/* Behringer, part 2 */

[7] The present day public perception of AIDS was an important consideration in the adoption and implementation of procedures established by the department of health and the medical center. The impact of the public perception has been widely recognized.

Individuals infected with HIV, whether HCP [health care professional] or patient, are concerned with maintaining the confidentiality of their health status. HIV infection is associated with sexual practice and drug use, universally regarded as personal and sensitive activities. In addition, the majority of people infected with HIV in the United States are members of groups that are traditionally disfavored. Even before the AIDS epidemic, gays and intravenous (IV) drug users were subject to persistent prejudice and discrimination. AIDS brings with it a special stigma. Attitude surveys show that even though most Americans understand the modes through which HIV is spread, a significant minority still would exclude those who are HIV-positive from schools, public accommodations, and the workplace. Unauthorized disclosure of a person's serologic status can lead to social opprobrium among family and friends, as well as loss of employment, housing and insurance. [Gostin, op. cit. supra at 46; footnotes omitted]

Intimately involved with the issue of confidentiality are the issues of pretest counselling and informed consent of the patient to allow the hospital to test. In May 1986, Ilana B. Pachter, M.D. of the medical center department of laboratories advised the medical and dental staff as follows:

Because of the far-reaching social and personal consequences of both the request for this test and the results of this test, it is recommended that patients never be tested without their knowledge and that appropriate written informed consent be obtained prior to performance of the HTLV-III ELISA test. The test should not be ordered using the blanket consent on hospital admission.

To fully implement an intelligent informed consent, [footnote 12] the department of health with both Selwyn and Day concurring, agreed that there must be pretest counselling of a patient prior to the administration of the HIV-test. This need has been widely recognized by the health care institutions, as well.

Hospitals that perform HIV tests for any purpose must recognize the extreme sensitivities associated with these tests by adopting policies that address the use of informed consent, the standards for using an HIV test as a screening device, notification of patients, the need for counseling, the appropriate use of test results to influence treatment decisions, and the maintenance of confidentiality of information about HIV status....

Hospitals routinely seek a general consent to treatment when a patient is admitted. Specific consents for individual laboratory tests for diagnostic procedures are rarely sought. ... But because a positive HIV test can have profound implications for an individual's health and lifestyle, it is widely accepted that patients should receive information about the implications of HIV testing before and after the test is performed. Patients who have been advised of the implications of testing beforehand may be better prepared to cope with the ramifications of a positive result....

The Committee recommends that when an HIV test is performed for any reason other than blind epidemiologic studies on HIV prevalence, the informed consent of the patient should be obtained. The physician is the most appropriate person to seek consent because he or she can fully explain the nature of the test and its implications. In obtaining the consent, the individual requesting the test should explain the reasons for conducting the test, describe the way in which the test results may affect the patient's care, review the personal significance for the patient of the possible results of the test, and arrange for appropriate counseling as determined necessary by the physician. [American Hospital Association, AIDS/HIV Infection Policy: Ensuring a Safe Hospital Environment, (November 1987) iv-v; see also New Jersey Hospital Association, Guidelines for Meeting the Challenges of AIDS (1988) adopting a similar policy]

In March, 1986, the New Jersey Department of Health circulated a memorandum to physicians and hospitals stressing the need for patient counselling in the administration and interpretation of HIV testing. In June 1987, when plaintiff was admitted to the medical center, counselling was a critical procedure.

While the immediate obligation of person-to-person counselling rests with the physician in charge of the case, the health care facility is still intimately involved in the counselling process. The record is devoid of any evidence that pretest counselling was administered to plaintiff either by the treating physician or by hospital personnel. More significantly, however, the form issued under the name of and utilized by the medical center for fulfilling the informed consent requirement is troublesome on its face. The form prepared by the medical center contained the following language:

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. [Emphasis supplied)

The form mentions a report only to the ordering physician. The procedures utilized by the medical center not only included a report to the attending physician; but, more significantly, allowed for placement of the test results on the chart without limitation on the availability and access of the chart to

the entire medical center community. While the regulations of the medical center appear to impose limits on access, Doody's testimony revealed that access to the chart by medical center personnel was virtually without restriction. Whatever assurance the patient received from the consent form as to the confidentiality of the test was dispelled by the charting of the results and the failure of the medical center to inform the patient of the potential for public exposure through the chart of the test records.

The issue of charting was the subject of intense debate between Selwyn and Day. Selwyn urged that the chart, or at least the test results, be available on a "need to know" basis with HIV test results being sequestered in a different location. Day, on the other hand, called for open access to the chart and test results because of the HCW's need to have full knowledge of the patient's condition in case of emergency or otherwise. When considering the issue in terms of a physician as a patient in his own hospital, the need for careful treatment of diagnostic or other medical information becomes more acute. Professor Gostin commented specifically in reference to HIV-positive physicians:

... physicians have strong grounds for desiring personal privacy and confidentiality of medical information. Their cooperation with the hospital in protecting against the spread of infections relies upon their trust that their serological status will be kept confidential. [Gostin, "HIV-Infected Physicians and the Practice of Seriously Invasive Procedures," Hastings Center Rep. (Jan.-Feb. 1989) at 32, 36.]

The significance of the concern expressed by Gostin was not lost on the infectious disease specialist or Lee. Notwithstanding that the results of plaintiff's HIV test were known on June 17, the results were not charted until late in the day of June 18, 1987 at about the time or just after plaintiff's discharge. Both physicians understood that charting of the results would lead to widespread disclosure of results. The decision as to timing was made with a clear knowledge that the results of the charting were entirely foreseeable. Unfortunately, the prophesy of the knowledge of the test results was fulfilled, and once the results were charted, the die was cast According to Lee, both he and the infectious disease specialist made an additional determination-not to notify Doody of the test results. All parties could and did predict a foreseeable result that was obvious.

[8-10] The medical center's disregard for the importance of preserving the confidentiality of plaintiff's patient medical records was evident even before the charting of the HIV test results. A review of plaintiff's hospital chart reveals not only the HIV test results, but the results of the bronchoscopy-PCP-which all concede was a definitive diagnosis of AIDS. While the medical center argues that the decision regarding charting is one for the physicians to make, the medical center cannot avoid liability on that basis. It is not the charting per se that generates the issue; it is the easy accessibility to the

charts and the lack of any meaningful medical center policy or procedure to limit access that causes the breach to occur. Where the impact of such accessibility is so clearly foreseeable, it is incumbent on the medical center, as the custodian of the charts, to take such reasonable measures as are necessary to insure that confidentiality. Failure to take such steps is negligence. See Martin v. Bengue, Inc., 25 N.J 359,136 A.2d 626 (1957); Menth v. Breeze Corp. Inc., 4 NJ 428, 73 A.2d 183 (1950); Avedisian v. Admiral Realty Corp., 63 NJSuper. 129, 164 A.2d 188 (App.Div.1960); Andreoli v. Natural Gas Co., 57 NJSuper. 356,154 A.2d 726 (App.Div.1959); Glaser v. Hackensack Water Co., 49 N.J Super. 591,141 A.2d 117 (App.Div. 1958); Lutz v. Westwood Transp. Co. 31 N.J Super. 285, 106 A.2d 329 (App.Div.1954), certif den. 16 NJ 205,108 A.2d 120 (1954). The argument that such information may have been transmitted by employees acting beyond the scope of their employment is not persuasive. The requirement of confidentiality is to protect the patient. This was not a patient hospitalized for a trivial or common-place malady. Insuring confidentiality becomes a matter of prime concern. The failure to recognize the potential for employee breach of confidentiality provides no defense. See National Premium Budget Plan Corp. v. National Fire Ins. Co., 97 N.J.Super. 149, 234 A.2d 683 (Law Div. 1967), aff'd 106 NJSuper. 238, 254 A.2d 819 (App.Div.1969), certif. den. 54 NJ 515, 257 A.2d 113 (1969); and see Restatement, Torts 449 (1965), which states:

If the likelihood that a third person may act in a particular manner is the hazard or one of the hazards which makes the actor negligent, such an act whether innocent, negligent, intentionally tortious, or criminal does not prevent the actor from being liable for harm caused thereby. [at 223, 234 A.2d 683]

Insuring confidentiality even by medical center employees required more, in the present case, than simply instructing employees that medical records are confidential. The charts are kept under the control of the medical center with full knowledge of the accessibility of such charts to virtually all medical center personnel whether authorized or not. Little, if any, action was taken to establish any policy or procedure for dealing with a chart such as plaintiff's.

In Doe v. Barrington, supra, Judge Brotman discussed the privacy basis for confidentiality of an AIDS diagnosis.

The sensitive nature of medical information about AIDS makes a compelling argument for keeping this information confidential. Society's moral judgments about the high-risk activities associated with the disease, including sexual relations and drug use, make the information of the most personal kind. Also, the privacy interest in one's exposure to the AIDS virus is even greater than one's privacy interest in ordinary medical records because of the stigma that attaches with the disease. The potential for harm in the event of a nonconsensual disclosure is substantial. ... [footnote 12] [729

F.Supp. at 884]

12. The "potential for harm" is demonstrated not only by the impact on plaintiff, but by numerous similar circumstances caused by a hysterical public reaction to AIDS. Judge Brotman cited a few examples: removal of a teacher with AIDS from teaching duties; refusal to rent an apartment to male homosexuals for fear of AIDS; firebombing of the home of hemophiliac children who tested positive for AIDS; refusal by doctors and health care workers to treat people with or suspected of having AIDS; refusal of co-workers of an AIDS victim to use a truck used by the victim; filing of a charge of attempted murder against an AIDS victim who spat at police; requiring an AIDS victim to wear a mask in a courtroom; denial to children with AIDS of access to schools; threatening to evict a physician who treated homosexuals: boycotting of a public school after a child with AIDS was allowed to attend; firing of homosexuals who displayed cold symptoms or rashes; refusal of paramedics to treat a heart attack victim for fear he had AIDS; refusal by police to drive an AIDS victim to the hospital; police demands for rubber masks and gloves when dealing with gays; refusal to hire Haitians; and urging of funeral directors not to embalm the bodies of AIDS victims. Doe v. Barrington, supra 729 F.Supp. at 384, n. 5; citations omitted.

[11,12] Because the stakes are so high in the case of a physician being treated at his own hospital, it is imperative that the hospital take reasonable steps to insure the confidentiality of not only an HIV test result, but a diagnosis which is conclusive of AIDS, such as PCP. These precautions may include a securing of the chart, with access only to those HCWs demonstrating to designated record-keepers a bona-fide need to know, or utilizing sequestration procedures for those portions of the record containing such information. While a designation in a chart of sequestered information such as a diagnosis or test result may lead to speculation or rumor among persons not having access to the chart, this speculation is an acceptable cost to prevent free access to a chart where real information improperly disseminated will cause untold harm. This court recognizes that in some circumstances, such as rounds at a teaching hospital, exposure to a patient's records must be greater than to solely physicians or students directly involved in the patient's care. It is incumbent upon the hospital to impress upon these physicians or students the significance of maintaining the confi-dentiality of patient records.

The issue of the confidentiality of hospital records of AIDS-positive physicians was addressed in X v. Y, 2 All E.R. 649 (Q.B.1987). In X v. Y, plaintiff, a British health authority, sought an injunction against defendant, a newspaper reporter, from publishing information about two physicians who were AIDS-positive and continuing in practice. In balancing the interests of a free press with the rights of a patient, the court held that the public interest in preserving the confidentiality of these hospital records outweighed the public

interest in a free press.

On the one hand, there are the public interests in having a free press and an informed public debate; on the other, it is in the public interest that actual or potential AIDS sufferers should be able to resort to hospitals without fear of this being revealed, that those owing duties of confidence in their employment should be loyal and should not disclose confidential matters and that, prima facie, no one should be allowed to use information extracted in breach of confidence from hospital records even if disclosure of the particular information may not give rise to immediately apparent harm. [Id. at 660]

The court went on to note:

I keep in the forefront of my mind the very important public interest in freedom of the press. And I accept that there is some public interest in knowing that which the defendants seek to publish (in whichever version). But in my judgment those public interests are substantially outweighed when measured against the public interests in relation to loyalty and confidentiality both generally and with particular reference to AIDS patients' hospital records.... The records of hospital patients, particularly those suffering from this appalling condition should, in my judgment, be as confidential as the courts can properly keep them in order that the plaintiffs may be free from suspicion that they are harbouring disloyal employees'.... [Id. at 661]

The present case involves no competing interest, such as a free press. The confidentiality breached in the present case is simply grist for a gossip mill with little concern for the impact of disclosure on the patient. While one can legitimately question the good judgment of a practicing physician choosing to undergo HIV testing or a bronchoscopy procedure at the same hospital where he practices, this apparent error in judgment does not relieve the medical center of its underlying obligation to protect its patients against the dissemination of confidential information. It makes little difference to identify those who "spread the news." The information was too easily available, too titillating to disregard. All that was required was a glance at a chart, and the written words became whispers and the whispers became roars. And common sense told all that this would happen.

This court holds that the failure of the medical center and Lee as director of the department of laboratories, who were together responsible for developing the misstated informed consent form, the counselling procedure and implementation of the charting protocol, to take reasonable steps to maintain the confidentiality of plaintiff's medical records, while plaintiff was a patient, was a breach of the medical center's duty and obligation to keep such records confidential. The medical center is liable for damages caused by this breach.

IV.

[13] Plaintiff, as a physician, asserts a cause of action under the New Jersey Law Against Discrimination (LAD), N.J.S.A. 10:5-4.1, [footnote 13] based on the restriction and ultimate curtailment of plaintiff's surgical privileges at the medical center. [footnote 14]

[14, 15] New Jersey prohibits unlawful discrimination, or any unlawful employment practice, against a person in a place of public accommodation on the basis that that person is handicapped. N.J.S.A. 10:5-4.1. A review of the definitional sections of the LAD bring both the medical center and plaintiff within its scope. A hospital such as the medical center falls within the definition of a place of public accommodation. N.J.S.A. 10:55(l). Plaintiff has abandoned his argument that he was an "employee" of the medical center. Plaintiff relies on N.J.S.A. 10:512(l), which provides that it shall be unlawful discrimination:

For any person to refuse to buy from, sell to, lease from or to, license, contract with or trade with, provide goods, services or information to, or otherwise do business with any other person on the basis of the race, creed. color, national origin, ancestry, age, sex, marital status, liability for service in the Armed Forces of the United States, or nationality of such other person.... [Emphasis supplied]

The medical center argues that the relationship of a surgeon to a hospital or an operating room is not one which falls under the privilege of the LAD.

In determining the applicability of the LAD to plaintiff, certain basic policy considerations must be stated. New Jersey has historically been "in the vanguard in the fight to eradicate the cancer of unlawful discrimination of all types from our society." Peper v. Princeton University, 77 N.J 55, 80, 389 A.2d 465 (1978). The LAD is to be liberally interpreted with due regard for "its remedial nature" and "humanitarian concerns." Panettieri v. C.V. Hill Refrig., 159 N.J.Super. 472, 483, 388 A.2d 630 (App.Div.1978).

The medical center asserts that not only is there no employer-employee relationship between the surgeon and the hospital, but there is insufficient evidence of "control" over the surgeon to warrant the application of the broad provisions of N.J.S.A. 10:512. The proofs presented indicate otherwise. The surgeon must be approved and accepted by the medical and dental staff and ultimately the board of trustees. In addition, the surgeon is subject to the by-laws of the medical center and its regulatory authority over those who practice there. The surgeon is subject to peer review and other methods of control over his or her practice. While there is not the relationship of employer - employee, the providing of a fully equipped, fully staffed, regulated and controlled operating room to a surgeon whose practice in the medical facility has been passed on and approved by the medical facility is sufficient to bring that surgeon within the scope of N.J.S.A. 10:512. See Desai

v. St. Barnabas Medical Center, 103 NJ 79, 510 A.2d 662 (1986); Berman v. Valley Hosp., 103 NJ 100, 510 A.2d 673 (1986); Belmar v. Cipolla, 96 NJ 199, 475 A.2d 533 (1984).

[16] The statute only applies, however, if plaintiff is determined to be handicapped. N.J.S.A. 10:54.1. In Poff v. Caro, 228 NJSuper. 370, 549 A.2d 900 (Law Div.1987), the Law Division determined, in the context of a refusal to rent to homosexuals, that "a person suffering from AIDS clearly has a severe handicap within the meaning of the Law Against Discrimination." Id. at 376, 549 A.2d 900.

Courts in other jurisdictions have universally held that AIDS is a handicap within the meaning of laws prohibiting handicap discrimination. Both federal trial and courts of appeal have held AIDS to be a handicap protected under the Rehabilitation Act of 1973, 29 USCA 794, which prohibits discrimination against the handicapped by recipients of federal funds. See, e.g., Chalk v. United States District Court, 840 F2d 701 (9 Cir.1988); Doe v. Dolton Elementary School Dist. No. 148, 694 F.Supp. 440 (N.D.Ill.1988); Ray v. School Dist. of DeSoto County, 666 FSupp. 1524 (M.D.Fla.1987). Likewise, various state courts have held AIDS to be a qualified handicap under their respective discrimination laws. See, e.g., Cronan v. New England Tel. Co., 41 FEP Cases 1273 (Mass.Super.Ct.1986). Cf School Bd. of Nassau Cty, Fla. v. Arline, 480 U.S. 273,107 S.Ct. 1123, 94 L.Ed.2d 307 (1987).

Plaintiff, as a surgeon suffering from AIDS, was protected by the LAD. [footnote 15]

Plaintiff's claim requires an examination of the restrictions placed on the exercise of his surgical privileges from June 1987, until his death on July 2, 1989. The restrictions took different forms during that period:

a) initially Doody cancelled all of plaintiff's surgery, pending review by the president of the medical and dental staff and chairman of the department of surgery;

b) thereafter, plaintiff's patients were required to sign an informed consent form, noting that plaintiff was HIV positive; and

c) finally, the medical center adopted a "policy" agreed to by the medical and dental staff and the trustees, limiting "any activity" including surgical procedures "that creates a risk of transmission of the disease to others." The adoption of this policy did not eliminate the use of the informed consent form.

The Supreme Court has set forth several standards which must be considered by a court reviewing hospital actions and policies. In Desai v. St. Barnabas Medical Center, supra, the Supreme Court noted that if a hospital policy decision reasonably serves an "evident public health purpose," it will

be sustained notwithstanding that the ultimate effect of the policy may be discriminatory. 103 N.J at 91, 510 A.2d 662. Notwithstanding the narrow standard of review articulated in Desai, the Supreme Court in Nanavati v. Burdette Tomlin Mem. Hosp., 107 N.J. 240, 526 A.2d 697 (1987), emphasized the importance of scrutinizing such policy when its effect is the revocation of staff privileges.

The test for judicial review of such a decision is whether it is supported by 'sufficient reliable evidence, even though of a hearsay nature, to justify the result'...

Underlying the more relaxed standard is our growing awareness that courts should allow hospitals, as long as they proceed fairly, to run their own business.

That sense is tempered by the recognition that doctors need staff privileges to serve their patients, and that the public interest requires that hospitals treat doctors fairly in making decisions about those privileges. Notwithstanding our more indulgent review of hospital decisions, a decision denying or revoking staff privileges merits a closer look than a decision setting the standard for the determination of those privileges. [Id. at 249250, 526 A.2d 697, citations omitted]

While neither Nanavati nor Desai dealt with rights established by the LAD, certainly the cautions expressed in Nanavati become paramount considerations in balancing the critical rights of the hospital and the equally important rights of a doctor alleging discriminatory conduct The medical center concedes that the action taken against plaintiff was a result of his AIDS diagnosis and the concern for the hospital and patients that the handicap generated.

[17] In the present case, by conceding that the only reason for suspending or terminating privileges is the positive AIDS diagnosis, a handicap protected by the statute, the medical center cannot dispute that plaintiff has established a prima facie case of discrimination under the LAD. Clowes v. Terminex Int'l, Inc., 109 NJ 575, 597, 538 A.2d 794 (1988); Andersen v. Exxon Corp., 89 NJ 483, 492, 446 A.2d 486 (1982).

[18, 19] By way of defense, the medical center asserts that the circumstances of plaintiff's condition and the effect thereof is sufficient basis for restricting plaintiff's privileges. In deter-mining whether a surgeon with AIDS may legitimately be restricted in his surgical privileges under the LAD, the test to be applied is whether the continuation of surgical privileges, which necessarily encompasses invasive procedures, poses a "reasonable probability of substantial harm" to others, including co-employees and, more importantly, patients. Jansen v. Food Circus Supermarkets, 110 NJ 363, 374-375, 541 A.2d 682 (1988); N.J.A.C. 13:13-2.8. There must be a "materially enhanced risk of serious injury." Jansen v. Food Circus Supermarkets, supra,

110 NJ at 376, 541 A.2d 682. And, critical to this case, there must be a distinction between the risk of an incident taking place and the risk of injury from such incident. In the present case both parties agree that the risk of incident, i.e., transmission of the HIV virus from physician to patient, is small, but that the risk of injury from such transmission is high, i.e., death.

In asserting a defense based on safety of patients and hospital personnel, the medical center assumes the burden of "establish[ing] with a reasonable degree of certainty that it reasonably arrived at the opinion that the employee's handicap presented a materially enhanced risk of substantial harm in the workplace." Id. at 383, 541 A.2d 682.

At the time of plaintiff's diagnosis, little was known about the potential transmission of HIV from surgeon to patient. While no "reported cases" were known to the experts-Selwyn or Day-neither disputed that there was such a risk. Selwyn interpreted the risk to be virtually nonexistent statistically; Day urged that the risk was real and greater than that revealed by the then-existing statistics. Both experts agreed that once HIV is transmitted and the patient contracted AIDS, the prognosis is death.

The medical center made painstaking inquiries to determine a proper result. The medical and dental staff, board of trustees, biomedical ethics committee, joint committees and various other groups all convened to discuss and debate the appropriate action to be taken. A review of the minutes of the various committees meeting on the subject reveals point and counterpoint as to all critical issues. Harsh debate ensued between the medical and dental staff and the medical center administration. Studies were produced from the CDC, epidemiologists and medical ethicists. The issue was fully aired. [footnote 16]

[20] The ultimate resolution reached by the medical center restricting invasive procedures where there is "any risk to the patient," coupled with informed consent, implicates serious policy considerations which must be explored. It is axiomatic that physicians performing invasive procedures should not knowingly place a patient at risk because of the physician's physical condition. Gostin, op. cit., supra at 34. The policy adopted by the medical center barring "any procedures that pose any risk of virus transmission to the patient" appears to preclude, on its face, the necessity of an informed consent form; if there is "any risk," the procedure cannot be performed. The problem created by the "any risk" standard is best evidenced by the facts of this case. When Doody made his initial decision to cancel plaintiff's scheduled surgical procedures, he did so over the objection of both the president of the medical and dental staff as well as the chairman of the department of surgery. In fact, the chairman went so far as to write:

... I have done some reading, research into this the past several months. From all I can find a doctor, surgeon, with AIDS cannot give this to his patient

as long as usual precautions are taken ... while operating. I believe he should be allowed to carry on as long as his general health status allows. I will admit him in surgery when possible if he desires.

Reasonable persons professing knowledge of the subject matter may differ as to whether there is "any" risk involved in an invasive surgical procedure by a surgeon carrying a disease that will lead to his death and, if transmitted during the surgical procedure, to the death of the patient. This court is well aware of the admonition expressed in Desai, as well as the concern expressed by Chief Justice Hughes in In re Quinlan, 70 NJ 10, 355 A.2d 647 (1976), when he stated for the Court:

Doctors *** to treat a patient, must deal with medical tradition and past case histories. They must be guided by what they do know. The extent of their training, their experience, consultation with other physicians. must guide their decision-making processes in providing care to their patient. The nature, extent and duration of care by societal standards is the responsibility of a physician. The morality and conscience of our society places this responsibility in the hands of the physician. What justification is there to remove it from the control of the medical profession and place it in the hands of the courts?

Such notions as to the distribution of responsibility, heretofore generally entertained, should however neither impede this Court in deciding matters clearly justiciable nor preclude a reexamination by the Court as to underlying human values and rights. Determinations as to these must, in the ultimate, be responsive not only to the concepts of medicine but also to the common moral judgment of the community at large. In the latter respect the Court has a non-delegable judicial responsibility. Id. at 44, 355 A.2d 647; citations omitted]

This court, too, must be concerned that the medical center decision-makers, while no doubt acting in good faith in the decision-making process, are acting with the knowledge that their decisions may well affect their ultimate ability to practice their chosen profession.

Nevertheless, there must be a way to free physicians. in the pursuit of their healing vocation, from possible contamination by self-interest or self-protection concerns which would inhibit their independent medical judgments for the well-being of their ... patients. [Id. at 49, 355 A.2d 647.]

There are principles of law that guard against the concern for self-interest, by including in the decision-making process the most critical participant -- the patient. The doctrine of informed consent, as an adjunct to the adopted medical center "any risk" policy, provides the necessary element of patient control which is lacking from the policy standing alone.

[21, 22] Before a physician may perform a surgical or invasive procedure

upon a patient, he must obtain the patient's informed consent.

[Informed consent] is essentially a negligence concept, predicated on the duty of a physician to disclose to a patient such information as will enable the patient to make an evaluation of the nature of the treatment and of any attendant substantial risks, as well as of available options in the form of alternative therapies. See in re Conroy, 98 NJ 321, 346 [486 A.2d 1209] (1985); Perna v. Pirozzi, supra, 92 NJ [446] at 459 [457 A.2d 431] (1983); Canterbury v. Spence, supra 464 F2d [772] at 780 [(C.A.D.C.1972)]; Kaplan v. Haines, supra. 96 N.J.Super. [242] at 255-258 [232 A.2d 840] [(1967)]. [Largey v. Rothman, supra, 110 NJ at 204 at 208, 540 A.2d 504 (1988)]

The physician exposing the patient to a course of treatment has a duty to explain, in terms understandable to the patient, what the physician proposes to do. The purpose of this legal requirement is to protect each person's right to self-determination in matters of medical treatment. See In re Farrell, 108 NJ 335, 347, 529 A.2d 404 (1987). The physician's duty is to explain, in words the patient can understand, that medical information and those risks which are material. Medical information or a risk of a medical procedure is material when a reasonable patient would be likely to attach significance to it in deciding whether or not to submit to the treatment.

[23] Taking into account what the physician knows or should know to be the patient's informational needs, the physician must make reasonable disclosure of the information and those risks which a reasonably prudent patient would consider material or significant in making the decision about what course of treatment, if any, to accept. Such information would generally include a description of the patient's physical condition, the purposes and advantages of the proposed surgery, the material risks of the proposed surgery, and the material risks if such surgery is not provided. In addition, the physician should discuss all available options or alternatives and their advantages and risks. Largey v. Rothman, supra, 110 N.J. at 211, 540 A.2d 504.

[24] Plaintiff argues: 1) the risk of transmission of HIV from surgeon to patient is too remote to require informed consent, and 2) the law of informed consent does not require disclosure of the condition of the surgeon. [footnote 17]

[25] Both parties focus on the risk of transmission and results therefrom in applying the two standards raised in plaintiff's claim under the LAD. The Jansen standard states that the risk must be one which will create a "reasonable probability of substantial harm," and the Largey standard requires disclosure of a "material risk" or one to which a reasonable patient would likely attach significance in determining whether to proceed with the proposed procedure. It is the court's view that the risk of transmission is not the sole risk involved. The risk of a surgical accident, i.e., a needlestick or

scalpel cut, during surgery performed by an HIV-positive surgeon, may subject a previously uninfected patient to months or even years of continual HIV testing. Both of these risks are sufficient to meet the Jansen standard of "probability of harm" and the Largey standard requiring disclosure.

[26] Both Selwyn and Day agreed that the statistical risk of transmission from health care worker to patient is small -- less than one-half of one percent. At the time of trial, there were no reported cases of transmission. See n. 9, supra at 630, 592 A.2d at 1267. But the statistical analysis is flawed. Gostin noted the following:

There has been no scrutiny of transmission of HIV from physicians to patients, and there is no recorded case where it has occurred. This is not surprising since there has been no systematic attempt to discover which physicians are HIV positive. [footnote 18] But there has been careful examination of transmission from patient to health care worker, and some indication of the level of risk in both directions can be ascertained. The possibility of transmission in health care settings has been demonstrated by approximately sixteen cases where health care workers seroconverted from occupational exposure to HIV ....

Physicians performing seriously invasive procedures, such as surgeons, have a potential to cut or puncture their skin with sharp surgical instruments, needles, or bone fragments. Studies indicate that a surgeon will cut a glove in approximately one out of every four cases, and probably sustain a significant skin cut in one out of every forty cases. Given these data, it has been calculated that the risk of contracting HIV in a single surgical operation on an HIV-infected patient is remote -- in the range of 1/130,000 to 1/4,500. [footnotes omitted]

It is impossible accurately to calculate the level of risk of HIV transmission from surgeon to patient Surgeons who cut or puncture themselves do not necessarily expose the patient to their blood, and even if they do the volume is extremely small. A small inoculum of contaminated blood is unlikely to transmit the virus. This suggests that the risk of infection from surgeon to patient is much lower than in the opposite direction. Nonetheless, the fact that the surgeon is in significant contact with the patient's blood and organs, together with the high rate of torn gloves, makes it reasonable to assume that the risk runs in both directions, as is the case with the hepatitis B virus. The cumulative risk to surgical patients, arguably, is higher. While an HIV-infected patient is likely to have relatively few seriously invasive procedures, the infected surgeon, even if the virus drastically shortens his surgical career, can be expected to perform numerous operations. Assuming that the surgical patient's risk is exceedingly low (1/130,000), the risk that one of his patients will contract HIV becomes more realistic the more operations he performs, 1/1,300 (assuming 100 operations) or 1/126 (assuming 500 operations). Patients, of course, cannot expect a wholly risk-free

environment in a hospital. But there does come a point where the risk of a detrimental outcome becomes sufficiently real that it is prudent for the profession to establish guidelines. [Gostin, op. cit., supra at 33]

While the debate will rage long into the future as to the quantifiable risk of HIV transmission from doctor to patient, there is little disagreement that a risk of transmission, however small, does exist. This risk may be reduced by the use of universal precautions, such as double gloving and the use of goggles and other similar devices.

In quantifying the risk, one must consider not only statistical data, but the nature of the procedure being performed. Plaintiff was a surgeon who specialized in surgery performed in the ear and mouth cavities. As Day indicated, much of plaintiff's surgery involved contact with the mucous membrane-an area particularly susceptible to transmission of HIV should the surgeon incur a surgical accident involving the potential for exchange of blood.

In addition, the quantifiable risk of transmission is not dispositive of either the "materiality" or "risk of harm" issue. As Day testified, the risk of a surgical accident, such as a scalpel cut or needle stick, where there is exposure to the HIV-positive surgeon's blood will cause a patient to be exposed to the testing required by CDC recommendation no. 5, supra, notes 7 and 8. This includes HIV testing over an extended period with the attendant anxiety of waiting for test results, and the possible alterations to life style and child-bearing during the testing period, even if those results ultimately are negative. The risk of surgical accidents was quantified by Day and Selwyn as exceeding five percent, although, as set forth above, Gostin estimates glove cuts at 25% and significant skin cuts at 2 1/2 percent. Gostin, op. cit., supra at 33. In assessing the "materiality of risk," this court concludes that the risk of accident and implications thereof would be a legitimate concern to the surgical patient, warranting disclosure of this risk in the informed consent setting. It is inconsistent with the underlying policy considerations expressed in Largey to suggest that the patient should be informed after the fact of the need for HIV testing and surveillance.

In balancing quantifiable risk with the necessity of informed consent, one must recognize the strong commitment of the New Jersey courts to the concept of a fully informed patient. Niemiera v. Schneider, 114 NJ 550, 555 A.2d 1112 (1989); Largey v. Rothman, supra. Plaintiff argues that the use of the in-formed consent form is tantamount to a de facto termination of surgical privileges. Plaintiff further urges that patient reaction is likely to be based more on public hysteria than on a studied assessment of the actual risk involved. The answer to these arguments is twofold. First, it is the duty of the surgeon utilizing the informed consent procedure to explain to the patient the real risk involved. If the patient's fear is without basis, it is likewise the duty of the surgeon to allay that fear. This court recognizes that

the burden imposed on the surgeon may not be surmountable absent further education of both the public and the medical community about the realities of HIV and AIDS. Second, the difficulties created by the public reaction to AIDS cannot deprive the patient of making the ultimate decision where the ultimate risk is so significant The last word has not been spoken on the issue of transmission of HIV and AIDS. Facts accepted at one point in time are no longer accurate as more is learned about this disease and its transmission. See n. 9 supra.

Plaintiff further argues that there is no requirement under the doctrine of informed consent that a surgeon's physical condition be revealed as a risk of the surgery itself. The informed consent cases are not so narrow as to support that argument. In Largey v. Rothman, supra, the court spoke of not only an evaluation of the nature of the treatment, but of "any attendant substantial risks." [footnote 19] 110 NJ at 208, 540 A.2d 504. See also Kaplan v. Haines, supra, 96 NJSuper. at 255-258, 232 A.2d 840. As noted earlier, the risks can foreseeably include a needlestick or scalpel cut and, even with universal precautions can result in an exchange of the surgeon's blood.

Plaintiff urges that these issues should be dealt with on a case-by-case basis, wherein the hospital or medical staff monitors an HIV-positive surgeon and makes a determination as to the surgeon's ability to perform a particular invasive procedure.

While this approach may be an appropriate starting point, it can not be dispositive of the issue. Plaintiff's position fails to account for "any risk" and, more important, fails to consider the patient's input into the decision-making process. The position plaintiff seeks to implement is replete with the "anachronistic paternalism" rejected in both Canterbury v. Spence, supra, and by the Supreme Court in Largey v. Rothman, supra.

Plaintiff's assertion that the risk of transmission is so low as to preclude the necessity of restriction on surgical practice or a requirement of informed consent prompts perhaps a different view of the issue. Dr. Gordon G. Keyes suggests:

Instead of anguishing over the precise probability of an HIV-positive provider spreading AIDS to a patient, a more sensible approach weighs the risk posed by HIV positive provider against the value of having these same providers performing invasive health care services. [Keyes, "Health Care Professionals with AIDS: The Risk of Transmission Balanced Against the Interests of Professionals and Institutions," 16 Journal of College and University Law 589, 603 (1990)]

In making this analysis, Keyes suggests utilizing the risk-benefit analysis found in Restatement, Torts 2d, 293(a)-(c) (1965). Under Keyes' theory, there are three elements to be considered:

(a) The social value which the law attaches to the interest which is to be advanced or protected by the conduct....

(b) The extent of the chance that this interest will be advanced or protected by the particular course of conduct....

(c) The extent of the chance that such interest can be adequately advanced or protected by another and less dangerous course of conduct [Keyes, op. cit., supra at 604, n. 114]

The author concludes as follows:

The following criteria determines the magnitude of the risk to the patient:

a. The social value which the law attaches to the interests which are imperiled. The law places a very high value on a patient's safety and well-being.

b. The extent of the chance that the actor's conduct will cause an invasion of any interest of the other.... It is not possible to precisely quantify the chance of spread of HIV to a patient. In general terms, the probability is small but real.

c. The extent of the harm once a patient becomes HIV positive, the likely outcome is death.

Of course risk must be balanced against the utility of a health care provider performing invasive procedures. The Restatement provides an analytical framework for this as well.

For negligence purposes, the utility of the conduct is related to:

(a) The social value which the law attaches to the interest which is to be advanced or protected by the conduct Society and the law have a significant interest in promoting access to medical care .... While society must protect the availability of vital services, there is no need to protect the services of any one provider. Generally, there will be many noninfected providers to replace those who have been restricted from performing invasive procedures.

(b) The extent of the chance that this interest will be advanced or protected by the particular course of conduct Society's interest in promoting acquisition of health care can only occur if providers see patients. Since only a small percentage of all providers will be excluded from performing only one aspect of health care, restrictions due to HIV positivity will only interfere with the provision of a very small fraction of the total health care services. All of these services can be adequately provided by non-infected practitioners. [Id. at 603 604, n. 114; citations omitted]

Summarizing Keyes' broader policy considerations, the restrictions on HIV-positive physicians from providing services, where there is a chance of transmittal from injury and transfer of blood spillage into a surgical site, would have a limited effect on practitioners; the HIV-positive physicians could still practice medicine although precluded from performing invasive procedures. Lastly, the ethical relationship of doctor to patient would require such a restriction on invasive procedures.

Health care providers and institutions should consider ethical aspects of the doctor-patient relationship in examining the risk posed by health care providers infected with HIV. The patient and doctor occupy unequal positions in the relationship. The doctor is trained to recognize. diagnose, and avoid contracting the patient's disease. The doctor stands in a position of trust-a fiduciary position-in relation to the patient. A small but palpable risk of transmitting a lethal disease to the patient gives the doctor an ethical responsibility to perform only procedures that pose no risk of transmission.

The patient, on the other hand, has no corresponding ethical duty to the doctor. The patient is neither trained nor expected to ascertain the provider's health status. While secretive patients may transmit their diseases to unwary doctors, doctors are responsible for both their own health and the health of their patients. [Id. at 605; footnotes omitted]

Professor Gostin has also recognized the availability of alternative medical services as a relevant consideration in the area of informed consent and the larger issue of performance of invasive procedures by HIV-positive physicians. While not adopting Keyes' analysis of the issue, Gostin notes:

Courts, therefore, require the physician to provide all information that a reasonable patient would find relevant to make an informed decision on whether to undergo a medical procedure. Risks that are relevant or "material" depend upon their severity, the probability that they would occur, and the circumstances under which they would be endured. As the severity of a potential harm becomes greater the need to disclose improbable risks grows, though courts have yet to assign a threshold for the probability of a grave harm beyond which it must be disclosed.

A reasonably prudent patient would find 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 physi-cian (where available) he can obtain all the therapeutic benefit without the risk of contracting HIV from his physician. The patient, then, can demon-strate 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. [Gostin, op. cit., supra at 3334; emphasis supplied]

[27] The obligation of a surgeon performing invasive procedures, such as plaintiff, to reveal his AIDS condition, is one which requires a weighing of plaintiff's rights against the patient's rights. New Jersey's strong policy supporting patient rights, weighed against plaintiff's individual right to perform an invasive procedure as a part of the practice of his profession, requires the conclusion that the patient's rights must prevail. At a minimum, the physician must withdraw from performing any invasive procedure which would pose a risk to the patient. Where the ultimate harm is death, even the presence of a low risk of transmission justifies the adoption of a policy which precludes invasive procedures when there is "any" risk of transmission. In the present case, the debate raged as to whether there was "any" risk of transmission, and the informed consent procedure was left in place. If there is to be an ultimate arbiter of whether the patient is to be treated invasively by an AIDS-positive surgeon, the arbiter will be the fully-informed patient. The ultimate risk to the patient is so absolute-so devastating-that it is untenable to argue against informed consent combined with a restriction on procedures which present "any risk" to the patient. [footnote 20]

In assessing the medical center's obligation under the LAD, it is the court's view that the burden under Jansen has been met, and there was a "reasonable probability of substantial harm" if plaintiff continued to perform invasive procedures. Plaintiff is not entitled to recovery under this statute. The medical center acted properly in initially suspending plaintiff's surgical privileges, thereafter imposing a requirement of informed consent and ultimately barring him from performing surgery. These decisions were not made spontaneously or without thought. One need only review the minutes of meeting after meeting where the debate raged and the various competing interests-the medical and dental staff and board-expressed their views. The seeking of input from medical ethicists and attorneys knowledgeable in this area belies any suggestion of prejudgment or arbitrariness on the part of the medical center. The result, while harsh to plaintiff, represents a reasoned and informed response to the problem.

V.

Plaintiff also claims damages as a result of tortious interference with economic relations. These claims are based on the medical center's suspending and restricting plaintiff's surgical privileges. These claims are derivative. Having determined that the actions of the medical center and Doody were proper, this cause of action must fail. To the extent that this cause of action is based on a breach of confidentiality, plaintiff has prevailed on that cause of action and will be entitled to damages therefore.

VI.

A judgment as to liability is granted in favor of plaintiff against defendant medical center and defendant Lee on counts 1, 2, 3 and 6 of the complaint. A judgment is entered in favor of defendant medical center and defendant Doody as to counts 4, 5, and 7, no cause for action.

FOOTNOTES

l. Although plaintiff in this matter is the Estate of William H. Behringer, all references to plaintiff will be to William Behringer.

2. This opinion deals with the issue of liability only. Damages will be dealt with after further briefing by the parties on issues raised by this opinion. The issue of damages will be dealt with by a separate opinion.

3. The implementing provisions of the policy adopted by the medical and dental staff provide as follows:

A known HIV seropositive member of the Medical and Dental Staff may be permitted to continue to admit and care for his patients in the hospital, but shall immediately suspend the performance of all surgical procedures, including surgical assisting. In addition, he shall not perform any procedures that involve piercing the integument, including IV's and phlebotomy. The member of the Medical and Dental Staff may request a review of privileges by his Department Chairman. The staff member's Department Chairman may recredential the member of the Medical and Dental staff with regard to allowing procedures in accordance with the policy for HIV seropositive Health Care Workers approved by the Medical and Dental Staff and Board of Trustees.

4. Hussain, Risk to Surgeons: A Survey of Accidental Injuries During Operations," 75 Brit. J. of Surgery 314 (1988).

5. But see Largey v. Rothman, 110 N.J. 204, 540 A.2d 504 (1958) discussed, in Ira at 651. 592 A.2d at 1279.

6. plaintiff objected to the admissibility and consideration of Day's opinion. The objection was premised on the conclusion that Day's views were outside of the "mainstream of accepted medical views." In addition, plaintiff argued that Day lacked the qualifications to offer opinions on the issue of AIDS transmission and other relevant matters because of her lack of training as an epidemiologist. See Rubanick v. Witco Chemical Corp., 225 N.J Super. 485. 542 A.2d 975 (law Div.1988), revd 242 N.J.Super. 36, 576 A.2d 4 (App.Div.1990). appeal pending - NJ. - (1991). While their conclusions differed about interpretation of terms such as 'significant risk," both Selwyn and Day relied on the same statistical information. The conclusions of the

parties were in dispute, but these conclusions were simply matters of interpretation of information. Both experts met the threshold requirement of establishing a factual and scientific basis for their opinions. Buckelew v. Grossbard 87 NJ 512. 524, 435 A.2d 1150 (1981). While less weight was given to Day's opinion than that of Selwyn, information about operating-room procedures and similar matters was considered and given substantial weight.

7. "Centers for Disease Control, Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type Ill/Lymphadenopathy-Associated Virus during Invasive Procedures," 35 Morbidity and Mortality Weekly Rep. 221-223 (1986).

8. This conclusion reached by Day is supported by the reference to the Centers for Disease Control's, "Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus in the Workplace." 34 Morbidity and Mortality Weekly Rep., 681-686. 69l~95 (1985), noted in recommendation no. 5:

Management of parenteral and mucous membrane exposures of HCWs.

If a HCW has a parenteral (eg., needlestick or cut) or mucous membrane (eg., splash to the eye or mouth) exposure to blood or other body fluids, the source patient should be assessed clinically and epidemiologically to determine the likelihood of HTLV-III/LAV infection. if the assessment suggests that infection may exist, the patient should be informed of the incident and requested' to consent to serologic testing for evidence of HTLV-III/LAV infection. If the source patient has AIDS or other evidence of HTLV-III/LAV infection, declines testing, or has a positive test, the HCW should be evaluated clinically and serologically for evidence of HTLV III/LAV infection as soon as possible after the exposure. and, if seronegative, retested after 6 weeks and on a periodic basis thereafter (eg., 3, 6, and 12 months following exposure) to determine if transmission has occurred. During this follow-up period, especially the first &12 weeks. when most infected persons are expected to seroconvert. exposed HCWs should receive counseling about the risk of infection and follow U.S. Public Health Service (PHS) recommendations for preventing transmission of AIDS (20, 21). (Emphasis supplied)

The same procedure applies with equal force to transmission from health care worker to patient.

Management of parenteral and mucous membrane exposures of patients. If a patient has a parenteral or mucous membrane exposure to blood or other body fluids of a HCW, the patient should be informed of the incident and the same procedure outlined above for exposures of HCWs to patients should be followed for both the source HCW and the potentially exposed patient. Management of this type of exposure will be addressed in more detail in the recommendations for HCWs who perform invasive procedures. (Id. at 684.]

9. A court is bound by the state of medical science at the time of the relevant fact circumstances, not on future speculation. Cf. Doe v. Barrington, supra, 729 FSupp. at 381; Ray v. school District of DeSoto County, 666 F.Supp. 1524, 1529 (M.D.Fla.1987). Subsequent to this trial, a case of transmission from health care worker to patient was reported. Centers for Disease Control, "Possible Transmission of Human Immunodeficiency Virus to a Patient during an Invasive Dental Procedure," 39 Morbidity and Mortality Weekly Rep. 489 (1990); Mishu, "A Surgeon with AIDS," 264 J.A.M.A. 467 (1990).

10. While McIntosh and Tarasoff dealt with the issue of psychotherapist/patient relations, the significance of the "duty to warn" is the subject of much discussion and debate among commentators in the context of both an HIV positive and AIDS - positive patient. See, eg., Hermann and Gagliano, "AIDS, Therapeutic Confidentiality, and Warning Third Parties," 48 MtLRev. 55 (1989); Costin, "Hospitals, Health Care Professionals, and AIDS: The "Right to Know" the Health Status of Professionals and Patients," 48 Md.L.Rev. 12 (1989); Comment, "Doctor-Patient Confidentiality versus Duty to Warn in the Context of AIDS Patients and Their Partners," 47 Md.L.Rev. 675 (1988); Note, "Between a Rock and a Hard Place: AIDS and the Conflicting Physician's Duties of Preventing Disease Transmission and Safeguarding Confidentiality," 76 Geo.L.J. 169 (1987).

11. By amendments to N.J.S.A. 26:5C-1 et seq. (which became effective January 12, 1990), the legislature recently addressed issues of confidentiality in the context of AIDS. N.J.S.A. 26:501 et seq. provides that a health-care facility must maintain the confidentiality of the records of patients diagnosed with AIDS or HIV infection. Information contained in these records may be disclosed only upon written authorization of the patient, with limited exceptions. NJSA. 26:501(b)(3). These disclosure restrictions remain effective after the patient is discharged.

12. The doctrine of informed consent will be discussed in greater detail, infra at 642-43, 592 A.2d at 1274.

13. N.J.S.A. 10:5-4.1 states:

All of the provisions of the act to which this act is a supplement shall be construed to prohibit any unlawful discrimination against any person because such person is or has been at any time handicapped or any unlawful employment practice against such person, unless the nature and extent of the handicap reasonably precludes the performance of the particular employment.

l4. Plaintiff also asserts a cause of action under the LAD based on the breach of confidentiality occuring while plaintiff was a patient. See part III, supra, at 631-32, 592 A.2d at 1268. Plaintiff claims that because of the stigma attached to his condition, the medical center and staff treated the

information differently, i.e., if plaintiff had been hospitalized for a less significant condition, the information would not have been disseminated in the same manner. Plaintiff has failed to establish a cause of action on this theory that plaintiff was treated differently. The different or discriminatory treatment was not to plaintiff. It was the information about plaintiff's condition that was treated differently. Plaintiff's medical records were dealt with in the same manner as any patient's medical records -- an important factor in supporting plaintiff's claim for breach of confidentiality. Plaintiff can not now claim that such treatment which resulted in wide-spread dissemination of information forms the basis of a cause of action under NJSA. 10:54 and 4.1.

15. A peculiar anomaly in this case is that while the disclosure of plaintiff's medical condition and records is protected by the laws of confidentiality and privilege, once plaintiff assumes his role of surgeon, his medical condition must become known so that the issues of dealing with the "handicapped" surgeon can be appropriately resolved by both the surgeon and the medical center. Thus, a whole class of persons became privy to plaintiff's condition, not as a function of a breach of confidentiality, but because of their duties and obligations as persons charged with the responsibility of overseeing and, in some cases, regulating surgical privileges. This included the president of the medical and dental staff, chairman of the surgical department who was informed of the condition by plaintiff personally, president of the medical center and various other personnel in the decision-making process. No claim is made by plaintiff for these disclosures which, under some circumstances may be subject to a qualified privilege. See, e.g., Nanavati v. Burdette Tomlin Memorial Hosp., 107 N.J. 240, 526 A.2d 697 (1987).

16. By letter of July 13, 1987. plaintiff wrote to the president of the medical and dental staff and said, inter alia:

I would appreciate it, if you are to hold a meeting to discuss me and my privileges, that you give me notice and an opportunity to appear before you to provide you with information which I believe will be relevant to your consideration.

Doody forwarded a letter to plaintiff on July 22. 1987. stating, inter alia: [The president of the medical and dental staff] and I have been trying to arrange a meeting with you, but unfortunately you have been unable to do so. I am forwarding this information to you because it is important to your activities at the medical center, but I still would prefer a meeting.

The letter proceeded to outline the procedures to be followed by plaintiff. including monitoring and use of the special informed consent form. The meeting Doody had hoped to arrange never materialized. While plaintiff has placed in issue the substance of the medical center's decision, he has not raised any issue regarding the procedures utilized by the medical center in

its decision-making process.

17. plaintiff also argues that the concept of informed consent has changed as Largey v. Rothman, supra, was decided in May 1988. and the relevant facts took place in June 1987. Under either the "prudent patient" standard as expressed in Largey, or the "reasonable physician" standard set forth in Kaplan v. Haines, 96 NJ. Super. 242, 232 A.2d 840. (App.Div.1967), aff'd 51 N.J. 404, 241 A.2d 235 (1968), the requirement of disclosure would remain the same.

18. This case does not involve nor will this court decide the issue of mandatory screening of physicians for HIV.

19. In addition to the concept of "risk" as a relevant factor in the area of informed consent, the "duty to warn" imposed on a physician provides additional support to conclude that an HIV-positive surgeon is required to inform a patient of his HIV positivity before performing an invasive procedure. The physician's "duty to warn" third parties of dangers created by the physician's patients is recognized in New Jersey. McIntosh v. Milano, supra. So too, physicians have a duty to report to the department of health infectious diseases, N.J.S.A. 26:4-15, including PCP, N.J.A.C. 8:57-1.2. It has been strongly urged that this "duty to warn" extends to third parties associated with AIDS victims. See n. 10, supra. If a physician has a duty to warn third parties of the HIV status of patients who may be, for example, sexual partners of the patient, it could legitimately be argued that the risk of transmission would similarly require the surgeon to warn his own patients.

20. While the chances of a patient acquiring HIV from an infected provider are small, infected patients have transmitted HIV to a dentist and other health care providers when small or inapparent quantities of blood are transferred during clinical procedures. Presumably, small blood transfers from the provider to patient likewise could cause transmission. One infected surgeon may perform many operations, increasing the opportunity for transmission. As small as the risk to any individual patient may be, the aggregate risk thus becomes significant enough that patient safety and prudent risk management dictate restricting infected providers from performing invasive procedures. [Keyes, op. cit., supra at 601-602]