An Indiana Doctor's Duty to Warn Non-Patients at Risk of HIV Infection from an AIDS Patient

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I. Introduction

Acquired Immune Deficiency Syndrome, commonly known as AIDS, is one of the major health problems in the United States. The reason is easy to understand if one looks at the now conventional medical model for AIDS.

1. AIDS is a fatal disease in which the body's immune system is rendered incapable of fighting certain unusual diseases and malignancies which cause the death of the patient.[1]
2. The disease of AIDS is caused by an unusual virus known as the AIDS virus or Human Immunodeficiency Virus (HIV) which attacks the body's immune system rendering it incapable of fighting the deadly diseases.[2] Over a period of years, this

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1. Report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic 7-10 (June 24, 1988) [hereinafter Presidential Report]; "Approximately 10% of HIV-infected persons with symptoms diagnostic of AIDS do live for at least five years." *Id.* at 8; *see also* Surgeon General's Report on Acquired Immune Deficiency Syndrome 9-10 (1987) [hereinafter Surgeon General's Report]; W. Curran, L. Gostin & M. Clark, AIDS: Legal and Regulatory Policy 221-233 (1988) [hereinafter Curran]. *Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome*, 36 Morbidity & Mortality Weekly Rep. Supp. 1, 3S-15S (1987) [hereinafter *CDC Revision*] contains the definition of AIDS by the Center for Disease Control for reporting purposes. As of February 20, 1989, in the United States there were 87,188 cases of AIDS reported to the Center for Disease Control and 49,976 deaths. Telephone interview with Surveillance and Evaluation Branch, U.S. AIDS Program, Center for Infectious Diseases, Center for Disease Control (Feb. 20, 1989). As of January 31, 1989, 451 cases and 236 deaths from AIDS were reported in Indiana. Indiana State Board of Health Indiana Monthly AIDS Summary (Feb. 1, 1989). The Surgeon General's Report, *supra*, at 6, estimates that by the end of 1991 there will have been 270,000 cases of AIDS in the United States.

2. Presidential Report, *supra* note 1, at 2, 7-10; *see also* Surgeon General's Report, *supra* note 1, at 9-10; Curran, *supra* note 1, at 221-26; R. Gallo & L. Montagnier, *AIDS in 1988*, Scientific American, Oct. 1988, at 40. This virus has been known in the scientific community by different names, *e.g.*, HTLV-III (Human T Lymphotropic Virus Type III) and LAV (Lymphodenopathy Associated Virus). By international agreement HIV

virus will likely cause the infected person to develop AIDS.[3] AIDS itself is the end-stage of the HIV infection and earlier stages may be without any signs of illness.[4]

3. Once the virus infects a person it becomes a permanent part of that person's body fluids, *e.g.*, blood, semen, breast milk, urine, saliva, tears, vaginal fluid, etc.[5]
4. The virus is transmissible to other people through the transfer of infected body fluids into the body of another. Theoretically, the virus can be transmitted through any of those body fluids, however, it is firmly believed that it cannot be transmitted by casual contact.[6] The documented cases of transmission in adults have all involved semen (sexual intercourse), and blood (blood transfusions, blood splashes, needle sticks or IV needle sharing).[7]
5. The infected person may be completely without symptoms and unaware of his or her infection. Thus, that person would be unaware that the virus is being transmitted to others.[8]
6. Currently there is no cure or vaccine for the infection or for AIDS itself.[9]

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is now the accepted designation. *CDC Revision*, *supra* note 1, at 15S. It is also accepted that there are two distinct viruses, HIV-1 and HIV-2. The CDC initiated surveillance for HIV-2 in the United States in January 1987 and so far its prevalence is near zero. *AIDS Due to HIV-2 Infection-New Jersey*, 37 Morbidity & Mortality Weekly Rep. 33 (1988). It is estimated that by the end of 1991 there will be 1.5 million persons infected with HIV in the United States. *Quarterly Report to the Domestic Policy Council on the Prevalence and Rate of Spread of HIV and AIDS-United States*, 37 Morbidity & Mortality Weekly Rep. 551 (1988); *see also* Presidential Report, *supra* note 1, at 3.

3. Presidential Report, *supra* note 1, at 8: "Although current data shows that approximately thirty-five percent of infected persons will develop AIDS within six years, some believe that with time it may approach 100 percent."

4. Presidential Report, *supra* note 1, at 7-8.

5. Curran, *supra* note 1, at 228. *See also Update: Universal Precautions for Prevention of Transmission of Human Immunodeficiency Virus, Hepatitus B Virus, and Other Bloodborne Pathogens in Health-Care Settings*, 37 Morbidity & Mortality Weekly Rep. 377 (1988) [hereinafter *Update*].

6. M. Sande, *Transmission of AIDS: The Case Against Casual Contagion*, 314 New Eng. J. Med. 380 (1986); *see also* T. Peterman & J. Curran, *Sexual Transmission of Human Immunodeficiency Virus*, 256 JAMA 2222 (1986).

7. Curran, *supra* note 1, at 228-30; *see also* W. Heyward & J. Curran, *The Epidemiology of AIDS in the U.S.*, Scientific American, Oct. 1988, at 72; *Update*, *supra* note 5, at 377.

8. Presidential Report, *supra* note 1, at 7; *see also* Surgeon General's Report, *supra* note 1, at 10-11; Curran, *supra* note 1, at 232-33.

9. Presidential Report, *supra* note 1, at 47-49; *see also* Surgeon General's Report, *supra* note 1, at 10; Curran, *supra* note 1, at 221; Francis & Petricciani, *The Prospects For and Pathways Toward a Vaccine for AIDS*, 313 New Eng. J. Med. 1586-

This picture of the virus is enough to make it one of the most feared organisms known to medicine, with a concomitant tendency to produce great anxiety in ordinary people. This anxiety is accentuated by the fact that most AIDS patients are homosexual men and/or IV needle-sharing drug abusers.[10] This fact has added another dimension to the stigma already attached to HIV infection as a deadly, contagious disease.

This type of communicable disease raises numerous legal and political problems for society. The key to understanding and dealing with these problems is to recognize the tension between two powerful social imperatives.

The first is the need to prevent the spread of the AIDS virus. The description of the nature of the virus can be seen as a recipe for social castastrophe unless checked. If the virus continues to spread it could put intolerable strains on our society's fundamental shared values of compassion for the sick, and individual freedom. The second imperative is to protect those persons known to be infected from social devastation. Many people will have a desire to know who is infected with the virus in order to take what they consider appropriate preventive action. Employers, insurance companies, landlords, hospitals, prisons, schools, blood banks, and neighbors may all try to claim some interest in knowing the HIV infection status of any given person. The problem is that when that status becomes known, the victims may be threatened with devastating reactions, such as loss of jobs, insurance, medical treatment, housing, family and friends. Resolving the conflict between these imperatives in specific areas in effective and humane ways is vital to the preservation of the social fabric.

The challenge to the legal system is to determine whose demands to know whether a person is infected outweigh the privacy interests of the infected person and what actions are appropriate based on that knowledge. This is an old problem—balancing the privacy interests of the infected person with the public health interests in protecting the public and curing the victim—in a new guise.[11] The urgency stems from the nature of this peculiar virus.

One aspect of that problem can be put this way: what is the duty of one who knows another person is infected with HIV? Does he serve the strong interests in privacy and not reveal his knowledge or does he

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90 (1985); Yarchoan, Mitsuya & Broder, *AIDS Therapies*, SCIENTIFIC AMERICAN, Oct. 1988, at 110; Matthews & Bolognesi, *AIDS Vaccines*, SCIENTIFIC AMERICAN, Oct. 1988, at 120.

10. Surgeon General's Report, *supra* note 1, at 15, 19; 37 MORBIDITY & MORTALITY WEEKLY REP. 290 (1988).

11. Jacobson v. Massachusetts, 197 U.S. 11 (1905) (compulsory vaccination).

serve the equally strong interests in prevention by warning those endangered by the infected person? This Article concerns one sub-part of that problem, namely, the case of the ordinary Indiana physician[12] who determines that one of his patients is infected with the virus. How is the doctor to determine whether he has a duty to warn non-patients who may be at risk of infection by the patient?

Traditionally the doctor's knowledge about the patient obtained through examination and disclosure by the patient is to be kept confidential to protect the privacy interests of the patient. On the other hand, the duty of confidentiality has never been held to be an absolute value and the problem is in specifying the circumstances under which the doctor must breach the duty of patient confidentiality.[13] This Article approaches this question by analyzing the factors an Indiana doctor must consider to determine whether he has a duty to breach the patient's privacy and warn a non-patient who has been or will be exposed to infection with the AIDS virus by the patient.

II. Doctor's Duty of Confidentiality Concerning The Medical Status of A Patient

The policy underlying the intuitively grasped need for a rule of confidentiality[14] is two-fold: (1) to protect the patient's privacy, *i.e.*, prevent revelations of the patient's medical condition which would subject the patient to humiliation and social stigma, and (2) to induce the full disclosure from the patient that is required for effective diagnosis and treatment by the doctor. The confidential nature of the doctor-patient relationship is generally taken for granted by doctor and patient alike. However, it has a patchy legal basis, its scope is unclear and the sanction for its breach varies.

A. Standards of Professional Conduct

In Indiana the standards of professional conduct for physicians are embodied in regulations adopted and enforced by a legislatively created

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12. Ind. Code § 25-22.5-1-1.1(g) (1988) states: "'Physician' means any person who holds the degree of doctor of medicine or doctor of osteopathy or its equivalent and who holds a valid unlimited license to practice medicine or osteopathic medicine in Indiana."

13. Closen & Isaacman, *The Duty To Notify Private Third Parties of the Risks of HIV Infection*, 21 J. Health and Hosp. Law 295 (1988); Dickens, *Legal Limits of AIDS Confidentiality*, 259 JAMA 3449 (1988); Comment, *Doctor-Patient Confidentiality Versus Duty To Warn in the Context of AIDS Patients and Their Partners*, 47 Md. L. Rev. 675 (1988); Comment, *The Physician's Duty To Warn Non-Patients: AIDS Enters the Equation* 5 Cooley L. Rev. 353 (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).

14. Collins v. Bair, 256 Ind 230, 268 N.E.2d 95 (1971); *see also* 12 R. Miller, Indiana Practice, Indiana Evidence § 504.101, at 391 (1984).

state agency, the Medical Licensing Board.[15] The sanctions for violation of these standards could be as severe as permanent revocation of the physician's license to practice.[16] The standard concerning confidentiality states:

> A practitioner shall maintain the confidentiality of all knowledge and information regarding a patient, including, but not limited to, the patient's diagnosis, treatment and prognosis, and all records relating thereto, about which the practitioner may learn or otherwise be informed during the course of, or as a result of, the patient-practitioner relationship. Information about a patient shall be disclosed by a practitioner when required by law . . . .[17]

This standard makes clear that an Indiana doctor owes an enforceable duty to his patients to keep their medical status confidential. This regulation is applicable to all Indiana physicians, and the possible sanctions for violation and attendant publicity must be assumed to be significant enough to cause each one to take this duty seriously. However, there are no court cases interpreting this regulation nor any published opinions or judgments of the Board on the subject. Therefore, neither the scope of the duty nor when the disclosure will be deemed "required by the law," are known.[18]

B. Civil Damage Suits For Breach

There are also no Indiana cases deciding whether the doctor's breach of this duty is compensable in a civil suit for damages. However, it is

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15. IND. CODE section 25-22.5-2-1 (1988) creates the Medical Licensing Board and section 25-22.5-2-7(8) empowers the Board to "[a]dopt rules establishing standards for the competent practice of medicine, osteopathic medicine, or any other form of practice regulated by a limited license or permit issued under this article."

16. IND. ADMIN. CODE tit. 844, r. 5-1-3 (1988) provides:

> Failure to comply with the above standards of professional conduct and competent practice of medicine may result in disciplinary proceedings against the offending practitioners. Further, all practitioners licensed in Indiana shall be responsible for having knowledge of the standards of conduct and practice established by statute and regulation pursuant to Ind. Code section 25-22.5-2-7.

The Board is also given the power to impose sanctions. *See* IND. CODE § 25-1-9-4(a) (1988). That section provides:

> A practitioner shall conduct the practitioner's practice in accordance with the standards established by the board regulating the profession in question and is subject to the exercise of the disciplinary sanctions under Section 9 of this chapter if, after a hearing, the board finds: . . . (3) A practitioner has knowingly violated any state statute or rule . . . regulating the profession in question.

IND. CODE section 25-1-9-9 sets out the allowable sanctions which range from a letter of reprimand to permanent revocation of the license.

17. IND. ADMIN. CODE tit. 844, r. 5-1-2(a) (1988).

18. *Id.*

clear that the Indiana Supreme Court could recognize such a remedy because this issue has been decided in several other jurisdictions with most of the courts finding that damages are awardable against the doctor for breach of the duty.[19] In deciding the question, those courts identified several expressions of public policy supporting a duty of confidentiality which permitted the recognition of a civil action for damages for breach of that duty.

One of the most common factors considered by the courts is the existence of licensing regulations which create disciplinary sanctions for breach of professional conduct, including the duty of confidentiality.[20] As noted above, Indiana has such a regulation binding its doctors.

A second significant factor is the ethical requirement of the profession as expressed in the American Medical Association's Principles of Medical Ethics, Principle No. IV:

> A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.[21]

This code is not binding on any non-member doctors. However, it does serve to remind all doctors of the fundamental value of confidentiality even though there is no way to determine the scope of the duty without knowing the scope of the exception "within the constraints of the law."[22]

Another expression of ethical self-understanding by the medical profession is the Hippocratic Oath. This ancient oath states:

> Whatever in connection with my professional practice, or not in connection with it, I see or hear, in the life of men, which ought not be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret.[23]

However, it is not known whether this oath is ever actually read and/or taken by a doctor.[24] The Indiana University Medical School does not

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19. *See* cases cited *infra* notes 20, 34, 37.

20. *See* Horne v. Patton, 291 Ala. 701, 287 So. 2d 824 (1974); Hammonds v. Aetna Casualty & Sur. Co., 243 F. Supp. 793 (N.D. Ohio 1965); Simonsen v. Swenson, 104 Neb. 224, 177 N.W. 831 (1920).

21. American Medical Ass'n, *Principles of Medical Ethics, No. IV* (1980).

22. *Id.*

23. J. Areen, P. King, S. Goldberg & A. Capron, Law, Science and Medicine 273 (1984).

24. *See* M. Etziony, The Physician's Creed (1973). The author reports a survey conducted by the British Medical Association to determine whether the British medical schools required such an oath. The survey found "there is no place of medical education in the British Isles at which the Hippocratic Oath is taken in the form popularly supposed. At a number of universities, however, the tradition of a formal oath-taking ceremony is in one way or another maintained." *Id.* at 146.

require the taking of the Hippocratic Oath before graduation.[25] However, it does have the graduate take an oath which includes the following provision: "I will respect the secrets which are confided in me."[26] The Medical Licensing Board does not require any oath as a prerequisite to the practice of medicine in Indiana.[27]

The last expression of public policy considered in these cases is the Doctor-Patient testimonial privilege which allows the patient to prevent the doctor from breaching patient confidentiality in a legal proceeding. Indiana has a statute[28] which the courts interpret to mean that a physician as a witness at a legal proceeding cannot be permitted or compelled to divulge, over the objection of his patient, medical information about the patient acquired in the course of his professional duty.[29] This rule allows the courts to determine the scope of the relationship, the definition of a patient waiver and definition of certain exceptions allowing the doctor to divulge the information without violating his duty of confidentiality. Although there are no Indiana cases on point, it is generally held that this evidentiary rule prevents the doctor from giving certain *testimony* but does not, by itself, create an enforceable duty to maintain confidentiality in extra-judicial situations where the doctor is not giving evidence as a witness.[30] Some courts have held that the existence of this testimonial privilege is a legislative expression of the social value of such confidentiality and that this expression of public policy can be relied upon to create a civil action for damages for its breach extra-judicially.[31]

With these manifestations of public policy available, Indiana courts could follow several other jurisdictions and create a civil remedy in damages for breach of the duty of confidentiality. Recovery has been predicated upon a theory of implied contract. In *Hammonds v. Aetna Casualty*,[32] the court held:

> Any time a doctor undertakes the treatment of a patient, and the consensual relationship of physician and patient is established, two jural obligations (of significance here) are si-

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25. Private communication with Mr. John Ficklin, Assistant Dean for Student and Curricular Affairs, Indiana University Medical School (Jan. 1989).

26. M. Etziony, *supra* note 24, at 88-89. This oath is the *Declaration of Geneva*, adopted by the General Assembly of the World Medical Association in Geneva, September 1948.

27. Ind. Code § 25-22.5-3-1 (1988) (no oath is required for licensing).

28. Ind. Code § 34-1-14-5 (1988).

29. R. Miller, *supra* note 14, at 391. *See also* Collins v. Blair, 268 N.E.2d 95 (Ind. 1971).

30. R. Miller, *supra* note 14, at 404-06.

31. *See* cases cited *supra* note 20.

32. 243 F. Supp. 793 (N.D. Ohio 1965).

> multaneously assured by the doctor. Doctor and patient enter into a simple contract, the patient hoping that he will be cured and the doctor optimistically assuming that he will be compensated. As an implied condition of that contract, this Court is of the opinion that the doctor warrants that any confidential information gained through the relationship will not be released without the patient's permission.[33]

If the recovery were limited to an action for breach of contract, however, the patient would generally be limited to economic loss flowing directly from the breach and would thus be precluded from recovering for emotional distress, loss of employment and the deterioration of certain relationships.[34] This limitation in remedy has caused several courts to rely upon tort, rather than contract remedies for the breach of the duty. In *MacDonald v. Clinger*[35] the court wrote:

> We believe that the relationship contemplates an additional duty springing from but extraneous to the contract and that the breach of such duty is actionable as a tort . . . .
> The relationship of the parties here was one of trust and confidence out of which sprang a duty not to disclose. Defendant's breach was not merely a broken contractual promise but a violation of a fiduciary responsibility to plaintiff implicit in and essential to the doctor-patient relation.[36]

Other tort theories that have been relied on are that the doctor's disclosure of confidential information was an invasion of privacy against the patient,[37] that it was a violation of public policy protecting confidentiality[38] and that the licensing statute itself created a duty enforceable in a tort action against the doctor.[39] In Indiana, such a suit by a patient against his doctor for breach of the duty of confidentiality would probably be one for malpractice. The Malpractice Statute provides, in part:

> "Malpractice" means any tort or breach of contract based on health care or professional services rendered, or which should

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33. *Id.* at 801.

34. MacDonald v. Clinger 84 A.D.2d 482, 446 N.Y.S.2d 801 (1982).

35. *Id.*

36. *Id.* at 804.

37. *See, e.g.*, Horne v. Patton, 291 Ala. 701, 287 So. 2d 824 (1974); Tower v. Hirschorn, 397 Mass. 581, 492 N.E.2d 728 (1986); Logan v. District of Columbia, 447 F. Supp. 1328 (D.C. 1978).

38. *See, e.g.*, Humphers v. First Interstate Bank of Oregon, 298 Or. 706, 696 P.2d 527 (1985); Alberts v. Devine, 395 Mass. 59, 479 N.E.2d 113 (1985).

39. Simonsen v. Swenson, 104 Neb. 224, 177 N.W. 831 (1920).

> have been rendered, by a health care provider, to a patient. . . . "Health Care" means any act or treatment performed or furnished, or which should have been performed or furnished, by any health care provider for, to, or on behalf of a patient during the patient's medical care, treatment, or confinement.[40]

Although there are no cases concerning a suit for breach of the duty of confidentiality it would seem to fit within the statute as a tort based on health care, that is, on the act of remaining silent which should have been performed by the doctor for the patient. The courts have construed the statute very broadly to cover almost any conceivable case of a patient against his doctor for a harm arising out of the provision of health care.[41]

III. Duty to Warn Non-Patients Endangered by a Patient

The duty of confidentiality is not an absolute rule but allows for exceptions in certain cases. The Indiana standard of professional conduct on confidentiality provides that "[i]nformation about a patient shall be disclosed by a practitioner when required by law."[42] The civil damage cases from other jurisdictions all recognize that there are exceptions to the duty which allow and even require the disclosure by the doctor of medical information about the patient.[43]

The question here is whether one of the exceptions exists in Indiana for the doctor who knows that his patient is HIV infected, that a non-patient has been or will be exposed to the risk of infection from the patient and that the doctor could possibly prevent the spread of the infection by disclosing to the non-patient that the patient is HIV infected. In other words, does the doctor have an enforceable duty to warn the non-patient of the patient's HIV infection? There are no cases in the United States on this precise issue. In Indiana, neither the legislature, the Medical Licensing Board nor the courts have considered it. However, other states have considered it in the context of tort suits for breach of a duty to warn non-patients about a patient with some other infectious disease or who is dangerously violent.

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40. Ind. Code § 16-9.5-1-1 (h) & (i) (1988).

41. *See, e.g.*, Ogle v. St. John's Hickey Mem. Hosp., 473 N.E.2d 1055, 1057 (Ind. Ct. App. 1985) ("Those seeking to avoid coverage under the Act travel a rocky road. The framers of the Act used *broad* language.") (emphasis in original); Scruby v. Waugh, 476 N.E.2d 533 (Ind. Ct. App. 1985) (action against physician for wrongful commitment to a mental hospital).

42. Ind. Admin. Code tit. 844, r. 5-1-2(a) (1988).

43. *See* cases cited *supra* notes 20, 34.

A. Civil Damage Suits for Breach

As a general rule, a person has no enforceable duty to come to the aid of an imperiled stranger, whose situation the person did not create.[44] When the avoidance of foreseeable harm to *P* required another person *D*, to warn *P* of such harm, the common law traditionally imposed liability for failure to warn only if *D* bore some special relationship to the threatened person.[45] Indiana follows the traditional common law rule. In *Neal v. Home Builders, Inc.*,[46] the supreme court observed: "The duty to exercise care for the safety of another arises as a matter of law out of some relation existing between the parties, and it is the province of the court to determine whether such a relation gives rise to such duty."[47] More specifically, in *Ember v. B.F.D., Inc.*,[48] the court of appeals stated:

> Negligence actions may be premised on the imposition of a legal duty to aid one in peril. . . . Normally there is no legal duty to come to the aid of a stranger. The imposition of a legal duty to aid or protect another person is dependent upon the existence of a special relationship.[49]

In the doctor-patient situation, the doctor clearly has such a special relationship with the patient and thus owes a duty of care to the patient. Just as clearly the doctor generally has no duty of care to non-patient

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44. W. PROSSER & W. KEETON, PROSSER AND KEETON ON TORTS § 56, 375 (5th ed. 1984); *see also* RESTATEMENT (SECOND) OF TORTS § 314 ("The fact that the actor realizes or should realize that action on his part is necessary for another's aid or protection does not of itself impose upon him a duty to take such action."). For an excellent discussion of this rule, see Leonard, *The Good Samaritan Rule as a Procedural Control Device: Is It Worth Saving?*, 19 U.C. DAVIS L. REV. 807 (1986).

45. Leonard, *supra* note 44, at 824. THE RESTATEMENT (SECOND) OF TORTS § 314A provides:

(1) A common carrier is under a duty to its passengers to take reasonable action
 (a) to protect them against unreasonable risk of physical harm, and
 (b) to give them first aid after it knows or has reason to know that they are ill or injured, and to care for them until they can be cared for by others.
(2) An innkeeper is under a similar duty to his guests.
(3) A possessor of land who holds it open to the public is under a similar duty to members of the public who enter in response to his invitation.
(4) One who is required by law to take or who voluntarily takes the custody of another under circumstances such as to deprive the other of his normal opportunities for protection is under a similar duty to the other.

46. 111 N.E.2d 280 (Ind. 1953).

47. *Id.* at 285.

48. 490 N.E.2d 764 (Ind. Ct. App. 1986).

49. *Id.* at 768-69.

strangers because he has no special relationship to them, even though the doctor could, by an affirmative act, prevent harm to them by another.

1. Contagious Disease Cases.—Several jurisdictions have held that a doctor who knew or should have known that his patient had a contagious disease had a duty to warn non-patient third parties who were at risk of catching the disease from the patient. In *Wojcik v. Aluminum Co. of America*,[50] the court held that a wife could recover from her husband's employer, whose doctors had taken X-rays of the husband which showed he had tuberculosis, for not advising her of her risk of infection from her husband. The court wrote:

> It is common knowledge that tuberculosis is a contagious and communicable disease. The risk of the plaintiff-wife contracting tuberculosis from her husband, when unaware that he was so afflicted, was reasonably forseeable by the defendant. Such a risk is within the range of probability and apprehension of an ordinarily prudent person. The defendant's negligent conduct toward the plaintiff-husband under the circumstances was negligence to the plaintiff-wife.[51]

Again in *Hoffmann v. Blackmon*,[52] a Florida court held that a doctor's failure to warn a husband of his disease constituted negligence to the wife. The court noted:

> It is recognized that once a contagious disease [tuberculosis] is known to exist a duty arises on the part of the physician to use reasonable care to advise and warn members of the patient's immediate family of the existence and dangers of the disease. . . . The duty is not negated by the physician negligently failing to become aware of the presence of such a contagious disease.[53]

Courts have also found a duty to warn in cases involving smallpox,[54] typhoid[55] and syphillis.[56]

There are other contagious disease cases discussing the doctor's failure to warn. However, those cases are not precisely on point because the doctors had affirmatively told the third party that there was no danger of infection from the patient when that was not true.[57] The doctor's

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50. 18 Misc. 2d 740, 183 N.Y.S.2d 351 (1959).
51. *Id.* at 357-58.
52. 241 So. 2d 752 (Fla. Dist. Ct. App. 1970).
53. *Id.* at 753.
54. Jones v. Stanko, 118 Ohio St. 147, 160 N.E. 456 (1928).
55. Davis v. Rodman, 147 Ark. 385, 227 S.W. 612 (1921).
56. Simonsen v. Swenson, 104 Neb. 224, 177 N.W. 831 (1920).
57. *See, e.g.*, Edwards v. Lamb, 69 N.H. 599, 45 A. 480 (1899) (septic poison from a wound); Skillings v. Allen, 143 Minn. 323, 173 N.W. 663 (1919) (scarlet fever).

negligence in diagnosing the nature of the patient's illness when coupled with his undertaking to advise the third parties as to their risk made him negligent in giving that advice. When the doctor undertakes to give advice to non-patients as to their risk of infection from his patient, the relationship supporting the imposition of the duty is established and it is clear that he must use ordinary care in giving that advice. Affirmative acts by a doctor, although ones he had no duty to undertake in the first place, must always be made with reasonable care on the doctor's part. Although those cases are not the same as cases where the doctor is held to have a duty to warn a non-patient stranger, the courts did assume that such a duty to warn existed.

The courts have also been alert to the problem of determining to whom the duty is owed. In *Gammill v. United States*,[58] a case involving hepatitis, the court held that the doctor did not owe this duty to a family he did not know. The court found:

> A physician may be found liable for failing to warn a patient's *family*, *treating attendants*, or other *persons* likely to be exposed to the patient, of the nature of the disease and the danger of exposure. . . . We note the limited persons to whom such a duty is owed, again suggesting the necessity of some special relationship between the physician and those to be warned. It would appear that at the bare minimum the physician must be aware of the specific risks to specific persons before a duty to warn exists.[59]

In *Derrick v. Ontario Community Hospital*,[60] the California Court of Appeals also held that the doctor's failure to warn the plaintiffs of the patient's contagious disease was not a breach of duty to the plaintiff saying:

> It would impose an intolerable burden upon [a] [h]ospital to notify all members of the public that one of its patients being released from the hospital is suffering from a contagious, communicable disease. We can think of no way in which [a] [h]ospital could discharge such a duty. We therefore decline to impose such a duty.[61]

These contagious disease cases have not elaborated the policy framework underlying the creation of the duty. Most of them simply take it

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58. 727 F.2d 950 (10th Cir. 1984).
59. *Id.* at 954 (emphasis in original).
60. 47 Cal. App. 3d 145, 120 Cal. Rptr. 566 (1975).
61. *Id.* at 571.

for granted that the existence of the contagious disease is a sufficient basis for imposing the duty to warn non-patients on the doctor. This intuition may be correct but it does not do away with the need to have a policy rationale for the duty; for only then can the scope of the duty be adjusted to fit the special circumstances presented by different types of contagious diseases. For example, influenza might not present the same problem as HIV infection. The court in *Derrick* acknowledged this problem, "[i]t should be recognized that 'duty' is not sacrosanct in itself, but only an expression of the sum total of those considerations of policy which lead the law to say that the particular plaintiff is entitled to protection."[62]
However, the only policy issue actually discussed in *Derrick* was the extent of the burden on the defendant, when there was no readily identifiable victim endangered by the patient.

2. Violent, Dangerous Patients.—Tarasoff v. Board of Regents[63] was the first case to discuss the duty a doctor may have to a non-patient endangered by one of his violent patients. In *Tarasoff*, the defendant was a psychologist employed by the University of California and, in the course of counseling an out-patient, the latter confided his intent to kill a specific young woman whom the psychologist had never met. The defendant notified the police and sought to have his patient committed. The police released the patient because he seemed rational to them and the patient was not committed. No further efforts were made to control the patient and the defendant did not notify the endangered non-patient nor her parents. The patient killed the young woman. Her parents sued the defendant psychologist for negligently failing to warn them or their daughter of the danger posed to her by the patient. This part of the suit was *not* based on the defendant's failure to control one he was in charge of, but rather, for his failure to warn the victim or her parents of the danger. The trial court dismissed the complaint for failure to state a cause of action.[64]

The California Supreme Court reversed and held that the fact that the victim was not a patient of the psychotherapist's did not relieve him of liability:

> When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such dan-

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62. *Id.*, (quoting Dillon v. Legg, 68 Cal. 2d 728, 734, 441 P.2d 912, 916, 69 Cal. Rptr. 72, 76 (1968)).

63. 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976).

64. *Id.* at 431, 551 P.2d at 340, 131 Cal. Rptr. at 20.

> ger. The discharge of this duty may require the therapist to take one or more of various steps, depending upon the nature of the case. Thus it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances.[65]

The *Tarasoff* court recognized that imposing a duty on the psychotherapist to warn the non-patient victim in this case was a deviation from the traditional common law "duty" rule.

> Although plaintiff's pleadings assert no special relation between [the victim] and defendant therapists, they establish as between [the patient] and defendant therapists the special relation that arises between a patient and his doctor or psychotherapist. Such a relationship may support affirmative duties for the benefit of third persons.[66]

Several states have accepted the *Tarasoff* rule and have recognized a doctor's duty to warn non-patients forseeably endangered by a violent patient.[67] Subsequent California cases have emphasized that there must be a readily identifiable victim before the duty can arise.[68] Other courts have required only that the doctor reasonably foresee that the risk created by the patients' condition would endanger other members of the general public.[69] This latter approach can be taken only where the doctor could and should have exercised control over the patient and thus prevented

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65. *Id.*

66. *Id.* at 436, 131 Cal. Rptr. at 23-24, 551 P.2d at 343-44. The RESTATEMENT (SECOND) OF TORTS § 315 provides:

> There is no duty so to control the conduct of a third person as to prevent him from causing physical harm to another unless:
>
> a) a special relation exists between the actor and the third person which imposes a duty upon the actor to control the third person's conduct, or,
>
> b) the special relation exists between the actor and the other which gives to the other a right to protection.

67. *See* Jablonski v. United States, 712 F.2d 391 (9th Cir. 1983); Hedlund v. Superior Court, 34 Cal. 3d 695, 669 P.2d 41, 194 Cal. Rptr. 805 (1983); Bardoni v. Kim, 151 Mich. App. 169, 390 N.W.2d 218 (1986); McIntosh v. Milano, 168 N.J. Super. 466, 403 A.2d 500 (N.J. Super. Ct. Law Div. 1979); Peck v. Counseling Service of Addison Co., 146 Vt. 61, 499 A.2d 422 (1985); Davis v. Lhim, 124 Mich. App. 291, 335 N.W.2d 481 (1983); Note, *The Duty To Warn Third Parties: A Retrospective on* Tarasoff, 18 RUTGERS L. J. 145 (1987).

68. *See* Mavroudis v. Superior Court of San Mateo Co., 102 Cal. App. 3d 594, 162 Cal. Rptr. 724 (1980); Thompson v. County of Alameda, 27 Cal. 3rd 741, 614 P.2d 728, 167 Cal. Rptr. 70 (1980).

69. *See* Petersen v. State, 100 Wash. 2d 421, 671 P.2d 230 (1983); Lipari v. Sears, Roebuck & Co., 497 F. Supp. 185 (D.C. Neb. 1980).

the harmful act. If the issue is not the doctor's duty to exercise such control but rather his duty to warn the victim, then that victim would have to be readily identifiable by the doctor.

Distinguishable from the *Tarasoff* duty-to-warn cases are two other situations when the doctor-patient relationship may suggest affirmative duties to non-patient strangers. One is the case where the non-patient is injured because the doctor failed to warn the *patient* that his medical condition posed a risk of harm to the general public. For example, the doctor's failure to warn a bus-driver patient that his medication could cause drowsiness, would expose the doctor to liabiity for injuries to passengers sustained in a bus accident caused by the patient's drowsiness.[70] There the doctor could not have had a duty to warn the injured passengers because he had no way of ascertaining which specific persons should be warned.

The second situation exists when the doctor has custody or control over a patient and he negligently allows the patient to escape that control and injure a third party. For example, in *Mathes v. Ireland*[71] a violent man allegedly killed the plaintiff's wife. The plaintiff claimed that the mother and grandparents of the insanely violent and dangerous man with whom they lived had a duty to control his activities and to prevent him from harming others because they knew of his condition. The court held that the duty alleged depended not upon family relationships but upon the actual assumption of care and control of one known to be dangerous and the duty inures to the benefit of third parties injured by the person to be controlled.[72] Although the third party here was a stranger to the defendants, the defendents owed the third party a duty of care to control the dangerous person of whom they had taken charge. Although the plaintiff did not sue a doctor, it is clear that if a doctor had taken charge of the violent patient and then failed to use due care in controlling that patient, the doctor could be held liable on the same theory.

In both of the above situations, the doctor owed a duty to the non-patient stranger but it was not a duty to warn the person of their risk of harm from the patient. The doctor did not have a duty to warn because there was no readily identifiable victim and therefore no feasible way to discharge the duty.

Partly in response to the *Mathes* case, the Indiana Legislature adopted a statute incorporating the principle of the *Tarasoff* case. The statute provides that a doctor owes no duty to non-patients to:

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70. *See* Kaiser v. Suburban Transp. Sys., 65 Wash. 2d 461, 398 P.2d 14 (1965); Freese v. Lemmon, 210 N.W.2d 576 (Iowa 1973) (failed to warn the patient of possible seizures causing him to be unable to control his automobile).

71. 419 N.E.2d 782 (Ind. Ct. App. 1981).

72. *Id.* at 784.

> Warn or take precautions to protect from, a patient's violent behavior, unless the patient has communicated to the provider of mental health services an actual threat of physical violence or other means of harm against a *reasonably* identifiable victim or victims, or evidences conduct or makes statements indicating an imminent danger that the patient will use physical violence or use other means to cause serious personal injury or death to others.[73]

The duty to warn is, thus, confined to narrow circumstances and may be discharged by a doctor who "makes reasonable attempts to communicate the threat to the victim."[74] But the statute does create a duty to warn reasonably identifiable non-patients even though there may be no relationship or undertaking of any kind between the doctor and the non-patient. It is, therefore, compatible with the *Tarasoff* rule.

B. Policy Considerations

The infectious disease and violent patient cases and the Indiana violent patient statute create a doctor's duty to warn non-patients and demonstrate that the interests favoring confidentiality often must yield to the interests of protecting the non-patient from serious harm. The question is whether they should control the HIV infection case. Indiana

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73. Ind. Code § 34-4-12.4-1 (1987) (emphasis added).

74. Ind. Code § 34-4-12.4-3 & 4 (1987):

> Sec. 3. The duty to warn of or to take reasonable precautions to provide protection from violent behavior or other serious harm arises only under the limited circumstances specified in section 2 of this chapter. The duty is discharged by a mental health service provider who takes one (1) or more of the following actions:
>
> (1) Makes reasonable attempts to communicate the threat to the victim or victims.
>
> (2) Makes reasonable efforts to notify a police department or other law enforcement agency having jurisdiction in the patient's or victim's place of residence.
>
> (3) Seeks civil commitment of the patient under [Ind. Code §] 16-14-9.1.
>
> (4) Takes steps reasonably available to such provider to prevent the patient from using physicial violence or other means of harm to others until the appropriate law enforcement agency can be summoned and takes custody of the patient.
>
> (5) Reports the threat of physical violence or other means of harm, within a reasonable period of time after receiving knowledge of the threat, to a physician or psychologist who is designated by the employer of a mental health service provider as an individual who has the responsibility to warn under this chapter.
>
> Sec. 4. A mental health service provider who discloses information that must be disclosed to comply with sections 2 through 3 of this chapter is immune from civil and criminal liability under Indiana statutes that protect patient privacy and confidentiality.

courts should answer yes only if the policy considerations justifying those examples also justify the recognition of a similar duty in the HIV infection case.

In *Tarasoff* the court noted, "[i]n analyzing this issue, we bear in mind that legal duties are not discoverable facts of nature, but merely conclusory expressions that, in cases of a particular type, liability should be imposed for damage done."[75] Support for this view may be found in the writings of Professor Prosser: "Duty is not sacrosanct in itself, but only an expression of the sum total of those considerations of policy which lead the law to say that the particular plaintiff is entitled to protection."[76]

There are many different expressions of the factors that need to be considered in creating a duty.[77] The relevant policy considerations in the

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75. Tarasoff v. Board of Regents, 17 Cal. 3d 425, 434, 551 P.2d 334, 342, 131 Cal. Rptr. 14, 22 (1976).

76. W. Prosser, The Law of Torts § 53 at 325-326 (4th ed. 1971).

77. The California court in *Tarasoff* found that the factors to be considered are:

> [F]orseeability of harm to the plaintiff, the degree of certainty that the plaintiff suffered injury, the closeness of the connection between the defendant's conduct and the injury suffered, the moral blame attached to the defendant's conduct, the policy of preventing future harm, the extent of the burden to the defendant and consequences to the community of imposing a duty to exercise care with resulting liability for breach, and the availability, cost and prevalence of insurance for the risk involved. 17 Cal. 3d at 434, 551 P.2d 334, 342, 131 Cal. Rptr. 14, 22 (1976).

Prosser also conceived of the creation of a duty as resting upon a multi-factor analysis: "In the decision whether or not there is a duty, many factors interplay: the hands of history, our ideas of morals and justice, the convenience of administration of the rule, and our social ideas as to where the loss should fall." Prosser, *Palsgraf Revisited*, 52 Mich. L. Rev. 1 (1953).

Prof. Leonard sets out a list of factors that should be considered by a court in determining the appropriateness of imposing a duty of care in Good Samaritan Cases: (1) forseeability of harm to the victim should defendant choose not to attempt a rescue; (2) the closeness of the causal link between defendant's failure to rescue and the victim's injury; (3) the ease with which defendant could have accomplished a rescue, and the cost to defendant of doing so; (4) the identifiability of defendant (as opposed to a possibly larger group) as a potential rescuer; (5) the moral blameworthiness of defendant under the circumstances of the case; (6) the similarity of the facts of the case to those which invoke a traditionally recognized exception; (7) the degree to which imposing a duty in this case will further the social policy of preventing future harm; and, (8) the consequences to the community of imposing a duty in this case. Leonard, *supra* note 44, at 863-64. An excellent discussion of each factor is included.

A more condensed approach is set out in Nelson by Tatum v. Commonwealth Edison Co., 124 Ill. App. 3d 655, ____, 465 N.E.2d 513, 519 (1984): "[T]he imposition and scope of a legal duty is dependent not only on the factor of forseeability . . . but involves other considerations, including the magnitude of the risk involved in defendant's conduct, the burden of requiring defendant to guard against that risk, and the consequences of placing that burden upon the defendant."

HIV infection case can be analyzed under two broad headings: (1) the social consequences of imposing the duty and (2) the burden on the doctor of doing so.

1. Social Consequences of Imposing the Duty.—The major reason to impose on a doctor the duty to warn non-patients endangered by an HIV infected patient is to prevent the spread of HIV infection *both to and by* the person who is warned. Stopping the spread of HIV infection is of great importance for two reasons. One, HIV infection may result in AIDS, a fatal disease; and two, even if the infected person were never to get AIDS, that person's HIV infection status may cause severe social devastation including loss of job, insurance, family, friends and housing resulting from the public fear of AIDS. In order for the duty to warn to contribute to disease prevention, it must be assumed that the doctor will know of the duty, discharge it, and that the warned party will take appropriate precautions against getting the infection and/or passing it to others. These assumptions need to be true sufficiently often to outweigh the costs of the duty. Due to the deadly nature of the AIDS virus, there are strong incentives for all concerned to avoid infection and to prevent its further spread.

If the duty is clearly established and enforceable most doctors are likely to learn of it through the efforts of medical associations, educational seminars, journals, the press, television and word of mouth from other doctors. Physicians are likely to discharge this duty both because it is required by law and because failure to do so may be followed by a civil damage suit with all the attendant publicity. Many doctors may discharge it because they believe such action is morally correct. Even though getting the non-patient to act to prevent his or her own infection and the infection of others may, in some cases, be difficult, that will not generally be the case. Fear of aquiring a fatal disease is a powerful stimulant to action.

The duty to warn does not rest upon the doctors ability to predict with a high degree of accuracy whether the non-patient will become infected from the patient without the warning by the doctor. In dealing with this issue, the *Tarasoff* court found, "[w]eighing the uncertain and conjectural character of the alleged damage done the patient by such a warning against the peril to the victim's life, we conclude that professional inaccuracy in predicting violence cannot negate the therapist's duty to protect the threatened victim."[78]

For purposes of deciding whether to require the warning, the crucial point is that the known means for reducing the chances of being infected,[79]

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78. *Tarasoff*, 17 Cal. 3d at 439, 551 P.2d at 346, 131 Cal. Rptr. at 26.

79. SURGEON GENERAL'S REPORT, *supra* note 1, at 17-19.

e.g., abstinence from sex or IV drugs, wearing condoms during sexual intercourse and not sharing IV drug needles, may not be known to the non-patient unless the doctor tells that person. Even if the non-patient has that general knowledge, he or she may not know that those means need to be used with the patient. Therefore, the doctor will generally have to warn the non-patient specifically about the patient in order to make an effective warning. If the non-patient has already been exposed to the virus by the patient, the non-patient may not know that both he or she and the patient could be infected and could be spreading the virus to others. All that can be said is that it is likely that in some cases, the doctor's warning will prevent someone from getting AIDS. The need to prevent the spread of the virus and the likelihood that in some cases the warning will do so is the strongest consideration in favor of creating the duty to warn.

Certain social consequences argue *against* requiring the doctor to warn the non-patient. First, the duty to warn would require the doctor to breach the patient's confidentiality as to the patient's HIV infected condition. If the patient were aware of that breach, he or she might not consult the doctor when ill, or not give full disclosure of symptoms to the doctor, thus rendering less effective the diagnosis and treatment. This could have the anamolous effect of causing *increased* harm to society from the patient who is untreated, unaware that he or she is HIV infected, and uneducated about how to prevent spreading the virus.

Second, disclosure to the third party of the patient's HIV infection could result in devastating humiliation, social stigma and various forms of discrimination for the patient. This is because nothing exists to *require* the non-patient to keep the information about the patient confidential.

These two issues were discussed in *Tarasoff* in which the court noted:

> We recognize the public interest in supporting effective treatment of mental illness and in protecting the rights of patients to privacy . . . and the consequent public importance of safe-guarding the confidential character of psychotherapeutic communication. Against this interest, however, we must weigh the public interest in safety from violent assault.[80]

The court then pointed out that the California statutory evidentiary privilege for psychotherapist, and patients required the breach of confidentiality by the psychotherapist if necessary to prevent harm to the patient or another. The court took this as an expression of policy on how to balance the two issues. The Indiana statute is an even stronger expression of a public safety policy because it is not limited to the

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80. *Tarasoff*, 17 Cal. 3d at 440, 551 P.2d at 346, 131 Cal. Rptr. at 26.

evidentiary privilege, but directly creates an enforceable duty to warn.[81]

2. *Burden on the Doctor.*—Imposing the duty to warn on the doctor will be a tolerable burden only if the doctor can understand the rule, determine when it is applicable and carry it out in time to prevent the harm to the non-patient. The rule could be formulated, paraphrasing the *Tarasoff* rule, as follows:

> When a doctor determines, or pursuant to the standards of his profession should determine, that his patient is HIV infected and presents a substantial risk of infecting or of having already infected a reasonably identifiable non-patient, he incurs an obligation to warn that non-patient of the danger of infection from the patient.[82]

Because the duty to warn a non-patient at risk of HIV infection from a patient is an exception to the general duty of confidentiality, it must be carried out with the least possible breach of the latter duty. As the *Tarasoff* court stated:

> The therapist's obligations to his patient require that he not disclose a confidence unless such disclosure is necessary to avert danger to others, and even then that he do so discreetly, and in a fashion that would preserve the privacy of his patient to the fullest extent compatible with the prevention of the threatened danger.[83]

The duty to warn should thus be seen as resting upon several more specific duties. The issue then becomes whether these duties are a tolerable burden on the doctor.

The duty to warn can only arise where the doctor knows, or under applicable professional standards reasonably should have determined, that the patient is infected with the AIDS virus. Only then is the patient a danger to others. Therefore, the doctor must first make an accurate diagnosis of the patient's medical condition. If the doctor thinks that HIV infection is a possibility, the most reliable method of determining that is to have the patient's blood tested for antibodies to HIV.[84] An Indiana statute provides:

> Except as provided in subsection (b), a person may not perform a screening or confirmatory test for the antibody or antigen to

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81. IND. CODE § 34-4-12.4-1 to -4 (1988).

82. *See* text accompanying *supra* notes 63-66.

83. *Tarasoff*, 17 Cal. 3d at 441, 551 P.2d at 347, 131 Cal. Rptr. at 27.

84. PRESIDENTIAL REPORT, *supra* note 1, at 73-81; CURRAN, *supra* note 1, at 226-28.

> the human immunodeficiency virus (HIV) without the consent of the individual to be tested or a representative as authorized under IC 16-8-12.[85]

The test may be performed if ordered by a physician who has the patient's consent and the "test is medically necessary to diagnose or treat the patient's condition."[86] Thus, the doctor must ask the patient for consent to the blood test for HIV antibodies and must "document whether or not the individual has consented."[87] The doctor would then have to inform the *patient* of his or her HIV infected status and to counsel the patient concerning the means by which the virus could be transmitted to other people.

The doctor has no duty to unknown persons or the general public, even though the doctor may believe the patient is going to have sex with someone and therefore may very well infect that person.[88] There is no duty on the doctor unless it is reasonably foreseeable that a readily identifiable person has been or will be at risk of HIV infection from the patient.[89] Therefore, the doctor has the duty to take reasonable steps to identify any third parties at risk of infection from the patient. To do this the doctor must answer two questions. First, what puts a third party at risk of HIV infection from the patient? Second, are any of those third parties reasonably identifiable by the doctor?

A non-patient third party could only become HIV infected from the patient by receiving into the non-patient's body some body fluid from the infected patient. In the case of adults, the only body fluids currently viewed as creating a serious risk of infection are semen and blood.[90] The medical model posits that the modes of transmission in almost all cases are sexual intercourse or IV drug abusers sharing needles.[91] The non-patients who fall into this category are those who have already been exposed to HIV infection from the patient, *e.g.*, past or current sex or needle-sharing partners, *and* those who are in danger of being exposed in the future. The reason for warning non-patients who may already have been infected by the patient is to prevent the spread of HIV by those persons who may be unaware that they are infected and infecting others.

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85. Ind. Code § 16-1-9.5-2.5(a) (1988).

86. Ind. Code § 16-1-9.5-2.5(b)(1) (1988).

87. Ind. Code § 16-1-9.5-2.5(a) (1988).

88. Leonard, *supra* note 44, at 824; *see also* text accompanying *supra* notes 43-45, 56-54.

89. *Tarasoff*, 17 Cal. 3d at 442, 551 P.2d at 347-48, 131 Cal. Rptr. at 27-28.

90. *See supra* note 7.

91. *Id.*

Are any of these non-patients reasonably identifiable by the doctor? It will depend on what the doctor should have known about the patient and the patient's relationship to others. This information can most easily be obtained at the time of taking a thorough medical history of the patient. The doctor should try to have the complete history of the patient include information about current and past sex partners or needle-sharing partners. Of course, the patient does not have to reveal this information and the question for the doctor is, how far to proceed in identifying such third parties. The phrase "reasonably identifiable" suggests a duty to take *some* affirmative steps to determine whether there are third parties at risk from the patient and it may be that merely asking the patient satisfies that duty, regardless of the answer. In *Tarasoff*, the court addressed this issue as follows:

> Defendant therapists . . . also argue that warnings must be given only in those cases in which the therapist knows the identity of the victim. We recognize that in some cases it would be unreasonable to require the therapist to interrogate his patient to discover the victim's identity, or to conduct an independent investigation. But there may also be cases in which a moment's reflection will reveal the victim's identity. The matter thus is one which depends upon the circumstances of each case, and should not be governed by any hard and fast rule.[92]

The only clear aspect of the rule is that the doctor owes no duty to the general public.[93]

Once the doctor knows of the specific non-patient, he or she has the duty to request the patient to agree to joint counseling with the non-patient. This is clearly the preferred way to accomodate the doctor's duty to patient confidentiality and the duty to warn the non-patient because there will be no breach of the duty of confidentiality where the patient consents to the doctor telling the non-patient in the context of a joint counseling session. If the patient will not agree to joint counseling the doctor must at least try to get the patient to consent to the doctor's

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92. 17 Cal. 3d at 439 n.11, 551 P.2d at 345 n.11, 131 Cal. Rptr. at 25 n.11. *See also* cases cited *supra* note 67.

93. *See* Gammill v. United States, 727 F.2d 950 (10th Cir. 1984); Derrick v. Ontario Community Hosp., 47 Cal. App. 3d 145, 120 Cal. Rptr. 566 (1975). Other cases have not required that the non-patient be an identifiable victim but only that the doctor reasonably foresee that the risk engendered by his patient's condition could endanger other persons. *See* Lipari v. Sears, Roebuck & Co., 497 F. Supp. 185 (D.C. Neb. 1980). This could only be workable for a duty to control case such as *Lipari* because, in a duty to warn case, the doctor has to contact a specific non-patient, whereas in a duty to control case the injured victim is not claiming the doctor should have contacted him or her personally.

notifying the non-patient and counseling that person about the risks of infection, modes of transmission and the means of prevention.

The real problem arises for the doctor only when the patient will not agree to allow the doctor to warn the non-patient. It may be thought that the doctor will not have to contact the non-patient over the patient's objection if the patient will inform the non-patient of the patient's HIV infection, the risk of transmission to the non-patient, means of prevention and other relevant information. If the patient could be relied upon to inform the non-patient of all the things the doctor would have mentioned, then the doctor would no longer have a duty to so warn because the purpose of such warning would be fulfilled. However, the doctor will seldom if ever have a basis for sufficient confidence that the patient will in fact, not only tell the non-patient of the patient's HIV infection, but also tell the non-patient of *the non-patient's* risk of infection, modes of transmission and means of prevention.

Another possibility is that the patient will not agree to tell the non-patient but he or she will agree to refrain from engaging in "high risk" behavior with the person, that is, stop sharing IV drug needles or having sexual intercourse only with condoms. If the patient actually followed through on promise, it would reduce the risk of infection to the non-patient, without informing the non-patient of the true situation. It is very questionable whether the doctor would satisfy his or her duty of using due care to prevent harm to the non-patient by exacting a promise from the patient that the patient will refrain from behavior that puts the non-patient at risk as this is a patient who has already refused to consent to the doctor notifying the non-patient. The doctor could rarely rely on the patient's promises in that context. Even if the doctor had confidence in the patient's willingness to carry out the promise, there is another reason to reject this solution. The fundamental value served by the duty to warn is the non-patient's autonomy. Requiring the doctor to warn the non-patient would honor that person's autonomy—that person's right to choose how much risk to take in his or her relationship with the patient. After all, the non-patient may choose to run no further risk of infection from the patient by totally severing the relationship.

If the doctor rejects the idea of relying on the patient alone to notify the non-patient of that person's risk from the patient, then the doctor has the duty to warn the non-patient himself. Of course, the warning may be unavailing because the non-patient may not choose to act to avoid infection or may not be able to so act. Without the doctor's warning the non-patient through ignorance will sometimes be helpless to avoid the harm from the patient.

The infectious disease cases, the *Tarasoff*-type cases, and the Indiana violent patient statute, whether explicitly or not, all find the balance of similar considerations favor the duty to warn. In *Tarasoff* the court found:

> In this risk-infested society we can hardly tolerate the further exposure to danger that would result from a concealed knowledge of the therapist that his patient was lethal. If the exercise of reasonable care to protect the threatened victim requires the therapist to warn the endangered party or those who can reasonably be expected to notify him, we see no sufficient societal interest that would protect and justify concealment. The containment of such risk lies in the public interest.[94]

Only a significant difference between those cases and the HIV infection case could justify a different result. The only difference which could be that significant is the potentially greater harm to the patient from the disclosure of his infection.

In most cases the harm from such disclosures will be small. The doctor is going to reveal the patient's condition only to specific, identified sex or needle-sharing partners of the patient. He or she is not disseminating the information to the general public. The non-patient might broadcast the information, but there would be little incentive to do that because it would be tantamount to admitting that the non-patient also was infected. It does not seem likely that the legislature or the courts would decline to create a duty to warn based on the evaluation that there is a significant difference in the impact on the patient of the disclosure of the patient's HIV infected condition.

IV. An Alternative to the Doctor's Duty to Warn a Non-Patient: Reporting Statutes

In the *Tarasoff* case, the duty to warn a non-patient was listed as *one* of the ways to discharge the duty of care owed to a reasonably foreseeable victim of the patient.

> When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist to take *one or more of various steps*, depending upon the nature of the case. *Thus it may call for him to warn the intended victim or others likely to appraise (sic) the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances.*[95]

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94. 17 Cal. 3d at 442, 551 P.2d at 347-48, 131 Cal. Rptr. at 27-28.
95. *Id.* at 431, 551 P.2d at 340, 131 Cal. Rptr. at 20 (emphasis added).

The therapist in *Tarasoff* did attempt to have the patient committed and requested the police to pick him up for such purpose. The police picked up the patient but released him because he seemed rational to them and he promised to stay away from the victim. The director of the department of psychiatry at the hospital where the therapist worked then ordered that no further action be taken to place the patient in an emergency treatment and evaluation facility. The court held that the therapist could not be held liable for failing to confine the patient because of a statute providing immunity in such a case. However, the court went on to note that the plaintiffs

> can amend their complaints to allege that, regardless of the therapists unsuccessful attempt to confine Poddar [the patient], since they knew that Poddar was at large and dangerous, their failure to warn Tatiana [the victim] or others likely to apprise her of the danger constituted a breach of the therapists duty to exercise reasonable care to protect Tatiana.[96]

The lesson here is that the taking of some step to protect the victim, where the therapist knows that it failed, will not excuse the failure to take further, more effective steps to protect him or her.

The test for whether the therapist must warn the victim becomes whether that additional step is "reasonably necessary in the circumstances" because the first step is known to have failed. The Indiana "*Tarasoff*" statute addresses this issue by providing that the duty to "take reasonable precautions"[97] to protect a victim from a violent patient is discharged by a doctor who takes *one or more* of several steps: makes a reasonable attempt to notify the victim, makes a reasonable effort to notify the police, seeks civil commitment or takes reasonable steps to prevent the patient from harming the victim until the police arrive.[98] The statute provides that *one* or more of these steps will discharge the duty of care to the victim.[99] However the statute does not address the situation, like *Tarasoff*, where the doctor attempted to commit the patient and actually had the patient arrested, but, knowing that both of these efforts had failed, *then* did not warn the intended victim. If taking any *one* of the listed steps is intended to be *by itself* a sufficient condition for discharging the doctor's duty of care to the intended victim, regardless of whether the doctor knew it had failed, then it is a sharp departure from the *Tarasoff* case and the rule requiring what is reasonably necessary

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96. *Id.*
97. Ind. Code § 34-4-12.4-3 (1988). *See also supra* note 74.
98. *Id.*
99. *Id.*

in the circumstances. It is most likely that the Indiana courts, in interpreting the statute, would follow *Tarasoff* and require the therapist to take reasonable precautions to protect the victim in light of the therapist's knowledge about the failure of previous precautions.

The question in the HIV case is whether the doctor's duty of care to prevent harm to the non-patient can be discharged by means other than the doctor warning the non-patient of the HIV infected status of the patient. The *Tarasoff* rule held, "thus it may call for him to warn the intended victim *or others likely to apprise the victim of the danger* . . . ."[100] The obvious candidate for this alternative way to discharge the doctor's duty of care to the non-patient is the doctor's compliance with a state system for reporting HIV infection cases to the health authorities.

Indiana statutes requiring doctors to report medical information about a patient to some official agency are quite common and apply to a variety of medical problems.[101] Indiana has a statute which requires that each licensed physician "shall report to the state board each case of human immuno-deficiency virus (HIV) infection, including each confirmed case of acquired immune deficiency syndrome (AIDS)."[102]

The doctor's report on the HIV infected patient to the public health authorities could be the legal equivalent of, and therefore a substitute for, the doctor's personal warning of the endangered non-patient only if the state has a program which meets three conditions. One, the doctor's report is required to contain sufficient identification of the patient; two, some state employee has a duty to contact the patient and attempt to determine the identity of any non-patients who have been or will be exposed to the virus through the patient; and three, it is the further duty of such employee to contact each such identifiable non-patient, to warn them of their exposure to HIV infection, to counsel them about the nature of the infection and to inform them of the means to prevent the further spread of the virus.

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100. *Tarasoff*, 17 Cal. 3d at 431, 551 P.2d at 340, 131 Cal. Rptr. at 20.

101. *See* IND. CODE § 31-6-11-3 (1988) (child abuse); *id.* § 35-46-1-13 (elderly abuse); *id.* § 35-47-7-1 (firearms or knife wounds); *id.* § 35-47-7-3 (burns); *id.* § 9-11-4-6(a) (intoxication evidence); *id.* § 16-4-10-7 (birth problems).

102. *Id.* § 16-1-9.5-2(b). The State Board of Health (SBA) has implemented this statute in IND. ADMIN. CODE tit. 410, r. 1-2.1-6(b)(14) (1988):

> For purposes of reporting under these rules, physicians and hospital administrators shall report all persons with evidence of HIV infection. To clarify, the state board of health recognizes three subcategories of HIV infections:
> (a) persons who meet the CDC definition of AIDS, as found in Morbidity and Mortality Weekly Report, Vol. 36, Supplement No.1S, August 14, 1987;
> (b) persons with serologic evidence of HIV injection; and
> (c) other persons with signs/symptoms which cause the attending physician to strongly suspect HIV infection.

The advantages of relying on such a reporting and notification program under the auspices of trained employees of the public health system, instead of relying on the doctor's duty to warn the non-patients are clear. They include: reliability in contacting each reported HIV infected patient; experience in identifying the appropriate non-patients; uniformity in the information given to the non-patient; comprehensiveness in counseling the non-patient regarding the risks of infection, prevention and infecting others; relief for the doctors of the burden in time and energy of doing something that is peripheral to their main tasks (and for which they may have very little training and knowledge) and prevention of the doctor's further breach of patient confidentiality by telling the non-patient directly of the patient's HIV infection.

There are, of course, disadvantages to such a notification system. The first is the cost of the state-run system. If the doctors are required to do it, the costs might tend to be spread across many practioners and would then be negligible for any one of them, thus saving a significant amount of state funds. To the extent that the doctors with HIV infected patients are clustered in a few urban clinics, this advantage from the doctor warning system would disappear.

Second, the State Board of Health (Board) employees may be perceived as "strangers" to the parties involved and, therefore, be less successful than the doctor in talking the patient into disclosing the identity of the non-patients. Also, notification by the doctor may be perceived by the patient and the non-patient as more intimate and humane, cushioning somewhat the shock of the revelation.

Such a reporting and notification program, even with some potential disadvantages, is obviously an attractive alternative to imposing the duty to warn on the individual doctors. But both alternatives could have a problem with the reliability of the notification effort. The doctor may be negligent or simply refuse to do the warning of non-patients in spite of the possible liability for that breach of duty, and underfunding of the state system would make its efforts less reliable than is needed. The superiority of the state system rests on the assumption that there would be adequate state funding to hire the required specialists to carry out the program in a prompt, effective and reliable way.

Indiana does have a reporting and notification program with the required three components of identifying the patient, identifying the non-patients and notification of those non-patients. The Board's rules require that all doctor's reports of communicable diseases contain the patient's full name, address, telephone number, age, sex, race, date of onset, diagnosis and the name and address of the attending physician.[103] The

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103. Ind. Admin. Code tit. 410, r. 1-2.1-2(c) (1988).

rules further provide that: "Referral of contacts by HIV infected persons is strongly encouraged. Confidential contact tracing should be performed by trained public health disease control specialists. All identified contacts should receive counseling and be offered serologic testing."[104]

The Board's rules define a "contact" as "a person . . . that has been in an association with an infected person . . . which might provide an opportunity to acquire the infective agent."[105] The contact-tracing employed on those persons is the use of "epidemiologic methods to confidentially locate, counsel and refer for medical evaluation and possible treatment a contact of a person having a communicable disease.[106]

It is clear that the Board will know the identity of these reported patients. However, the rule does not explicitly require that each reported patient be contacted to identify any non-patient "contacts." The rule only provides "Referral of contacts by HIV infected persons is strongly encouraged."[107] The question then is whether the Board interprets that rule to *require* contact with each reported patient. The Board's internal policy statement[108] on "partner notification" describes a program aimed at infected persons at Counseling and Testing Sites (CTS) only.[109] Each person tested at such a site is requested by Board employees to identify potentially exposed partners in sex or needle-sharing. However, there is nothing in the policy applicable to the ordinary doctor who has an infected patient who is reported by name to the Board. It appears from the rules and the policy statements that there is *no program* for contacting those reported patients.

The statute does state that "All identified contacts should receive counseling and be offered serologic testing."[110] However, the "contacts" of the patients reported to the Board by a doctor will not receive this counseling unless the patient is first contacted and requested to identify the non-patient contacts. This does not seem to be part of the Board's contact-tracing program.

Thus, the Indiana program for reporting/contact-tracing does not appear to have all three components required to make it the substantial equivalent of the doctor's warning the non-patient. In Indiana, the

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104. *Id.* r. 1-2.1-7(b)(14).

105. *Id.* r. 1-2.1-1(e).

106. *Id.* r. 1-2.1-1(f).

107. *Id.* r. 1-2.1-1(e).

108. Indiana State Board of Health, Acquired Disease Division, Contact Notification Policy (Aug. 31, 1988).

109. A Counseling and Testing Site (CTS) is a place for anonymous testing of people for HIV infection. Persons tested at these sites cannot be reported using personal identifiers; rather they are to be reported using a numeric identifier code. IND. ADMIN. CODE tit. 410, r. 1-2.1-6(b)(14). Board employees do their contact-tracing by meeting the patient personally at the CTS. *Id.*

110. IND. CODE § 16-1-9.5-2.5(a) (1988).

doctor's duty of reasonable care to non-patients can apparently only be discharged by personally insuring that they are warned either by himself or in some cases by the patient.

V. Recent Indiana Non-Disclosure Statutes

A determination of whether the legislature has precluded the courts from creating a doctor's duty to warn requires an examination of Indiana legislation concerning HIV infection. Recent Indiana legislation provides that: "[A] person may not disclose or be compelled to disclose medical or epidemiological information involving a communicable disease or other disease that is a danger to health as defined under rules adopted under section 1 of this chapter."[111] The Board has adopted rules under that section which define HIV infection as a communicable disease and thus within this confidentiality provision.[112] The statute further provides: "Except as provided in subsection (a), a person responsible for . . . reporting . . . information required to be reported under this chapter who recklessly, knowingly or intentionally discloses or fails to protect medical or epidemiological information classified as confidential under this section commits a Class A misdemeanor."[113]

The statute forbidding disclosure of medical information about a person's HIV infection has several exceptions. The one pertinent here is that it allows "release" of the information "to protect the health or life of a named party."[114] This would allow a doctor to convey the medical information about his HIV infected patient to a non-patient only if the non-patient was "a named party." It is unclear what is meant by "a named party." There is no provision in the reporting statute or regulations for including the name of a third party in the report. They provide for reporting the *patient's* name but say nothing about any third party's name.

One possible interpretation of the phrase is that it allows a doctor to release medical information to protect the health or life of a non-patient that the doctor can reasonably identify and therefore "name." That would be a sensible limitation on the divulging of such information to third parties and is used in the violent patient statute. This interpretation could also explain why the 1988 version of the statute changed the language to "*a* named party,"[115] from the 1987 language of "*the*

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111. Ind. Code § 16-1-9.5-7(a) (1988).
112. Ind. Admin. Code tit. 410, r. 1-2.1-2(d) (1988).
113. Ind. Code § 16-1-9.5-7(b) (1988).
114. *Id.* § 16-1-9.5-7(a)(3).
115. Act approved March 4, 1988, Pub. L. No. 123, § 4, 1988 Acts 1698, 1700.

named party."[116] The 1987 version most naturally referred to the *patient*, not a third party, because the patient is named in the doctor's report to the board. The 1988 version can be read as "a party named by the doctor as one known to the doctor to be at risk of HIV infection from the patient." If this interpretation of the statute is accepted then the non-disclosure statute contains an exception which *allows* the doctor to warn non-patients endangered by a patient. Therefore, the Indiana courts would not be foreclosed from recognizing an enforceable *duty* on the doctor to warn such a non-patient.

A second possible interpretation is that "a named party" refers only to the HIV infected *patient* named in the doctor's report to the Board. This implies the legislature intended no substantive change when it amended the 1987 version, "the named party" to "a named party" in 1988. Here the doctor would be permitted to divulge the information about his patient to another doctor, perhaps a specialist of some sort, in order "to protect the health or life" of the patient. That is a sensible rule and surely must be allowed in some form. However, if this second interpretation is accepted the statute forecloses the Indiana courts from recognizing the doctor's duty to warn such endangered non-patients by disclosing to them information about the HIV infected patient without that patient's consent.

This second interpretation would allow Board employees to do "contact tracing" in an attempt to prevent the non-patient's infection. They would do this by contacting the patient, named on the doctor's report, and request the patient to identify non-patients who may have or will be at risk of infection from the patient. Thus, notification of the non-patient is dependent upon the patient's willingness to identify such persons. If the patient does so, he or she has consented to the disclosure to the non-patient.[117] At this time the Board does not have a program for contacting the named patient to obtain the names of non-patients endangered by the patient, however, one could be instituted at any time.

In the absence of any controlling legislative history, the choice by a court between the two interpretations will turn on whether the court reasons that the legislature intended to preclude the courts from recognizing a doctor's duty to warn non-patients endangered by a patient's HIV infection. That the legislature intended such preclusion is rendered less plausible by the fact that the legislature imposed upon doctors a very similar duty to warn or take other reasonable precautions to protect

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116. Act approved April 24, 1987, Pub. L. No. 196, § 1, 1987 Ind. Acts 2272, 2275.

117. Ind. Code § 16-1-9.5-7(e) (1988), which provides that "[a]n individual may voluntarily disclose information about that individual's communicable disease."

third parties from serious harm from a violent patient.[118] Why would the legislature create that duty and then totally foreclose the creation of the same duty in the HIV infection case? Because the harm in both situations is serious, the only plausible way to explain such an inconsistency would be to impute the view to the legislature that the disclosure of the patient's HIV status is so much more harmful to the patient than disclosure of a patient's violent propensities, that disclosure of the former should not be allowed. If the legislature held that view, it could have made it clear in the non-disclosure statute. The existence of the inconsistency ought to be enough to cause a court to adopt the first interpretation which permits the judicial creation of a doctor's duty to warn. If the legislature does not agree, it always has the last word.

VI. Conclusion

In light of this analysis, several conclusions are discernible. First, the Indiana doctor is under an enforceable duty of confidentiality to the patient and there is ample precedent from other jurisdictions to allow an Indiana court to hold that a breach may be compensated in a civil damage suit. Second, there are no cases imposing on doctors a duty to warn non-patients exposed to HIV infection from a patient. However, Indiana has a statute creating such a duty in the case of violent patients and there are numerous cases from other jurisdictions imposing such a duty for other types of communicable diseases and for violent patients. Third, the Indiana program requiring the doctor to report HIV infected patients to the State Board of Health is not an adequate substitute for the doctor's personally warning the non-patient at risk from the patient. Therefore, the possibility is completely open for the Indiana courts to recognize a doctor's duty to warn a non-patient who has been or will be exposed to the HIV from the patient. Fourth, this possibility could be foreclosed by the legislature.

Thus, when the Indiana doctor determines that he or she has a HIV infected patient, the doctor is currently in a position of legal uncertainty concerning a duty to warn non-patients exposed to the virus by the patient. However, in the disease and violent patient cases and the Indiana statute on violent patients, the duty to warn has been found to outweigh the duty of confidentiality. There is no reason to believe that the Indiana courts will not reach this same conclusion when faced with the case of a HIV infected patient.

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118. *Id.* § 34-4-12.4-1 to -4.