meyer & Pauker, *Routine Preoperative Screening for HIV: Does the Risk to the Surgeon Outweigh the Risk to the Patient?*, 259 J. A.M.A. 1357 (1988); Henry, Willenbring & Crossley, *supra* note 3; Meyer & Pauker, *Screening for HIV: Can We Afford the False Positive Rate?*, 317 NEW ENG. J. MED. 238 (1987); Sherer, *Physician Use of the HIV Antibody Test: The Need for Consent, Counseling, Confidentiality, and Caution*, 259 J. A.M.A. 264 (1988).

[133] *See* Centers for Disease Control, *Public Health Service Guidelines for Counseling and Antibody Testing to Prevent HIV Infection and AIDS*, 36 MMWR 509

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vigorous debate concerning the adequacy of information about the prevalence and incidence of HIV infection.[134] Moreover, preoccupation with disclosure obscures the distinction between the fact of infection and disclosure of that fact; the prevailing view seems to regard disclosure, rather than infection, as the problem.[135]

A physician's concern for his or her patient can extend to concealing the latter's condition from public health authorities, even when disclosure is required by law.[136] This practice should be condemned, as should failing to test to shield patients themselves from the information.

The argument against testing often assumes that because of severe emotional and psychological reactions from learning of HIV-infection, the patient benefits from not knowing.[137] This argument is tenuous, especially when it also assumes that the information is useless unless it changes the patient's behavior or leads to therapeutic intervention. Such reasoning underlies the argument against testing in situations such as marriage licence applications.[138] But it seems to ignore testing's educational value for the patient. It also reflects the patronizing viewpoint that the patient should not be burdened with the responsibility of knowledge about the condition.

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(1987).

[134] The past year has seen a growing willingness in the medical community to advocate widespread and routine antibody testing. The Centers for Disease Control has begun anonymous HIV-antibody testing of 1.6 million blood samples. *See* Goldsmith, *HIV Prevalence Data Mount, Patterns Seen Emerging by End of This Year*, 260 J. A.M.A. 1829 (1988).

[135] An example of preoccupation with disclosure, according to such critics, is the statement by a primary care physician about one of his patients who had been diagnosed with AIDS but whose condition was not reported to the state public health department at the time of diagnosis. Sherer, *supra* note 132, at 264. Six months later, another physician ordered an HIV-antibody test for the patient, obtained a positive result, and reported the diagnosis to the public health department. *Id.* The first physician stated that the patient's "life was ruined by the inappropriate disclosure of a positive human immunodeficiency virus (HIV)-antibody test." *Id.* This doctor obviously viewed the disclosure of the patient's condition, rather than the condition itself, as the fundamental cause of the patient's difficulties.

[136] *Id.*

[137] *See* Glass, *AIDS and Suicide*, 259 J. A.M.A. 1369 (1988).

[138] *See, e.g.*, Gostin, Curran & Clark, *The Case Against Compulsory Testing for AIDS — Testing, Screening and Reporting*, 12 AM. J. OF LAW & MED. 7, 34-37 (1987); *id.* at 12 (arguing that "the significance of a positive result is unclear"). In view of the correlation between a positive antibody test and the development of clinical illness, and because of the infectiousness of HIV, however, the significance of a positive result seems clear.

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### *E. The Possibility of a False Positive*

A leading reason offered by those who oppose HIV-antibody testing is the possibility of a "false positive" result that can occur with the sensitive enzyme-linked immunosorbent assay (ELISA).[139] However, the possibility of a false positive can exponentially be reduced by follow-up testing with the highly specific Western blot test.[140]

Currently recommended HIV-screening procedures (ELISA and Western blot tests performed in sequence) by reference laboratories have a false positive rate of approximately 1 in 20,000 in unselected healthy populations.[141] Testing procedures in the Army program[142] and at the Minnesota Blood Center[143] appear to be more accurate, with a joint false-positive rate of below 1 in 100,000. Other programs have estimated rates of 1 in 10,000.[144]

These rates assume that testing and interpretation closely follow the technical specifications. These rates may overstate the accuracy of test results; the recent College of American Pathologists proficiency study suggests that the joint false-positive rate in practice may actually be as high as 1 in 1,250.[145] This disparity arises from the highly technical nature of the Western blot test and the variation of results depending on the skill of the person performing it. Thus, although the follow-up use of the Western blot test substantially reduces the possibility of a false positive, it also requires more technical skill than the ELISA test and thus has limited availability.[146]

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[139] *See, e.g.*, *id.* at 11-13. The "sensitivity" of a test is a measurement of its ability to detect without fail the presence of antibodies and to minimize the possibility of a false negative result; it is to be distinguished from the "specificity" of a test, as in the case of the highly specific Western blot test, which measures the ability to avoid false positivity by reacting only to specific antibodies that are sought to be identified. *See generally* Petricciani, *Licensed Tests for Antibody to Human T-Lymphotropic Virus Type III: Sensitivity and Specificity*, 103 ANNALS INTERNAL MED. 726 (1985).

[140] Hagen, Meyer & Pauker, *supra* note 132, at 1358.

[141] *Id.*

[142] *Hearings Before the Subcommittee on Regulation and Business Opportunities of the House Committee on Small Business*, 100th Cong., 1st Sess. (1987) (testimony of Donald S. Burke, M.D.).

[143] *Id.* (testimony of Lawrence H. Mike, M.D., J.D.).

[144] Cleary, Barry, Mayer, Bronott, Gostin & Fineberg, *Compulsory Premarital Screening for the Human Immunodeficiency Virus: Technical and Public Health Considerations*, 258 J. A.M.A. 1757 (1987).

[145] Barnes, *New Questions About the AIDS Test Accuracy*, 238 SCIENCE 884 (1987); Hagen, Meyer & Pauker, *supra* note 132, at 1358.

[146] If facilities for performing a Western blot test are not immediately available, therefore, arrangements should be made to forward the blood specimen to an appropri-

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By simple arithmetic, if the likelihood of a false positive exceeds the rate of infection in the test population, then the number of false positives will exceed the number of true positives in the population.[147] Thus, "if the prevalence of HIV infection increases greatly in people who do not belong to high risk groups, then HIV testing will become more important."[148] Opponents of widespread, routine antibody testing cite this phenomenon and also argue that the Western blot test will sometimes confirm a false ELISA result. The false-positive rate will thus be much higher, they argue, perhaps as high as 1 in 100.[149] However, although the likelihood of a false positive may be as low as 1 in 100,000 and as high as 1 in 1,250, it is probably in the neighborhood of 1 in 10,000 to 1 in 20,000.[150]

In any event, in recommending an HIV-antibody test for a patient, a physician should consider the possibility of a false positive result. To what extent this possibility should operate as a factor in the physician's deliberations will vary from case to case. A primary factor should be the likelihood of transmission in the event that the patient is actually infected. If the patient has one or more sexual partners who would be at risk of infection, then the public-health factors in favor of testing the patient should preponderate. The same consideration suggests that routine antibody testing for pregnant women is appropriate.[151]

Although health-care providers should be required to perform competently the HIV-antibody test, healthy subjects may have to assume part of the public-health responsibility by accepting the possibility of a false positive. The apparent willingness of most Americans to accept this responsibility has been overlooked. Provisional data reported recently by the Centers for Disease Control in a study of 3,097 persons

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ate reference laboratory in the event the ELISA tests are repeatedly "reactive," that is, positive. Goldsmith, *supra* note 134.

[147] Hearst & Hulley, ***Preventing the Heterosexual Spread of AIDS: Are We Giving the Best Advice?***, 259 J. A.M.A. 2428 (1988).

[148] *Id.* at 2432.

[149] In addition to using a worst-case scenario for the accuracy of test results, commentators who oppose widespread, routine antibody testing on these grounds assume a low prevalence of infection among the "low-risk" populations that cannot be confirmed in the absence of widespread routine antibody testing.

[150] *See supra* notes 141-45 and accompanying text (probable range assumes recommended HIV antibody screening procedures).

[151] The routine screening of pregnant women for venereal disease at prenatal clinics was common practice in the United States before the discovery of penicillin. A. BRANDT, *supra* note 45, at 44. A woman's knowledge about her HIV status would be a highly controlling factor in determining whether to become pregnant; premarital testing would therefore tend to prevent the occurrence of HIV-related abortions.

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show that 71% of the adults surveyed were willing to have their blood tested with assurances of privacy of test results.[152] "Other surveys have shown that a high percentage of infected persons is concentrated in the minority of persons who are not willing to be tested."[153]

### F. *Informed Consent*

If a physician decides that an HIV-antibody test would be appropriate for a patient, the latter's consent should be obtained before performing the procedure. In some states, such as California,[154] Massachusetts,[155] and Oregon,[156] public health laws specifically require the patient's informed consent as a prerequisite to the HIV-antibody test, even if the patient's blood has already been drawn for other analysis.

In other states, however, the need for informed consent to test a blood sample that has already been drawn is a subject of debate.[157] The informed-consent doctrine normally requires informing a patient of facts material to the decision whether to allow a medical procedure.[158] Some patients might refuse to allow blood sampling if it were likely that an HIV-antibody test would follow. For the medical procedure of drawing blood the kinds of tests performed are arguably material to the patient's decision. Civil rights advocates argue, therefore, that informed consent is necessary before performing an HIV-antibody test on blood that has already been drawn, even in the absence of an HIV-antibody-testing-informed-consent statute.

The problem with rigidly requiring informed consent in all cases is

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[152] Centers for Disease Control, *Quarterly Report to the Domestic Policy Council on the Prevalence and Rate of Spread of HIV and AIDS in the United States*, 259 J. A.M.A. 2657 (1988).

[153] *Id.*

[154] CAL. HEALTH & SAFETY CODE § 199.22 (West Supp. 1989). A bill recently introduced in California would eliminate the need for written consent and require only verbal consent. *See* S.B. 2851, *reported in* AIDS Pol. & Law (BNA), March 23, 1988.

[155] MASS. GEN. LAWS ANN. ch. 111, § 70F (West Supp. 1988).

[156] H.B. 2067, reported in AIDS Pol. & Law (BNA), Feb. 24, 1988.

[157] *See* Bager, Levine & Wolf, *HIV Antibody Screening: An Ethical Framework for Evaluating Proposed Programs*, 256 J. A.M.A. 1768, 1769-70 (1986) (arguing that ethical screening requires consent from patient and sensitive, supportive counseling about HIV infection and its transmission before and after testing regardless of the test result); Henry, Willenbring & Crossley, *supra* note 3 (illustrating widely disparate attitudes on the issue of consent); *see also* Goldsmith, *AMA House of Delegates Adopts Comprehensive Measures on AIDS*, 258 J. A.M.A. 425 (1987).

[158] *See, e.g.*, Canterbury v. Spence, 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); Cobbs v. Grant, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 506 (1972); Harnish v. Children's Hosp. Med. Center, 387 Mass. 152, 439 N.E.2d 240 (1982).

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illustrated by the remarks of one physician:

> [I]t is not rare for me to be asked to see elderly patients with undiagnosed syndromes involving wasting, mental status changes, or other signs and symptoms that could — but almost certainly do not — represent HIV infection. If such a patient received transfusions during the first half of this decade . . . then at some point during evaluation (barring an alternative diagnosis) an HIV test may be indicated. *What pre-test counseling would the regulators have me give in such a circumstance*? How much anxiety and family disruption would they have me cause by attempting to obtain fully informed consent? Would not less harm be done in these circumstances by proceeding with the test just as I might proceed with a VDRL [Venereal Disease Research Laboratory] or brucella titer, and by providing appropriate posttest counseling and support in the rare case in which the HIV test is unmistakably positive?[159]

The problem of testing is directly related to the asserted need for universal pretest counseling. Advocates who favor pretest counseling in every case, however, have overlooked the implication of their own contention that the prevalence of infection is low: the likelihood of a true positive may be so low as to be immaterial for purposes of consent. A preferable course is to save the resources on pretest counseling in low prevalence populations and apply those resources to cases in which positive results are obtained or can be expected.

### G. *Special Problems in the Hospital*

In hospitals, factors in addition to individual patient welfare, such as infection-control and occupational safety and health, may suggest HIV-antibody screening. Thus, in hospitals a conflict arises between the patient's right to privacy and the interests of hospital personnel to be informed about the safety and health conditions in their occupational environment. But hospitals have no uniform practices or policies regarding informed consent for HIV-antibody screening.[160] Fewer than half of the responding hospitals in a recent survey had a policy concerning HIV-antibody testing.[161]

In response to a question about the actual use of the HIV-antibody test by physicians, a third of the hospitals responded that when physicians ordered HIV-antibody testing, specific patient consent was rarely obtained.[162] Fifty percent of the responding hospitals recommend, but

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[159] Decker, *The Use of HIV Antibody Testing by Physicians*, 259 J. A.M.A. 2994 (1988) (emphasis added).

[160] Henry, Willenbring & Crossley, *supra* note 3.

[161] *Id.*

[162] *Id.* at 1820.

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do not require, that the physician obtain consent from the patient and provide risk-reduction information.[163] Of these hospitals, approximately 58% reported that risk reduction counseling was "usually given"; 36% responded that it was "sometimes" given; and approximately 6% responded that such counseling was only "rarely" provided.[164]

The survey shows that significant differences exist in how hospitals deal with HIV-antibody testing issues.[165] The variation indicates "considerable uncertainty about the role of HIV antibody testing within hospitals at both the national and state levels."[166]

### H. *Occupational Safety and Health*

A rational approach to balancing HIV-antibody testing as an element of infection control policy, with responsibilities of confidentiality and disclosure, requires a realistic assessment of the risks of HIV transmission in hospitals and other institutions.[167] A 1988 study of seropositive health-care workers indicated a total of 41 infected health-care workers with no identified risk factor.[168] The proportion of health-care workers with an undetermined risk "appears to have risen from 1.5% in 1982 to 6.2% in 1987."[169]

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[163] *Id.*

[164] *Id.* at 1821.

[165] *Id.*

[166] *Id.*

[167] The Centers for Disease Control summarize the large medical literature on HIV transmission. *See* Centers for Disease Control, *Update: Human Immunodeficiency Virus Infections in Health-Care Settings*, 36 MMWR 3 (Supp. 1987) [hereafter *Health-Care Settings*]; *Preventing Transmission, supra* note 37; Centers for Disease Control, *Recommendations for Preventing Possible Transmission of Infection with Human T-Lymphotropic Virus III/Lymphadenophathy-Associated Virus in the Workplace*, 34 MMWR 681 (1985) [hereafter *Preventing Possible Transmission*]; *see also* Kuhls, Viker, Parris, Garakian, Sullivan, Boglai & Cherry, *Occupational Risk of HIV, HBV and HSV-2 in Health Care Personnel Caring for AIDS Patients*, 77 AM. J. PUB. HEALTH 1306 (1987).

[168] Centers for Disease Control, *AIDS and HIV Update: Acquired Immunodeficiency Syndrome and Human Immunodeficiency Virus Infection Among Health-Care Workers*, 259 J. A.M.A. 2817 (1988) (consisting of 8 physicians, including 4 surgeons, 1 dentist, 5 nurses, 11 nursing assistants or orderlies, 7 housekeeping or maintenance workers, 4 clinical laboratory technicians, 1 respiratory therapist, 1 paramedic, 1 mortician, and 2 others).

[169] *Id.*

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1. Routine Screening of Hospital Patients

The Centers for Disease Control does not recommend routine HIV-antibody testing to control hospital infection.[170] An extremely small risk of HIV transmissions now exists in hospitals, and the same infection control procedures that limit the risk of hepatitis B virus (HBV) suffice to minimize the risk of HIV transmission.[171]

The risk of HIV transmission in hospitals may now be extremely low, but as the prevalence of infection increases so does the risk of transmission.[172] To cite the low risk of transmission as a basis to rule out routine testing for hospital admissions therefore assumes that a low infection rate will continue. Without routine testing for hospital admissions, however, the continued validity of that assumption cannot be verified. Also, some other infections that HIV carriers harbor can be transmitted more easily than the HIV infection. An example is cytomegalovirus, which is characteristically shed by HIV carriers and can represent a threat to pregnant women, to infants, and to other susceptible persons.[173]

The circularity of logic involved in this issue contributes to growing anxiety among health-care workers.[174] Responding to these concerns, the United States Department of Labor's Occupational Safety and Health Administration (OSHA) initiated rulemaking in late 1987 to reduce occupational exposure to HBV and HIV under authority of Section 6(b) of the Occupational Safety and Health Act.[175] In response to the proposed regulations, OSHA received comments from health-care workers.[176] These comments reflect the understandable apprehension

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[170] The Surgeon General, however, has recommended that all patients undergoing elective surgery submit to routine screening. Breo, *Dr. Koop calls for AIDS Tests Before Surgery*, Am. Med. News, June 26, 1987, at 1, 17-21.

[171] *Health-Care Settings*, *supra* note 167.

[172] *See generally* Friedland & Klein, *Transmission of the Human Immunodeficiency Virus*, 317 NEW ENG. J. MED. 1125 (1987); Redfield, Markham, Salahuddin, Wright, Sarngadharan & Gallo, *Heterosexually Acquired HTLV-III/LAV Disease (AIDS-Related Complex and AIDS): Epidemiological Evidence for Female-to-Male Transmission*, 254 J. A.M.A. 2094, 2094-96 (1985).

[173] *See generally* Gerberding, Bryant-LeBlanc, Nelson, Moss, Osmond, Chambers, Carlson, Drew, Levy & Sande, *Risk of Transmitting the Human Immunodeficiency Virus, Cytomegalovirus, and Hepatitis B Virus to Health Care Workers Exposed to Patients with AIDS and AIDS-Related Conditions*, 156 J. INFECT. DIS. 1, 1 (1987).

[174] *See, e.g.*, Link, Feingold, Charap, Freeman & Shelou, *supra* note 5.

[175] 100 Stat. 1690, 1690-92 (1986) (codified as 29 U.S.C. § 655 (Supp. IV 1986)); *see* 52 Fed. Reg. 45,438 (1987) (to be codified at 29 C.F.R. pt. 1910).

[176] *See* B. MCDONALD, BLOODBORNE DISEASES IN THE WORKPLACE: INDEX TO PUBLIC COMMENTS AND RESOURCES ON FILE WITH THE U.S. OCCUPATIONAL

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that a low risk of transmission is still an unacceptable risk if it can be minimized further by isolating, or at least identifying, the potential sources of infection within the hospital.[177]

Although it is true that the universal application of infection control procedures for the prevention of hepatitis B infection, which should already be in effect, will minimize the risk of HIV transmission, HIV infection cannot be prevented by vaccination and is more serious than HBV infection. It is unfair to deny health-care workers heightened vigilance in the presence of an increased threat.

The concerns about occupational safety and health are acute when a needle-stick injury or other accidental exposure to body fluids occurs in hospitals, creating a possibility of transmitting HIV from patients to health-care workers. An exposed health-care worker will want to know if the patient is HIV-positive. If the patient is informed of the accident but refuses to provide consent for an HIV-antibody test, an impasse results. Under strict interpretation of informed consent, the hospital and health-care worker have no recourse except to seek a court order compelling testing.[178]

In states without a statute requiring informed consent for HIV-antibody testing, hospitals could require patients at the time of admission to sign a waiver. Such waivers may be feasible even in specific-consent jurisdictions if executed separately and properly. It seems clear, however, that the hospital should not have to negotiate or to litigate the right to test a blood sample that has already been drawn and is in the hospital's custody.

### 2. Disclosure of Results to Health-Care Personnel

Different issues arise when the patient consents to an HIV-antibody test following accidental exposure of a health-care worker, and the results are positive. The exposed health-care worker and the patient's health-care team should know the results,[179] but others who come into contact with the patient do not necessarily need the same information. Until recently, California public-health law specifically prohibits a physician from disclosing a patient's HIV-antibody test results to *any*

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SAFETY AND HEALTH ADMINISTRATION (1988).

[177] *Id.*

[178] *See, e.g.*, FED. R. CIV. P. 35 (discovery order for physical examination of party to civil action).

[179] *But see* Doe v. Shasta General Hosp., No. 92336 (Cal. Super. Ct., Shasta County Jan. 20, 1988) (order overruling defendant's demurrer).

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other person.[180] This statute had seemed to contradict a more general provision in the state's Civil Code allowing disclosure to health-care professionals for diagnosis or treatment of the patients.[181]

As a practical matter, other health-care workers may learn of seropositivity. When this happens the patient who conscientiously consented to screening may be treated unlike unscreened HIV-positive patients. The prospect of differing treatment is bound to affect negatively other patients' willingness to consent. It also draws into question the utility of segregating AIDS patients in a hospital while other patients are untested for HIV-antibody seropositivity, an equally infectious condition. These factors weigh heavily in favor of routine testing for hospital admissions.

### 3. The HIV-Positive Health-Care Worker

A health-care worker may also transmit body fluids to a patient through accidental exposure. The patient will want to know if the health-care worker is HIV-positive. If the patient's physician knows the health-care worker's HIV-positivity, what is the physician's obligation to preserve the confidentiality of such information? The physician may ethically be obliged to inform the patient of a threat of infection from another seropositive physician who is preparing to perform surgery or other invasive procedures or from any seropositive health-care worker who poses a threat of infection under the particular circumstances.

Ultimately, the question of liability becomes whether the adverse consequences to the HIV-infected individual are attributable to the disclosure or to the infection itself.[182] The question is more than academic because if the harm is due to the disclosure, rather than to the infection, then the responsibility for such harm belongs to the discloser. A fact finder thus has the opportunity to weigh the medical and ethical considerations that prompted disclosure and to award damages or to find that disclosure violates a criminal statute.

In summary, statutes that would impose liability on physicians for disclosing relevant information about others to their patients conflict with physicians' duty to their patients. When the information relates to the physician's own patient, however, the physician's liability to third parties can be even greater.

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[180] *See* CAL. HEALTH & SAFETY CODE § 199.21 (West Supp. 1989); *see supra* notes 83-89 and accompanying text.

[181] CAL. CIV. CODE § 56.10(c)(1) (West Supp. 1989).

[182] *See supra* note 135.

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## IV. The Duty to Inform

To begin, patients with HIV should fundamentally moderate their behavior if their infection poses a risk to third parties. Aside from the current legislative impetus to criminalize the knowing transmission of HIV, the sexual transmission of an infectious disease is already a criminal act in many states.[183] The physician who fails to disclose a patient's condition faces potential liability to a third person infected by the physician's patient.

Historically, physicians have had the duty to warn third persons who are at foreseeable risk of harm from the physicians' patients. This duty is specifically imposed by statutes that require physicians to report information about patients in other limited (but potentially overlapping) circumstances.[184] The Judicial Council of the American Medical Association recognized this problem when applied generally to medical records:

> The obligation to safeguard the patient's confidences is subject to certain exceptions which are ethically and legally justified because of overriding social considerations. Where a patient threatens to employ serious bodily harm to another person, and there is a reasonable probability that the patient may carry out the threat, the physician should take reasonable precautions for the protection of the intended victim, including notification of law enforcement authorities.[185]

The duty to inform has been recognized both as grounds for a cause of action against the physician and as a defense to a tort claim against the physician for breach of confidentiality.

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[183] *E.g.*, N.Y. Pub. Health Law § 2307 (West 1985) (making sexual intercourse a misdemeanor for person knowing self to be infected with infectious venereal disease). *See generally* Maharam v. Maharam, 123 A.D.2d 165, 510 N.Y.S.2d 104 (1986) (holding that statute authorizes wife to maintain tort action against husband for wrongful transmission of genital herpes on either fraud or negligence theories).

[184] *See, e.g.*, People v. Stritzinger, 34 Cal. 3d 505, 668 P.2d 738, 194 Cal. Rptr. 431 (1983) (holding that child abuse reporting law fulfilled compelling state interest sufficient to require reporting to law enforcement disclosure of child abuse made to a psychiatrist).

[185] American Medical Ass'n, Current Opinions of the Judicial Council, *Current Opinion 5.05*. *See generally In re* von Goyt v. State, 461 So. 2d 821 (Ala. Civ. App. 1984) (applicable to custody dispute); Schwartz v. Thiele, 242 Cal. App. 2d 799, 151 Cal. Rptr. 767 (1966) (disclosure appropriate when patient dangerous to self or others); Simonson v. Swenson, 104 Neb. 224, 177 N.W. 831 (1920) (applicable to contagious diseases).

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### A. *Cause of Action Against Physician for Failure to Inform*

Physicians have been liable for failing to warn the daughter of a patient who was suffering from scarlet fever,[186] failing to warn a patient's wife of the danger of infection from the patient's wound,[187] failing to warn a third party about the patient's seizures,[188] and for failing to warn a patient's neighbor about the patient's smallpox.[189] Similarly, in *Tarasoff v. Regents of the University of California*,[190] a psychiatrist had a duty to warn a woman that his patient was contemplating killing her.[191] Courts in several states[192] have recognized the physician's "duty to protect" as epitomized in the *Tarasoff* case,[193] but in reality the physician's duty to warn third persons at risk of infection from the physician's patient existed prior to *Tarasoff*. One court even cited the principle of disclosure in the case of communicable diseases as a basis for extending the *Tarasoff* doctrine to include the plaintiff's property interests.[194]

Moreover, a duty to warn the *patient* is the basis for a cause of action by a third party.[195] If a physician negligently fails to diagnose a

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[186] *See* Skillings v. Allen, 143 Minn. 323, 173 N.W. 663 (1919).

[187] *See* Edwards v. Lamb, 69 N.H. 599, 45 A. 480 (1899).

[188] *See* Lemmon v. Freese, 210 N.W.2d 576 (Iowa 1973).

[189] *See* Jones v. Stanko, 118 Ohio St. 147, 160 N.E. 456 (1928); *see also* Hoffman v. Blackmon, 241 So. 2d 752 (Fla. 1970), *cert. denied*, 245 So. 2d 257 (Fla. 1971); Wojcik v. Aluminum Co. of Am., 18 Misc. 2d 740, 183 N.Y.S.2d 351 (1959). *See generally Physicians and Surgeons*, 61 AM. JUR. 2D 170 (1964). A fortiori a physician is liable for his failure to warn the patient of a risk from infection when the patient becomes infected by the physician. Piper v. Menifee, 51 Ky. 465 (12 B. Mon. 1851) (failure of physician to warn patient that physician had smallpox).

[190] *Tarasoff*, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976).

[191] *See id.*; *see also In re* Lifschutz, 2 Cal. 3d 415, 467 P.2d 557, 85 Cal. Rptr. 829 (1970).

[192] *See* Bloom & Rogers, *The Duty to Protect Others From Your Patients —* Tarasoff *Spreads to the Northwest*, 148 W.J. MED. 231 (1988).

[193] *See, e.g.*, Jablonski v. United States, 712 F.2d 391 (9th Cir. 1983); Mutual of Omaha, Inc. v. Am. Nat'l Bank, 610 F. Supp. 546 (D. Minn. 1985); Chrite v. United States, 564 F. Supp. 341 (E.D. Mich. 1983); Lipari v. Sears, Roebuck & Co., 497 F. Supp. 185 (D. Neb. 1980); Bradley Center, Inc. v. Wessner, 161 Ga. 576, 287 S.E.2d 716 (1982); Estate of Mathes v. Ireland, 419 N.E.2d 782 (Ind. App. 1981); Durflinger v. Artiles, 234 Kan. 484, 673 P.2d 86 (1983); Cairl v. State, 323 N.W.2d 20 (Minn. 1982); McIntosh v. Milano, 168 N.J. Super. 466, 403 A.2d 500 (1979); Peck v. Counseling Serv. of Addison County, 146 Vt. 61, 499 A.2d 422 (1985); Petersen v. State, 100 Wash. 2d 241, 671 P.2d 230 (1983).

[194] *Peck*, 146 Vt. 61, 499 A.2d 422.

[195] *See, e.g.*, Myers v. Quesenberry, 144 Cal. App. 3d 888, 193 Cal. Rptr. 733 (1983) (failure to warn of possible dangers of driving while diabetic); Gooden v. Tips,

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serious communicable disease and a third party contracts the disease from the physician's patient, any harm that results to the third party is foreseeable.[196] The physician's duty to inform those who are foreseeably at risk of infection is therefore a factor that will generally support a decision to test the patient.[197]

### *B. Duty to Warn as Defense to Patient's Action Against Physician for Breach of Confidentiality*

The physician's duty to third parties is an affirmative defense to a patient's action against the doctor for breach of confidentiality or defamation. Courts have specifically applied this principle to contagious diseases. For example, in *Simonson v. Swensen*,[198] a physician was able to establish a good-faith (although erroneous) belief that his patient, with a preliminary diagnosis of syphilis, might be infectious to others who came into casual contact with him. The physician advised the patient to move out of the small hotel in which he was staying, and when the patient failed to do so the physician informed the hotel. The physician's preliminary diagnosis was not confirmed by a Wasserman test. Nevertheless, the court recognized the physician's duty and held that the communication of information was within the physician's discretion.

### *C. Reconciling Conflicting Duties of Confidentiality and Disclosure*

Reconciling the common-law duty to warn with countervailing confidentiality requirements in AIDS cases has confounded the experts.[199] The AMA Council on Ethical and Judicial Affairs has issued the following guidelines:

> Where there is no statute that *mandates or prohibits* the reporting of seropositive individuals to public health authorities and a physician knows

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651 S.W.2d 364 (Tex. Ct. App. 1983) (failure to warn of dangers of driving while taking tranquilizer).

[196] *McIntosh*, 168 N.J. Super. 466, 403 A.2d 500.

[197] *But see* Doe v. Prime Health/Kansas City, Inc., No. 88 C 5149 (District Court of Johnson County, Kansas Oct. 18, 1988) (unpublished) (permanently enjoining health care-provider from advising the ex-wife of patient that he had tested positive for AIDS, even though ex-wife was also patient because couple no longer married, ex-wife tested twice negative, patient did not intend to resume sexual relations, and would substantially stigmatized if his illness became public knowledge).

[198] 104 Neb. 224, 177 N.W. 831 (1920).

[199] *See* Matthews & Neslund, *The Initial Impact of AIDS on Public Health Law in the United States — 1986*, 257 J. A.M.A. 344, 346-47 (1987) (quoting general counsel of Centers for Disease Control that duty to inform open issue).

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> that a seropositive individual is endangering a third party, the physician should (1) attempt to persuade the infected patient to cease endangering the third party; (2) if persuasion fails, notify authorities; and (3) if the authorities take no action, notify the endangered third party.[200]

The AMA statement attributing identical significance to state statutes that mandate *and* prohibit the reporting of seropositive individuals reflects the prevailing confusion. The AMA statement also fails to prescribe a realistic course of action after a physician reports the identity of a seropositive individual; it seems to require the physician to monitor the state public health department after disclosing the information to that department.

Physicians who find themselves in this situation have an obvious dilemma: which course of action — disclosing to the third person at risk or maintaining confidentiality — carries a greater *likelihood* of being sued; and which course of action involves a greater *extent* of potential liability?

Assuming that the physician would be liable regardless of which course he or she pursued, potential liability could be minimized by warning the third person, because the damages from contracting HIV infection and developing AIDS are presumably greater than those that flow from disclosing HIV infection. The ethical considerations involved in balancing the interests to be protected similarly weigh. Sound public-health principles of minimizing the spread of disease also militate against imposing liability on a physician's good-faith disclosure to a patient of the risk of exposure from another health-care worker.[201]

Of course, physicians must carefully examine the confidentiality and reporting provisions of their state public-health statutes to determine whether the contemplated disclosure is exactly the kind of disclosure that state law prohibits. They must also avoid exceeding the scope of any otherwise applicable privilege. For example, they must not post a

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[200] *Ethical Issues*, *supra* note 7, at 1361 (emphasis added).

[201] *See Simonson*, 104 Neb. 224, 177 N.W. 831 (holding that physician not liable for disclosure of confidential information about sexually transmitted disease, when she in good faith and with reasonable care believed it necessary to prevent spread of the disease); *accord* Hoover v. Williamson, 236 Md. 250, 203 A.2d 861 (1964) (finding duty to advise patient of known health risks); Berry v. Moench, 8 Utah 2d 191, 331 P.2d 841 (1985) (disclosing patient information to prospective marriage partner conditionally privileged). *But cf.* Horne v. Patton, 291 Ala. 701, 287 So. 2d 824 (1973) (finding invasion of privacy for releasing medical information to patient's employer); *see also* Betesh v. United States, 400 F. Supp. 238 (D.D.C. 1974); Schwartz v. Thiele, 242 Cal. App. 2d 799, 51 Cal. Rptr. 767 (1966); Alerts v. Devine, 395 Mass. 59, 479 N.W.2d 113, *cert. denied sub. nom.* Carroll v. Alberts, 474 U.S. 1013 (1985).

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patient's test results on the door of the patient's hospital room for the sweeping purpose of "protecting" the public at large, for which the risk of infection is less than foreseeable.

## CONCLUSION

Physicians face difficult ethical and legal problems in treating AIDS and in managing AIDS-related information and medical records. The subject of AIDS in general has appropriately been viewed as a civil-rights issue, with corresponding emphasis on civil rights such as freedom from discrimination. Ultimately, however, AIDS is a public-health issue, and traditional public-health principles will set the best course for dealing with AIDS.

Early diagnosis and disclosure are the cornerstone of sound public-health policy. In a health-care system founded primarily on the relationship between doctor and patient, the physician's discretion to make reasonable determinations about disclosure and notification in the interest of public health must not unnecessarily be impeded. This discretion is threatened by federal and state proposals to enact confidentiality standards increasing the liability that physicians already face in the management of medical records. The better course is to enforce the civil-rights protections already afforded to persons suffering from infectious disease, and to avoid placing additional restrictions on the ability of physicians and health-care workers to exercise their public-health responsibilities.

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