/* This case is reported in 249 N.J.Super 597. This is the most comprehensive opinion concerning the legal rights of physicians who are HIV positive to continue to work, as well as HIV privacy litigation. It is presented in two parts. */

Behringer Estate

v.

Princeton Medical Center

CARCHMAN, J.S.C.

Plaintiff, William H. Behringer, [footnote 1] was a patient at defendant Medical Center at Princeton (the medical center) when on June 17, 1987, he tested positive for the Human Immunodeficiency Virus (HIV, and combined with Pneumocystis Carinii Pneumonia (PCP), was diagnosed as suffering from Acquired Immunodeficiency Syndrome (AIDS). At the time, plaintiff, an otolaryngologist (ENT) and plastic surgeon, was also a member of the staff at the medical center. Within hours of his discharge from the medical center on June 18, 1987, plaintiff received numerous phone calls from well-wishers indicating a concern for his welfare but also demonstrating an awareness of his illness. Most of these callers were also members of the medical staff at the medical center. Other calls were received from friends in the community. Within days, similar calls were received from patients. Within a few weeks of his diagnosis, plaintiff's surgical privileges at the medical center were suspended. From the date of his diagnosis until his death on July 2, 1989, plaintiff did not perform any further surgery at the medical center, his practice declined and he suffered both emotionally and financially.

Plaintiff brings this action seeking damages for: (1) a breach of the medical center's and named employees' duty to maintain confidentiality of plaintiff's diagnosis and test results, and (2) a violation of the New Jersey Law Against Discrimination, N.J.S.A. 10:51 et seq., as a result of the imposition of conditions on plaintiff's continued performance of surgical procedures at the medical center, revocation of plaintiff's surgical privileges and breach of confidentiality. Defendant denies any breach of confidentiality and asserts that any action by the medical center was proper and not a violation of N.J.S.A. 10:51 et seq.

This case raises novel issues of a hospital's obligation to protect the confidentiality of an AIDS diagnosis of a health-care worker, as well as a hospital's right to regulate and restrict the surgical activities of an HIV-positive doctor. This case addresses the apparent conflict between a doctor's rights under the New Jersey Law Against Discrimination, N.J.S.A. 10:51 et seq., and a patient's "right to know" under the doctrine of ''informed

consent.'' This case explores the competing interests of a surgeon with AIDS, his patients, the hospital at which he practices and the hospital's medical and dental staff.

After a bench trial and consideration of the evidence presented, this court makes findings of fact and conclusions of law as set forth below.

To summarize, this court holds:

1. The medical center breached its duty of confidentiality to plaintiff, as a patient when it failed to take reasonable precautions regarding plaintiff's medical records to prevent plaintiff's AIDS diagnosis from becoming a matter of public knowledge.

2. Plaintiff, as an AIDS-afflicted surgeon with surgical privileges at the medical center, was protected by the law Against Discrimination. N.J.S.A. 10:5-1 et seq.

3. The Medical Center met its burden of establishing that its policy of temporarily suspending and, thereafter, restricting plaintiff's surgical privileges was substantially justified by a reasonable probability of harm to the patient

4. The "risk of harm" to the patient includes not only the actual transmission of HIV from surgeon to patient but the risk of a surgical accident i.e., a scalpel-cut or needle stick, which may subject the patient to post-surgery HIV testing.

5. Defendant medical center, as a condition of vacating the temporary suspension of plaintiff's surgical privileges, properly required plaintiff, as a physician with a positive diagnosis of AIDS, to secure informed consent from any surgical patients.

6. The medical center's policy of restricting surgical privileges of health care providers who pose "any risk of HIV transmission to the patient" was a reasonable exercise of the medical center's authority as applied to the facts of this case, where plaintiff was an AIDS-positive surgeon. [footnote 2]

I.

A.

Plaintiff, a board-certified ENT surgeon, developed a successful practice during his ten years in the Princeton area. His practice extended beyond the limited area of ear, nose and throat surgery and included a practice in facial plastic surgery. He served as an attending physician at the Medical Center since 1979 and performed surgery at the medical center since 1981.

In early June 1987, plaintiff felt ill. He complained of various symptoms and treated himself. Acknowledging no improvement, plaintiff consulted with a physician-friend (the treating physician). On June 16, 1987, plaintiffs companion arrived at plaintiff's home and observed that plaintiff was in distress. A call was made to the treating physician, and at approximately 11:00 p.m., plaintiff and his companion proceeded to the medical center emergency room, where plaintiff was examined initially by a number of residents and, thereafter, by the treating physician. The treating physician advised plaintiff that a pulmonary consultation was necessary, and a pulmonary specialist proceeded to examine plaintiff. A determination was made to perform a bronchoscopy-a diagnostic procedure involving bronchial washings-to establish the existence of PCP, a conclusive indicator of AIDS. The pulmonary consultant assumed that plaintiff, as a physician, knew the implications of PCP and its relationship to AIDS. In addition, the treating physician ordered a blood study including a test to determine whether plaintiff was infected with HIV-the cause of AIDS.

Plaintiff's companion has no recollection of specific information being transmitted to plaintiff regarding the HIV test, nor does she recollect any specific "counselling" or explanation being given to plaintiff about the significance, impact or confidentiality of a positive result of the HIV test. While the companion specifically denies any direct conversation between plaintiff and his doctors regarding the HIV test, the pulmonary consultant indicated that during his conversation with plaintiff, the pulmonary consultant discussed PCP as one of a number of possible diagnoses resulting from the test. Plaintiff was admitted to the medical center that evening.

Conforming to medical center policy, plaintiff executed a consent form granting to the pulmonary consultant the general consent to perform a bronchoscopy. In addition, plaintiff executed a special consent form granting specific consent to perform an HIV blood test. During the morning of June 17, 1987, plaintiff submitted to a bronchoscopy and returned to his room in the afternoon, where he was described as "sedated" and "out of it." Later that day, the pulmonary consultant reported to plaintiff that the results of the tests were positive for PCP, and he concluded that this information was new to plaintiff. Early that evening, the treating physician returned to plaintiff's room, and in the presence of plaintiff's companion, informed plaintiff that the HIV test was positive. Plaintiff was also informed that he had AIDS. Plaintiff's reaction, according to plaintiff's companion, was one of shock and dismay. His emotions ranged from concern about his health to fear of the impact of this information on his practice. Plaintiff's companion described her initial response as "who else knew?" The treating physician responded that he had told his wife; both plaintiff and his companion, close personal friends of both the treating physician and his wife, responded that "they understood."

It was readily apparent to all persons involved at this point that plaintiff's presence in the medical center was cause for concern. An infectious disease

consultant and staff epidemiologist suggested to plaintiff that he transfer to Lenox Hill Hospital in New York or other available hospitals in the area. After inquiry, it was determined that no other beds were available. This concern for an immediate transfer appeared to be twofold-to insure the best available treatment for plaintiff (the treating physician suggested that AZT treatment be considered) and to prevent plaintiff's diagnosis from becoming public. It is apparent that all parties involved to this point-plaintiff, the treating physician, the epidemiologist and plaintiff's companion-fully understood the implications of the AIDS diagnosis becoming a matter of public knowledge. A determination was made that plaintiff would leave the hospital and be treated at home. Plaintiff was discharged from the hospital on the afternoon of June 18, 1987. To minimize the significance of his condition, plaintiff walked out of the hospital rather than following the normal medical center practice of being wheeled out.

Plaintiff's concern about public knowledge of the diagnosis was not misplaced. Upon his arrival home, plaintiff and his companion received a series of phone calls. Calls were received from various doctors who practiced at the medical center with plaintiff. All doctors, in addition to being professional colleagues, were social friends, but none were involved with the care and treatment of plaintiff. All indicated in various ways that they were aware of the diagnosis. Statements were made either directly to plaintiff's companion or by insinuation, such as an inquiry as to whether the companion was ''tested.'' She did not deny references to the diagnosis but admits that she "tacitly acknowledged the diagnosis in one instance by silence." During the evening of June 18, she received a call from social non-medical friends who indicated their knowledge of the diagnosis and expressed support to her and plaintiff. She indicated that the relationships with various neighbors and friends changed as a result of the diagnosis. There was less social contact and communication and what she perceived as a significant diminution in the popularity of plaintiff.

Plaintiff's condition and the growing awareness of that condition in the community impacted upon not only plaintiff's social relationships but, more significantly, on his practice as well. In July 1987, plaintiff returned to his office practice. During his short absence from his office and in the ensuing months, calls were received at his practice from doctors and patients alike who indicated an awareness of plaintiff's condition and in many cases, requested transfer of files or indicated no further interest in being treated by plaintiff. At one point plaintiff's companion instructed Jeannie Weinstein, plaintiff's receptionist, not to confirm any information regarding AIDS, and "instruct patients that plaintiff did not have AIDS." Over an extended period of time, the practice diminished as more of plaintiff's patients became aware of his condition.

Cancellations continued at an exceedingly high rate. The effect of plaintiff's condition was not limited simply to patient relationships, but affected

employees as well. As early as June 18, 1987, Weinstein, a long-standing employee of plaintiff, received an office telephone call from a local physician inquiring as to whether plaintiff had AIDS. Weinstein responded that she knew nothing about it but, thereafter, met with other employees in the office and told them of the phone call. During the two-week period after this call, some 15 to 20 calls were received from various patients indicating knowledge of plaintiff's condition. An extensive list was prepared by Weinstein indicating cancellation of appointments and patient requests for records. The list, for reasons not sufficiently explained, was kept only until September 1987, when the listing stopped. During this period, three employees left plaintiff's employ and a replacement employee left one day after being hired upon learning that plaintiff had contracted AIDS. During the two years following his AIDS diagnosis, plaintiff suffered from an ulcer, was hospitalized for one week for a virus, and as a result of his AIDS condition, lost sight in one eye. Plaintiff continued in an office practice until his death on July 2, 1989.

B.

The medical center's reaction to plaintiff's condition was swift and initially precise. Upon learning of plaintiff's diagnosis from the chief of nursing, the president of the medical center, defendant Dennis Doody (Doody), immediately directed the cancellation of plaintiff's pending surgical cases. This initial decision was made with little information or knowledge of potential transmission of the disease; thereafter, the chairman of the department of surgery, having privately researched the issue, reached a contrary result and urged that plaintiff could resume his surgical practice. The medical center procedure for suspending a physician's surgical privileges provides for summary suspension by a vote of the department chair, president of the medical center, president of the medical and dental staff, chairman of the board of trustees, and the physician in charge of the service. While Doody was defeated in a vote for summary suspension, the surgery remained cancelled, and the matter was ultimately brought before the board of trustees.

Doody's motivation in seeking the suspension of surgical privileges was described as one of concern for patients but also, and perhaps more important, concern for the medical center and its potential liability. Little was known about the dilemma now facing the medical center. In any event, plaintiff's surgical privileges were cancelled and would never, during plaintiff's life, be reinstated.

During the ensuing months, the medical center embarked on a torturous journey which shifted course as views were explored and, ultimately, a consensus reached between the medical and dental staff, hospital administration and the board of trustees.

On July 2, 1987, plaintiff privately informed the chairman of the department of surgery at the medical center of his medical condition. Plaintiff felt that the chairman of his department should know of his health status and informed the chair that plaintiff wished to continue to practice, including performing surgery.

Doody called a special meeting of the executive committee of the medical and dental staff which took place on July 13,1987. The medical and dental staff is a body of physicians and dentists operating under the aegis of the board of trustees of the hospital. The board approves the staff's by-laws and retains ultimate decision-making authority. At this meeting, the executive committee passed a motion holding that "HIV positivity alone is not a reason for restricting a Health Care Worker from [the performance of] invasive procedures on the basis of data currently available." Defendant Doody, the lone dissenter, admittedly presented no scientific or medical basis for disagreeing with the committee's recommendation. Both the medical literature from the centers for disease control (CDC) and other authorities that were discussed, as well as defendant medical center's staff epidemiologist noted that there were no known cases of transmission of HIV from a health care worker (HCW) to a patient. Later, however, the epidemiologist recommended to defendant Doody that an HIV-infected surgeon should not operate. Defendant Doody acknowledged at trial, and believed at the time of the special meeting, that the CDC was "the number one resource on infectious disease in the United States."

A second meeting of the executive committee of the medical and dental staff was held on July 16,1987 to continue discussing the issues raised by plaintiff's medical condition. The committee maintained its recommendations that, based on all available, current scientific information, a surgeon with AIDS or one who is HIV-positive should retain all of his privileges, be subject to careful monitoring for competence and follow CDC recommended precautions for invasive procedures. At this meeting, the physicians who were present concluded that there was no risk of transmission that would require an HIV-positive surgeon to disclose that fact to a patient as part of informed consent. However, Doody and the medical center's legal counsel offered the opinion that despite the absence of reported cases of transmission from HCW to patient, a physician's HIV positive status should be divulged in any informed consent form because of "legal and social considerations." The committee concluded that a full meeting of the board of trustees was necessary to resolve the issue.

A special meeting of the board of trustees was held on July 20, 1987. At this meeting the board of trustees was addressed by the chairman of the department of surgery, the medical center's staff epidemiologist, as well as physicians comprising the executive committee of the medical and dental staff, who reiterated that no cases of HIV transmission from HCW to patient had ever been reported. At the meeting, the issue of informed consent was

discussed at length. All members of the board of trustees were provided with a packet of information that included current CDC statements regarding performance of invasive procedures by HCWs and copies of the minutes of the medical and dental staff executive committee meetings, including a letter from the staff to the board setting forth the staff's position. Doody and the board were also informed that CDC recommended operating room precautions were expected to prevent HIV transmission. The board of trustees was told that the CDC recommended individualized decision-making for HIV-positive HCWs, suggesting that decisions regarding continued practice by an HIV-positive physician should be made on a case-by-case basis. Doody expressed concern about the hospital's reputation as well as potential litigation given public fear of AIDS. After consideration of all of the information presented, the board voted to require the use of a special "informed consent form" to be presented to patients about to undergo surgery by HIV-positive surgeons. The form read as follows:

THE MEDICAL CENTER AT PRINCETON, NEW JERSEY SUPPLEMENTAL CONSENT FOR OPERATIVE AND/OR INVASIVE PROCEDURE

I have on this date executed a consent, which is attached hereto, for (Procedure) _____ to be performed by Dr. _____. In addition, I have also been informed by Dr. _____ that he has a positive blood test indicative of infection with HIV (Human Immunodeficiency Virus) which is the cause of AIDS. I have also been informed of the potential risk of transmission of the virus.

(witness) (signature of patient)

All parties recognized that in the absence of patients willing to undergo invasive procedures by HIV-positive surgeons, this was a "de facto prohibition" from surgical practice. Subsequent to the July 20, 1987 meeting of the board of trustees, various committees met as the issues concerning HIV-positivity and HCWs continued to be discussed at the medical center. To further explore the issues, three meetings of the joint conference committee of the board of trustees and the medical and dental staff were held and are especially noteworthy. These meetings occurred on October 29, 1987, November 19, 1987 and December 17, 1987. At the first meeting, the epidemiologist spoke about the medical information available concerning the issue of an HIV-positive surgeon performing invasive procedures. At the second meeting, Robert Cassidy, Ph.D., an ethicist and a member of the faculty of the Robert Wood Johnson Medical School, discussed the legal requirements for informed consent in New Jersey. At the third meeting, Paul Armstrong, Esquire, presented the report of the Council on Ethical and Judicial Affairs of the American Medical Association, which deals with the issue of AIDS in the health care environment. The American Medical Association report contains among its recommendations the following:

The Council's new opinion on PHYSICIANS AND INFECTIOUS DISEASES is: A physician who knows that he or she has an infectious disease should not engage in any activity that creates a risk of transmission of the disease to others.

In the context of the AIDS crisis, the application of the Council's opinion depends on the activity in which the physician wishes to engage.

The Council on Ethical and Judicial Affairs reiterates and reaffirms the AMA's strong belief that AIDS victims and those who are seropositive should not be treated unfairly or suffer from discrimination. However, in the special context of the provision of medical care, the Council believes that if 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. If no risk exists, disclosure of the physician's medical condition to his or her patients will serve no rational purpose; if a risk does exist, the physician should not engage in the activity.

Armstrong concluded his remarks by stating that the above provided a standard with regard to HCWs with HIV seropositivity or AIDS which had not existed prior to its promulgation.

At the conclusion of the meeting on December 17, 1987, it was suggested that if the board of trustees was to change its policy regarding HIV-positive surgeons, the impetus for such change should come from the medical and dental staff. The president of the medical and dental staff agreed that the issue would be addressed at the January meeting of the staff's executive committee.

At its January 25, 1988 meeting, the staff's executive committee, after lengthy discussion, recommended that the following policy be adopted by the board of trustees:

1. The Medical Center at Princeton Medical and Dental Staff will continue to care for patients with AIDS without discrimination.

2. A physician or Health Care provider with known HIV seropositivity will continue to treat patients at the Medical Center at Princeton, but will not perform procedures that pose any risk of virus transmission to the patient.

This policy was proposed to the entire medical and dental staff, and on February 11, 1988, a meeting of the full medical and dental staff was held, at which time this new policy regarding HIV seropositive surgeons was discussed. A recommendation was forwarded to the board of trustees that this two-part policy be adopted.

On June 27, 1988, the board of trustees met and, after questions and discussions, adopted the following policy for HIV seropositive health care workers:

POLICY FOR HIV SEROPOSITIVE HEALTH CARE WORKERS

1. The Medical Center at Princeton Medical and Dental Staff shall continue to care for patients with AIDS without discrimination.

2. A physician or health care provider with known HIV seropositivity may continue to treat patients at The Medical Center at Princeton, but shall not perform procedures that pose any risk of HIV transmission to the patient. [Emphasis supplied]

This policy included a procedure for the recredentialling of physicians. [footnote 3] Although the policy was adopted, the board did not change its prior requirement that a physician obtain written informed consent from the patient prior to the performance of surgical procedures.

Plaintiff's privileges, as a "potential risk," were ultimately suspended under this policy, and no action was taken by him challenging the policy or seeking recredentialling under the policy.

Following his diagnosis of AIDS, plaintiff never again performed surgery at the medical center.

C.

The administration of plaintiff's blood test, resulting in a finding of HIV positivity, warrants a critical examination of the testing procedures and efforts made by medical center to insure confidentiality of results.

In 1985, the medical center began testing blood for HIV seropositivity for its blood bank. Since HIV testing was available for blood donors, HIV testing was also made available to staff physicians, both for inpatients and outpatients. Initially, the reporting procedures for both inpatients and outpatients required the physician to submit the blood to the laboratory with only a code number. After the test was completed, the results were returned to the physician under the code number, without the patient's name. This procedure was approved by the New Jersey Department of Health. The testing procedure was administered by the department of laboratories under the direction of defendant Leung Lee, M.D. (Lee) and the actual responsibility for implementation of the procedure was delegated to Ilana Pachter, M.D., at that time an employee of medical center.

II.

By 1986, many hospitals began to realize that the established procedures were unworkable for inpatients. In 1986, a meeting was held by the New Jersey Department of Health, which was attended by representatives of many New Jersey hospitals, including Pachter of the medical center. The consensus at the meeting was that inpatient testing could not be conducted under a code number system for a variety of reasons including lack of cooperation by members of the medical staff. In addition, it was felt that HIV positive status was an important medical fact that should be included within a patient's medical chart.

In response to this meeting, the department of health issued new guidelines in October 1986 dealing with the reporting of HIV results for hospital inpatients. The new guidelines included the following:

1) Testing facilities must make reasonable efforts to maintain confidentiality. 2) For in-patients and clinic out patients, specimens may be received with the patient's name on them. These specimens must be encoded, (e.g., assignment of lab I.D. numbers) in the laboratory before testing occurs, so that test results do not appear with the patient's name in the laboratory's work records. The results of these assays may be placed on the patient chart in the same manner as other routine tests.

These stated procedures were designed to recognize and deal appropriately with the issue of confidentiality. While health care facilities recognized the need for confidentiality, an additional, yet critical, element of HIV-test protocol required communication with the patient. This communication took the form of pretest counselling of patients prior to the administration of the HIV test.

[1] Pretest counselling for HIV blood tests has been the standard of practice since the beginning of HIV testing. Such counselling includes discussion about the disclosure of test results and an identification of those having access to test results. Before HIV tests are given, patients are counselled as to the privacy and confidentiality implications of being identified as HIV-infected. These implications are explained to symptomatic and asymptomatic patients alike. Members of the medical center's department of laboratories attended New Jersey Department of Health seminars prior to June 1987, at which pretest counselling was addressed.

Pretest counselling was not a procedure limited to New Jersey. It was recommended by public health authorities, including the CDC prior to June 1987. In 1987, accepted medical practice called for patient counselling concerning, inter alia, privacy and confidentiality prior to obtaining consent for an HIV test.

While no question was raised at trial that the responsibility for pretest counselling appropriately rested with the treating physician, the record is devoid of any suggestion that any pre test counselling of plaintiff, either in

oral or written form, took place during the period June 16 to June 18, 1987. While plaintiff was, by profession, a physician, he was, during this period, a patient at the medical center. No one in this litigation suggests that plaintiff was not entitled to all of the protections afforded any other patient. The informed consent form promulgated by the department of laboratories at the medical center and signed by plaintiff, does little to correct this apparent deficiency. The form provides as follows:

CONSENT FORM . .

I William Behringer hereby give my consent to the Medical Center at Princeton to have my blood tested for antibodies to HTLV III Virus as ordered by my physician. The results of the test will be reported only to the ordering physician.

Date 6/17/87 Patient signature William Behringer

Witness (illegible)

PATIENT CODE NO. 865353

The test was ordered by the treating physician on admission and administered sometime on June 17, 1987. The informed consent form indicated a time of 1:00 p.m. At approximately 2:00 p.m., the infectious disease specialist went to the department of laboratories at the medical center to determine the status of plaintiff's HIV blood test. Upon learning that the test had not been conducted, the infectious disease specialist asked lee to conduct the test on an expedited basis. Lee agreed and instructed the blood bank supervisor to conduct the test as soon as possible. Plaintiff's name was identified to the supervisor by the infectious disease consultant and Lee. Since plaintiff's blood sample was already in the lab, the sample had been given a code number, and plaintiff's name was removed from the sample. Plaintiff's name and code number had been placed in a locked filing cabinet pursuant to laboratory procedures. The supervisor went to the locked file cabinet, looked up plaintiff's name and obtained the code number for his blood sample. The blood sample was then located by reference to the code number and was given to a laboratory technician with instructions to conduct the HIV test. This occurred sometime between 2:30 and 3:30 p.m. The technician was not provided with the name of the patient for whom the HIV test was being conducted.

Since the technician left work at 3:30 p.m. each day and since the test takes approximately four hours, she did not conclude the test and thus did not learn the results. The test was concluded by the supervisor at approximately 6:00 p.m., at which time the results, which were positive, were relinked to plaintiff's name in the record maintained in the locked file cabinet pursuant to the standard procedures followed by the department of laboratories.

Prior to the test, the infectious disease specialist who had requested the test be conducted asked Lee to telephone him with the results as soon as they became available. Accordingly, Lee instructed the supervisor to telephone him at home with the results as soon as they were available.

Early that evening, the supervisor called Lee at home and informed him that plaintiff's HIV test was positive. As he had been instructed, Lee called the infectious disease specialist and advised him of the results.

During the late afternoon or early evening of June 17, 1987, after receiving the positive HIV results, the infectious disease specialist spoke with plaintiff and suggested he might want to seek treatment at another hospital to protect his confidentiality. Later, the infectious disease specialist attempted without success to arrange for the transfer of plaintiff to either Lenox Hill Hospital or Columbia Presbyterian Hospital in New York City.

On June 18, 1987, pursuant to normal procedures, the department of laboratories ran a follow-up confirmation HIV test. The result was again positive and a preprinted form was prepared indicating a positive result. The preprinted form was taken by the supervisor and presented to Pachter, who signed it.

Normal procedures within the department of laboratories called for the test result to be taken by a blood-bank technician and handcarried to the patient's chart and placed in the section of the chart designated for laboratory results. All other laboratory test results are placed in the patient's medical chart by clerical personnel. This special procedure for HIV test results was implemented by the department of laboratories as an additional safeguard for patient confidentiality.

The above procedure was not immediately carried out but was delayed in an effort to protect plaintiff's confidentiality. In a telephone conversation during the afternoon of June 18, the treating physician and Pachter agreed that since plaintiff was to be discharged from the medical center late that afternoon, the HIV test results should be held back and charted as late in the day as possible. Therefore, consistent with the agreement reached with the treating physician, Pachter instructed the supervisor to handcarry the result to the patient's chart just before she left for the day.

Since the supervisor worked until 4:30 p.m. each day, she believes that she took the HIV-positive result to plaintiff's chart sometime between 4:15 and 4:30 p.m. on June 18, 1987.

Upon arriving at the nurses station on plaintiff's floor, the supervisor was unable to locate the chart. She asked the nurse on duty for the chart, at which time the nurse went to plaintiff's hospital room, obtained the chart and delivered it to the supervisor. She, without commenting on the HIV test or the results, placed the test results in the section of the chart designated for

laboratory results.

At approximately 4:30 p.m. on June 18,1987, plaintiff was discharged from the medical center.

The implications of charting the results of the HIV test were well recognized. Both Lee and the infectious disease specialist discussed the acute need to keep the test results confidential and even went so far as to affirmatively determine not to disclose the results to Doody; moreover, the charting was withheld by design until plaintiff left the hospital.

While there is some dispute as to the propriety of charting as an acceptable medical practice, the medical center felt there were safeguards in the general confidentiality guidelines set forth in its by-laws and employee manuals. According to stated policy, charts were limited to those persons having patientcare responsibility, but in practical terms, the charts were available to any doctor, nurse or other hospital personnel. Despite the CDC's recommendation that access to HIV results be limited, the medical center had no policy physically restricting access to the HIV test results or the charts containing the results to those involved with the particular patient's care. In addition, the broad confidentiality policies of the medical center specifically restrict HCWs from discussing patient's charts with other HCWs.

The employees of the medical center were not given any instructions advising them of the confidentiality of HIV test results. The department of laboratories of the medical center took no steps to ensure that HIV test results were kept confidential by other departments of the medical center after being placed in patient charts. Under Lee, the department of laboratories ran no confidentiality training programs despite the fact that it was responsible for HIV testing.

Plaintiff's medical chart was kept at the nurses' station on the floor on which plaintiff was an inpatient. Not only was the HIV result charted, but his AIDS diagnosis was noted at numerous places therein. No effort was made to keep knowledge of this diagnosis limited to persons involved in plaintiff's care. There was no written or verbal restriction against any HCW involved in plaintiff's care discussing plaintiff's diagnosis with other medical center employees. Employees not involved in his care did learn of plaintiff's diagnosis. Employees of the medical center who had been plaintiff's patients ceased going to him for medical services. Given the significance of a physician-patient with a diagnosis of AIDS and the lack of special procedures directed at securing confidentiality, the inevitable happened. As noted earlier, within hours of the diagnosis, word of plaintiff's illness was "on the street." Any suggestion of subsequent breaches of confidentiality are superfluous.

D.

Plaintiff was diagnosed in June 1987 as having AIDS as a result of the positive HIV blood test and the diagnosis of PCP.

The expert testimony presented by both plaintiff and defendants, while differing significantly as to conclusion, was consistent as to the scientific underpinnings upon which their conclusions about HIV positively and AIDS were based. Both plaintiff's expert, Peter Selwyn, M.D., an epidemiologist and the head of AIDS research at the Montefiore Medical Center in the Bronx, New York, and defendant's expert, Lorraine Day, M.D., an orthopedic surgeon from San Francisco, California, who has been an active spokesperson nationally on the issue of AIDS, based their conflicting opinions on the following common data:

1) A British study revealed that there were 112 needlestick and scalpel cuts in 2,000 reported operations, (5%). [footnote 4]

2) The CDC has reported nine cases of transmission of HIV from patient to HCW.

3) A risk of transmission of HIV from HCW to patient of 0.5% or less is a quantifiable risk.

4) As of June 1989, the date of plaintiffs death, there was no reported case of transmission of HIV from HCW to patient.

5) Once contracted, AIDS is fatal usually within two years.

As to the effect of these studies and facts, the experts sharply disagree. Selwyn opined that there was no reasonable medical or scientific basis for defendant's decision restricting plaintiff's surgical privileges which, Selwyn claims, was based on unfounded fears of HIV transmission as a potential area for litigation against the hospital.

Selwyn has been extensively involved in the clinical treatment of AIDS, AIDS-related teaching and research, and the development of AIDS-related policy at both the local and global levels. As an assistant professor of epidemiology at Albert Einstein College of Medicine and a physician at Montefiore Medical Center in New York, Selwyn has been responsible for conducting AIDS-related epidemiological studies, and has personally cared for several hundred patients with HIV infection or AIDS. He has participated in the formation of hospital policies and hospital training programs concerning HIV infection and AIDS, and has studied the nature and risk of HIV transmission. He is well-qualified as an expert in this field.

In his analysis of the issues, Selwyn utilized scientifically accepted information, statistics and health care facility reactions to the treatment of hepatitis B virus and transmission between patient and HCW.

Hepatitis B, the virus that causes hepatitis, is a blood borne infectious

disease transmitted through similar routes as HIV. Selwyn noted that the estimated rate of death among HCWs who contract hepatitis B, which develops into chronic disease in approximately six to ten percent of those cases, is higher than any estimates of HCWs occupationally infected with HIV.

In addition, he stated that for both hepatitis B and HIV, the risk of an HCW transmitting the virus to a patient is substantially less than the risk of a patient transmitting the virus to an HCW. Moreover, the risk of transmission of HIV from an HCW to a patient is even lower than the risk of an HCW transmitting hepatitis B to a patient. The recorded estimates of hepatitis B transmission from physicians to patients have all been based on anecdotal reports and are essentially reduced to situations where breaches in medical technique, such as a dentist's failure to wear gloves, were associated with increased likelihood of blood-to-blood contact. Where such breaches did occur and then precautions were instituted and studied, transmission of hepatitis B did not occur again. The medical center's epidemiologist agreed with Selwyn on this issue. The epidemiologist informed the medical and dental staff and Doody that change in technique would affect the risks of such transmissions.

Hepatitis B is less likely to be fatal but is more readily transmitted than HIV. Selwyn estimated that statistically the risk of death from exposure to a surgeon with HIV would be about the same as that from exposure to a surgeon with hepatitis B. Of critical importance, however, is that of the transmitted diseases, if the HIV infection develops into AIDS, fatality is certain.

While Selwyn noted the similarities between HIV and hepatitis B transmission, he indicated that there were no restrictions placed on hepatitis B-positive doctors performing invasive procedures; however, the record is absent any facts indicating any cases of hepatitis B-positive doctors performing any invasive procedure at the medical center. In this regard, Selwyn did note that such matters as surgeon's wound infection rates or a history of substance abuse would be critical to a patient's knowledge of the risks attendant to a surgical procedure, but no informed consent requirements have been imposed on physicians anywhere which require the physician to inform patients of such risks.

Selwyn observed that even assuming that an HIV-positive physician nicked a finger during surgery and a drop of the physician's blood fell into the patient, the risk of that patient contracting HIV is less than one-half of one percent. Selwyn explained that the actual risk of ultimate transmission is diluted by the probability of a series of events happening, all of which would be necessary before exposure occurs. Whether an injury occurs, whether it occurs within range of the patient's blood, whether the surgeon's blood makes its way out from beneath two layers of gloves, and whether there is then a transmission of the surgeon's blood into the patient's blood, are all

independent events that geometrically reduce the chance of blood-to-blood contact. This reduces the less than one-half of one percent chance of infection associated with contact. Day conceded that the chance of all these events occurring in a procedure was .0025%. Selwyn added that the risk factor was affected by the nature of the surgery performed, e.g., orthopedic surgeons or gynecological surgeons operating in some areas by "feel" bear a higher risk of accident than do surgeons such as ENT specialists.

Selwyn's conclusion that the risk of transmission of HIV from an HIV-positive surgeon to a patient is remote was an accepted premise in 1987 at the time defendants learned plaintiff had AIDS.

Selwyn further concluded that no restrictions should have been placed on plaintiff's practice simply because of HIV infection. For situations like plaintiff's, Selwyn recommended that the hospital, department chief, and HIV-positive physician monitor the physician's competence to perform, institute whatever precautions might further reduce the already remote risk of transmission, and discuss the surgeon's techniques and procedures. All parties must be educated as to the actual risk or absence of risk of transmission and discussion and agreement must be private.

Selwyn felt that an informed consent requirement was inappropriate. He testified that while a patient might "want" to know the health status of the physician, the risk was not so significant that a patient would "need" to know the information. He did not feel this was a "risk within a reasonable medical opinion." Selwyn concluded that only risks "within a reasonable medical opinion" were necessarily divulged to a patient. [footnote 5] Although internal review by doctors' clinical supervisors has been used satisfactorily in other instances where doctors have medical problems, the medical center took no such steps in this case.

[2] Day's conclusions differed significantly from those of Selwyn, especially in the area of restriction on practice. Day has served as the chief of orthopedic surgery at San Francisco General Hospital. While not an epidemiologist, she has served on numerous AIDS-related committees including the AIDS Task Force of the American Academy of Orthopedic Surgeons. She lacked the training or full understanding of AIDS-related issues that was demonstrated by Selwyn and provided much undocumented statistical information which must be discounted, or in some cases, disregarded. Day, however, did provide some practical insight into a practitioner's concerns about AIDS as applied to both the affected doctor and patient. [footnote 6] Day testified that transmission of the disease can occur when HIV infected blood comes in contact with an intact mucous membrane and, further pointed out that an ENT surgeon performs surgery in the area of an intact mucous membrane. In addition, she noted that much of ENT surgery is performed "blind," making the ENT surgeon a high-risk candidate for surgical nicks or cuts. As a practical matter, she added, surgeons incur

needle sticks and other cuts in the operating room on a regular basis, and the wearing of surgical gloves does not protect a surgeon from needle sticks or bleeding into the patient's surgical wound or oral cavity.

Day vigorously disputed Selwyn's conclusion that a patient need not know the surgeon's HIV-positive status. Both Selwyn and Day made reference to recommendation no. 5 in the CDC's recommendations and guidelines concerning AIDS, dated April 11, 1986, which provides:

If an incident occurs during an invasive procedure that results in exposure of a patient to the blood of an HCW, the patient should be informed of the incident, and previous recommendations for management of such exposures should be followed. [footnote 7]

While Selwyn accepted recommendation no. 5, Day was highly critical of its application. She indicated that the effect of HIV exposure on a patient would be significant, including periodic HIV testing over a period of at least one year and counselling regarding major lifestyle changes, involving such matters as sexual practices and decisions regarding conceiving children. [footnote 8] The impact of the application of recommendation no. 5 would be enormous anxiety and mental anguish, which could be avoided if the patient were advised of the surgeon's condition before the surgery and, obviously, the surgical accident Day strongly advocated the patient's "need" to know the surgeon's status by use of an informed consent procedure.

The experts differed significantly in the area of confidentiality and the charting of the results of the HIV blood test. Selwyn felt that the charting and dissemination of information from plaintiff's chart, including the results of the bronchoscopy, required special handling. In addition, Selwyn concluded that because of the absence of counselling of plaintiff there was no "informed consent" as to the HIV blood test. Both experts agreed that the responsibility for counselling is an obligation imposed on the treating physician; nevertheless, insuring that counselling takes place and is conducted in an appropriate manner is a responsibility that is shared by the hospital as well.

Selwyn opined that access to the chart should be limited to persons within the "clinical realm" having "a need to know." He noted that the CDC guidelines require universal precautions, i.e., treating all patients as if they were HIV positive-to avoid transmission. If usual precautions are observed, nothing clinically is gained by charting the test results without restriction. In addition, Selwyn felt that the use of special measures to insure confidentiality must be considered when dealing with an HCW. Various alternatives to unrestricted charting of an AIDS diagnosis include charting the HIV result separately or segregating the chart. Day, voicing a contrary position, felt the chart should be readily available with all information displayed so as to provide any person treating the patient on an emergency

basis with full information as to the test results and diagnosis. Ironically, at Day's hospital the HIV test results were kept in a separate envelope attached to the chart.

II.

Any examination of the legal issues in this matter requires an understanding of AIDS and HIV.

AIDS is a viral disease that weakens or destroys the body's immune system. The disease is caused by the presence of the Human immunodeficiency Virus ("HIV"), which attacks the body's T-lymphocyte cells that are a critical part of the body's immune system. As a result, the body is unable to withstand infections it would normally suppress. These resulting infections, known as "opportunistic diseases," eventually cause permanent disability and death. AIDS is defined by New Jersey health regulations as the presence of both the HIV virus and one or more opportunistic diseases. Thus, a person may test positive for the HIV virus and yet not exhibit any signs of illness; that person is asymptomatic. Persons who exhibit effects of immunodeficiency, such as fever, weight loss, night sweats, or diarrhea, but do not have any opportunistic diseases are described as having AIDS-related Complex ("ARC"). See NJAC. 8:57-1.14(b). AIDS has no known cure. [Doe v. Barrington, 729 F.Supp. 376, 380 (D.N.J.1990); footnotes omitted; see also Board of Ed. of Plainfield v. Cooperman, 209 N.J.Super. 174, 195-200, 507 A.2d 258 (App.Div.1986), mod & aff'd 105 NJ 587, 589-590, 523 A.2d 655 (1987)].

A summary of the testimony of Selwyn and Day reveals the following facts about AIDS. AIDS is diagnosed by the presence of one of the indicator opportunistic infections, such as PCP or Kaposi's sarcoma. Thus, the diagnosis of AIDS is consistent with a positive HIV blood test and PCP. HIV infection is not AIDS and there is some dispute as to the length of the "incubation period" between HIV infection and the onset of AIDS. The experts here speculated that this period ranges from months to years.

[3] While the issue of HIV transmission is still subject to some controversy and debate, three methods of transmission have been generally identified: (1) intimate sexual contact; (2) parenteral (e.g., injection or other invasive procedure breaking the skin) or mucous-membrane inoculation of blood; and (3) from a woman to her child during pregnancy, delivery, or shortly after birth (through infected breast milk). Casual contact between persons has not been established as a means of transmission. While HIV is described as less contagious than other viruses, Selwyn and Day generally agree that one suffering from AIDS is more contagious than one simply HIV infected. At the relevant times in this action there were no reported cases of transmission of HIV infection from a health care worker to a patient. [footnote 9] Notwithstanding the absence of a reported case at the time of trial, neither

side argued that such transmission was not possible. Both sides agreed that the risk of transmission could be quantified. The nature, extent and significance of such risk is a critical and contested issue in this case.

HIV was isolated in 1983. Thereafter, scientists developed tests that detect the presence of HIV antibodies in blood. The mean latency period between initial infection by the virus and the onset of AIDS is, according to current figures, in excess of five years. This may he an underestimate of the actual mean latency period, because at the time of trial, the AIDS epidemic had only been under observation for approximately eight years.

AIDS proves fatal in virtually every reported case. Although no cure for AIDS presently exists, doctors have made progress in treating the opportunistic infections associated with AIDS. In addition, certain treatments have shown promise in slowing the progression from HIV infection to AIDS to death. People with AIDS often have extended periods during which they have only minor symptoms, if any, and are able to lead full, productive lives.

AIDS presents a significant medical and social crisis for New Jersey and the United States as a whole. At the time of trial, over 3,000 residents of New Jersey were diagnosed with AIDS; an estimated 100,000 New Jersey citizens-one out of every 75 residents-were infected with HIV. Bushburg & Convisor, Clinical Guidelines for the Diagnosis & Treatment of AIDS (N.J.Dept. of Health 1988) at 8.

III.

Plaintiff asserts that the medical center, Doody and Lee breached a duty of confidentiality in failing to restrict access to plaintiff's medical records, thus causing widespread and improper dissemination of information about plaintiff's medical condition. Plaintiff argues that as a result of this breach of confidentiality, his ability to practice was impaired so significantly that his medical practice was damaged, if not destroyed. Plaintiff's confidentiality-based claims arise out of his status as a patient While plaintiff was unable to identify specifically the actual sources of the disclosure of his diagnosis, he argues that the medical center's failure to implement meaningful restrictions on access to his medical records is sufficient to establish liability. In sum, he urges that the failure of the medical center to take reasonable precautions regarding access to his records establishes liability. Defendants argue that any disclosure by its employees or others outside of its control is its responsibility and cannot be the basis of liability.

[4, 5] The physician-patient privilege has a strong tradition in New Jersey. The privilege imposes an obligation on the physician to maintain the confidentiality of a patient's communications. Stempler v. Speidell, 100 N.J. 368, 495 A.2d 857 (1985). This obligation of confidentiality applies to patient

records and information and applies not only to physicians but to hospitals as well. Unick v. Kessler Memorial Hosp., 107 N.J Super. 121, 257 A.2d 134 (Law Div.1969). This duty of confidentiality has been the subject of legislative codification which reflects the public policy of this State. N.J.S.A. 2A:84A-22.1 et seq. The patient must be able "to secure medical services without fear of betrayal and unwarranted embarrassing and detrimental disclosure...." Piller v. Kovarsky, 194 N.J Super. 392, 396, 476 A.2d 1279 (Law Div. 1984). The privacy right on which the privilege is based has been held to a level warranting constitutional protection. See United States v. Westinghouse, 638 F.2d 570, 577 (3 Cir.1980); Doe v. Barrington, supra, 729 F.Supp. at 382.

Notwithstanding the strong policy in favor of the physicianpatient privilege and the ensuing obligation of confidentiality, exceptions to the privilege have been widely recognized. In Hague v. Williams, 37 N.J 328,181 A.2d 345 (1962), which predates N.J.S.A. 2A:84A-22.1 et seq., plaintiff claimed damages as a result of the disclosure of a child's condition to an insurance carrier. The Supreme Court noted both a "public interest" and a "private interest of the patient" exception to the privilege. In McIntosh v. Milano, 168 NJSuper. 466, 403 A.2d 500 (Law Div.1979) Judge Petrella discussed the concept of the "duty to warn" third parties as an exception to the general rule of confidentiality. McIntosh noted that the Principles of Medical Ethics recognizes the non-absolute nature of the obligation of confidentiality.

A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community. [American Medical Association, Principles of Medical Ethics (1957) 9; McIntosh v. Milano, supra, 168 N.J. Super. at 491, 403 A.2d 500]

See also Tarasoff v. Regents of Univ. of California, 17 Ca 1. 3d 425, 551 P.2d 334,131 Cal.Rptr. 14 (1976). [footnote 10]

An additional exception to the concept of confidentiality is a physician's or hospital's statutory obligation to report contagious diseases to health authorities. N.J.S.A. 26:4-15 requires that "[e]very physician shall, within 12 hours after his diagnosis that a person is ill or infected with a communicable disease ... report such diagnosis and such related information as may be required by the State Department of Health." N.J.S.A. 26:4-19 similarly requires that the supervisor of a public or private institution report to the local health board any diagnosis of a contagious disease made within the institution. N.J.A.C. 8:57-1.3 sets forth a list of communicable diseases reportable by physicians. The list was amended in 1983, effective March 7, 1982, to require that patients diagnosed with PCP-plaintiff's diagnosed condition-be reported to the New Jersey Department of Health.

[6] Certainly, a most apparent exception to the general rule of

confidentiality is the implied right to make available to others involved in the patient's care information necessary to that care. Plaintiff does not argue that the legitimate disclosure of his medical information under this patient care exception is a basis of his cause of action. Both N.J.S.A. 2A:84A-22.2 and the recently enacted provisions of N.J.S.A. 26:5C-8 (which postdate the events in this matter) allow for the dissemination of a patient's records and information

...[t]o qualified personnel involved in the medical education or in the diagnosis and treatment of the person who is the subject of the record. Disclosure is limited to only personnel directly involved in medical education or in the diagnosis and treatment of the person.

It is against this basic policy and statutory framework that the conduct of a hospital dealing with an AIDS patient must be measured. [footnote 11]

/* Continuted in part 2 */