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WHO'S AFRAID OF WHOM? COURTS REQUIRE HIV-INFECTED DOCTORS TO OBTAIN INFORMED CONSENT OF PATIENTS

Mary K. Logan*

INTRODUCTION

Three recent appellate court decisions in California, Maryland and Minnesota are cause for great concern among health care providers infected with HIV. These cases form the basis of an emerging legal trend to require HIV-infected doctors to disclose their HIV status to their patients. Furthermore, non-infected patients may sue HIV-infected doctors who fail to make this disclosure for emotional distress suffered for fear of contracting HIV. The cases are unique in that the patients need not prove actual exposure to HIV—they are merely required to show that their doctors cared for them while infected with HIV.

These landmark decisions contrast sharply with AIDS phobia cases that do not involve health care providers, and differ markedly

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2. See infra notes 9-47 and accompanying text (discussing the three key cases).

3. See infra notes 9-47 and accompanying text (discussing the three key cases).

from "fear of" cases generally. More importantly, they have serious public policy implications — courts have opened the door to future suits by patients who claim the right to be informed of other medical conditions affecting their health care providers, such as hepatitis, tuberculosis and substance addiction. In addition, these cases fly in the face of the efforts of public health officials to put fears about HIV in perspective.

Three alternative legal analyses are available to future courts faced with evaluating these difficult, emotionally driven cases. These analyses would discourage needless litigation and support statements by leading infection control experts that the risk of transmission of HIV in a health care setting is infinitesimal.

Part I of this Article analyzes the three key cases. Part II discusses the law of emotional distress as it may relate to this issue. Part III discusses some public policy concerns raised by the three decisions. Part IV briefly discusses the possibility of these cases being extended in the future. Finally, Part IV explores the merits of the alternative legal analyses, and proposes that courts reject the


6. See infra notes 9-47 and accompanying text (discussing the three recent cases which require physician disclosure).

7. See infra notes 136-50 and accompanying text (discussing the alternative theories).

notion that patients have a right to pursue claims for emotional distress absent actual exposure to HIV or other infectious diseases.

I. The Key Cases

A. Faya v. Almaraz

In Faya v. Almaraz,9 a Maryland appellate court held that as a matter of law, plaintiffs may sue their HIV-infected doctor for emotional distress caused by the fear of contracting HIV. Dr. Almaraz, an oncologist specializing in breast cancer, performed surgery on the two plaintiffs in 1988 and 1989, two years after he learned that he had HIV.10 At the time he performed surgery on one of the plaintiffs, he did not have active AIDS.11 Approximately two weeks prior to performing surgery on the other plaintiff, Dr. Almaraz was diagnosed with cytomegalovirus retinitis, his first active symptom of AIDS.12

Almaraz gave up his medical practice in March 1990, and died of AIDS the following November.13 In December 1990, the two plaintiffs learned about Almaraz’ illness in a local newspaper — almost two years after the first plaintiff’s last contact with him and over a year after the second plaintiff’s surgery.14 Both plaintiffs immediately underwent HIV testing, with negative results.15 Five days after reading the newspaper account of Almaraz’ illness, the plaintiffs filed civil lawsuits for compensatory and punitive damages against his estate, his professional corporation, and the hospital at which the surgeries were performed.16

10. Id. at 329.
11. Id.
12. Id. AIDS is the acute clinical phase of HIV, caused by a seriously compromised immune system. Prior to the onset of AIDS, individuals with HIV typically are asymptomatic. Id. at 328. The more common symptoms of AIDS include Kaposi’s sarcoma, severe and prolonged yeast infections and herpess, cytomegalovirus infections, tuberculosis, and pneumocystis carinii pneumonia. Id. at 328-29 (discussing the disease and summarizing several key articles on the progression of the disease). Individuals with asymptomatic HIV are able to continue their daily lives; the disease does not impair their ability to perform the essential functions of their jobs, and without external intervention no one would know the individual’s HIV status by looking at, talking with, touching or working with him/her. Id. Individuals with active AIDS also can continue to perform the essential functions of their daily lives, until a crucial point, which is different in each instance, at which the individual’s illness interferes with daily living to a critical extent. Id.
13. Id.
14. Id.
15. Id.
16. Id.
The complaints alleged typical tort theories of liability based on emotional distress. The underlying claim was that Almaraz had a duty to inform his patients of his illness and that the hospital should not have permitted him to perform surgery absent the plaintiffs' informed consent. The plaintiffs claimed severe emotional distress, manifested by headaches, sleeplessness, anxiety, and other ailments resulting from their discovery of Almaraz' failure to disclose and their subsequent surveillance testing for HIV. They did not contract HIV, nor did they claim exposure to Almaraz' blood during their surgeries.

The defendants filed motions to dismiss for failure to state a valid claim. Their motions were based on the position that 1) neither Almaraz nor the hospital owed a duty to disclose (or discover) Almaraz' HIV status, 2) the plaintiffs failed to allege that HIV entered their bodies during the surgeries, and 3) their injuries were not compensable because they were based on a fear that never materialized into HIV. The trial court agreed and dismissed the complaints.

The appellate court reversed, concluding that "it was foreseeable that Dr. Almaraz might transmit the AIDS virus to his patients during invasive surgery." As a result of this foreseeable risk, the court held that Almaraz had a duty to disclose his HIV status before performing surgery on the plaintiffs, in order to give them the opportunity to decide whether to proceed under the circumstances. Almaraz' failure to make this disclosure led the court to determine that the plaintiffs could pursue their claims of emotional distress caused by the fear of contracting HIV from Almaraz.

In reaching this conclusion the court relied on the American Medical Association's (AMA) policy regarding HIV-infected physicians. In particular, the court cited a portion of the policy that

17. Id. at 330.
18. Id.
19. Id.
20. Id. HIV is a bloodborne disease — it must reach an individual's bloodstream to be transmitted. For example, such as from a wound in the infected person that bleeds into a healthy person, allowing the blood of both to co-mingle. Id. at 332 (discussing HIV transmission).
21. Id.
22. Id. at 330-31.
23. Id. at 333.
24. Id.
25. Id.
26. Id. at 334 (citing AMERICAN MEDICAL ASSOCIATION, DIGEST OF HIV/AIDS POLICY
states (1) HIV transmission is a theoretical possibility during invasive medical procedures; and, thus (2) HIV-infected physicians should disclose their HIV seropositivity to patients before performing procedures that pose a significant risk of HIV transmission to patients.27

The court also held that the allegations of harm from the fear of contracting HIV were not unreasonable, even though the plaintiffs failed to allege any mode of transmission.28 The court limited recovery for this fear to the period between the time they learned of Almaraz' illness and the time they received their own negative test results — a "reasonable window of anxiety."29 Therefore, the plaintiffs' allegations were sufficient to survive motions to dismiss, and they were permitted to pursue at the trial court their claims for emotional distress based solely on Almaraz' failure to disclose his HIV status to them prior to their surgeries.30

B. Kerins v. Hartley

The next significant decision is the 1993 California appellate court decision, Kerins v. Hartley (Kerins I).31 In Kerins I, Dr. Gordon, a surgeon, performed abdominal surgery on the plaintiff on November 5, 1986, and five days later received the results of testing that confirmed he had HIV.32 Gordon continued to practice medicine for a period of time thereafter. In April 1988, he announced that he had AIDS during a televised news broadcast seen by the plaintiff patient.33 The plaintiff immediately underwent HIV testing and learned approximately two weeks later that the results were negative.34 She then claimed that Gordon breached a duty to disclose his HIV status as soon as he had knowledge of it, and that she suffered severe emotional distress upon learning of Gordon's ill-
ness. Gordon (subsequently his estate) and the other defendants filed motions for summary judgment, claiming that the plaintiff was not entitled to a recovery as a matter of law. The trial court agreed and dismissed the action.

The appellate court in Kerins I relied heavily on the ruling in Faya and held that the plaintiff could pursue her claim of emotional distress caused by the fear of contracting HIV. The court concluded that her emotional distress became unreasonable (and thus not compensable) once she 1) received reasonable assurance that she had not been exposed to Gordon's blood; 2) received negative HIV test results; and 3) had an opportunity to obtain counseling on the accuracy and reliability of the HIV tests and on the remote possibility of seroconverting to HIV-positive status more than 19 months after her surgery. The court in this initial ruling concluded that these elements of her claim required a factual inquiry, and thus, summary judgment was inappropriate.

The court engaged in a fairly detailed analysis of the existing case law on emotional distress based on the fear of contracting AIDS. It chose to follow the Faya case in which the plaintiffs were not required to prove actual exposure to HIV.

35. Id. at 624.
36. Id. at 625.
37. Id. at 627-32.
38. Id. at 631.
39. Id. at 632.
40. Id. at 627-32.

41. On February 24, 1994, the Supreme Court of California issued a one paragraph order transferring the case back to the Court of Appeal, with direction to vacate its decision and reconsider the case in light of Potter v. Firestone Tire & Rubber Co., 863 P.2d 795 (Cal. 1993). Kerins I, 868 P.2d 906 (Cal. 1994). Potter was a fear of cancer case in which the California Supreme Court adopted a landmark rule that damages for fear of contracting cancer could not be recovered in a negligence action in the absence of physical injury unless the plaintiff is able to plead and prove that the fear stems from reliable scientific evidence that is more likely than not that the feared cancer will develop. Potter, 863 F.2d at 799-800. The California Court of Appeal in Kerins I thus faced the arduous task of reformulating its decision. The appellate court issued its new opinion on August 23, 1944, using the Potter analysis. Kerins II, 33 Cal. Rptr. 2d 172 (Cal. Ct. App. 1994). This new decision of great import is discussed later in the body of this Article.

In addition, on July 6, 1994, the California Court of Appeal decided Herbert v. The Regents of the Univ. of Ca., 31 Cal. Rptr. 2d 709 (Cal. Ct. App. 1994), involving a suit for negligent infliction of emotional distress stemming from a 3 year old boy's needlestick injury from discarded used needles in a hospital examining room. Id. at 711. The court upheld the defendant's summary judgment decision based on the Potter decision, because the scientific evidence was that the boy's risk of contracting HIV was .5 percent (assuming the needle was infected, a fact which was unknown) and thus significantly below the required "more likely than not" standard established in the Potter decision. Id. at 713.
HIV-INFECTED DOCTORS

A. K.A.C. v. Benson

In *K.A.C. v. Benson*, the plaintiff-patients of Dr. Benson filed a suit for intentional infliction of emotional distress alleging that Dr. Benson performed medical procedures, including invasive gynecological procedures, while he was HIV-infected and had "oozing sores on his hands and arms." The Minnesota appellate court relied heavily on *Faya* and *Kerins I* in concluding that the plaintiffs could pursue their claims if they could show that "they were in the zone of danger of contracting HIV, that they reasonably feared for their safety, and consequently suffered emotional distress." Whether the plaintiffs were in this zone of danger was a genuine issue of material fact to be determined in the trial court.

With respect to damages, the court agreed with the decision in *Faya* that the fear of exposure to HIV is reasonable only from the time patients learn of their possible exposure to the time they receive their negative test results. Finally, the court ruled that based on the standard of care in the medical community, Benson had a duty to disclose his HIV status to his patients before performing invasive procedures on them.

Therefore, the court in *K.A.C.* found the decisions in *Faya* and *Kerins I* to be strong persuasive authority, and it rejected without discussion the other case law regarding exposure to HIV. The court agreed that the plaintiffs' initial distress at hearing their health care provider had HIV should not be dismissed as unreasonable.

43. *Id.* at *5.
44. *Id.* at *10 (citing Stadler v. Cross, 295 N.W.2d 552, 553 (Minn. 1980)).
45. *Id.*
46. *Id.* at *15-16. It should be noted that the court concluded this period was consistent with the periods allowed for damages in *Faya* and *Kerins I*. *Id.* While this result is consistent with *Faya*, it would appear that the *Kerins I* court allowed for a broader period of recovery, because it encompassed an investigation of the surgery itself (to determine whether she was exposed) and counseling regarding the reliability of HIV testing. *Kerins I*, 21 Cal. Rptr. 2d 621, 631 (Cal. Ct. App. 1993), review granted, 860 P.2d 1182 (Cal. 1993), transferred in light of Potter v. Firestone Tire & Rubber Co., 863 P.2d 795 (Cal. 1993), 868 P.2d 906 (Cal. 1994), transferred to and summary judgment granted in, 33 Cal. Rptr. 2d 172 (Cal. Ct. App. 1994).
47. K.A.C., 1993 Minn. App. LEXIS 1201 at *18. Interestingly, the plaintiffs' expert, Dr. Sanford Kuvin, is a Florida physician who served as the expert witness in Kimberly Bergalis' lawsuit against her dentist, Dr. David Acer, for transmission of HIV to her during dental care. For a discussion of the Acer and Bergalis dispute, see Bruce Lambert, *Kimberly Bergalis Is Dead at 23: Symbol of Debate Over AIDS Tests*, N.Y. TIMES, Dec. 9, 1991, at D9.
II. THE LAW OF EMOTIONAL DISTRESS

The traditional law of negligent infliction of emotional distress is found in sections 313(1) and 463A of the Restatement (Second) of Torts.\(^\text{48}\) The doctrine provides that a defendant is generally liable for an illness resulting from emotional distress if she knew or should have known that her conduct involved an unreasonable risk of causing the distress and her conduct actually results in bodily harm.\(^\text{49}\) A plaintiff cannot recover damages unless she can show a physical injury together with the emotional distress.\(^\text{50}\) The reason for this rule, which in earlier years was followed by a majority of courts, is that compensating for emotional distress absent physical harm would burden courts and defendants, because distress that does not result in physical consequences is likely to be temporary and harmless.\(^\text{51}\) Physical injury carries with it a certain authenticity that ensures the distress is not imagined or feigned, and absent physical injury, the fault is not great enough that a defendant should be required to compensate for it.\(^\text{52}\)

In recent years, the doctrine has evolved significantly to accommodate changes in our society.\(^\text{53}\) The advent of toxic tort litigation resulted in courts allowing recovery for emotional distress under circumstances that were not contemplated in the earlier years. A number of variations on the traditional rule have emerged, and an increasing number of jurisdictions are permitting recovery without an

\(^{48}\) Restatement (Second) Of Torts §§ 313(1), 463A (1965).

\(^{49}\) Id.

\(^{50}\) Id.

\(^{51}\) Id.

\(^{52}\) Id. § 436A, cmt. b (1965); see, e.g., Payton v. Abbott Labs, 437 N.E.2d 171, 174 (Mass. 1982) (finding that lack of evidence of physical harm precludes a cause of action for emotional distress and anxiety when that emotional stress and anxiety result from an increased likelihood that the plaintiff will suffer a serious disease in the future); Stites v. Sundstrand Heat Transfer, Inc., 660 F. Supp. 1516, 1526 (W.D. Mich. 1987) (finding that plaintiffs may recover for physical injury resulting from emotional distress if the injury is “definite and objective,” and not fictitious and imaginary).

\(^{53}\) See Marrs, supra note 5, at 1-3 (discussing the increasing restrictions courts have put on recovery under negligent infliction of emotional distress and the development of the different theories for establishing liability: 1) physical impact rule; 2) zone of danger rule; 3) foreseeable plaintiff approach; and 4) proximate cause approach); accord Paul V. Calandrella, Note, Safe Haven for a Troubled Tort: A Return to the Zone of Danger for the Negligent Infliction of Emotional Distress, 26 Suffolk U. L. Rev. 79, 90-100 (1992); see also Blanche Wilkinson, Note, Bystander Emotional Distress Claims in Medical Malpractice Action, 15 Am. J. Trial Advoc. 605, 606-13 (1992) (stating that courts are beginning to allow bystanders to recover for negligent infliction of emotional distress in cases where they suffer no physical injury or physical manifestation of mental disturbance).
accompanying physical injury.\textsuperscript{54}

The most common rule today is that a plaintiff may recover damages for emotional distress if the defendant's negligence would cause distress in a reasonable person.\textsuperscript{55} A key element in toxic tort cases is that the plaintiff has been \textit{exposed} to a toxic chemical (e.g., the plaintiff drank water contaminated with carcinogens from chemicals disposed of by the defendant).\textsuperscript{56} The exposure creates a reasonable fear (and consequently emotional distress) that the plaintiff will contract cancer as a result of ingesting the chemicals.\textsuperscript{57} Real exposure to the dangerous agent is necessary to make the fear reasonable. A plaintiff would not be entitled to recover for the fear of contracting cancer from drinking water absent proof that the water was actually contaminated by some action or inaction of the defendant.\textsuperscript{58}

\textbf{A. Emotional Distress and HIV-Infected Health Care Providers}

The courts in \textit{Faya}, \textit{Kerins I} and \textit{K.A.C.} easily and perhaps unknowingly stretched even the most liberal interpretations of the tort theory of negligent infliction of emotional distress. As noted above, a key element in contemporary toxic tort cases is exposure to a dangerous agent that creates a reasonable fear of contracting a serious illness. In all three cases, the courts did not require the plaintiff patients to show actual exposure to HIV during their medical treatment in order to survive motions to dismiss or motions for summary judgment.\textsuperscript{59} This is a significant departure from existing tort law, because in effect it eliminates actual exposure as one of the elements of proof. If the courts followed these three cases in the context of contaminated water, a plaintiff would be entitled to proceed to trial with a fear of cancer claim absent proof that the water was actually contaminated by the defendant.

The court in \textit{Faya} acknowledged that it was not requiring the plaintiffs to allege in their complaints any possible mode of trans-
mission of HIV during their surgeries. The court briefly discussed the type of proof that would be required if the plaintiffs were obligated to show actual exposure. The plaintiffs would have to show a failure by Dr. Almaraz to use appropriate barrier techniques during the surgeries or some incident, such as a serious needlestick that spilled Dr. Almaraz's blood during the surgery. This would allow Dr. Almaraz' blood to be commingled with that of the plaintiffs. However, the court reasoned that it would unfairly punish the plaintiffs to require them to allege an actual mode of transmission when they lacked the requisite information to do so. The court in Kerins I agreed with this relaxation of proof.

The court in K.A.C. came close to requiring proof of exposure when it ruled that the plaintiffs were obligated to show they were in a zone of danger. This zone of danger test, however, was met simply by proof that Benson performed invasive procedures on them while suffering from exudative dermatitis. They were not required to prove that these procedures were performed by Benson without gloves (and thus that he placed his injured hands in direct contact with the bodies of the patients while performing gynecologic examinations or delivering babies), that his gloves were torn while his hands were in contact with the plaintiffs' bodies, or that he suffered some injury while performing the medical procedures on them (possibly resulting in blood-to-blood contact).

What led to this relaxation of traditionally and purposefully strict tenets in the law of torts (i.e., not requiring the plaintiffs to plead and prove actual exposure to HIV)? The decision in Faya is key, since it was decided first and given significant weight by the courts in Kerins I and K.A.C.

Two elements of the analysis of informed consent in Faya are crucial to understanding the court's departure from traditional tort

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61. Id. at 337.
62. Id.
65. Id. at *8-11.
theory. First, the court did not accurately examine how the doctrine of informed consent should be applied. Ordinarily, the courts require informed consent whenever a risk is significant or material in some way. The underlying concept is that patients have a right of autonomy, and they need adequate information about medical treatment before they can make an informed decision to accept or reject that treatment.

The court's decision was driven in large part by the AMA policy regarding HIV-infected physicians. That policy, however, was adopted in 1992, after Dr. Almaraz performed surgery on the two patients at issue and in the aftermath of the renowned Florida case involving a dentist, Dr. David Acer, who is reported to have transmitted HIV to as many as six dental patients. At the time of the AMA's consideration of this major policy, many members of Congress, the media, and the American public advocated mandatory testing of health care workers and informed consent, because of the Acer case.

Two principles in the AMA policy are crucial in the Faya court's analysis of informed consent. The first is that there is a "theoretical possibility" that an infected physician might transmit HIV to a patient during invasive procedures. The second is that an infected physician should obtain the patient's consent before performing procedures that pose a significant risk of transmission.

The court readily accepted these two conclusions without any true

66. See e.g., Sard v. Hard, 379 A.2d 1014, 1019 (Md. 1977) ("Simply stated, the doctrine of informed consent imposes on a physician, before he subjects his patient to medical treatment, the duty to explain the procedure to the patient and to warn him of any material risks or dangers inherent or collateral to the therapy . . . .").

67. Despite this uniform tenet underlying the doctrine of informed consent, the courts vary in the test they use for determining whether any given risk is material or significant. In the context of health care, some would ask what a reasonable doctor would disclose under the same or similar circumstances; some would ask what a reasonable patient would want to know; some accept as reasonable what the plaintiff patient would want to know. See Michelle Wilcox DeBarge, Note, The Performance of Invasive Procedures by HIV-Infected Doctors: The Duty to Disclose Under the Informed Consent Doctrine, 25 CONN. L. REV. 991, 997-1001 (1993) (discussing the courts' application of the "professional standard" throughout the 1950's and 1960's and the development of the "patient-oriented standard" in the early 1970's which requires that a doctor disclose all information that a reasonable person in the patient's position would find material in making a medical decision).


70. Id.


72. Id.
examination of their meaning in context. The court did not evaluate the meaning of this "theoretical possibility" that a patient might be infected by a physician with HIV. The mainstream scientific community agrees that the risk of transmission of HIV to a patient from an infected health care provider is infinitesimal.\textsuperscript{73} The Florida case involving Dr. Acer is acknowledged by leading experts to be an anomaly among the millions of medical and dental procedures that have been performed over the past 10 years by HIV-infected health care providers; no one truly knows what happened.\textsuperscript{74} The \textit{Faya} court did not expressly hold that the risk of transmission of HIV from doctor to patient was a significant or material risk, as traditionally required under the doctrine of informed consent. The court concluded simply that the risk was a theoretical possibility.\textsuperscript{75}

Part of the analysis of informed consent, however, involves weighing the gravity of the potential harm. The court in \textit{Faya} focused on this part of the analysis when it noted that, "[w]hile it may be unlikely that an infected doctor will transmit the AIDS virus to a patient during surgery, the patient will almost surely die if the virus is transmitted."\textsuperscript{76} The gravity of the harm, death, appears in \textit{Faya} to transform any theoretical possibility into a significant or material risk; it is material simply by the fact that its only outcome, however remote, is death.\textsuperscript{77}

\textbf{B. Other Types of "Fear of" HIV Cases}

The public hysteria about AIDS has led to a number of lawsuits in other settings, where the plaintiff has claimed emotional distress based on a "fear of" contracting HIV.\textsuperscript{78} The courts have generally ruled that the plaintiff must show actual exposure to HIV in order to pursue a claim for emotional distress.\textsuperscript{79} Perhaps the most re-

\textsuperscript{73} \textit{See} Molinari, \textit{supra} note 8, at 710.
\textsuperscript{74} Some have posited that perhaps Acer committed murder, but authorities have found no evidence to support such a theory. Laurie Garrett, \textit{Dentist's Lethal Legacy: Gave AIDS virus to patients in Florida}, \textit{Newsdash}, Aug. 18, 1991, at 4.
\textsuperscript{75} \textit{Faya}, 620 A.2d at 334 (citing AMA policy).
\textsuperscript{76} \textit{Id.} at 333.
\textsuperscript{77} \textit{Cf. Doe v. Washington Univ.}, 780 F. Supp. 628, 633-34 (E.D. Mo. 1991) (upholding a dental school's decision not to allow an HIV-infected student to complete his standard clinical studies, and noting that "to permit even an occasional death to occur because of a failure to scrupulously guard the safety of patients would appear to be morally unacceptable and contrary to the fiduciary responsibility of the medical profession").
\textsuperscript{78} \textit{See infra} notes 80-104 and accompanying text.
\textsuperscript{79} \textit{See infra} notes 80-104 and accompanying text.
nowned case was Christian v. Sheft,80 in which Rock Hudson's lover, Marc Christian, was awarded $14.5 million by a jury for his claim of emotional distress, based in part on his fear of contracting AIDS.81 Christian tested negative for the virus, but the jury concluded that Hudson conspired with his secretary, Mark Miller, to hide the truth about Hudson's condition.82 While the case was emotionally charged and perhaps subject to criticism for the size of the award, the emotional distress analysis was sound: Hudson engaged in unprotected sex with Christian, knowing that he was infected with HIV. He thus exposed his partner to a deadly disease.83 Here, exposure was easy to prove, because it is well accepted in the scientific community that unprotected sex with an HIV-infected partner is an exposure.

Similarly, in Johnson v. West Virginia University Hospitals, Inc.,84 the court permitted damages for emotional distress where the plaintiff hospital security guard could show actual blood-to-blood exposure to HIV through a bite inflicted by an infected patient.85 The guard tested negative, but the court determined his fear was reasonable since he was exposed to and could have contracted the disease.86 This case can be easily distinguished from Faya and its progeny, because in Johnson, the informed consent doctrine is inapplicable. Importantly, however, the court did require actual exposure to HIV by the plaintiff.

By contrast, in Neal v. Neal,87 the appellate court affirmed the trial court's dismissal of an action filed by a wife against her husband for the fear of contracting a sexually transmitted disease.88 The wife was unable to prove that her husband or his sex partners were infected, and therefore, there was no actual exposure.89 Similarly, in Doe v. Doe,90 the New York Supreme Court dismissed a wife's action for fear of contracting HIV from her husband.91 The
claim was based on the husband’s failure to disclose a homosexual relationship.\(^9\) The husband, however, tested negative for HIV, and the wife refused to submit to testing to validate or disaffirm her fear of exposure.\(^8\) Both cases involved the notion that the defendants should have disclosed extramarital relationships to their spouses, much like the doctrine of informed consent to medical care.\(^8\) Unlike in informed consent cases, however, the plaintiffs in *Neal* and *Doe* failed to show actual exposure to HIV, and therefore, the cases were dismissed.\(^8\)

A number of other similarly situated plaintiffs have tested the fear of AIDS theory to no avail. In *Burk v. Sage Products, Inc.*,\(^9\) a paramedic was stuck by a used needle on a hospital floor occupied by several HIV-infected patients.\(^7\) The plaintiff tested negative for HIV five times, and he could not prove that the discarded needle had been used on an HIV-infected patient.\(^8\) He filed a suit for emotional distress against the manufacturer of the syringe container, claiming that he lived in fear of contracting HIV.\(^9\) The court dismissed the case, because the plaintiff could not show that he was actually exposed to HIV-infected blood.\(^10\)

In *Funeral Services by Gregory, Inc. v. Bluefield Community Hospital,*\(^10\) a mortician and his wife sued for emotional distress

\(^92\) *Id.* at 596.
\(^93\) *Id.* at 598.
\(^94\) *Id.* at 596 (dismissing fraud claim against husband for failing to disclose to wife his homosexuality and at "high risk" candidacy for AIDS); *Neal v. Neal*, 873 P.2d 871, 876 (Idaho 1994) (dismissing claim for negligent and intentional infliction of emotional distress resulting from wife's fear that she may have contracted a sexually transmitted disease as a result of husband's extramarital affairs).

\(^95\) *Doe*, 519 N.Y.S.2d at 599; *Neal*, 873 P.2d at 876. However, in *Neal*, the court precluded summary judgment for the defendant on a battery charge on the basis that the defendant's failure to disclose his extra-marital relationship to his wife satisfied the lack of consent requirement for battery. *Id.* at 876-77.

\(^97\) *Id.* at 286.
\(^98\) *Id.*
\(^99\) *Id.*

\(^100\) *Id.* at 288; see also *Carroll v. Sisters of St. Francis Health Serv. Inc.*, 868 S.W.2d 585 (Tenn. 1993). This case, which was decided after *Faya* and *Kerins I*, distinguishes the two cases and rejects their approach. The case involved a claim by a hospital patient's sister that she was stuck by a used needle and feared that she would contract HIV. *Id.* at 586. She tested negative for HIV six times over a three-year period. *Id.* at 586-87. She also could not show actual exposure to HIV. *Id.* at 594. The court held that because the plaintiff tested negatively for HIV and could not prove that she had actually been exposed to the virus, she failed to meet the "actual exposure" approach. *Id.*

based on a hospital's release of an HIV-infected body to his funeral home for preparation without disclosing that the body was infected. The mortician had used appropriate infection control procedures during the embalming process, and he tested negative to HIV four times. The court rejected the plaintiffs' claim, on the ground that there was no evidence of an actual exposure to HIV.

It should be noted as well that the plaintiff easily could have shown exposure, had it occurred.

The courts in Faya, Kerins I and K.A.C. distinguished these cases with the simple conclusion that it would be unfair to punish the plaintiffs by requiring them to prove actual exposure to HIV during their medical treatments. The courts did not explain why it is unfair to impose this requirement on a hospital patient but fair to impose it on others, such as a paramedic stuck by a used needle.

The arguable difference between the patient-plaintiff cases and the other "fear of" HIV cases is that, in Faya and Kerins I, which involved surgery, the plaintiffs would not have personal knowledge of whether an exposure to HIV occurred while they were anesthetized. In addition, patients arguably cannot be expected to understand what behaviors or incidents during treatment might expose them to HIV, unlike the clear understanding by most people that unprotected sex and used needles can create a genuine risk of transmission.

These arguments have some merit. As discussed in the section below, however, public policy considerations outweigh these arguments and require that claimants in "fear of" HIV cases allege and prove actual exposure to the disease in order to recover damages for emotional distress.

102. Id. at 81.
103. Id. at 82.
104. Id.; see also Lubowitz v. Albert Einstein Med. Ctr., 623 A.2d 3 (Pa. Super. Ct. 1993) (holding that patient who underwent in vitro fertilization process and received placental blood that initially tested positive for AIDS could not recover under negligent or intentional infliction of emotional distress where the blood was later found to be AIDS negative). There is only one other current case in which the court did not follow the otherwise consistent theme in this line of cases. Castro v. New York Life Ins. Co., 588 N.Y.S.2d 695 (N.Y. App. Div. 1991); cf. Estate of Behringer v. Medical Ctr. at Princeton, 592 A.2d 1251, 1271-72, 1279 (N.J. Super. Ct. Law Div. 1991) (holding that the defendant-hospital breached its duty of confidentiality when it widely disseminated the HIV-positive status of a physician who was both a patient and a staff member of the hospital, but that the hospital acted appropriately in restricting the physician's staff privileges because of the risk, however slight, that the physician may have transmitted HIV to patients).
III. PUBLIC POLICY CONSIDERATIONS

Although the decisions in Faya, Kerins I and K.A.C. arguably do nothing more than allow the trial courts to hear these cases, the courts by implication adopted two significant public policies. First, patients have an actionable right to know if their physicians have HIV. Second, patients need not prove actual exposure to HIV in order to recover damages for emotional distress. There can be little doubt that these two public policies would be supported by the vast majority of the American public, which is terrified by this dreaded disease.\(^{106}\)

The decisions, however, also have public policy implications that go far beyond the specific rulings. While it is possible that the courts may have weighed these other policy considerations, their opinions do not hint of such examination. Most importantly, the courts did not consider the privacy rights of the physicians. Any HIV-infected physician or dentist who discloses her HIV-positive status to patients will likely face a barrage of complex legal and practical difficulties. Patients may abandon the physician’s medical practice for fear of contracting the disease. The physician may have difficulty selling his practice to another physician, since the practice has been stigmatized as dangerous.\(^{107}\) It may be difficult to maintain professional liability insurance coverage, because the carrier may view HIV as an illness (or disability) that impairs the physician’s ability to practice medicine. Litigious patients likely will file “fear of” lawsuits anyway, some challenging that the physician failed to make the disclosure soon enough. Painfully personal, the media may seize upon the disclosure as a newsworthy event, parading the physician’s private medical condition before the public, family, friends,

\(^{106}\) Doctors with AIDS: Fears vs. Facts, CHI. TRIB., Oct. 28, 1991, at C12; Barbara Gerbert et al., Physicians and Acquired Immunodeficiency Syndrome: What Patients Think About Human Immunodeficiency Virus in Medical Practice, 262 JAMA 1969 (1989); Joseph Kirby, AIDS fears shaping health-care choices, CHI. TRIB., Aug. 19, 1991, at C1; cf. Estate of Behringer, 592 A.2d at 1271-72, 1279 (finding that hospital breached its duty of confidentiality when it made accessible the records of an HIV-infected patient who was also a physician at the hospital, but found that the hospital correctly restricted the physician’s surgical privileges due to the possible risk of HIV transmission to patients).

\(^{107}\) Some buyers of medical practices now request an attestation from the seller that s/he is not infected with HIV, because of the fear of a serious adverse economic impact on the practice if it becomes known that the seller has HIV. See Harlene Ellin & George Papajohn, Tests Help Allay AIDS Fears in One Town, CHI. TRIB., Sept. 24, 1991, at C1. For example, a young dentist in a small town in Illinois had just purchased the dental practice of a dentist who was retiring when the retiring dentist died of AIDS. Id. Patients for weeks thereafter canceled dental appointments for fear that they might contract HIV through the office. Id.
professional colleagues, and acquaintances. Finally, in some communities there may be public health implications if doctors are driven away (or patients stay away) because of a community's fear of contracting HIV.

AIDS confidentiality statutes were designed to protect the privacy of individuals with HIV, for these very reasons. The disease carries with it such stigma that confidentiality laws were enacted to protect those who are infected from wearing the new scarlet "A" on their foreheads, which would subject them to ridicule and scorn by society. The policy behind the tort theories of defamation and invasion of privacy is the same: our society values the pride, integrity and autonomy of the individual, and the law generally protects an individual's right to be free of harassment, shame and public ridicule caused by others. Forcing an HIV-infected health care provider to disclose her HIV-positive status to every patient contradicts this important policy, especially when there is no consideration for the type of care being rendered, the provider's compliance with infection control precautions, the stage of the disease, or other important facts.

The ease of reaching the conclusion that Dr. Almaraz and the other HIV-infected physicians were obligated to disclose their illness, without any consideration of privacy concerns, confirms that the courts are not immune to the societal panic about this disease. The courts effectively ruled that full disclosure is required, without further analysis, if there is any possibility, regardless of how remote, that HIV might be transmitted. The decisions might have been the same, even had the courts considered the physicians' privacy rights. After all, a patient's right to be free of harm outweighs a physician's right to privacy. Had the courts given serious consideration to these privacy concerns, however, they may have explored the issue of risk (i.e., the real possibility of a patient being harmed) more thoroughly.


109. See In re Milton S. Hershey Med. Ctr., 634 A.2d 159, 162 (Pa. 1993) (finding that although disclosure of the physician's HIV status was necessary to protect the public health, the disclosure was also structured to protect the privacy interests of the physician).

110. SCOTT BURRIS ET AL., AIDS LAW TODAY: A NEW GUIDE FOR THE PUBLIC 135 (1993); cf. In re the Claim of John Doe v. City of New York, 15 F.3d 264, 266 (2d Cir. 1994) (holding that there is a constitutional right to privacy regarding an individual's HIV status).
The court in *Faya*, for example, made no effort to evaluate, or direct the trial court to evaluate, whether the theoretical possibility of transmission was a real risk to the two plaintiffs. The court acknowledged that the virus is transmitted only if it reaches an individual's bloodstream, which means infected blood must commingle with healthy blood. The court should have applied this knowledge to the case by requiring a factual analysis at the trial court level of, for example, whether the surgeries were sufficiently invasive to constitute a risk, whether the staff and Dr. Almaraz strictly followed the infection control protocol recommended by the Centers for Disease Control and Prevention (CDCP), and whether there were any accidents during the surgeries that might have allowed the commingling of Dr. Almaraz's blood with the plaintiff's blood. If Dr. Almaraz followed infection control protocol carefully and no accidents occurred during the surgeries, then there would have been no opportunity for blood-to-blood contact with his patients and thus no real risk of transmission of HIV to the patients.

Congress, the CDCP, and the state legislatures have balanced the conflicting interests of patients and providers more delicately, despite the intense public pressure to adopt guidelines and laws mandating that health care providers be tested for HIV on some regular basis. In 1991, Congress directed the states to adopt the CDCP guidelines for preventing transmission of HIV to patients. These guidelines include the requirement or recommendation that infected health care professionals report to a local expert review committee for assistance in determining whether and to what extent their medical practices should be curtailed to protect patients from the risk of HIV.

In Michigan, for example, the Department of Public Health has adopted guidelines that 1) require all health care workers to adhere to appropriate infection control precautions, 2) advise health care workers with exudative lesions or weeping dermatitis to refrain from performing invasive procedures, 3) encourage all health care workers to undergo personal assessments to determine their need for HIV

113. *A Shameful Senate AIDS Vote*, supra note 69, at 33.
115. See Centers for Disease Control and Prevention, supra note 112, at 19.
(and hepatitis) testing, 4) encourage infected health care workers to seek counseling to better understand the prevention of HIV and hepatitis transmission and receive advice on appropriate special precautions, 5) encourage infected health care workers to seek appropriate medical care and periodic evaluation of health status, counseling on the advisability of continuing to work in the health care setting, and information on safer sex and partner notification, 6) inform infected health care workers that they must inform their physician and/or health care facility when there is a significant risk of compromised health care, 7) and inform infected health care workers who perform invasive procedures that they should practice only after the evaluation, and with continued monitoring, by their personal physician and/or under recommendations of public health officials, expert panels, or in compliance with institutional policies that are consistent with these recommendations. Interestingly, the Michigan guidelines also include an excellent background discussion of risk. It includes a note that the risk of transmission of HIV should be placed in perspective with the other risks patients face as they enter the health care system (e.g., 1 out of every 10,000 persons undergoing general anesthesia dies; and 1-2 out of every 100,000 persons treated with penicillin have an anaphylactic reaction resulting in death).

As of January 1994, every state in the nation has either complied with the federal law or sought an extension of time for compliance. As a result, HIV-infected providers are generally required or encouraged to seek the guidance of an expert review panel as to whether any restrictions on their medical practices are warranted.

The federal guidelines acknowledge that an HIV-infected health care provider should not make the decision alone about whether patients are at risk; an expert review panel provides objectivity about risk based on the panel’s expert knowledge of the disease, the doctor’s medical practice, the status of the doctor’s physical and emo-

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117. Id.
tional health, and other factors. Therefore, the CDCP, Congress and, the state legislatures acknowledge that a number of issues must be considered in evaluating the safety of the medical practice of an HIV-infected doctor. The "theoretical possibility" that HIV may be transmitted from doctor to patient is evaluated on a case-by-case basis, and practice restrictions and/or disclosure requirement are dictated only in those unusual cases where the expert review panel forms the conclusion that such restrictions and/or disclosure are warranted.

The AMA policy on HIV-infected physicians includes a statement that infected physicians should report to a local expert review panel or public health officer. When read in its entirety, the AMA policy appears to require a connected series of events. An HIV-infected physician should first report to an expert review panel. If the panel releases the physician as posing no harm to patients, then the risk evaluation ends. If the panel recommends restrictions on the physician's practice, based on the risk to patients, then the physician should follow the restrictions or disclose his/her status to patients before performing the procedures that pose a risk.

The court in Faya failed to evaluate the AMA policy on infected physicians in its entirety, and therefore, it did not conduct this type of analysis. Had it done so, and considered as well the privacy interests of the physician, it might have reached a far different conclusion. At the very least, the evaluation of conflicting interests would have been more objective and fair to all parties in the litigation.

Another public policy implication of these three decisions is their impact on the public's fear of HIV. This implication is most clearly recognized in Kerins I. The defendants argued on appeal that their position (supporting non-disclosure) was supported by the growing body of case law protecting HIV-infected persons from unfair discrimination. They cited several key California cases on this point,

119. Infected Dentists, supra note 118, at 34.
121. Id.
122. Id.
123. Id.
in which HIV-infected persons were protected from discrimination in the context of employment (not in the health care field), school, and places of public accommodation. The court rejected these cases out of hand, on the ground that they deal with a risk of transmission "so speculative that the fear of infection is unreasonable or irrational."

Infection control experts would not be so quick to distinguish the two situations. They continue to reassure hundreds of thousands of health care providers that using infection control procedures protects them from HIV-infected patients, even during the bloodiest of surgical procedures. Very few health care workers have become infected with HIV occupationally over the past ten years, and the transmissions have tended to result from significant injuries while handling infected blood products, where there was an opportunity for a sizeable amount of infected blood to commingle with the health care worker's blood. It is generally accepted, moreover, that health care workers are at greater risk of contracting HIV from patients than the reverse.

Finally, the courts may have encouraged frivolous litigation by allowing plaintiffs to sue their doctors without any actual exposure to HIV. In Faya, for example, the plaintiffs immediately filed suit upon learning from a televised news broadcast that their doctors had HIV, at the peak of their emotional trauma. No one would doubt the real horror that a patient would feel at that moment of discovery that his surgeon had HIV. However, this real horror in Faya was not based on any scientific fact; it was based on pure emotion. Although the court thankfully limited the plaintiffs' recovery in Faya to a narrow window in time, there is little in the decision other than the limitation on damages that would discourage other plaintiffs from filing a suit at the height of their anxiety. Once in court, it


126. Kerins I, 21 Cal. Rptr. 2d at 629.


128. *Id.*

129. *Id.*

would be difficult to "channel the jury's discretion.""\textsuperscript{131}

The sad reality of the fact that these three cases have opened the door to frivolous litigation is the $850,000 settlement of a "fear of" class action suit against the employer of a dentist from Georgia who died of AIDS.\textsuperscript{132} The trial court denied the defendant's motion for summary judgment, and within several months the case settled for this amount.\textsuperscript{133}

IV. THE RISK OF EXTENSION OF THESE CASES IN THE FUTURE

Given the fact that the courts in Kerins I and K.A.C. so readily adopted the analysis and conclusions in Faya, it is reasonable to assume that future courts will follow as well. Therefore, there is a risk that future professional liability cases will focus on other health issues involving the provider. Disclosure also may be required of those with histories of alcoholism, drug abuse, and schizophrenic episodes, or those with cataracts or heart disease.

Taken to extremes, it is imaginable that patients may require a complete health history of their doctors when making a first appointment and annually thereafter. Licensing boards may be expected to review a practitioner's health as a condition of license renewal each year. Managed care plans and hospitals may require a health history, including disclosure of HIV status, when providers sign up or join a staff. Liability insurance carriers may deny coverage. The door has been opened. It is impossible to predict how wide, but ingenious plaintiffs' attorneys will continue to push the limits.

These decisions and others like it may ultimately be used by places of public accommodation to defend against claims that they have violated Title III of the Americans with Disabilities Act.\textsuperscript{134} The Act makes an exception for activities that pose a "direct

\begin{itemize}
\item \textsuperscript{131} Carroll v. Sisters of St. Francis Health Serv., 868 S.W.2d 585, 593 (Tenn. 1993).
\item \textsuperscript{132} Patients of dentist who died of AIDS to split $850,000. \textit{ATLANTA CONST.}, Sept. 7, 1994, at D4.; Suit settled over dentist who died of AIDS, \textit{CHI. TRIB.}, Sept. 8, 1994, at 14. The settlement has stunned dentist employers in Georgia, who now fear their own liability exposure for the disease status of their employees. It will take years for these issues to be resolved in Georgia. In the meantime, employers of health care workers will be asking whether they should require all employees to be tested regularly for HIV; whether they should reassign or terminate infected employees; and how they should weigh their potentially conflicting legal obligations to employees under disability laws and to patients under state tort laws. \textit{Id.}
\item \textsuperscript{133} Taylor v. Morrison Dental Assoc., P.C., No. X91-2445-H, slip op. at 5 (Ga. Sup. Ct. Apr. 21, 1994) (denying the defendant's motion for summary judgment on the count alleging intentional infliction of emotional distress).
\item \textsuperscript{134} 42 U.S.C. §§ 12181 - 12189 (Supp. 1993).
\end{itemize}
threat" of harm. Astute defense attorneys will try to use these decisions to support the argument that the "theoretical risk" of transmission is equivalent to a "direct threat" of harm, thus allowing public accommodations (e.g., liability carriers; landlords of medical arts buildings) to exclude HIV-infected health care providers from participation. In short, the courts in *Faya, Kerins I* and *K.A.C.* took a legitimate scientific inquiry out of the hands of the scientific community, and gave license to the world to do likewise.

V. ALTERNATIVE APPROACHES FOR FUTURE CASES

As the above discussion illustrates, *Faya, Kerins I* and *K.A.C.* are inconsistent with the great body of emotional distress law. The *Faya* court, which the other two courts followed, used the doctrine of informed consent in an entirely new way. The doctrine is traditionally used in the context of health care to require doctors to give patients information about the *procedure* the doctor intends to perform. With only one previous exception (which the court in *Faya* did not even cite), the courts have not extended informed consent to require doctors to provide patients with a history of their own physical or mental conditions.

There are innumerable theoretical risks of harm that can occur during medical care; untoward events can happen at the hands of the best and the brightest physicians. Furthermore, health care providers routinely continue to provide care to patients with other physical or emotional illnesses that could result in harm, and yet they make no disclosure of these illnesses to their patients prior to treatment. Upon reflection, it is difficult, if not impossible, to make a reasonable distinction between a doctor's HIV status and other illnesses (e.g., hepatitis B, tuberculosis, alcoholism, exhaustion, diabetes; cocaine addiction; heart condition, cataracts, Parkinson's Disease). The court's analysis might have changed had it compared HIV to these other risks.

For the most part, these other risks are accepted by society as a part of everyday life. Death from HIV is not tolerated in the same way. It is unique because of its stigma as a sexually transmitted disease, owned by the gay community, drug addicts and others. It is perceived erroneously by the public as a disease that is transmitted

135. *Id.*
easily in health care settings, and through saliva, mosquitoes, handshakes and shared household items. As a result of these stigmas, perceptions, and fears, it may have been more difficult for the courts in these cases to remove themselves from the emotion of this dreaded disease.

Perhaps, moreover, the courts were not immune to the public hysteria surrounding the Florida transmission of HIV by a single dentist. This was not a quiet incident of a patient dying from anesthesia; it was a national media event for over a year, with near daily reminders to the world, including judges, that health care providers were to be feared, not trusted.

The body of law on informed consent thus is devoid of reported decisions analyzing whether a surgeon has an obligation to inform a patient that he has cataracts; that he has schizophrenic episodes; that he is addicted to cocaine; that he is a diabetic; or that he has Parkinson's Disease. In short, it would appear that the courts traditionally have not examined whether a doctor's health status may have affected her performance in a specific case. 137

It is not too late for future parties and courts to analyze "fear of" provider cases quite differently. There are at least three alternative approaches available that would avoid these negative public policy implications while maintaining the integrity of traditional emotional distress tenets. At the same time, a different evaluation would allow patients exposed to a real risk of contracting HIV to pursue legitimate "fear of" lawsuits.

A. Actual Exposure

One simple approach would be to require a plaintiff to prove actual exposure to HIV in order to prevail in an action for emotional distress based on the fear of contracting HIV from a health care provider. This type of analysis would be consistent with the decisions in the "fear of" HIV cases involving situations other than infected health care providers. It has the decided advantage of keeping out of the courts and away from juries and judges the emotionally driven plaintiffs who have filed lawsuits solely on the

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137. It should be noted, however, that perhaps these cases exist and simply do not get analyzed or reported. This could happen for various reasons. Perhaps plaintiffs' attorneys are not accustomed to making inquiries through interrogatories and depositions to determine whether a plaintiff's injury occurred as a result of some physical or emotional condition of the doctor. Perhaps these cases are settled very quickly, or perhaps no one ever finds out about the doctor's condition.
basis of irrational fears about this dreaded disease. As a result, our legal system would be upholding the overwhelming weight of scientific opinion regarding the transmission of HIV. This approach also would save for litigation only those rare, egregious cases in which a plaintiff’s fears are reasonable because they are based on a real risk of transmission of HIV. Finally, it would respect the privacy rights of HIV-infected health care providers by upholding their right not to disclose their condition to their patients.

Unfortunately, however, this approach is easily criticized because it fails to solve the difficulty of a plaintiff proving actual exposure to HIV during medical treatment. In addition, many opponents would posit that infected providers must inform patients of their status (if they know) prior to performing procedures that reasonably could result in actual exposure, because allowing an actual exposure to occur would be a heinous violation of the provider’s ethical duty of nonmaleficence (do no harm). Six patients of Dr. Acer were exposed to HIV and have contracted the disease, and one has died to date; their circumstances alone support an emotionally compelling argument that allowing any exposure incident to occur is tantamount to murder.

B. Expert Review Panels

Another approach is available that would solve these problems. It would be more complex than a simple test of actual exposure, but it would balance all interests adequately. The first step in this alternative analysis would be to determine whether the doctor has followed state health department guidelines by submitting to an authorized expert review panel for a consultation about risk. If a panel has decided that the provider may continue to practice without restriction, then the court should defer to the expertise of the panel and conclude that the provider had no duty as a matter of law to disclose her HIV status to the patient prior to medical treatment, absent proof of actual exposure to HIV.

138. The real life horror of this type of litigation is evident with Faya. By the end of 1993, there were 30 “fear of” lawsuits pending against the estate of Dr. Almaraz. In 1993, 1,800 patients unsuccessfully attempted to have the court certify a class action against the estate. Former Patients File $640 Million Lawsuit, THE LEGAL INTELLIGENCER, Nov. 29, 1993, at 5.

139. A defendant provider’s compliance with the conclusions of the expert review panel could be asserted first as an affirmative defense in response to a complaint by a plaintiff who alleges that s/he suffered emotional distress from the fear of contracting HIV. Then, the defense could be used to support a motion for summary judgment, supported by affidavits from the provider and...
If the provider has not submitted to an authorized panel, then it would be appropriate for a trial court to allow a patient to proceed with the case and submit expert testimony that the provider’s actions put the patient at risk. The provider’s failure to receive a panel’s blessing should not relieve a plaintiff of the obligation to prove that the doctor’s conduct posed a real risk of transmission. It should, however, be sufficient to allow the plaintiff to survive a motion for summary judgment. The trial in this case would require the help of expert testimony in place of the expert review panel to determine whether the doctor placed the patient at real risk (and, therefore, should have obtained a patient’s consent before providing care). Failure to submit to the panel could be used to support the patient’s claim. Alternatively, if the doctor has submitted to a panel and ignored its recommendations to discontinue certain medical procedures based on risk, then the court might rely on the decision of the panel and conclude that the doctor breached his duty to patients and placed them at risk. Only in these instances would it be reasonable to relieve the plaintiff of the burden of showing actual exposure to HIV. Ignoring the panel’s recommendations also might support an award of punitive damages, for knowingly exposing a patient to the disease.

The beauty of allowing courts to rely on the decision of an expert review panel in determining whether a plaintiff should be allowed to proceed is that it relieves the court of the obligation of making a scientific determination of risk. It also alleviates the societal pressure of performing an objective evaluation of risk in the context of an emotionally charged case about a dreaded disease.

In order for this alternative to work well, several safeguards would need to be firmly in place. First, reporting to a panel would need to be mandatory. Currently, the trend is for the reporting to be voluntary. By making the panel’s role purely voluntary, states have opened the door for courts to downplay the importance of the panel’s determination.

Furthermore, panels should have appropriate safeguards to ensure that they are performing their job properly. These safeguards are important to protect both the public and the provider. For example, providers should be required to consult with the panel on a periodic,
regularly scheduled basis. The panel should have the authority to inspect a provider's workplace to ensure that proper infection control precautions are used. The panels should also be appropriately credentialed with various types of specialists (e.g., individuals who diagnose and treat patients with HIV and AIDS; infection control experts; individuals who understand the nature of the provider's practice).

Third, severe disciplinary action should be a mandatory response to a provider's failure to comply with the panel's conclusions. Providers who do not comply should not be allowed to continue treating patients, absent extraordinary circumstances that adequately explain their non-compliance and that do not place patients at risk of transmission.

C. Kerins II

The last alternative also available to the courts was adopted in Kerins II by the appellate court when Kerins I was vacated and remanded for further consideration in light of the California Supreme Court decision in Potter v. Firestone Tire and Rubber Co., a fear of cancer case. On remand, the court extended and applied the Potter standard and determined that,

in the absence of physical injury or illness, damages for fear of AIDS may be recovered only if the plaintiff is exposed to HIV or AIDS as a result of the defendant's negligent breach of a duty owed to the plaintiff, and the plaintiff's fear stems from a knowledge, corroborated by reliable medical or scientific opinion, that it is more likely than not he or she will become HIV seropositive and develop AIDS due to the exposure.

Accordingly, the plaintiff's claim could not go forward because there was only a speculative possibility that she would develop AIDS at some point in the future (less than 0.3 percent).

Interestingly, the court in Kerins II also addressed whether the case should be decided differently because of oppressive, fraudulent or malicious conduct. The court again extended and applied the Potter standard's requirements for fraud or malice and determined that

143. Kerins II, 33 Cal. Rptr. 2d at 178.
144. Id.
in addition to proving oppressive, fraudulent or malicious conduct, the plaintiff must show that the fear is reasonable, that the exposure has significantly increased the plaintiff's risk of HIV, and that the plaintiff's actual risk of threatened HIV is significant.\(^\text{146}\) The court easily concluded that the plaintiff failed to meet this burden.\(^\text{146}\)

Finally, the court in *Kerins II* examined the issue of informed consent.\(^\text{147}\) The plaintiff argued that Dr. Gordon committed battery by performing surgery without first disclosing his HIV status prior to surgery.\(^\text{148}\) The court declined to examine the many social policy issues at stake if it were to require (or fail to require) disclosure of a physician's health to a patient in advance of surgery.\(^\text{149}\) Instead, the court held that the plaintiff could not recover emotional distress damages on a technical battery theory when her fear of developing HIV was not based on a significant risk of contracting HIV.\(^\text{150}\)

It remains to be seen whether courts in other states will adopt the *Potter* standard, as applied by the court in *Kerins II*, in these "fear of" cases against health care providers. The *Potter* standard is by far the most favorable one for protecting the rights of infected providers and discouraging frivolous litigation. It may, however, prove to be too liberal for widespread adoption in other states. The other two alternatives to *Faya, Kerins I* and *K.A.C.* discussed above are more moderate approaches that balance the interests of all parties in a manner that should be fair and equitable.

**Conclusion**

The courts in *Faya, Kerins I*, and *K.A.C.* missed an opportunity to establish important public policy weighing the interests of patients with the interests of HIV-infected health care providers. They instead chose the easier route of allowing terrified patients to pursue claims for emotional distress absent any showing of real exposure to HIV. The courts failed to acknowledge that a patient's autonomy (right to know) is in direct conflict with a provider's autonomy (right of privacy). As a result, they did not balance these rights in any meaningful way.

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145. *Id.* at 179.
146. *Id.*
147. *Id.* at 180-81.
148. *Id.*
149. *Id.* at 181.
150. *Id.*
The practical implication of these decisions is that infected providers risk significant liability exposure unless they obtain the consent of all patients prior to treatment, regardless of the real risk of exposure. The result of course is that these individuals will have no medical practice, because they will have no patients to treat. The absence of any real risk analysis or consideration of the public policy implications in these cases shows that judges are not immune to the emotional panic caused by this dreaded disease and leads one to ask: who's afraid of whom?