The law and the AIDS-infected healthcare worker

Key words: Acquired immune deficiency syndrome (AIDS), emotional damages, human immunodeficiency virus (HIV), mere fright.

Many organizations representing healthcare workers, including the American Association of Nurse Anesthetists, have developed policies regarding the obligations of their members in the face of acquired immune deficiency syndrome (AIDS). Typically, these policies concern the obligation to treat patients with AIDS and voluntary or involuntary testing for AIDS. Troublesome issues are raised as to whether infected healthcare workers who continue to practice have an obligation to advise patients and others with whom they come into contact of their human immunodeficiency virus (HIV) status.

Unfortunately, society applies a double standard to healthcare workers. Healthcare workers are often ethically bound to render care to patients without regard to the patient’s HIV status. However, should the healthcare worker become infected, society does not recognize a parallel obligation to the healthcare worker. Recently, an appellate court refused to rule that the likelihood of provider-to-patient transmission was so remote that an infected healthcare worker had no obligation to warn patients that he was infected with AIDS.

In the case of *Faya v Almaraz*, 1993 Md. LEXIS 28 (Maryland, March 9, 1993), the Court of Appeals of Maryland overruled a trial court and held that a surgeon could be held liable for emotional damage suffered by patients on whom he had operated without informing them he was HIV infected. The Court of Appeals indicated that the hospital might also be liable to these patients.

Two cases arose when an oncological surgeon who had tested as HIV positive in 1986 continued to perform operations. In October 1989, the surgeon was diagnosed as suffering from cytomegalovirus retinitis, an eye infection. The HIV-positive status of the surgeon coupled with the diagnosis of cytomegalovirus retinitis confirmed a positive diagnosis for AIDS. At the time of the operation on the first patient, the surgeon knew that he was HIV positive, and at the time of the operation on the second patient, the surgeon knew not only that he was HIV positive but also that he had AIDS. The surgeon gave up his practice on March 1, 1990, terminated his association with the hospital in June of 1990, and died of AIDS on November 16, 1990.

His patients learned of their surgeon’s illness for the first time when they read an article in a local newspaper on December 6, 1990, one year after the second patient’s operation and 20 months after the first patient’s operation. Both patients immediately underwent blood tests for AIDS which came back negative. Nevertheless, the patients filed suit against the surgeon’s estate, his professional association, and the hospital for compensatory and punitive damages based on negligence, negligent failure to obtain the patients’ informed consent,
fraud, and intentional infliction of emotional distress. Other charges were negligent misrepresentation, breach of contract, loss of consortium, breach of fiduciary duty, and battery.

The gist of the complaints was that the surgeon should have advised the patients that he was HIV positive (or, later, that he was suffering from AIDS) and that the hospital was culpable for permitting him to operate without informing his patients. The patients claim that because of the possibility of a puncture (notwithstanding protective garments worn by the surgeon) which might result in a commingling of blood, they were exposed to a hazard they would otherwise have avoided by withholding their consent to the surgery, namely the risk of AIDS. They also allege that the hospital failed to take steps, such as suspending the surgeon's privileges to prevent him from operating on uninformed patients.

**Unfounded fears**

The plaintiffs did not test positive for AIDS. They are claiming, however, that they incurred injuries in the form of exposure to HIV and risk of AIDS, physical injury, and financial cost resulting from surveillance, blood testing for HIV antibodies, pain, fear, anxiety, grief, nervous shock, severe emotional distress, headache, and sleeplessness. Representatives of the surgeon claim that the physician owed no duty to disclose his ailment as part of the doctor-patient exchange leading to informed consent. The hospital contended that it had no duty to investigate and ascertain the doctor's HIV status and that it was not responsible for obtaining informed consent. Both the representatives of the surgeon and the hospital argued that injuries which result from the fear of a risk that turns out to be unfounded do not give rise to a cause of legal action.

The trial court dismissed both complaints on the grounds that there had been no reported case of transmission of AIDS from a surgeon to a patient, and the fact that the patients had tested HIV negative more than six months after their surgery made it extremely unlikely that they would develop AIDS. Thus, their fears were unfounded. The plaintiffs appealed.

The first issue before the appellate court was the question of whether the surgeon had a legal duty to the patients to advise them that he was HIV positive. While there were no cases which dealt specifically with the HIV virus, there have been a number of other cases concerning healthcare workers infected with other dangerous diseases. In these cases, the important factor used to determine the duty to disclose was foreseeability. The Maryland court discussed an earlier case in which a nurse alleged that a doctor with whom she had been intimate was negligent in failing to inform her of his genital herpes. The court observed that "one who knows he or she has a highly infectious disease can readily foresee the danger that the disease may be communicated to others with whom the infected person comes into contact" (B.N. v. K.K., 312 Maryland 142). Because of the foreseeability of transmission, the court had held that the doctor had a legal duty either to refrain from sexual contact with others or to inform his sexual partners of his disease.

In the case of a surgeon with HIV, the plaintiffs claim that the doctor might transmit the AIDS virus to his patients during invasive surgery. Despite the fact that medical literature indicates that with proper barrier techniques the risk of HIV transmission during surgery is extremely low, they argued that the surgeon had an obligation either to refrain from performing surgery or to warn them of his HIV-positive condition. The AIDS dilemma is that while it may be unlikely that an infected doctor will transmit the AIDS virus during surgery, if the doctor does transmit the virus, the patient will almost surely die.

**AMA policy**

The court supported its conclusion with a policy adopted by the House of Delegates of the American Medical Association (AMA). The AMA recommended that "HIV infected physicians should disclose their HIV seropositivity to a public health officer or a local review committee, and should refrain from doing procedures that pose a significant risk of HIV transmission, or perform those procedures only with the consent of the patient and the permission of the local review committee." The court believed that this statement justified its position. However, the AMA statement is not specific. It refers only to procedures that "pose a significant risk of HIV transmission." Is surgery a procedure that poses a significant risk of HIV transmission? The AMA did not attempt to answer this question. It advised "a physician who has HIV disease or who is seropositive should consult colleagues as to which activities the physician can pursue without creating a risk to patients."

Nor did the Maryland Appellate Court determine that this type of surgery posed "a significant risk of HIV transmission," nor even that the doctor had an obligation to disclose. This was a review of a dismissal of a case by the trial court. In dismissing the case, the trial court had come to the conclusion that there were no facts which could show that the doctor had a duty to inform. All the appellate court had to determine was that there was, at the
very least, a factual dispute over whether the surgeon was obligated to disclose, and it was required to reverse the trial court. The court could not say, as a matter of law, that there was no set of facts which could impose a duty upon the doctor to warn his patient.

Unfortunately, the court did not rule that HIV transmission was foreseeable nor did it consider whether the doctor was engaged in a type of surgery that medical experts would testify was inappropriate for a physician infected with the HIV virus. The court was satisfied to leave this question for the jury—an approach which leaves every HIV-infected healthcare worker to have to rely on a trial and the emotions of a jury to learn whether he or she had an obligation to disclose.

Looked at in the comfort of legal analysis, the case is all too easy to decide. It may be too much to expect at this early stage of litigation that the appellate court would uphold the dismissal of the case. Were there specific facts which would lead to the conclusion that this doctor had an obligation to disclose or is the court inviting juries to give vent to their emotions and fears in an area already crowded with emotion and fear? Unfortunately, this lack of analysis does a great disservice to a very complex and difficult issue. The AMA statement, on which the court relied, is a very conservative statement. It attempted to leave the analysis of permissible procedures to the medical community. Instead, the statement is being used to permit juries to make these decisions. Other professional organizations have taken different positions.

Different views

Among those taking differing views is the American Association of Nurse Anesthetists. In its "Guidelines on HIV/AIDS Prevention and Management for the Certified Registered Nurse Anesthetist," the AANA stated that disclosure of a CRNA's HIV/AIDS status should be made to a patient only if the patient were exposed to body fluids of an infected CRNA. (These guidelines were adopted by the AANA Board of Directors on August 8, 1991. In 1992, the AANA produced the "Infection Control Guide,"* which contains the AANA's current position on AIDS and the infected healthcare worker.) Nor was the AANA alone in taking this stand. In its "Position Paper: The HIV-Infected Healthcare Worker," issued in December 1990, the Association for Practitioners in Infection Control (APIC) and the Society of Hospital Epide-

*Copies of the "Infection Control Guide" can be ordered by sending $15 per copy to: AANA, Practice Department, 222 South Prospect Avenue, Park Ridge, IL 60068-4001.

miologists of America (SHEA) concluded that disclosure of HIV infection is not required because a requirement for such disclosure would very likely require a healthcare worker to abandon healthcare "an unwarranted outcome in light of our current understanding of the risks for [healthcare worker] -to-patient transmission of HIV."3

The AANA justified its position on the estimated probability of transmission from an HIV-infected healthcare worker to a patient during an invasive procedure being between one per 100,000 and one per 1,000,000 procedures. APIC and SHEA compared the risk of HIV infection to the risk of transmission of hepatitis B virus. They noted that despite an estimated 4,000 healthcare workers in the United States who perform invasive procedures and who are also hepatitis B virus carriers, there have been "at least 19" reported outbreaks of hepatitis B virus infection in the last 20 years throughout the world.

To be fair, some respected healthcare organizations have come to the opposite conclusion. In an editorial, the New England Journal of Medicine wrote that patients have a right to know whether a doctor or nurse who performs invasive procedures is infected with HIV.4 If physicians and nurses who represent a potential source of HIV infection are obligated to refrain from invasive procedures or to disclose their HIV status (probably resulting in their inability to perform invasive procedures), the New England Journal of Medicine also insisted that healthcare workers "should expect to have reasonable alternative work."4

Nature of injury

There is another part of Faya v Almaraz less likely to get headlines, but much more controversial, and that is the nature of the injury inflicted. Neither patient claimed that there had been anything wrong with the surgery, nor that they had become infected with the HIV virus, nor even that there was any substantial likelihood that they would become infected with the HIV virus. Rather, they claimed they were injured because "they were put in fear of having contracted HIV and thereby suffered the derivative consequences of that fear which were manifested by emotional and mental distress, headaches, sleeplessness, and, in addition, the pain and expense associated with repeated blood tests." Is fear and its associated physical ailments an injury for which the law provides compensation? Faya v Almaraz held that the patients might be compensated for damages arising from fear even though other courts have held to the contrary.

In Burke v Sage Products, Inc., 747 F.Supp 285 (Ed. Penn. 1990), the court rejected a paramedic's
claim based on a fear of contracting AIDS after he suffered a needlestick from a discarded syringe. The plaintiff was unable to demonstrate that the syringe had actually been in contact with an HIV-infected person. Other courts have concurred that there can be no recovery where the plaintiff can demonstrate neither a channel of exposure to the virus nor demonstrable injury in the form of an HIV-positive test.

On the other hand, similar exposure under circumstances where AIDS is known to be present has given rise to a different result. In Johnson v West Virginia University Hospitals, 413 S.E. 2d 889 (W. Va. 1991), the court affirmed a judgment for a police officer who had been attacked in a hospital by an AIDS-infected person who had first bitten himself on the arm, thereby drawing his own infected blood into his mouth and then bitten the officer. In Carroll v Sisters of St. Francis Health Services, 1992 Tenn. App. LEXIS 845, the court ruled that someone who had been pricked by a needle while visiting her sister in the hospital might have a cause of action against the hospital based on a possibility that the needles were contaminated with the AIDS virus.

In Fava v Almaraz, the court held that there was a possibility that the patient’s fear of acquiring AIDS might have been reasonable. However, because of the substantial period that had elapsed since exposure, once they were tested for AIDS, there was a 95% certainty that they were AIDS-free. Therefore, they could only recover for their fear and its physical manifestations in a window beginning with their knowledge that the surgeon was infected with AIDS and the return of their test results that they were not suffering from AIDS.

Mere fright

Finally, in many jurisdictions, the law used to be that there was no recovery for a tort damage if the only injury was mere fright or mental suffering. Courts were reluctant without more objective evidence to award damages based solely on “mere fright,” because fright can easily be simulated. In recent years, where plaintiffs have demonstrated symptoms which result from “mere fright” but which are difficult to simulate, the courts have been more inclined to agree that there can be a recovery.

Sometimes when a plaintiff’s rights have appeared to be violated, but where no damage actually results, you have a situation which trial lawyers refer to as “no harm; no foul.” Although the defendant may have violated someone’s legal right, no harm has been done and there is no reason for the courts to encourage lawsuits if no one was really hurt. On the surface, Fava v Almaraz would appear to be such a case, and yet the court stops short of ruling that the plaintiff was not entitled to bring an action or to pursue potential damages.

Healthcare workers are then doubly endangered by AIDS. Not only are they exposed to it as an occupational hazard, but unless courts are willing to provide some guidelines, should healthcare workers become infected they may be forced into positions where they may no longer practice their professions.

REFERENCES