Infected Physicians and Invasive Procedures: National Policy and Legal Reality

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> It is one thing to trust physicians' promises to diagnose, to treat, and not to make matters worse unnecessarily. It is quite another to trust them to know what is for their patients' bene t, in the many senses of the word, when choices are available which can make matters both better and worse. (Jay Katz, cited in DeBarge 1993)

EVERY INDIVIDUAL IN OUR SOCIETY IS A POTENTIAL candidate for an invasive or surgical procedure. Most individuals, faced with this prospect, do not consider the possibility that their physician might harbor a serious, transmissible bloodborne pathogen, such as hepatitis B virus (HBV), hepatitis C virus (HCV), or the human immunode ciency virus (HIV). The potential transmission of bloodborne pathogens from physician to patient during invasive procedures is an emotionally charged issue that puts the patient's interests in direct con ict with the interests of physicians. It is a con ict of life versus livelihood.

Reports of the transmission of HBV (Goodwin, Fannin, and McCracken 1976; Rimland, Parkin, Miller, et al. 1977; Reingold, Kane, Murphy, et al. 1982; Polakoff 1986; Welch, Webster, Tilzey, et al. 1989; *British Medical Journal* 1991; Heptonstall 1991; Prentice, Flower,

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Morgan, et al. 1992; Johnston, MacDonald, Lee, et al. 1992; Heptonstall, Collins, Smith, et al. 1994; Harpaz, Von Seidlein, Averhoff, et al. 1996; *Hospital Employee Health* 1996; Incident Investigation Teams and Others 1997), HCV (Esteban, Gomez, Martell, et al. 1996; Bosch 1998), and HIV (Lot, Seguier, Fegeux, et al. 1999) from physicians to patients during invasive procedures have again raised the question of whether it is advisable for physicians infected with these types of dangerous or lethal bloodborne pathogens to perform invasive procedures, and, if so, under what conditions.

The transmission of HBV from surgeons who are infected with that virus, and in whom hepatitis B e antigen (HBeAG)—a marker for high infectivity—is present, has been well documented (Goodwin et al. 1976; Rimland et al. 1977; Reingold et al. 1982; Polakoff 1986; Welch et al. 1989; *British Medical Journal* 1991; Heptonstall 1991; Prentice et al. 1992; Johnston et al. 1992; Debarge 1993; Heptonstall et al. 1994; Harpaz et al. 1996; *Hospital Employee Health* 1996). In the United Kingdom, ten clusters of HBV involving 81 patients of HBeAG-positive surgeons have been reported (*Hospital Employee Health* 1996). In 1996, one report quanti ed the HBV infection rate among patients of an HBeAg-positive cardiac surgeon, which occurred despite his adherence to accepted infection-control precautions during surgery (Harpaz et al. 1996). In addition, it has been documented that HBV-positive surgeons with no detectable HBeAg have transmitted HBV to patients during invasive procedures (Incident Investigation Teams and Others 1997). It now appears that a subset of persons infected with e antigen–negative mutants may be as infectious as those who are e antigen positive (Boxall and Ballard 1997; Reiss-Levy, Wilson, Hedges, et al. 1994), and e antigen–negative mutants have been associated with fulminant hepatitis and a type of chronic hepatitis that is more severe than nonmutant HBV (Lee 1997).

Patients of an HCV-positive cardiac surgeon have been infected with that virus (Esteban et al. 1996). More recently, an HCV outbreak reported in Spain was traced to an anesthetist with the same HCV genome as the infected patients (Bosch 1998). At the time, 217 of his patients were infected and 2,000 more are now being screened for HCV.

Restricting the practice of infected physicians who perform invasive procedures became a subject of discussion in the United States in 1990 when the rst case of HIV transmission from a dentist to a patient was

reported (Gostin 1989; Barnes, Rango, Burke, et al. 1990; Centers for Disease Control 1990; Gostin 1991; Orentlicher 1991; Lo and Steinbrook 1992). The issue recently came to the public's attention again when the French Ministry of Health announced the probable transmission of HIV from an infected surgeon to his patient during orthopedic surgery (AIDS/TB Committee of the Society for Healthcare Epidemiology of America 1997).

The Centers for Disease Control and Prevention (CDC) is revising its recommendations on the management of health care workers infected with bloodborne pathogens. Proposed drafts of revised recommendations are currently embargoed. We are at the threshold of an opportunity to adopt a national policy that can protect the welfare of patients without unduly restricting the practices of infected physicians. Several court decisions have been rendered and various laws have been passed since the rst case of HIV transmission from dentist to patient was reported. We will review the legal aspects of this issue in order to assist policy makers and to highlight the importance of gathering the opinions of professionals from multiple disciplines when devising policy in this area.

National policy can address the issue of infected physicians performing invasive procedures in several ways. We will consider two approaches: restricting the practice of the infected physician and/or requiring disclosure of serostatus before undertaking an invasive procedure as part of informed consent. This evaluation inevitably requires us to assess the legal considerations associated with the two approaches and to consider the attendant feasibility and likely effectiveness of the legal ndings.

We have narrowed our discussion to the legal issues that bear on the restriction of practice and disclosure. We have chosen to consider the development of national policy governing physicians known to be infected with a bloodborne pathogen who perform invasive procedures. The problem of using screening procedures to identify infected physicians who pose a risk is a separate, albeit extraordinarily important, issue that merits its own consideration.

Our focus is on the legal aspects of this complex ethical and scienti c topic. Although we will be devoting the most space to physicians, our conclusions apply as well to other health care professionals who perform or assist with invasive procedures.

Current Recommendations of the Centers for Disease Control and Prevention (CDC)

Despite mounting evidence of HBV, HCV, and HIV transmission from health care workers to patients during invasive procedures, policies similar to those enacted in England, which restrict some infected physicians from performing invasive procedures (*Hospital Employee Health* 1996; *Communicable Disease Report Weekly* 1995), have yet to be adopted in the United States.

U.S. national policy on this issue was established in 1991, when the CDC published its recommendations (Centers for Disease Control 1991). The CDC recommendations do not impose speci c restrictions on infected health care workers performing invasive procedures. Instead, the CDC recommendations state that infected health care workers should not perform exposure-prone procedures unless they have sought counsel from an expert panel and notify prospective patients of the healthcare worker's seropositivity prior to undergoing an exposure-prone procedure." The expert panels should consist of health professionals from a variety of medical backgrounds. The CDC rejects mandatory testing of health care workers who perform invasive procedures, but it encourages voluntary testing. A recent CDC document on prevention and control of HCV states that there are no recommendations for restricting the professional activities of health care workers with HCV (Centers for Disease Control and Prevention 1998).

The CDC recommendations de ne characteristics of exposure-prone procedures but do not identify speci c procedures (Centers for Disease Control 1991). The CDC proposal that the identi cation of exposure-prone procedures be left to medical, surgical, and dental organizations was opposed by many organizations on the grounds that more scienti c data were needed to make these decisions (Anderson 1993). The American Medical Association (AMA) initially supported the CDC's efforts to develop a list of exposure-prone procedures, stating that it is simply unacceptable for the medical profession to stand by, wait, and watch for possible cases of health care workers infecting patients with HIV in order to bring more scienti c con dence to our recommendations .... Ambiguity or uncertainty should be resolved in favor of our patients' interest" (Anderson 1993).

In June, 1992, the CDC of cially adopted its initial recommendations but did not provide a list of exposure-prone procedures. The agency

determined that each state health department should decide for itself which, if any, procedures are exposure prone (Centers for Disease Control 1991). Subsequent federal legislation required states to adopt the CDC recommendations or their equivalent (Gerberding 1996).

The CDC strategy has resulted in widely divergent policies for regulating infected health care workers (Anderson 1993). In Texas and Arkansas, for example, infected physicians must inform patients of their infected status before undertaking an invasive procedure (Anderson 1993). Other states leave it to the discretion of the review panel to determine whether physicians must disclose their infected status. However, most states have adopted laws or regulations that do not require infected physicians to disclose their infectious status to patients prior to surgery (McIntosh 1996).

The landscape is further complicated by case law. Statutes and regulations regarding disclosure exist in most states (McIntosh 1996). However, it is still possible to le civil suits, which leave to the courts the options of assessing the validity of the statutes or regulations, of interpreting them, or of deciding whether disclosure will be required in states whose statutory or regulatory schemes are silent on the issue.

Grounds for Liability

A patient who has been infected by a physician or who has unwittingly submitted to an invasive procedure performed by an infected physician may bring a claim for battery, misrepresentation, or negligence (Strausberg and Getz 1992). To date, claims against physicians for battery or misrepresentation for failing to disclose their HIV status to patients have not been successful because the plaintiffs were unable to demonstrate that they had been damaged. In each case, the plaintiff was not infected by HIV but claimed emotional distress as a result of the exposure.[1] The legal basis for most claims has been, and will likely continue to be, negligence for failure to obtain informed consent to perform an invasive procedure when the physician is infected.

[1] *Faya v. Almaraz and Rossi v. Almaraz*, 620 A2d 327 (Md. 1993); *Health Law Rep.* 3:1190 (BNA) (August 11, 1994) citing *Marchia v. Long Island Railroad Co.*, CA2, No. 93-7521, July 29, 1994; *Brzoska et al. v. Olsen*, 1994 WL 233866 (Del. Super. Ct.).

Negligence

To prove negligence, a plaintiff must show the following:

1. the existence of a duty, recognized by law, to adhere to a standard to protect others against unreasonable risks
2. that a breach of the duty occurred
3. a causal connection between the conduct and
4. resulting injury or damages (Strausberg and Getz 1992)

Before the 1970s, the professional standard formed the basis for judging whether informed consent was necessary. The professional standard" refers to what a reasonable practitioner would do under the same circumstances; in other words, the medical community set the standard.[2] However, with *Canterbury v. Spence*[3] *and Cobbs v. Grant*,[4] many courts adopted a new standard, requiring the physician to disclose all information that a reasonable person, not a reasonable physician, in the patient's circumstances would consider material to a treatment decision. Thus, it is relevant that opinion polls have indicated that most Americans believe physicians infected with HIV should disclose their status to patients (Orentlicher 1991). A 1991 *Newsweek* poll found that 94 percent of adults surveyed agreed that physicians and dentists should be required to inform patients if they are infected with HIV; 63 percent thought HIV-infected surgeons should not be allowed to practice (Lo and Steinbrook 1992). A 1987 Gallup poll found that 86 percent of respondents thought patients should be told if their physician has AIDS (Orentlicher 1991).

The American Medical Association's Council on Ethical and Judicial Affairs has stated that physicians who know they are infected by a transmissible pathogen should not engage in any activity that creates a transmission risk to others. The Council stated: [I]f a risk of transmission of an infectious disease from a physician to a patient exists, disclosure of that risk to patients is not enough; patients are entitled to expect that their physicians will not increase their exposure to the risk of contracting an infectious disease, even minimally" (Orentlicher 1991).

[2] *Natanson v. Kline*, 350 P.2d 1093 (Kan. 1960).
[3] 464 F. 2d 772 (D.C. Cir 1972), *cert. denied*, 409 U.S. 1064 (1972).
[4] 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972).

A more attenuated AMA statement on HIV-infected physicians dated January 17, 1991, read:

> The health of patients must always be the paramount concern of physicians. Consequently, until the uncertainty about transmission is resolved, the American Medical Association believes that HIV infected physicians should either abstain from performing invasive procedures which pose an identi able risk of transmission or disclose their seropositive status prior to performing a procedure and proceed only if there is informed consent. As a corollary, physicians who are at risk of acquiring HIV infection, and who perform invasive procedures should determine their HIV status. (Altman 1991)

The 1996 *AMA Policy Compendium* states that any HIV-infected physician should disclose his or her serostatus to a state public health of cial or local review committee. The review committee may recommend to the appropriate authority restrictions upon the physician's practice if there is signi cant risk to patients' welfare.

The Superior Court of New Jersey, in *Behringer Estate v. Princeton Medical Center*,[5] addressed the issue of informed consent in the case of a physician with AIDS who practiced otolaryngology and facial plastic surgery. The physician's estate brought suit against the hospital where he worked, claiming the hospital had discriminated against him by, among other things, requiring him to obtain informed consent before performing invasive procedures.

The court upheld the use of informed consent, concluding that it was an important check on the medical profession when determining the existence of risk. Regardless of whether the prudent patient or reasonable physician standard is used, the court held that informed consent is required.

The *Behringer* case is noteworthy for its recognition of the inherent con ict of interest in decisions by the expert panels of health professionals that have been recommended by the CDC (Centers for Disease Control 1991). The court determined that a panel member's judgment may be in uenced by the knowledge that any limitations placed on the practice of colleagues might ultimately affect his or her own career.[5] Consequently, the court concluded that informed consent is necessary when a determination that no risk exists was reached by experts with a vested interest in the outcome of that decision.

[5] 592 A.2d 1251 (N.J. Super. Ct. 1991).

Signi cantly , the court found that transmission risk was not the only one to consider. The risk of exposure to surgical personnel, which could subject the patient to months of HIV follow-up testing and prophylactic treatment, was alone suf cient to require disclosure.

In making its determination, the court considered these factors:

1. the severity of the risk
2. the probability that transmission of HIV would occur
3. the circumstances surrounding the experience of risk

The court found that as the severity of a potential harm increases, the need to disclose risks of low probability becomes more pressing. The court also emphasized the element of choice:

> A reasonably prudent patient would nd information that his physician is infected with HIV material to his decision to consent to a seriously invasive procedure because the potential harm is severe and the risk, while low, is not negligible. Moreover, he can avoid the risk entirely without any adverse consequences for his health: *By choosing another equally competent physician (where available) he can obtain all the therapeutic bene ts without the risk of contracting HIV from his physician.* The patient, then can demonstrate not only that the information is material to his decision, but that he would have made a different decision had he been given the facts. (citation omitted)[5]

Within this context, the court held that New Jersey's strong policy supporting patient rights weighed against the physician's individual right to perform an invasive procedure. The court found that when the ultimate harm is death, a policy that precludes the performance of invasive procedures is justi ed when there is any" risk of transmission.[5]

The decision has been noted for the court's recognition that the risk of transmitting infectious diseases from physician to patient is unlike general risks associated with medical procedures, as it can be eliminated if a noninfected physician performs the procedure (DeBarge 1993).

Some have argued that courts, by upholding disclosure,[6] will permit irrational or invidious discrimination. The *Behringer* court addressed this concern as follows: If the patient's fear is without basis, it is likewise the duty of the physician to allay that fear."[5]

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[6]*Leckelt v. Board of Commissioners*, 909 F.2d 820 (5th Cir. 1990); In *re Milton S. Hershey Medical Ctr.*, 634 A.2d 159 (Pa. 1993); *Bradley v. Univ. of Texas, M.D. Anderson Cancer Center*, 3 F.3d 922 (5th Cir. 1993).

Others have concluded that the *Behringer* court was correct because there is a choice between infected and uninfected physicians. Patients who choose to undergo surgery by an uninfected physician may be acting rationally, rather than irrationally, because a patient is entitled to have all risks within his or her doctor's control eliminated (Debarge 1993; McIntosh 1996). One observer commented: If the CDC and the Occupational Safety and Health Administration consider the risk of HIV transmission to a physician following an exposure to a patient to be signi cant enough to require repeated follow-up testing, then a reasonable patient would also likely conclude that the risk of exposure to an infected physician is suf ciently serious and material to require disclosure (McIntosh 1996).

Not only has informed consent been upheld, but courts have also allowed civil suits to be brought for failure to obtain it.

From a policy perspective, informed consent alone cannot adequately protect patients. However, given that the CDC recommendations do not restrict infected physicians from undertaking procedures that pose a risk of exposure, it remains one of the limited tools available to protect patients.

Despite increasing evidence that bloodborne pathogens can be transmitted by physicians to patients during invasive procedures, the CDC recommendations for protecting patients have not been updated. A 1997 compendium of CDC guidelines restates the 1991 recommendations for health care workers infected with HBV (Friede, O'Carroll, Nicola, et al. 1997).

A survey of ve large medical centers in New York City concerning their HBV-related policies illustrates the limited protection available to patients. The survey found that the 1991 CDC guidelines are still generally observed and that few hospitals restrict the clinical privileges of health care workers infected with HBV unless there is evidence of e antigen. Only one hospital reported checking e antigen–negative workers for HBV DNA in serum samples, which is the best indication of active viral replication (Ristinen and Maintani 1998).

Ristinen and Maintani have taken the position that the CDC has emphasized the rights of health care workers while focusing to a lesser degree on the risk of transmission of serious and potentially fatal bloodborne pathogens to patients.

Another perspective expressed by an advisory council to the National Institute of Allergy and Infectious Disease is that the CDC bowed to political pressure in making its recommendations" rather than basing

them on available scienti c evidence (Anderson 1993). Current CDC recommendations shift the responsibility for decision-making to practitioners and their patients. In response, the courts, as the case of *Behringer* made clear, have correctly assessed that informed consent is vital to the protection of patients' interests. Although imposing liability for failure to obtain informed consent is important, it is by no means suf cient because it begs the question of whether consent within this context can ever be truly informed. Patients may nd it dif cult to evaluate scienti c information concerning risk and may be reluctant to request an alternative physician when their own physician is infected.

A uniform national policy is needed that explicitly spells out which procedures are exposure prone and present a risk to patients. Once these are identi ed, the CDC recommendations should be revised to state that infected physicians should not perform exposure-prone procedures that present a risk of transmitting bloodborne pathogens to patients. However, until such a de nitive national policy is established, informed consent is one of the limited, though less than ideal, means available to protect patients by requiring disclosure of an otherwise hidden risk.

Emotional Distress

The issue of informed consent has arisen in cases initiated by patients who have undergone surgery performed by an HIV-infected surgeon but were not informed prior to surgery that the surgeon was HIV positive. The plaintiffs brought suit for emotional distress resulting from fear of acquiring AIDS.

Some courts have allowed suits to be brought on the basis of fear of acquiring AIDS, even in the absence of proof that the source of the exposure was HIV positive or that the plaintiff actually seroconverted.[7] In *Faya v. Almaraz* and *Rossi v. Almaraz*,[8] for example, two patients brought negligence actions against an HIV-positive oncologist for failing to inform them that he was HIV-positive. The Maryland Court of Appeals held that the patients could recover for the emotional distress they endured from the moment they learned of the physician's status to the time they received their own HIV-negative test results.

[7] *Carroll v. Sisters of St. Francis Health Services*, 1992 WL 276717 (Tenn. App. 1992); *Castro v. New York Life Insurance Co.* 153 Misc.2d 1, 588 N.Y.S2d 695 (1991); *Kaehne v. Schmidt* 163 Wisc.2d 524, 474 N.W.2d 107 (Wis. App. 1991) (unpublished opinion).
[8] *Faya v. Almaraz and Rossi v. Almaraz.*, 620 A.2d 327 (Md. 1993).

Most courts have required the plaintiffs to prove actual exposure to HIV as a result of a physical injury that results in emotional distress and physical manifestations of such distress to recover damages.[9]

A recent national survey of emotional distress claims for potential or actual exposure to HIV provides a state-by-state analysis of what is required to prove such a claim (Fisher 1997).

Restricting a Physician's Practice and Discrimination

Although there is judicial authority to support disclosure of a physician's HIV status to patients, the issue of whether restricting an infected physician's practice is discriminatory has been raised.

The Federal Rehabilitation Act[10] prohibits employment discrimination by the federal government, federal contractors, and recipients of federal assistance on the basis of handicap if the individual is otherwise quali ed" to perform the job. Likewise, the Americans with Disabilities Act (ADA)[11] prohibits discrimination on the basis of disability in both public and private employment. The ADA follows section 504 of the Rehabilitation Act in de ning handicap.

The United States Supreme Court ruled in *School Board of Nassau County v. Arline*[12] that an individual with a contagious disease is considered handicapped under the Rehabilitation Act and is therefore protected from discriminatory practice. The Supreme Court has also held that individuals with contagious diseases are otherwise quali ed for

[9] *Johnson v. West Virginia University Hospitals*, 186 W.Va. 648, 413 S.E.2d 889 (1991); *Burk v. Sage products Inc.*, 747 F. Supp. 285 (E.D. Pa 1990); *Barrett v. Danbury Hosp.* 232 Conn. 242, 654 A.2d 748 (1995); *Neal v. Neal*, 125 Idaho 617, 873 P.2d 871 (1994); *Funeral Services by Gregory, Inc. v. Blue eld Comm. Hosp.*, 186 W.Va. 424, 413 S.E.2d 79 (1991), *overruled on other grounds, Courtney v. Courtney*, 190 W.Va 126, 437 S.E.2d 436 (1993); *Kerins v. Hartley*, 27 Cal. App. 4th 1062, 33 Cal. Rptr. 2d 172 (1994); *Doe v. Surgicare of Joliet, Inc.*, 268 Ill. App.3d 793, 643 N.E.2d 1200 (1994); *Ordway v. County of Suffolk*, 154 Misc.2d 269, 583 N.Y.S.2d 1014 (Sup. Ct. Suffolk Co. 1992); *Hare v. New York*, 173 A.D.2d 523, 570 N.Y.S.2d 125, *appeal denied*, 78 N.Y.2d 859, 575 N.Y.S.2d 455 (1991); *Doe v. Doe* 136 Misc.2d 1015 519 N.Y.S.2d 595 (Sup. Ct. 1987); *Lubowitz v. Albert Einstein Medical Ctr.*, 424 Pa. Super. 468, 623 A.2d 3 (1993); 2 Health L. Rep. 1685 (BNA) (Dec. 20 1993) citing *KAC v. Benson*, Minn. Ct. App. Nos. C6-93-1306 and C4-93-1328, Dec. 14, 1993.

[10] 29 U.S.C. §794(a) as amended by the Rehabilitation, Comprehensive Services, and Development Disabilities Amendments of 1978, P. L. 95-602 §119, 92 Stat. 2955.

[11] Americans with Disabilities Act, P. L. 101-136, 104 Stat. 327.

[12] 480 U.S. 273 (1987).

employment if they do not pose a signi cant risk" of transmitting disease. It is noteworthy that in determining the standard by which signi cant risk should be judged, the Court adopted certain features of the recommendations formulated by the AMA:

1. the mechanism of disease transmission
2. the duration of the risk
3. the severity of the risk
4. the probability that the disease will be transmitted

The Court also noted that an individual is not otherwise quali ed if reasonable accommodations will not eliminate the risk.

The *Arline* decision was codi ed in the Civil Rights Restoration Act, which is applicable to a person with a contagious disease if he or she does not pose a 'direct threat to the health or safety of other individuals.'"[13] The legislative history of this act demonstrates that the language direct threat" refers to the standard of signi cant risk" used by the court in *Airline*.

More recently, the Supreme Court has ruled that asymptomatic HIV infection is a disability under the ADA and, regarding the direct threat provision, determination of whether a signi cant health risk exists from accommodating such a disabled person must be based on medical or other objective evidence, not only on a good-faith belief that a signi cant risk exists.[14]

The question then becomes whether restriction of an infected physician's practice can be considered discriminatory. Notwithstanding the very recent Supreme Court decision,[14] courts in the past have consistently upheld practice restrictions placed upon surgical personnel infected with HIV or HBV under the ADA and/or the Rehabilitation Act.[15] The courts determined that the plaintiffs were not otherwise quali ed because they posed signi cant risks to patients that could not be reasonably accommodated.

The case that has most extensively addressed this issue is again *Behringer Estate v. Princeton Medical Center*,[5] in which the HIV-infected

[13] P. L. 100-259, 9, 102 Stat. 28, 31–32 (1988).

[14] *Bragdon v. Abbot*, 118 S.Ct. 2196 (1998).

[15] *Doe v. University of Maryland Medical System Corp.*, 50 F.3d 1261 (4th Cir. 1995); *Bradley v. Univ. of Texas*, 3 F.3d 922 (5th Cir. 1993); *Mauro v. Borgess Medical Center*, 886 F. Supp. 1349 (W.D. Mich. 1995); *Scoles v. Mercy Health Corp.*, 887 F. Supp. 765 (E.D. Pa. 1994).

physician brought his claim under a state antidiscrimination law whose language is similar to that of the Americans with Disabilities Act. When the plaintiff, who was an otolaryngologist and plastic surgeon, was diagnosed with AIDS, the president of the medical center where the plaintiff had staff privileges immediately canceled his surgical cases. Subsequently, the matter was presented to the hospital's board of trustees, which adopted a policy stating that an HIV-positive health care worker could continue to treat patients but could not perform any procedures that pose any risk of transmission to the patient. HIV-infected surgeons were also required to obtain informed consent before operating. The test applied by the court was whether the surgeon's continued performance of invasive procedures caused a reasonable probability of substantial harm to others; the court upheld the restrictions placed on the surgeon by the hospital and found that there was no discrimination.

Doe v. University of Maryland Medical System Corp.[15] is also noteworthy for the court's treatment of the CDC recommendations. *Doe* involved an HIV-positive neurosurgery resident who was permanently suspended from practice. Dr. Doe brought suit against the employing institution, claiming violation of the Rehabilitation Act. A panel of experts was convened in accordance with the CDC recommendations to determine the circumstances under which Dr. Doe should be allowed to practice. The panel recommended that Dr. Doe be allowed to return to surgical practice but restricted him from undertaking certain surgical procedures. The panel did not recommend that Dr. Doe be required to obtain informed consent. The hospital rejected the panel's recommendations and terminated the resident, concluding that all procedures he would undertake were exposure prone within the CDC de nition.

The court upheld the institution's decision and found that the hospital's decision to bar Dr. Doe from performing procedures the hospital determined to be exposure prone was consistent with the CDC recommendations. Implicit in this decision is the court's upholding of an institution's right to terminate or restrict the practice of an HIV-positive physician against the advice and counsel of the expert committee recommended by the CDC.

The court, in *Doe v. Washington University*,[16] reached the same conclusion when it determined that an HIV-positive dental student was not otherwise quali ed to perform invasive procedures because the risk was

[16]780 F. Supp. 628 (E.D. Mo. 1991).

in con ict with the axiom to do no harm as embraced by the Hippocratic Oath.

Conclusion

The contrast between existing recommendations and relevant court rulings is notable. Recent judicial rulings have upheld informed consent and the restriction of an infected physician's practice under some circumstances where the physician has been HIV positive.

Courts have consistently denied discrimination claims of infected health care workers and have upheld restrictions on the practice of HIV-infected physicians who perform invasive procedures, despite the low transmission risk. In rendering their decisions, courts have relied heavily on AMA policies. Legal authority is consistent with early AMA policy in holding that there is no tolerable level of risk of HIV transmission from physician to patient. The judiciary has also carefully guarded patient autonomy by requiring informed consent before an infected physician undertakes an invasive procedure, even when the medical community has determined that no risk exists.[5]

The following legal principles driving these decisions can be derived from the cases reviewed:

1. The health and welfare of patients takes precedence over the rights of infected physicians to perform invasive procedures.
2. No minimal level of risk of transmitting infection from physician to patient is tolerated for a disease in which the potential for harm is serious or for which there is a substantial risk of transmission.
3. The patient's right to self-determination is upheld by requiring that an infected physician obtain informed consent before performing any invasive procedure.

Although the cases reviewed here involve HIV, it is likely that the same principles will hold for HBV and HCV. Whereas the severity of disease caused by HBV and HCV is often, but not always, less than that of HIV, the risk of transmission is higher. Level of risk is given considerable weight in a court's determination of whether or not to allow infected physicians to perform invasive procedures (Keyes 1990).

The lack of a uniform national policy means that patients' rights and the risks they assume in undergoing treatment do not depend on a national medical standard, but rather on the state or institution where treatment is provided. Thus, a uniform national policy, based on speci c criteria for identifying procedures with a theoretical risk of HIV, HBV, and HCV transmission, is still needed. These criteria may then be used to identify invasive procedures that infected physicians should not perform. Such criteria probably should be pathogen speci c, given the differences in transmissibility among HIV, HBV, and HCV.

Both legal and medical realities call for a straightforward policy that provides decision makers with clear guidance in determining whether, and under what conditions, infected physicians should perform invasive procedures. We have recommended the establishment of a multidisciplinary national committee to develop a uniform national policy. This committee would be responsible for determining which procedures are exposure prone.

Clearly, a shortcoming of the current CDC recommendations is that they do not adequately represent the patient's interest. The regulation of infected health professionals by committees composed primarily of health professionals presents a serious con ict of interest. Faced with making a decision to limit an infected colleague's practice, health professionals must be aware that their decisions could affect their own practices and livelihoods in the future.

This inherent con ict of interest has hampered the development of a coherent national policy that fairly addresses the opposing and incommensurate considerations of physicians' livelihoods versus patients' lives and health.

An essential component of future policy development is a balanced approach that fosters equitable representation and protection of all involved parties. Not only would a more representative, multidisciplinary committee correct for the con ict of interest that currently exists; it might also create the opportunity to break the current stalemate in the development of a de nitive national policy. Committees composed of medical professionals, with only token representation of other disciplines, do not suf ciently balance and protect the interests of patients.

There are models for establishing a multidisciplinary committee. Among them is the National Bioethics Advisory Commission, whose members include representatives from the professions of ethics, law, and

medicine, as well as representatives from the community. The latter are important because they speak for the interests and values of potential health care recipients. It would also be instructive to consider the federal regulations governing Institutional Review Board membership.[17]

There comes a point when both legal and medical reality call for a decisive policy that may present serious consequences for infected physicians; however, the principles upon which medical practice was founded must not be compromised to avoid dif cult decisions. Percival, writing on medical ethics, commented on this point nearly two centuries ago:

> And [the patient] has the strongest claim from the trust reposed in his physician, as well as from the common principles of humanity, to be guarded against whatever would be detrimental to him . . . . (DeBarge 1993)

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