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# HIV AND ENTRENCHED SOCIAL ROLES PATIENTS' RIGHTS VS. PHYSICIANS' DUTIES[1]

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## INTRODUCTION

PHYSICIANS, so it will be argued, have by virtue of their profession a weightier obligation than patients to disclose their HIV infection, and also have a duty to refrain from performing *exposure-prone invasive procedures*. This argument supports both the AMA and CDC guidelines on HIV infected health care workers (HCWs), while undermining the recommendations against disclosure suggested by the National Commission on AIDS (NCA). The argument is divided into three parts. First, a distinction is made between *entrenched* and *fuzzy* roles. Second, the physician-patient relationship is described as essentially fiduciary rather than purely businesslike or merely contractual. Third, the conflict between patients' and physicians' right to know is portrayed as one between patients' and physicians' right to life. Last, given that the probability of infection from seropositive patients to seronegative physicians, and, conversely, is roughly the same, it is recommended as a fair social policy that whenever an invasive procedure occurs, both physicians and patients have a duty to disclose any serious infection that may jeopardize their lives.

## I

In November of 1990 Dr. Almaraz, a successful cancer surgeon from Johns Hopkins Hospital, died of AIDS without ever informing patients of his seropositivity. In June of 1991 the case of Kimberly Bergalis made headlines all over the country. Ms. Bergalis and four more persons appear to have been the first cases in which a dentist (Dr. David J. Arcer who died of AIDS in September of 1990) who had not informed patients of his condition infected them with the virus.[2] These cases are similar in that both the surgeon, Dr. Almaraz, and the dentist, Dr. Arcer, continued performing *invasive procedures*[3] long after they had discovered their seropositive condition.[4]

My argument is germane to the following controversial issues: (1)

whether physicians have a weightier moral obligation than patients to disclose their serologic status,[5] (2) whether both patients and physicians have an equivalent moral right to know their serologic status and hence an equivalent duty of disclosure,[6] or (3) whether a policy of confidentiality and universal precautions is more reasonable than a policy of disclosure, given that the level of risk of HIV infection is minimal, and the potential for discrimination against those infected is highly probable.[7] In defense of (1) it will be argued that physicians, by virtue of their profession, have a weightier moral obligation than patients to refrain from intentionally bringing about harm and/or undue risk[8] of harm to them.[9] If this is so, they have a weightier obligation than patients either to disclose their seropositivity, or to refrain from performing invasive procedures. This argument supports the AMA and the CDC guidelines for HIV infected health care workers (HCWs), while undermining the recommendations against disclosure suggested by the National Commission on AIDS.[10]

To defend this position, it is necessary to explore to what extent the roles of physicians and patients generate distinct or equivalent moral obligations. Whereas it is usually acknowledged that both physicians and patients have general rights and obligations by virtue of being moral agents, it is no less recognized that people, by having voluntarily chosen their profession, acquire professional and hence specific moral obligations or duties that supervene upon their social roles.[11] Since some social roles are more clearly defined than others, they can be characterized in two different ways: (a) *entrenched* and (b) *fuzzy*. Roles are entrenched only if (1) there are clearly established laws, regulations, norms, institutions, and moral principles that circumscribe and therefore define them, (2) one can expect people exercising them in society to behave accordingly, and (3) one can hold role players publicly accountable for violating prescribed rules of behavior. Unlike the roles of celebrity, genius, and hero to mention only a few, the roles of soldier, teacher, and doctor are entrenched in our contemporary society.[12] To a large extent, the role of a soldier is to defend country and obey superiors, the role of a teacher to impart knowledge, and the role of a doctor to preserve and improve human life and/or to mitigate human suffering. On the contrary, the roles of celebrity, genius, and hero are fuzzy. Since there are few or no laws, regulations, norms, and institutions defining them, their understanding is open-ended and therefore contestable.

As professionals, people's autonomy is conditioned by their entrenched roles.[13] This is the case only if (1) a role is voluntarily chosen instead of imposed, (2) the boundaries, rules, and norms governing a role are reasonably understood by the individual in question, (3) the rules and norms governing roles are morally permissible, (4) the roles themselves are also morally permissible, and (5) the nature of the role is such that it contributes to the general



welfare by promoting primary goods and/or by fulfilling basic needs which are vital for people to flourish.[14]

A violation of any of the first four conditions creates problems for ascribing responsibility to role players. For example, if we coerce people into certain roles, no matter how admirable these may be, their accountability significantly diminishes. Accountability, however, presupposes not only absence of coercion, but also having a reasonable understanding of the nature of social roles. Moreover, people are accountable for violating roles only if those roles are morally permissible. A violation of the fifth condition presupposes that the role in question carries no significant moral weight and therefore generates no significant moral obligation.

Since it can be plausibly argued that conflicts between obligations and rights related to social roles are unavoidable, a way of addressing them is by having a lucid understanding of these roles. Thus if a collision should occur, one would presumably know how to pass judgment.[15] For example, physicians' natural and professional duty of nonmaleficence may collide with their right to privacy (when, e.g., they have reason to believe they are seropositive and choose not to disclose it), or even with their right to life (when, e.g., they perform invasive procedures on seropositive patients thereby risking being infected by them). Similarly, patients' natural obligation of nonmaleficence may clash with their right to privacy (when, e.g., they have reason to believe they are seropositive and choose not to disclose it), or even with their right to life (when, e.g., they have reason to believe they are seropositive and do not inform physicians performing invasive procedures on them because they are justified in believing that were they honest with their physicians, the latter would refuse to treat them). If this is so, then a question arises, should physicians and/or patients disclose their serologic status before exposing others to a higher than expected risk?[16]

Those who argue against disclosure present several reasons. First, since the virus is not airborne but bloodborne, the probability, e.g., of a surgeon transmitting the virus to a patient is remote and therefore negligible (although theoretically and physically possible).[17] Second, once physicians disclose their seropositivity, they will probably be stigmatized by society making them vulnerable to discriminatory practices and social ostracism. And third, if physicians are compelled to be tested and hence disclose their seropositivity, many would presumably avoid testing if possible, or attempt in some way to subvert the results. Therefore, society would be worse off than if their serologic status had remained confidential. By avoiding testing, however, seropositive persons may inadvertently spread their infection to others.

Evidently, the above mentioned reasons for preserving physicians' confidentiality at the expense of unduly risking people's lives also apply to patients and citizens who are seropositive.[18] Consequently, it can be argued that, to avoid discriminating against seropositive individuals and to pro-

mote voluntary testing, a reasonable policy for society would be to preserve confidentiality across the board.[19]

Yet if one weighs the reasons for and against disclosure, it is doubtful that confidentiality should be preserved at all cost, especially when people's lives are at stake. By imposing an obligation on others to refrain from unjustifiably acquiring personal information about us or our ways of life, provided such information is not already public, the right to privacy helps prevent discrimination against us. But this right is not sacrosanct. Like other rights, privacy sometimes must yield to other considerations, e.g., when there is a serious risk to life.[20] The severity of the risk depends not only on how likely it is that the harm in question could occur, how severe the consequences are if in fact it does occur, but also on how likely it is that the harm could be corrected. For example, an improbable but fatal risk generates substantive moral obligations on those responsible for it. However, a highly probable but nonfatal risk generates weaker moral obligations on those who, e.g., have a viral infection, such as the common cold, and opt to interact with other noninfected individuals. Evidently, unlike the common cold, HIV infection is lethal and therefore irreversible.[21] Thus, a policy of confidentiality across the board avoids some of the nuances involved in the controversy on AIDS and confidentiality.

Suppose that Dr. Smith, a cancer surgeon, knows that he is seropositive and that if he performs invasive procedures on patients, there is a statistically minor but lethal risk of infecting some of them. But he has reason to believe that if he were to come forth and tell patients about his seropositivity, most likely he would lose his practice and, consequently, his quality of life would diminish. What should Dr. Smith do when confronted with this dilemma? Should he disclose his seropositivity and risk losing his practice? Should he opt not to disclose and risk infecting patients? Or perhaps he should, as the CDC and the AMA have recommended, just abstain from performing exposure-prone invasive procedures.

## II

To answer the above questions it is necessary to focus on the role physicians voluntarily play in society and the duties associated with it.[22] If *health care* is deemed just one social good among many, then it would be possible to conceive the practice of medicine as purely businesslike or as merely contractual. But if the consensus is that health care is a *basic need*[23] to which people are equally entitled despite their station or social role, then businesslike and contractual models are inadequate for the following reasons: (1) physicians and hospitals have the necessary knowledge and technological resources for health care provision, (2) patients depend upon their physicians for the provision of health care but not the opposite, (3) physicians' autonomy is partly conditioned by their professional obligations, (4) patients' autonomy is partly conditioned by their health care needs, and (5) patients are in a vulnerable position vis-à-vis physicians concerning their health care needs. Therefore, to presuppose, as businesslike and contractual models do, that both patients and physicians are in a symmetrical relationship in respect of their actual health care needs, their capacity for fulfilling those needs, or their capacity for affecting one another's autonomy and well-being is simply question-begging.[24]



Still, it can be argued that the physician-patient relation is one of mutual trust and care rather than purely businesslike or merely contractual. That is to say, their relationship is essentially *fiduciary*. Unlike businesslike and contractual models, a fiduciary model entails a relation of moral responsibility in which the autonomy of the parties involved is characterized not only by their ability and willingness to act according to self-regarding considerations, but also by their ability and willingness to fulfill their moral duties.

Since patients depend upon physicians for fulfilling their health care needs, the notion of duty takes precedence over the notion of right in this relationship, because to maintain their health and well-being patients require the help of physicians, who have the ability and expertise to render it. Thus, by stressing the notions of need and duty, the fiduciary model is compatible with the spirit of the medical profession. Moreover, it seems preferable on moral grounds to models that highlight the notion of rights over duties. This is partly so because, by focusing on a fiduciary relation, the adversarial thrust embedded in both businesslike and contractual models is avoided.[25]

Despite how the physicians' role is defined, there is reason to believe they have at least two different kinds of general obligations or duties: (1) a positive duty of beneficence, and (2) a negative duty of nonmaleficence. First, as moral agents, physicians have a *natural positive duty of beneficence* to render aid to those who need it; patients are in need of aid, so they have a natural positive duty to help them.[26] But this positive duty is broad in scope, and, therefore, applies to all moral agents *qua* moral agents despite their being patients or physicians. Additionally, physicians have concrete and specific *artificial* (self-assumed) *positive duties* to their patients in virtue of their entrenched professional role. These are *entrenched professional duties*; they are species of artificial ones, i.e., they are self-assumed. Moreover, they supervene upon entrenched professional roles. Because their scope is narrower than the scope of natural duties, they are sanctioned by but are not reducible to natural ones. For example, (1a) as professionals, physicians have an *entrenched positive duty* to provide effective treatment to their patients, or, if such treatment is unavailable, at least to attempt relieving patients' suffering.[27]

Second, as moral agents, physicians have a *natural negative duty of nonmaleficence* to refrain from intentionally bringing about harm and/or undue risk of harm to people, from which follows that physicians have a natural negative duty to refrain from intentionally bringing about harm and/or undue risk of harm to patients.[28] Like natural positive duties, natural negative duties are broad in scope and hence apply to all moral agents *qua* moral agents. Additionally, physicians have an *entrenched negative duty* to their patients in virtue of their entrenched professional role.[29] For example, (2a) as professionals, physicians have an *entrenched negative duty of nonmaleficence* to refrain from intentionally bringing about harm and/or undue risk of harm to their patients.[30]

Similarly, patients have (1) a *natural positive duty of beneficence* to render aid to those who need it, and (2) a *natural negative duty of nonmaleficence* to refrain from intentionally bringing about harm and/or undue risk of harm to people. Unlike physicians *qua* physicians, patients *qua* patients have no entrenched duties. If they have duties besides their natural ones, these are *tacit* instead of entrenched ones. One may argue, e.g., that patients, by voluntarily going to see their physicians, tacitly agree to be honest with them, to follow their recommendations, and to avoid exposing them to undue risk of harm. Unlike the notion of entrenched professional duties, the notion of tacit duties is open-ended and hence contestable. The reason is that tacit duties — being neither natural nor artificial — are suspect. Apparently, they are neither clearly sanctioned by the moral law nor self-assumed. This being so, one may plausibly argue that their weight is less morally significant than that of entrenched duties.

Suppose a physician lies to an unsuspecting patient or intentionally withholds information from him that may adversely affect that patient's health. For example, since the possibility of infecting a patient accidentally is minimal while the possibility of losing her practice, if she discloses her condition, is relatively high, a seropositive physician may opt not to share that information with her patient. If she consequently infects him, she would be guilty of violating a physician's natural duties, her entrenched professional duty of beneficence, and, what is more important, her entrenched professional duty of nonmaleficence. She is publicly accountable to the extent that the AMA may reprimand, suspend or expel her from the organization. The State Licensing Board where she practices may also institute proceedings to suspend or revoke her license, and she may be held legally liable for unduly risking patients' lives.

Conversely, suppose that unknown to a physician a patient lies to or withholds information from her about his health that may adversely affect her life and well-being. For example, since the possibility of a seropositive patient infecting a surgeon is minimal (especially if universal precautions are observed), and the possibility of being discriminated against, if he discloses his seropositivity, is highly probable, a patient may opt not to disclose his HIV infection to the surgeon. If he consequently infects her, there is reason to believe that the patient, as a moral agent, violated his natural duties of fidelity and nonmaleficence. But this may be a hasty conclusion. Perhaps there are mitigating reasons excusing a patient's behavior. A patient, e.g., may lie or may withhold information from his physician because he has reason to believe that were he honest with her, she would refuse to treat him. Moreover, it seems controversial to contend that a patient, by lying or withholding information from his physician, violates his tacit duties. On what grounds are we going to hold patients publicly accountable for violating these duties if it is doubtful whether such duties exist? If they do exist, it would still be possible to excuse patients' behavior provided that their health be at stake.



It can be argued that in a physician-patient relationship there is a tacit understanding of nonmaleficence, but also of mutual respect and benefit. Apparently, patients have specific and concrete artificial (self-assumed) duties, e.g., a positive duty of fidelity to be honest with their physicians, and a negative duty of nonmaleficence to refrain from intentionally bringing about harm and/or undue risk of harm to them. If this is the case, the role of patients would appear to be entrenched instead of fuzzy. This claim may be interpreted in two ways: (1) as factual or (2) as normative. If interpreted as a factual description of patients' role, it seems false or inaccurate at best. Given that their role is presently fuzzy, it is uncertain to what extent patients *qua* patients acquire specific and concrete duties. Unlike physicians, they need not be publicly accountable for violating their social role.

The opposing argument that the role of patients should be considered as an entrenched one, is a normative claim beyond the scope of this paper. But there are two reasons for supposing this a dubious claim. First, unlike physicians, patients do not choose to become patients, they are in need of care. Therefore, it is puzzling how patients *qua* patients could be held accountable for misbehaving. Obviously, they could always be held accountable for misbehaving as moral agents, but that is not the issue. Second, patients come in so many different shapes and forms, e.g., from normal adult persons who voluntarily seek treatment to children, the comatose, the insane, and the mentally challenged who are not responsible moral agents. Given the plasticity of the notion of patient, it is perplexing how a persuasive argument could be developed for interpreting their role as being entrenched.

Yet patients, as moral agents, have a natural negative duty of nonmaleficence to refrain from intentionally bringing about harm to physicians in two ways. (1) They have a *direct* obligation to refrain from intentionally exposing them to undue risk of harm. And (2) they also have an *indirect* obligation to refrain from risking the lives of "others" by having exposed

their physicians to undue risk of harm.[31] Similarly, to preserve patients' health and the integrity of the medical profession, physicians must avoid exposing them to *undue risk of harm*. If, e.g., a physician **P** performs an *invasive procedure* on patient **Q**, but withholds information from the latter about her seropositivity, she violates the Hippocratic Oath and, what is more important, her natural and entrenched negative duties of nonmaleficence by exposing **Q** to undue risk of harm without **Q**'s informed consent.[32]

## III

There are those who claim that the above argument cuts both ways.[33] If physicians have a duty to inform patients about their HIV infection, then, similarly, patients have a duty to inform physicians about theirs. Since the possibility of a physician infecting a patient is equivalent or lesser than that of a patient infecting a physician, an argument could be construed to fix the locus of responsibility on infected patients rather than on infected physicians, or to fix it equally on both. If this is the case, the argument continues, one must accept that both patients and physicians have an *equivalent moral duty* of disclosure.

To claim that the above argument cuts both ways is to ignore the entrenched role of physicians and their corresponding entrenched professional duties. These are asymmetrical duties because individuals just by being patients have no such duties despite their health or lifestyle, and because being a patient, unlike being a physician, is a fuzzy role. But fuzzy roles generate tacit duties at best. If there is a conflict between tacit and entrenched duties, the latter outweighs the former, given that, unlike tacit duties, entrenched professional duties are necessarily self-assumed. The positive duty to care about the preservation of their patients' health is a substantive self-assumed moral obligation. If this were not so, the medical profession would be considered as one among many equally honorable professions. But in fact the medical profession occupies a privileged position in most societies because of the power over life and death and human suffering which it wields. Moreover, people generally expect physicians as well as soldiers, firefighters and police officers to accept a higher level of risk in the performance of their duties than citizens at large.

Like other entrenched roles, the role of physician generates substantive moral obligations. Similar considerations, e.g., apply to police officers. By voluntarily choosing to become law enforcement officers, they acquire an entrenched professional duty to face a higher level of risk than other members of society for the sake of protecting citizens' lives and well-being. Similarly, those who voluntarily choose to become physicians acquire an entrenched professional duty to face a higher level of risk than other citizens for the sake of preserving their patients' health.[34] By voluntarily



choosing to play a specific role (if the role is morally permissible) individuals therefore accept the duties associated with it.

Some may argue that the above is not a good analogy for the following reasons. First, police officers voluntarily accept the risks associated with their profession, but it is doubtful that physicians do so as well. Physicians may contend that they acquiesce to a standard level of risk higher than the degree accepted by citizens at large, but not necessarily to the extent of becoming infected with a lethal disease such as AIDS. Physicians' fear of contagion need not be based on self-regarding reasons alone, but on other-regarding reasons as well. They may fear risking their lives, but also the life of others, e.g., members of their family, colleagues, and patients. Second, it can be argued that, unlike physicians dealing with seropositive patients, police officers are risking their lives but not necessarily other people's lives.

The first reason illustrates the current controversy about physician's professional role during the AIDS epidemic. Some may contend that there is no duty to treat seropositive persons and risk facing catastrophic consequences.[35] Others will counter that, given the nature and history of the profession, there is a serious duty to provide treatment despite this risk.[36] Like the nature of the law enforcement profession, the nature of the medical profession is such that there is always a possibility of facing a serious risk to one's life. The second reason for objecting to the analogy as inaccurate is because police officers, like physicians, may also in the line of duty risk other people's lives. In the law enforcement profession the possibility of revenge by malefactors is always present. Revenge could occur, e.g., against police officers themselves, members of their family, friends, or neighbors.

Despite the above analogy, patients and physicians are bound by general moral principles of beneficence, fidelity, and, what is more important, nonmaleficence. Thus, patients can be expected to inform physicians about their HIV infection and perhaps even about their lifestyle, since the latter may be related to their lethal infection. By informing physicians, patients alert them to take extra-precautions and hence avoid exposing them, their families, and their future patients to undue risk of infection. As moral agents and as patients, individuals have both (1) a natural positive duty of fidelity, and, more important, (2) a natural negative duty of nonmaleficence. Therefore, patients ought to refrain from intentionally bringing about harm and/or undue risk of harm to their physicians. Apparently, both patients and physicians are bound by an equivalent natural negative duty of nonmaleficence.

Yet when a seropositive physician performs *invasive procedures* on patients without their informed consent, she may be held morally responsible for violating their trust, their autonomy, and her entrenched positive duty of beneficence. More importantly, she violates both her natural and her entrenched negative duties of nonmaleficence by exposing patients to a

known risk that, however minor, could be fatal. Patients' lives are worth no more than physicians' lives. However, other things being equal, it can be plausibly argued that people's right to life, or the claim they have upon others to refrain from intentionally bringing about harm and/or undue risk of harm to them, seems weightier than, e.g., their right of privacy.[37] If there is a right to privacy, it can also be plausibly argued that this right imposes only a *prima facie* negative duty to refrain from unjustifiably acquiring personal information about people's lives or ways of life only if such information is not already public. Still, if there is a conflict between a person's right to life and another person's right to privacy, the first outweighs the second because the right to life, unlike the right of privacy, generates not only a *prima facie* positive duty of beneficence, but also a *categorical* negative duty of nonmaleficence.

Given that being alive is a necessary condition for people to flourish, a convincing argument can be made that there is a right to life and that this right imposes at least two important duties: (1) a *prima facie* positive duty of beneficence, and (2) a categorical negative duty of nonmaleficence. For example, (1) a moral agent X has a *prima facie* positive duty of beneficence to render aid to those in need of it only if X's action poses no *significant risk*[38] to her life or well-being, and, more importantly, (2) X has a *categorical* negative duty of nonmaleficence to refrain from intentionally bringing about harm and/or undue risk of harm to other innocent persons.[39] This being the case, it can be argued that negative duties in general, e.g., to refrain from robbing, maiming, killing innocent people, or intentionally exposing them to undue risk of harm are weightier than positive ones.[40] This is because moral agents can and hence are expected to control their behavior; however, it is uncertain whether they can in fact help others. For example, they may lack sufficient resources to share with those who need them, or they may have weightier obligations to others that may prevent them from helping those in need of aid. Moreover, a serious problem about the notion of positive duties is fixing the locus of responsibility. To whom does one owe help? To every individual who needs it? To those we can help? Consequently, the notion of positive duties is less transparent, and, therefore, more controversial than the notion of negative ones.

But if there is a conflict between competing rights to life, e.g., between HIV positive physicians and non-HIV positive patients, and, conversely, one needs to appeal to other considerations to decide the extent of their moral responsibility. There are those who argue that both patients and physicians have an actual morally equivalent right to know of one another's HIV infection, and, therefore, an equivalent moral duty to inform.[41] On the contrary, there are those who maintain, as do the members of the National Commission on AIDS, that seropositive HCWs have no duty of disclosure.[42] They are seemingly missing the complexity of the moral issue in question. As moral agents, both patients and physicians have a *prima facie* right to know of one another's HIV infection based on their general natural duties. However, the question is whether to accept that physicians' right to know is as strong as patients' right to know.



This last claim is controversial. By virtue of their entrenched professional role, physicians acquire entrenched professional duties that patients lack. Consequently, even if one recognizes that patients as moral agents have duties to their physicians, it can be concluded that there is a weightier presumption in favor of either (1) physicians' voluntary disclosure of their seropositivity to their patients, or (2) their voluntary abstention from practicing invasive procedures on them, or both. This presumption is based on the premise that physicians *qua* physicians have a *categorical* entrenched negative duty of nonmaleficence to refrain from intentionally bringing about harm and/or undue risk of harm to their patients. Patients have a right to know based on both their right to life and their autonomy. Therefore, they are entitled to make an informed decision about whom they will allow to affect their bodily integrity and consequently their lives.[43]

This being so, it is contended that, even though some physicians are more at risk of being infected by their patients than *vice versa*, they have a weightier obligation than patients to disclose their serologic status only if they will expose them to *undue risk* of harm. In the present discussion, the debate is between patients' and physicians' right to life. If there is a conflict between competing rights to life, it seems that one must search for additional moral considerations to resolve it. That is precisely what I have attempted in this paper. By appealing to the language of social roles, I have argued for a moral presumption in favor of seropositive physicians disclosing their serologic status, or for ceasing practicing invasive procedures, provided there are seronegative physicians available to perform them.

In this paper no argument has been presented for any specific social policy. However, given that the risk of HIV infection from seropositive patients to seronegative physicians and, conversely, is approximately equivalent — especially if one follows universal precautions — or in some circumstances is even higher for physicians than for patients (e.g., surgeons and HCWs practicing in areas with high incidence of AIDS); it follows that given our respect for human life, we should adopt nondiscriminatory and hence fair social policies. Thus if an invasive procedure occurs, both physicians as well as patients have a duty to disclose any serious infection that may jeopardize their lives.

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## NOTES

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2. Dr. Arcer seems to have infected one more person, Ms. Sherry Annette Johnson. See *The New York Times*, May 8th (1993), p. 7

3. The Centers for Disease Control (CDC) defines *invasive procedures* as "surgical entry into tissues, cavities, or organs or repair of major traumatic injuries." See CDC, "Recommendation for Prevention of HIV Transmission in Health-Care Settings," *MMWR*, vol. 36, suppl. no. 2S (1987), pp. 6S-7S. Evidently, the problem of establishing a clear and noncontroversial criterion of what precisely constitutes an "exposure-prone" invasive procedure is a difficult issue beyond the scope of this paper. However, it is assumed that in some cases a relevant distinction could be made between invasive and noninvasive procedures. See CDC, "Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures," *MMWR*, vol. 40, no. RR-8 (July 12, 1991), p. 4. Assuming the CDC criterion for invasive procedures, e.g., it seems that general practitioners perform fewer and less risky procedures than surgeons.

4. In Dr. Almaraz's case no infected individual has been found. See Audrey Smith Rogers, Ph.D., MPH; John W. Froggatt III, MD; Timothy Townsend, MD, et al, "Investigation of Potential HIV Transmission to the Patients of an HIV-Infected Surgeon," *JAMA*, vol. 269, n. 14 (April 14, 1993), pp. 1795-1801.

5. For an argument defending the claim that patients have a weightier moral obligation than physicians to disclose their HIV infection, see Sandra E. Marshall, "Doctors' Rights and Patients' Obligations," *Bioethics*, vol. 4 (1990), pp. 293-310. See also Terence W. O'Connor, "Do Patients Have the Right to Infect Their Doctor?" *The Australian and New Zealand Journal of Surgery*, vol. 60 (1990), pp. 157-62.

6. Dr. Timothy Townsend, senior director of Medical Affairs at Johns Hopkins, argues that both patients and physicians have a right (presumably one that carries equivalent moral weight) to know of one another's HIV infection. He contends that "either neither has the right to know or both have the right to know." See *The New York Times*, December 8 (1990), p. 11.

7. For opposition to disclosure and mandatory AIDS testing, see National Commission on AIDS (NCA), *Preventing HIV Transmission in Health Care Settings*, July (1992); also NCA, *Report of the Working Group on Social/Human Issues* (April, 1991), especially pp. 20-21; Evelyn Shuster, "A Surgeon with Acquired Immunodeficiency Syndrome: A Threat to Patient Safety? The Case of William H. Behringer," *The American Journal of Medicine*, vol. 94 (1993), especially pp. 96-98. For a view against disclosure, but in favor of restricting seropositive physicians from performing "seriously invasive" procedures, see Larry Gostin, "The HIV-Infected Health Care Professional: Public Policy, Discrimination, and Patient Safety," *Law, Medicine & Health Care*, vol. 18 (1990), pp. 303-10; by the same author, "CDC Guidelines on HIV or HBV-Positive Health Care Professionals Performing Exposure-Prone Invasive Procedures," *Law, Medicine & Health Care*, vol. 19 (1991), pp. 140-43. For a categorical view against disclosure or restriction of seropositive HCWs, see Chai R. Feldblum, "A Response to Gostin, 'The HIV-Infected Health Care Professional: Public Policy, Discrimination, and Patient Safety'," *Law, Medicine & Health Care*, vol. 19 (1991), pp. 134-39. For an interesting utilitarian argument against physicians' disclosure, see also Norman Daniels, "HIV-Infected Professionals, Patient Rights, and the 'Switching Dilemma'," *JAMA*, vol. 267 (1992), pp. 1368-71.



8. The criteria of *undue risk* is to be understood contextually. However, it seems the following set of sufficient conditions provides us with a good grasp of what we generally mean by undue risk.

A person, **A**, exposes another person, **B**, to undue risk if

(1) **A** is aware of the risk in question.

(2) **B** is unaware of it.

(3) **B** does not seek it.

(4) If **A** had informed **B** about this risk, **B** could have either chosen to avoid it by refusing to take it, or could have chosen to take necessary precautions to face it head on.

If paternalism is to be avoided, then it should be recognized that moral agents have the right to choose when and how to face certain risks, provided they have no weightier obligation clashing with this right.

9. Harm is a protean term. One may be harmed in different ways, e.g., by violating one's interests, by infliction of physical pain, or by causing severe mental distress. For a succinct discussion of the concept of harm, see Joel Feinberg, *Social Philosophy* (Englewood Cliffs: Prentice-Hall, Inc., 1973), pp. 25-31. But, for the sake of the argument presented here, the concept of harm is restricted to physical harm. As Charles Fried explains, "physical harm" is "an impingement upon the body which either causes pain or impairs functioning." See Charles Fried, *Right and Wrong* (Cambridge: Harvard University Press, 1978), p. 30.

10. See American Medical Association, "AMA Statement on HIV-Infected Physicians" (January 17, 1991); AMA, *Digest of HIV/AIDS Policy*, (June 1993), especially p. 13; CDC, *Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus*, especially p. 5; NCA, *Report of The Working Group on Social/Human Issues*, especially pp. 20-21; see also NCA, *Preventing HIV Transmission in Health Care Settings*.

11. For an illuminating discussion on the nature of "social roles," see Germain Grisez and Russell Shaw, *Beyond the New Morality: The Responsibilities of Freedom* (Notre Dame: University of Notre Dame Press, 1974), pp. 116-27. See also the classic essay by F. H. Bradley, *"My Station and its Duties,* 170 in *Ethical Studies* (New York: Oxford University Press, 1988) pp. 160-213.

12. The degree of entrenchment of a social role depends upon a particular society. Thus the nature and understanding of a social role may vary from place to place and from time to time.

13. By "autonomy" it is meant the ability and willingness of people to act not only according to self-regarding reasons, but also compatibly with their duties to others.

14. The term "primary goods" is borrowed from John Rawls. He divides primary goods into (1) primary social goods such as rights and liberties, opportunities and powers, income and wealth, and, above all, self-respect; and (2) natural primary goods such as health, vigor, and intelligence. See John Rawls, *A Theory of Justice* (Cambridge: Harvard University Press, 1971) pp. 62, 92. The sense of "basic needs" used here is well captured by David Wiggins in *Needs, Values, and Truth* (Oxford: Basil Blackwell, 1991), p. 14. Roughly, a person needs something if and only if she will be harmed if she cannot get it.

15. There are at least two different kinds of obligations or duties: (1) *natural*, and (2) *artificial*. (1) Natural obligations: these are moral requirements imposed on moral agents regardless of recognition or approval of them. The obligatory nature of these duties issue from our recognition of others as having equal moral standing. For example, see John Rawls, *op. cit.*, pp. 114-15. (2) Artificial obligations: these correspond to what H. L. A. Hart identifies as "obligations." These are voluntarily acquired, e.g., promissory obligations, and, unlike natural obligations, are owed to specific moral agents who have corresponding claims or rights. See H. L. A. Hart, "Are There Any Natural Rights?" *Philosophical Review*, vol. 64, no. 2 (1955), p. 179.

16. The expected level of risk that one is required to face will depends in part upon the social role one occupies in society. For example, firefighters, police officers, soldiers, and HCWs, to mention only a few, are expected to face higher level of risk than ordinary citizens.

17. Similarly, the probability of a seropositive patient infecting a physician is generally low. According to James R. Allen, "even after mucous membrane exposure or parenteral inoculation of infected blood, fluids, or secretions is extremely low - probably less than one per 200 hundred incidents." See James R. Allen, "Health Care Workers and the Risk of HIV Transmission," *Hastings Center Report*, vol. 18, no.2 (April/May 1988), pp. 2-4.

18. For an interesting argument on how to balance confidentiality with a right to know, see Morton E. Winston, "AIDS, Confidentiality, and the Right to Know," in *Biomedical Ethics*, 3rd edition, edited by Thomas A. Mappes & Jane S. Zembaty (New York: McGraw-Hill, 1991), pp. 173-79. For an argument overriding the duty of confidentiality when third parties are at risk, see Benjamin Freedman, "Violating Confidentiality to Warn of a Risk of HIV Infection: Ethical Work in Progress," *Theoretical Medicine*, vol. 12 (1991), pp. 309-23; Troyen A. Brennan, "AIDS and the Limits of Confidentiality: The Physician's Duty to Warn Contacts of Seropositive Individuals," *Journal of General Internal Medicine*, vol. 4 (1989), pp. 242-46; and Bernard Lo, "Ethical Dilemmas in HIV Infection: What have we learned?" *Law, Medicine & Health Care*, vol. 20 (1992), especially p. 97.

19. For a new proposed policy against disclosure in the state of New Jersey, see *The Star-Ledger*, September 29 (1993), front page; *The Record*, September 29 (1993), front page.

20. See, e.g., Judith Wagner Decew, "The Scope of Privacy in Law and Ethics," in *The Nature and Process of Law: An Introduction to Legal Philosophy*, edited by Patricia Smith (New York: Oxford University Press, 1993), especially pp. 725-26.

21. According to the best scientific data available.

22. I benefitted from two important articles. See Robert M. Veatch, "Models for Ethical Medicine in a Revolutionary Age," in *Biomedical Ethics*, pp. 55-58; see also in the same volume Tom L. Beauchamp and Laurence B. McCullough, "Two Models of Moral Responsibility in Medicine," pp. 59-66.



23. It is assumed that health care is a basic need or at least an important one. The reason is that without adequate health care people's health would deteriorate. People's health, however, is necessary for exercising their autonomy and for preserving their well-being. Moreover, people's autonomy and well-being are necessary for them to flourish. For a thorough and sympathetic exploration of the concept of needs, see David Braybrooke, *Meeting Needs* (Princeton: Princeton University, 1987). For a defense of health care as a basic need, see Kai Nielsen, "Autonomy, Equality, and a Just Health Care System," in *Biomedical Ethics*, pp. 562-67; see also Norman Daniels, "Health-Care Needs and Distributive Justice," in *Ethical Issues in Modern Medicine*, 3rd. edition, edited by John Arras & Nancy Rhoden (California: Mayfield, 1989), pp. 501-09. For some problems associated with the concept of needs, see Charles Fried, *Right and Wrong*, pp. 119-31.

24. In criticizing the contractual model I benefitted from John Ladd, "Legalism and Medical Ethics," in *Ethical Issues in Modern Medicine*, pp 65-71.

25. There is a trend in society to extrapolate the adversarial model of the legal profession to other social roles. By being so concerned with the rights of physicians and patients, the physician-patient relationship is inadvertently infused with a sense of mistrust and antagonism.

26. It is assumed that natural positive duties are *prima facie*, i.e., they may be overridden by weightier moral considerations. For a classic discussion of *prima facie* duties, see W. D. Ross, *The Right and the Good* (Oxford: Oxford University Press, 1930), especially Ch. II.

27. Like natural positive duties, entrenched positive duties are also *prima facie*.

28. Unlike natural positive duties, natural negative duties are categorical. This is because they are sanctioned by categorical norms of right and wrong. These norms are directed to moral agents to prescribe choices and thereby proscribe behavior. To say that a norm is categorical is to say that it is impermissible to intentionally violate it. For an interesting defense of this deontological view, see Charles Fried, *Right and Wrong*, Ch. I, pp. 7-29. Critics may reply that the notion of categorical norms is too rigid and hence morally suspect. However, for my argument to work it is enough to recognize that negative duties are generally more stringent than positive ones. For a classic defense of this position, see Philippa Foot, "The Problem of Abortion and the Doctrine of the Double Effect," in *Virtues and Vices* (Berkeley: University of California Press, 1978), pp. 27-31.

29. Like natural negative duties, entrenched negative duties are categorical because they are also sanctioned by categorical norms. See note 28.

30. These duties are implicitly and explicitly stated in both The Hippocratic Oath and in different versions of ethical codes of the American Medical Association (AMA). For example, see "The Hippocratic Oath" and "Principles of Medical Ethics (1980)" in *Biomedical Ethics*, pp. 53-54. See also American Medical Association, *Report of Council on Ethical and Judicial Affairs*, (December 1987), pp. 168-70.

31. The class of "others" may include, e.g., future patients, patients' family, physicians' family and colleagues.

32. Critics may contend that the risk of a seropositive physician transmitting the virus to a patient is virtually negligible, and that since society does not normally

recognize that patients have a right to know certain aspects of a physician's private life, e.g., whether he is an alcoholic, a drug user, or a wife-beater, it follows that physicians have no obligation to disclose such information to their patients. But they are missing the point. The risk of HIV transmission is theoretically and physically possible. Moreover, even disallowing patients' right to know certain aspects of their physicians' private life, it does not follow that physicians have no obligation to disclose private information (especially if this information could affect patients' well-being), or to voluntarily refrain from unduly risking patients' lives. Similarly, although the notion of informed consent has not being used to question the serologic status of physicians, it does not follow that it should not be expanded to do so.

33. See Townsend, *op. cit.*

34. Physicians' duty to risk their lives, like police officers' duty to risk theirs, is not absolute. There may be extenuating circumstances under which they may not be required to risk their lives, and, therefore, their doing so may be considered either foolish or heroic. For a defense of the claim that physicians have a serious duty to treat AIDS patients, see Edmund D. Pellegrino, "Altruism, Self-Interest, and Medical Ethics," in *Biomedical Ethics*, pp. 113-14; in the same volume see John D. Arras, "AIDS and the Duty to Treat," pp. 115-21. See also AMA, *Report of Council on Ethical and Judicial Affairs*; AMA, "AMA Statement on HIV Infected Physicians;" and AMA, *Digest of HIV/AIDS Policy.*

35. Appealing to the history of the medical profession seems not to settle this issue. For example, see Daniel M. Fox, "The Politics of Physicians' Responsibility in Epidemics: A Note on History," *Hastings Center Report*, vol. 18, no. 2 (April/May 1988), pp. 5-9; see also Walter J. Friedlander, "On the Obligation of Physicians to Treat AIDS: Is There a Historical Basis?" *Reviews of Infectious Diseases*, vol. 12 (1990), pp. 191-203. For some of the arguments questioning a categorical duty to treat AIDS' patients, see Norman Daniels, "Duty to Treat or Right to Refuse," *Hastings Center Report*, vol. 21, no. 2 (March-April 1991), pp. 36-46.

36. For two important articles defending the obligation of physicians to treat AIDS' patients, see John D. Arras, "The Fragile Web of Responsibility: AIDS and the Duty to Treat," *Hastings Center Report*, vol. 18, no. 2 (April/May 1988), pp. 10-20; George J. Annas, "Legal Risks and Responsibilities of Physicians in the AIDS Epidemic," *Hastings Center Report*, vol. 18, no.2 (April/May 1988), pp. 26-32. See also note 38.

37. The right to privacy is contestable. There are authors, like Judith Thomson, who argue that the right to privacy is not a distinct right, but a derivative one that embodies a cluster of rights such as property rights and rights over one's person. See Judith Jarvis Thomson, "The Right to Privacy," *Philosophy and Public Affairs*, vol. 4 (1975), pp. 295-314. While others argue contra Thomson that the right to privacy is a distinct right, like the right to life or the right to liberty, and hence not always reducible to other rights. See Thomas Scalon, "Thomson on Privacy," *Philosophy and Public Affairs*, vol. 4 (1975), pp. 315-322; in the same issue see James Rachels, "Why Privacy is Important," pp. 323-333. See also Jeffrey H. Reiman, "Privacy, Intimacy, and Personhood," *Philosophy and Public Affairs*, vol. 6 (1976); W. A. Parent, "Privacy, Morality, and the Law," *Philosophy and Public Affairs*, vol. 12 (1983).

38. The criteria of "significant risk," like the criteria of "undue risk," must be contextually construed. Evidently, there are limits on the moral law that requires one to help those in need of it. If this were not so, the distinction between one's duty of beneficence and acts of supererogation would be blurred.



39. The exposition of the right to life has benefitted from Ramon M. Lemos, *Rights, Goods, and Democracy* (Newark: University of Delaware Press, 1986) especially Chs. 3 and 4.

40. See Philippa Foot, *Virtues and Vices*, pp. 27-31. For a sympathetic but critical view of Foot's distinction, see Charles Fried, *Right and Wrong*, pp. 19-20.

41. See Townsend, *op. cit.*

42. National Commission on AIDS, *Preventing HIV Transmission in Health Care Settings* (July of 1992)

43. It is assumed that paternalism medical or otherwise is always in need of justification. For a good collection on paternalism, see Rolf Sartorius (ed.), *Paternalism* (Minneapolis: University of Minnesota Press, 1983), especially the essay by Allen E. Buchanan, "Medical Paternalism," pp. 61-81.