Lose a piece of the rock: Physician liability for failing to notify private third parties of HIV risk

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Since 1851, individuals have successfully sued physicians for injuries sustained through infectious disease transmission from the physicians' patients. Liability to third parties must be considered in the management of patients with infectious diseases. Because of this potential liability, physicians with human immunodeficiency virus-infected patients must consider notifying identified third parties of their respective risks of infection.

Physicians may face an unusual type of lawsuit. Someone who may not be a patient of the physician will claim that the physician negligently breached a duty of care by not warning him or her of the infectious risks of sexual or needle-sharing activity with the physician's human immunodeficiency virus (HIV)-infected patient. The lawsuit will include physicians as defendants, along with the patient, because most acquired immunodeficiency syndrome (AIDS) victims, unlike Rock Hudson, do not have wealthy estates. Practicing physicians are more likely to pay an award of damages than the average AIDS victim.

Gostin^{1,2} recently presented a review of court decisions involving AIDS litigation. Our

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article reviews the factors used to determine the existence of a standard of care and shows why physicians must carefully assess the risks their patients may pose to others.

The basics of negligence

Legally, negligence occurs when one party has a duty toward another and breaches that duty. To determine the duty of care to these third-party persons, courts look at (1) prior judicial decisions; (2) statutes, rules, and regulations; and (3) professional guidelines and public health recommendations. Liability for negligence requires the additional demonstration of injury caused by the negligent conduct.

Applied to the scenario of HIV infection, if a physician is to be held liable to someone for an injury resulting from patient contact, the person claiming damages must prove (1) that the physician had a duty to protect him or her from unreasonable risk, (2) that the physician failed to conform with that duty (standard of care), and (3) that the person suffered injury because of (4) the physician's failure to conform with the standard of care.

Physician's duty to protect others

The Second Restatement of Torts succinctly outlines the basis of liability to third parties:

One who takes charge of a third person whom he knows or should know to be likely to cause bodily harm to others if not controlled is under a duty to exercise reasonable care to control the third person to prevent him from doing such harm.³

Other legal treatises contain similar statements defining the professional's liability to third parties.⁴

Physicians, because of their training, skill, and knowledge regarding health hazards, know or should know what may harm others. Physicians, because of their role in the doctor-patient relationship, assume responsibilities toward others. Judicial decisions make this legal theory a reality.

In a statement similar to Restatement §319, the Minnesota supreme court decided to hold a physician liable for his negligent advice to immediate family members of an infectious patient:

Generally speaking one is responsible for the direct consequence of his negligent acts whenever he is placed in such a position with regard to another that it is obvious that if he does not use due care in his own conduct he will cause injury to that person.⁵

The court rejected the physician's argument that a doctor-patient relationship did not exist between himself and the family:

Assuredly this is a case where there is every reason to hold that defendant was [*sic*] under a legal duty to plaintiff, and it is of little practical consequence whether we call the duty contractual or noncontractual. The health of the people is an economic asset. The law recognizes its preservation as a matter of importance to the state. To the individual nothing is more valuable than health. The laws of this state have been framed to protect the people, collectively and individually, from the spread of communicable diseases.⁶

Courts have repeatedly decided that physicians who become aware of a medical hazard incur an affirmative obligation to disclose such information to others. For example, in 1921, in a suit brought against a group of physicians for damages by a family infected with typhoid fever, the supreme court of Arkansas succinctly stated:

It is a sound rule of law that one who by reason of his professional relation is placed in a position where it becomes his duty to exercise ordinary care to protect others from injury or danger is liable in damages to those who are injured by reason of his failure to exercise such care.⁷

In 1970, a Florida appellate court held:

[A] physician owes a duty to a minor child who is a member of the immediate family and living with a patient suffering from a contagious disease to inform those charged with the minor's well being of the nature of the contagious disease and the precautionary steps to be taken to prevent the child from contracting such disease and that the duty is not negated by the physician negligently failing to become aware of the presence of such a contagious disease.⁸

In 1986, a Michigan appellate court stated:

Duty is an issue of law and for the court to decide. A duty arises from the relationship of the parties and the decision as to its existence involves a determination of whether the defendant has any obligation to avoid negligent conduct for the benefit of the plaintiff (or her decedent, as here). Generally, a party has no duty to protect another who is endangered by a third person absent a special relationship with either the dangerous person or the potential victim.⁹

In the Michigan case, the defendant had a physician-patient relationship with the one who allegedly infected the third party, leading to his death. Doctor-patient relationships are special relationships and, accordingly, a duty of care arose.

In sum, several court cases have articulated an affirmative obligation upon physicians to inform at-risk third parties of infectious risk. Who is at risk will depend on the nature of the infectious agent. Prior judicial decisions form a basis for evaluating cases involving similar circumstances and similar relationships. The cases reviewed show a clear trend toward holding physicians liable for failing to warn certain persons outside the doctor-patient relationship about communicable disease risks. Prior judicial decisions are not the only basis for recognizing this special duty to others. Various statutes, rules and regulations, professional guidelines and recommendations also support an affirmative obligation for physicians to warn persons outside of their practice of infectious risk.

Statutes, rules, and regulations

Laws, whether based on legislatively enacted statutes and ordinances or administratively created rules and regulations, set valid standards of care. This rule of law has been clear since

at least 1887, when the supreme court of Connecticut heard a challenge to an ordinance that required "every physician, or person acting as such, who shall have any patient within the limits of said city sick with small-pox [*sic*] or varioloid [*sic*], or other infectious disease, shall forth with report the fact."¹⁰ In *State v Wordin*, the court held:

A proper regard for human life demands that a contagious fatal disease shall be barred rather than driven out. The inequality of burden of which the defendant complains is only in seeming. Persons offering their services to the public as healers of disease, and requiring pecuniary compensation thereof, thereby assert their ability to detect the presence of it when the great mass of the people cannot.... Therefore, with impartial action, it compels that member of the community who is the first to have sight and knowledge of it to give note of warning to others from whom its presence is hidden.... The burden is made to rest upon every member of the only class which is in a condition to contribute anything to the accomplishment of the purpose of the ordinance.¹¹

The physician was held liable. In 1928, the supreme court of Ohio similarly held liable a physician who had failed to recognize a diagnosable infectious disease:

If it were a defense for such a practicing physician, who had failed to discover and give due notice of the presence of such a disease, to say that he had not therefore treated a disease of that kind, and had not observed symptoms such as the patient involved manifested, the escape from the provisions of the statute would surely be marvelously easy.¹²

More recently, a similar conclusion was reached by a court in *Derrick v Ontario Community Hospital*.¹³

Statutes and regulations that mandate the reporting of AIDS exist in all 50 states.¹⁴ In some states, reporting is mandated by statute; in others, by administrative regulation. Irrespective of the origin of the reporting requirement's origin, legitimate public health measures, such as reporting patient information, has been upheld by the Supreme Court.¹⁵

A licensed medical practitioner's violation of a public health statute or regulation may result in a misdemeanor criminal conviction. The same violation may result in a medical

licensure disciplinary action. In a civil suit, violation of a reporting regulation establishes, at the least, an inference of negligence.

Not all states require that physicians report the diagnosis of HIV infection. Reporting requirements are not based on the current understanding of AIDS, namely, that the syndrome begins with infection with HIV and years later the infected person develops the other characteristics—opportunistic infections, cancers, and so forth—that afford the diagnosis of AIDS.

Historically, AIDS was recognized prior to the discovery of the syndrome's etiologic agent, HIV. This resulted in a distinction between HIV infection and AIDS. The statutory language used to define AIDS and the case definition published by the Centers for Disease Control (CDC) reflect this discrepancy¹⁶ and create certain problems.¹⁷ The Presidential Commission on the Human Immunodeficiency Virus Epidemic has aptly articulated the position that HIV infection and AIDS should be treated as one disease:

The term "AIDS" is obsolete. "HIV infection" more correctly defines the problem. The medical, public health, political, and community leadership must focus on the full course of HIV infection rather than concentrating on later stages of the disease (ARC [AIDS-related complex] and AIDS). Continual focus on AIDS rather than the entire spectrum of HIV disease has left our nation unable to deal adequately with the epidemic. Federal and state data collection efforts must now be focused on early HIV reports, while still collecting data on symptomatic disease.¹⁸

The goal of communicable disease reporting laws is not solely to collect statistics but also to protect uninfected third parties. Because physicians are uniquely aware of communicable hazards, the absence of an HIV-specific reporting statute may not excuse failure to warn at-risk third parties. Clearly, HIV infection is a communicable disease.

Practicing physicians sometimes raise three other arguments to support the failure to warn at-risk third parties. The first is that such notice would violate patient confidentiality and provide a different basis for a lawsuit—"a damned if I do and damned if I don't" situ-

ation. The second is that such notice would violate professional ethics. Both arguments are specious. The third argument is that the duty of contact tracing belongs to the state public health department. This is a persuasive argument, but can only be used in states where the health department requires the reporting of HIV infection and performs contact tracing and partner notification.

The common law has recognized circumstances where the breach of patient confidentiality is excusable.¹⁹ Additionally, many states contain HIV-specific statutes that expressly protect physicians who, in good faith, either notify identified at-risk third parties of infectious risk²⁰ or report the problem to the appropriate government officials.²¹ The common law and statutes support an immunity for good-faith physician reporting of medical hazards.

Professional ethics, along with professional guidelines, not only allow^{22,23} for the breach of patient confidentiality but in some circumstances suggest committing such a breach.

Professional ethics and guidelines

The concern about professional ethics has been specifically addressed by several medical organizations. Esteemed professional groups have issued guidelines for physicians in situations where disclosure may arise. For example, the American College of Physicians and the Infectious Disease Society of America jointly recommended that if the HIV-infected patient refuses to inform others, the physician should consider the professional responsibility to the patient's consorts. They conclude: "It is clear that, under some circumstances, the duty to inform will take precedence over the duty to protect confidentiality."²⁴

The Public Health Service (PHS), through the CDC, has issued similar recommendations to clinicians: "If [persons who are HIV-antibody positive] are unwilling to notify their partners or if it cannot be assured that their partners will seek counseling, *physicians* or health department personnel should use confidential procedures to assure that the partners are notified [*italics added*]."²⁵

A reasonable interpretation of the PHS rec-

ommendation is that the physician has a duty to assess patient compliance regarding notification of partners. If the patient seems non-compliant, then in states in which the health departments do not provide this service, the physician will need to notify contacts.²⁶

In 1988, the American Medical Association (AMA), in a special pamphlet released to its members, stated:

In the realm of duty to warn, the Council on Judicial and Ethical Affairs has outlined a course of action to be taken by physicians: Where there is no statute that mandates or prohibits reporting of seropositive individuals to public health authorities and it is clear that the seropositive individual is endangering an identified third party, the physician should (1) attempt to persuade the infected individual to cease endangering the third party; (2) if persuasion fails, notify authorities; and (3) if the authorities take no action, notify and counsel the endangered third party.²⁷

The AMA recommendations fail to suggest how a primary care practitioner can determine whether "persuasion fails" or when "authorities take no action." This oversight invites disaster. From the third party's standpoint, any delay in notification could translate into exposure to infection. Exposure of the third party to infection could then translate into exposure of the physician to a lawsuit.

The CDC and the PHS have issued guidelines for physicians diagnosing patients who have HIV and may be exposing others to infection:

Sexual partners and those who share needles with HIV-infected persons are at risk for HIV infection and should be routinely counseled and tested for HIV antibody. Persons who are HIV-antibody positive should be instructed in how to notify their partners and to refer them for counseling and testing. If they are unwilling to notify their partners or if it cannot be assured that their partners will seek counseling, physicians or health department personnel should use confidential procedures to assure that the partners are notified.²⁵

The guidelines expressly delineate circumstances that create an affirmative duty to notify sex and needle-sharing partners of their respective HIV risk. The guidelines do not delineate when the burden of notification belongs

to the physician rather than health department personnel. The guidelines do not address how the physician is to judge when reliance on the patient to notify the partner(s) is justifiable. Arguably, one cannot rely on intravenous drug users to be responsible.

Physician's failure to conform to the standard of care

A duty to disclose can be demonstrated with judicial decisions, statutes, administrative recommendations, and professional society guidelines. Who is within the scope of the duty? Infectious disease cases suggest some answers.

As early as 1851, the supreme court of Kentucky held a physician liable for the direct spread of smallpox between patients.²⁸ The Kentucky high court stated that the physician must "take such precautions as necessary to prevent the communication of the infection by his own visits."²⁹ Later cases expanded the physician liability for spread of communicable diseases to include occasions where the physician, by an act of omission, contributed to others' infection.

In *Davis v Rodman*, the court specifically stated:

It was therefore the duty of the appellees, when called to attend the children of appellants, to notify the latter, other nurses, and attendants of the nature and character of the disease, to warn them of the danger of infection, and to instruct them as to the usual methods approved by the profession, of which they have knowledge, for the prevention and spread of the disease.³⁰

This duty has been limited to foreseeable third parties and readily foreseeable third parties.³¹ In *Mussivand v David*, the Ohio supreme court held a physician liable for a married woman's transmission of herpes to her husband.³² The court specifically recognized the spouse as a foreseeable sexual partner.³³ Thus the failure, negligent or intentional, of the physician to ask about marital status, living arrangement, and sexual activity will not excuse the duty to warn. Failure to obtain a complete sexual history may itself be considered substandard professional conduct.³⁴

Failure to notify the patient of the communicable disease diagnosis³⁵ or erroneous advise

also exposes the physician to liability. For example, in *DiMarco v Lynch Homes-Chester County, Inc*, a Pennsylvania appellate court recognized the validity of a negligence claim against two physicians and their medical practice group liable for erroneously advising a patient infected with hepatitis B about her sexual conduct.³⁶

Departure from public health agency recommendations or professional society recommendations is a departure from the conduct of a professional in good standing.

Plaintiff suffered injury

In simple terms, any viral infection represents an alteration of the normal uninfected state. Although HIV infection may not produce symptoms for years, HIV infection inexorably progresses to AIDS and death. This catastrophic consequence is amplified by the debility, disfigurement, and social repercussions that accompany the disease. The ability to bear or parent children is diminished; the HIV-infected person's sex life is destroyed for all practical purposes. The infected person is very likely to become the victim of social ostracism and discrimination. There is no doubt that infection with HIV represents injury, and there is even reason to accept that HIV exposure, apart from subsequent infection, may represent injury.

In the widely publicized case involving Rock Hudson,^{37,38} his lover alleged that Hudson, Hudson's secretary, and Hudson's physicians conspired to keep the actor's diagnosis secret. Christian was awarded several million dollars for his fear of developing AIDS even though he failed to show physical injury. A precedent now exists for a claim based on emotional distress for exposure to HIV.

Plaintiff's injuries resulting from the physician's failure to conform to the standard of care

The injured third party must allege that he or she could have taken steps to avoid exposure to the virus if the physician had warned him or her of the danger. The medical records should show when the physician should have entertained and confirmed the diagnosis of

HIV infection in the patient. Subsequent failure or delay in notification of the third party can be used to establish the link between the breach of duty (failure to warn) and the injury (HIV infection or fear of infection).

Summary

An affirmative obligation on the part of physicians to ensure that third parties are notified of their risks of HIV infection has been established by judicial decisions in infectious disease cases. Administrative recommendations expressly covering disclosure to third parties, state public health statutes and regulations, and professional society guidelines support the application of this principle to HIV infection. A physician who fails to disclose a patient's HIV infection to identified or reasonably identifiable sexual or needle-sharing partners (or both) may become embroiled in a negligence claim based on failure to warn.

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5. *Skilling v Allen*, 173 NW 663 (1919).
6. *Id.*, at 664.
7. *Davis v Rodman*, 227 SW 612, 614 (1921).
8. *Hoffman v Blackmon*, 241 So2d 752, 753 (Fla App 1979), cert denied, 330 A2d 355 (1974).
9. *Shepard v Redford Community Hospital*, 390 NW2d 239, 241 (Mich 1986).
10. *State v Wordin*, 14 A 801 (Conn 1887).
11. *Id.*, at 804.
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30. *Davis v Rodman*, 227 SW 614 (1921).
31. *Gammill v United States*, 727 F2d 950, (10th Cir 1984). The court stated: "It would appear that at the bare minimum the physician must be aware of the specific risks to specific persons before a duty to warn exists." *Id.*, at 954.
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