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Sex, Lies, and Lawsuits: A New Mexico Physician's Duty to Warn Third Parties Who Unknowingly May Be at Risk of Contracting HIV from a Patient

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SEX, LIES, AND LAWSUITS: A NEW MEXICO PHYSICIAN'S DUTY TO WARN THIRD PARTIES WHO UNKNOWINGLY MAY BE AT RISK OF CONTRACTING HIV FROM A PATIENT

INTRODUCTION

The Hippocratic Oath states, in part, "[a]ll that may come to my knowledge in the exercise of my profession or outside of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal."[1] At one time, all physicians were presumed to have taken this oath before receiving their license to practice. Although many of the strictures contained within the Oath are at variance with current medical practices and needs of society,[2] the central and most admirable feature of the Oath, the respect it generates for the patient, is readily apparent in current medical creeds.[3] The public relies on this respect as a guarantee of privacy and confidentiality when disclosing medical information to a physician during medical treatment. At the same time, however, people expect physicians to notify them about preventative measures to avoid contracting disease and also to warn them when they might be at risk for disease.

In an effort to mitigate public expectations, both courts and legislatures have recognized a duty in the medical profession to maintain confidentiality[4] as well as a duty to warn third parties at risk of infection.[5] Judicial and statutory guidelines, however, are often ambiguous. Without clear legal guidelines, the physician must rely on his or her own intuition to resolve the apparent dilemma between confidentiality and potential protection of third parties. Clouding this intuition, however, are a physician's emotional involvement and ethical obligations. Moreover, whichever way the physician decides to resolve the dilemma inevitably invites litigation.

The emergence of Acquired Immunodeficiency Syndrome (AIDS) has intensified the conflict between a physician's duty to maintain confiden-

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1. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 768 (28th ed. 1994).

2. *See* John H. Leversee, *Hippocrates Revisited: A View from General Practice*, *in* HIPPOCRATES REVISITED 95-100 (Bulger ed., 1973) (recognizing that the Oath's positions on abortion and the right to die are increasingly outdated).

3. *See, e.g.*, THE DECLARATION OF GENEVA, World Medical Association (1948) (utilized during the University of New Mexico School of Medicine's commencement ceremonies, "I will respect the secrets which are confided to me").

4. *See, e.g.*, Hammonds v. Aetna Casualty & Surety Co., 237 F. Supp. 96 (N.D. Ohio 1965) (recognizing a physician's duty to maintain patient confidentiality); N.M. STAT. ANN. § 24-1-20 (Repl. Pamp. 1994) (mandating confidentiality of medical information).

5. *See, e.g.*, Jones v. Stanko, 160 N.E. 456 (Ohio 1928) (allowing a breach of patient confidentiality in favor of warning a third party of a contagious disease); N.M. STAT. ANN. § 24-1-8 (Repl. Pamp. 1994) (mandating disclosure to public health officials of unethical behavior endangering others).

tiality and a duty to warn third parties at risk of infection. Disclosing the medical history of a person with AIDS is in itself a distressing occurrence. However, a breach of confidentiality through disclosure can ostracize a patient's family and friends, as well as provoke discrimination in employment and housing.[6] Failing to warn an unsuspecting person about exposure to the virus, however, can lead to contraction of the disease, which is currently incurable. Instead of facing the impossibility of resolving this dilemma, a physician may refuse to treat patients infected with AIDS.

In New Mexico, a physician has a statutory duty to keep HIV-related information confidential.[7] The legislature has also recognized a physician's duty to warn third parties who may be at risk because of a patient's behavior.[8] Notwithstanding the recognition of a physician's duty to warn and to maintain confidentiality in New Mexico, a great deal of uncertainty currently exists as to the legal status of warnings to third parties. Physicians in New Mexico are left to resolve individually the conflict between protection of third parties and patient confidentiality and face potential liability for their decision. Without clear legal guidelines, physicians may refuse to treat HIV infected patients, the availability of medical treatment for AIDS patients may decrease, and statewide medical costs will increase.

This paper examines the conflict between a physician's duties of confidentiality and protection in New Mexico. Part I examines the medical and statistical background of AIDS. The next section reviews physician-patient confidentiality, including the need for confidentiality and the legal basis behind the confidentiality, in the specific context of AIDS. Part III examines the existence and scope of judicially and statutorily recognized exceptions to physician-patient confidentiality. Specifically, mandatory reporting statutes and contagious disease and mental illness cases from other jurisdictions will be considered. Part IV discusses physician-patient confidentiality and its recognized exceptions in New Mexico. Section V analyzes a New Mexico physician's current duty to third parties who may be in danger of contracting HIV from a physician's patient. Although it is unlikely that a physician will be held liable for failing to disclose AIDS-related information to third parties in New Mexico, possible suggestions for clarifying the physician's duty are presented in the conclusion.

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6. *See generally* Lawrence Gostin et al., *The AIDS Litigation Project: A National Review of Court and Human Rights Commission Decisions, Part II: Discrimination*, 263 JAMA 2086 (1990).

7. *See* N.M. STAT. ANN. § 24-2B-6 (Repl. Pamp. 1994) (mandating confidentiality of HIV related information). *See also infra* part IV.B.1.

8. *See* Wilchinsky v. Medina, 108 N.M. 511, 775 P.2d 713 (1989) (recognizing a physician's duty to the driving public when administering narcotics to his patients in his office). *See also infra* part IV.B.2.

I. AIDS - THE DISEASE[9]

In 1981, the United States Center for Disease Control (CDC)[10] officially reported the first case of Acquired Immunodeficiency Syndrome (AIDS).[11] Although there is evidence that AIDS may have existed before that time, the United States and other countries have now been dealing with the disease for more than ten years. At the end of 1981, there were only 189 documented AIDS cases.[12] In contrast, by January 1994, approximately 361,164 people in the United States had been diagnosed with AIDS,[13] with more than forty percent having already died as a result of the disease.[14] The World Health Organization predicts that by the year 2000, there will be 40 million HIV-infected men, women, and children in the world.[15]

AIDS is a devastating and fatal disease. It is not a single disease, in itself, but rather the culminating infection of various life threatening diseases, infections and cancers.[16] This group of diseases and infections is the result of a virus that impairs the body's immune system, rendering it ineffective. The virus has become known as Human Immunodeficiency Virus (HIV).[17] To combat infection, the human body's immune system relies heavily upon a category of blood cells known as CD4-T lymphocytes.[18] HIV depletes or impairs CD4-T cells.[19] Consequently, as CD4-T cell depletion occurs, the immune system becomes unresponsive, resulting in the body's susceptibility to opportunistic infections and other

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9. This is not meant to be a detailed discussion of AIDS. It is only meant to provide the reader with the knowledge necessary to understand this paper. For a more comprehensive discussion of AIDS, *see* AIDS TESTING: A COMPREHENSIVE GUIDE TO TECHNICAL, MEDICAL, SOCIAL, LEGAL, AND MANAGEMENT ISSUES (Gerald Schochetman & J. Richard George eds., 2d ed. 1994) [hereinafter AIDS TESTING]; B.D. SCHOUB, AIDS AND HIV IN PERSPECTIVE: A GUIDE TO UNDERSTANDING THE VIRUS AND ITS CONSEQUENCES (1994) [hereinafter SCHOUB].

10. Since its detection, the Center for Disease Control (CDC) has monitored and defined the progress of HIV. In 1987, the CDC defined the progress of the virus from the moment of initial infection through four general stages. Centers for Disease Control, *Revision of the CDC Surveillance Case Definition for AIDS*, 36 Mortality & Morbidity Weekly Rep. No. 1S (1987). In January 1993, the CDC adopted an expanded AIDS case definition that took into account severe immunosuppression per se and added recurrent bacterial pneumonia, pulmonary tuberculosis, and invasive cervical carcinoma in HIV seropositive people to the long list of AIDS-defining conditions. Centers for Disease Control, *1993 Revised Classification System for HIV Infection and Expanded Surveillance Case Definition for AIDS Among Adolescents and Adults*, 41 Morbidity & Mortality Weekly Rep. RR 17 (1992). Because most of the current legislation was enacted previous to the 1993 re-classification, this paper will rely primarily on the prior CDC AIDS definition.

11. *See* SCHOUB, *supra* note 9, at 2. AIDS was previously referred to as Acquired Immune Deficiency Syndrome. *See generally* AIDS AND THE LAW 26 (Harlon L. Dalton et al. eds., 1987).

12. CDC, *The HIV/AIDS Epidemic: The First 10 Years*, 40 Morbidity & Mortality Weekly Rep. 357, 358 (1991) [hereinafter *HIV/AIDS Epidemic*].

13. CDC, *Summary of Notifiable Disease, United States 1993*, 42 Morbidity & Mortality Weekly Rep. 15 (1994). There was a significant increase from 1992 to 1993, attributable to the CDC's revised classification expanding the definition of people with AIDS. *See supra* note 10.

14. *Id.* at 15.

15. *See HIV/AIDS Epidemic*, *supra* note 12, at 357.

16. *See* SCHOUB, *supra* note 9, at 23-31.

17. *See, e.g.*, *id.* at 19.

18. *See* AIDS TESTING, *supra* note 9, at 35 (stating "CD4T cells are a pivotal cell in the orchestration of an effective immune response").

19. *Id.* at 32.

disorders.[20] Opportunistic infections arise from organisms normally found in the environment, but not usually harmful to those with healthy immune systems.[21]

A. HIV Testing

Currently, there is no test available to confirm the presence of HIV itself.[22] Tests primarily detect the presence of antibodies that have developed in a person's body to fight off HIV infection. Of these, the two most widely known are the enzyme-linked immunosorbent assay technique (ELISA) and the Western Blot test.[23] Due to its short incubation period, the ELISA is usually the first test to be performed on a blood sample. Although results are generally available within twenty-four hours, the ELISA is known to produce a high level of false positive results.[24] The Western blot has an extremely low rate of error, but is more expensive and has a much longer incubation period.[25] Normal medical procedure involves performing the Western blot test only after two successive ELISA tests return positive.[26] People who test positive are presumed capable of transmitting the infection to others.

B. Latency Period and Symptoms

A related problem with the HIV tests is the latency period associated with the detection of HIV antibodies. Currently, there is no way of determining whether HIV-positive people will eventually contract AIDS,[27] or how long the process may take, as the time between exposure and onset of symptoms varies from six months to more than ten years.[28] As a result of the latency period, symptoms often vary significantly.

Within a month or two of contracting the virus, many people exhibit symptoms similar to mononucleosis or the flu, such as fever, headaches, night sweats, and diarrhea.[29] During this time, infected people do not test positive for HIV, as the body does not start producing antibodies to HIV until sometime after the second month. This creates difficulty

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20. *Id.*

21. *See* SCHOUB, *supra* note 9, at 25-26.

22. The development of an accurate test not for antibodies, but for the virus itself will dramatically change standards for such testing by eliminating the problem of the "window period" between infection and production of antibodies.

23. *See* AIDS TESTING, *supra* note 9, at 54.

24. *See id.* at 56-57. False positives are the result of the nature of the test and its relatively short incubation period of four to six hours. In studies of non-high risk group participants, as many as nine out of ten test results returned false positive. *Id.*

25. *Id.* at 57-59.

26. H. Alten et. al., *Determination of the Prevalence of HIV-1 p24 Antigen in United States Blood Donors and an Assessment of the Potential Efficacy of this Market for Blood Screening*, 323 NEW ENG. J. MED. 1312, 1317 (1990).

27. It is assumed that all HIV infections lead to AIDS, but this has not been proven.

28. RON BROOKMEYER & MITCHELL H. GAIL, AIDS EPIDEMIOLOGY: A QUANTITATIVE APPROACH 111 (1994).

29. MARTIN GUNDERSON ET AL., AIDS: TESTING AND PRIVACY 15-16 (Margaret P. Battin et al. eds., 1989).

in early identification of HIV because even people suspicious that the early flu-like illness may be HIV related will not test positive right away.

Shortly thereafter, individuals test positive for HIV, but often remain asymptomatic.[30] Thus, a person in seemingly good health could be a carrier of HIV for some time without realizing it. With no symptoms to indicate the presence of the disease, an HIV-positive person may infect numerous others by foregoing the precautions necessary to prevent the spread of the disease.

As the immune system deteriorates, symptoms begin to materialize. Typically, an infected person first notices a loss of energy.[31] Additional symptoms include generalized lymph node swelling, fevers, diarrhea, and weight loss.[32] The body also begins to require more sleep and may experience a lack of resistance to infection. These symptoms, however, could indicate many common illnesses and do not necessarily imply HIV-infection.

When the immune system becomes more susceptible to secondary infections, such as Kaposi's sarcoma, pneumocystic pneumonia, and lymphoma, the infected person is considered to be in the advanced stages of AIDS. At this point, HIV has destroyed most of the body's white blood cells, leaving the host's ineffective immune system defenseless to opportunistic infections.[33]

C. *Transmission*

HIV is not an airborne virus and is not transmitted through casual contact such as hugging or shaking hands. The virus can only be transmitted from one individual to another through blood products, bodily secretions, or fluids.[34] Thus, individuals who share intravenous drug needles, who engage in unprotected sex, who have had a blood transfusion, who have had a blood splash or a stick with a medical instrument with infected blood on it, or who are born to HIV positive or AIDS infected mothers have been known to contract HIV.[35] However, outside of having unprotected sex, sharing intravenous needles, and being born to or breast-feeding from an infected mother, the risk of transmission approaches zero.[36] Thus, sexual partners and people who share intravenous needles are considered high-risk groups for contracting the HIV infection.[37]

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30. *Id.* at 16.
31. *Id.*
32. *Id.* at 16-17 (these conditions formerly defined AIDS-related complex (ARC)).
33. All states require the reporting of a diagnosis of AIDS to public health authorities. Originally, most AIDS legislation only recognized this final full-blown stage for public health reporting purposes, but statutes now require reporting of the disease even when asymptomatic or exhibiting only mild symptoms. *See, e.g.*, COLO. REV. STAT. ANN. § 25-4-1402 (West 1990) (requiring a report in writing to the state or local department of health on every individual known to have a HIV related illness). *Cf.* COLO. REV. STAT. ANN. § 25-4-1402.5 (researchers conducting HIV-related medical research exempt from reporting requirement) (effective July 1, 1994).
34. *See generally* SCHOUB, *supra* note 9, at 91-120.
35. *See* Larry O. Gostin, *A Decade of a Maturing Epidemic: An Assessment and Directions for Future Public Policy*, 5 NOTRE DAME J.L. ETHICS & PUB. POL'Y 7 (1990).
36. *See* WORLD HEALTH ORGANIZATION, AIDS: IMAGES OF THE EPIDEMIC 9 (1994).
37. Gostin, *supra* note 35, at 11.

D. *Prevention and Cure*

Presently there is no known cure for the HIV infection or AIDS.[38] The virus has the ability to mutate in certain genes, producing a modified protein coat.[39] Mutation severely reduces the likelihood of creating an effective vaccine because vaccines that can effectively combat a particular viral strain may not protect against the mutated strain with its altered protein coat.[40] Thus, once a person has HIV, treatments are limited to alleviating symptoms. Different drugs have been introduced as treatments,[41] but they are all still in the experimental stages.[42] As a result, it is generally agreed that early treatment of asymptomatic HIV infection can be advantageous in the prevention or delay of illness.[43]

II. PHYSICIAN-PATIENT CONFIDENTIALITY

Physician-patient confidentiality is an integral part of medical treatment for many reasons. The various implications of AIDS heightens the role of confidentiality in medical treatment. Although the integrity of the medical profession is directly dependent on the ability of physicians to maintain confidentiality, state legislatures[44] and courts[45] currently impose a legal duty on physicians to maintain confidentiality.

A. *The Need for Confidentiality*

Confidentiality between physicians and patients serves several purposes. First, confidentiality encourages patients to be completely truthful with their physicians and to provide all information necessary for treatment, including embarrassing and humiliating problems. Second, confidentiality ensures that sensitive medical conditions that patients wish to remain private are not disclosed in an effort to protect patients from potential mistreatment due to people's prejudices and fears of disease.

Maintaining doctor-patient confidentiality in the context of AIDS is essential for compassionate treatment of those infected with HIV. In addition to horrific diseases and the unavailability of a cure, individuals infected with HIV face social opprobrium and discrimination due to irrational fears and prejudices. Persons with AIDS and those only suspected of having it, including children, have not only lost the support of friends and family, but have also been denied housing, employment,

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38. *See, e.g.*, HIV INFECTION: A CLINICAL MANUAL 34 (Howard Libman & Robert A. Witzburg eds., 2d ed. 1993).

39. SCHOUB, *supra* note 9, at 189.

40. *Id.*

41. In 1987, the FDA approved azidovudine (AZT) for use in the treatment of the virus itself. AIDS IN THE WORLD 233-34 (Jonathan M. Mann et al. eds., 1992). In 1991, ddI was approved. *Id.* Both drugs inhibit an enzyme in the HIV from replicating itself. The FDA has also approved a third drug, ddC, for use in combination with AZT. *Id.*

42. *See id.* at 234, 238 (discussing different combinations of drugs and treatment timing).

43. *See* SCHOUB, *supra* note 9, at 177.

44. *See infra* part II.B.1 (discussing statutory basis for physician-patient confidentiality).

45. *See infra* part II.B.2 (discussing judicial basis for physician-patient confidentiality).

insurance, and admission to schools.[46] As a result, persons at risk for HIV have strong grounds for desiring personal privacy and confidentiality of medical information.

Discrimination against people with AIDS consequently affects the health care community's ability to provide an effective program of preventing and controlling AIDS. Because there is presently no cure for AIDS, the only way to curb the advancement of the disease is by educating those who are uninfected about preventative measures, and initiating behavioral changes in those infected and those in the high-risk groups. Education and counseling form the foundation for behavioral change. The public-health community must ascertain who is infected and at high risk in order to provide education and counseling to the proper people.

In addition to education and counseling, volunteer testing is also an integral part of an effective program of preventing and controlling AIDS. Volunteer testing usually takes one of two forms: anonymous and confidential.[47] During anonymous testing, a person receives a number in lieu of disclosing his or her identity.[48] Results are dispersed according to that number.[49] Confidential testing, on the other hand, does not displace a person's identity, but rather relies on a procedure to insure that the person's identity as well as test results will remain confidential.[50] Because volunteer testing necessarily leads to early detection and treatment of HIV at the same time ensures a level of trust in health-care providers responsible for providing needed treatment, maintaining confidentiality is essential. Because of discrimination and stigma, however, people will not participate in volunteer testing if they feel that test results or information will not remain confidential. Thus, successful efforts aimed at controlling the AIDS virus and preventing its spread necessarily depend upon confidentiality of medical information.

Recognizing the need to ensure patient privacy, the CDC has published a list of suggestions for reducing further transmission of AIDS.[51] In this list, the CDC recommends that doctors provide more protection of patient confidentiality.[52] Similarly, the American Hospital Association has recommended that hospitals take special care to ensure the confidentiality of information pertaining to the treatment of AIDS patients.[53] Additionally, the American Medical Association has called for legislation to

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46. *See* Gostin, *supra* note 6, at 2086-87.

47. *See generally* RONALD BAYER, PRIVATE ACTS, SOCIAL CONSEQUENCES 121 (1989); RONALD VALDISERRI, PREVENTING AIDS 219-45 (1989).

48. *Id.*

49. *Id.*

50. *Id.*

51. *See* CDC, *Additional Recommendations to Reduce Sexual and Drug Related Transmission of Human T-lymphotropic Virus Type III/Lymphodenopathy-Associated Virus*, 35 Morbidity & Mortality Weekly Rep. 152 (1986).

52. *Id.*

53. *See* American Hospital Ass'n, REPORT AND RECOMMENDATIONS OF THE SPECIAL COMMITTEE ON AIDS/HIV INFECTION POLICY (1988).

protect the confidentiality of antibody test results unless withholding the test results would threaten the public health.[54]

B. Legal Recognition of Physician-Patient Confidentiality

Implied in the Hippocratic Oath,[55] the duty of confidentiality subsequently began only as an ethical requirement. Indeed, the elevated integrity of the medical profession appears to have been built on physicians' ability to maintain confidentiality. Eventually, however, courts and legislatures began to recognize the existence of the duty of confidentiality, and have held physicians liable for failing to protect a patient's confidentiality.

1. Statutory Recognition

Nationwide, state legislatures have imposed a legal requirement upon physicians to maintain patient confidentiality.[56] Most confidentiality statutes impose an obligation on physicians to maintain the confidentiality of their patients' medical records or files.[57] The statutory duty of confidentiality includes not only the physician, but also anyone else who comes in contact with the records.[58] Some states also recognize a physician-patient privilege, which protects information disclosed to a physician by a patient from being made public during any type of legal or administrative proceeding.[59] The ability to waive this privilege resides solely with the patient or his representative.[60] Due to the personal nature of the information involved, many states provide specific statutory protection for information regarding contagious and sexually transmitted diseases.[61]

State legislatures, however, do not usually classify HIV infection as a sexually transmitted disease for purposes of confidentiality statutes. To clarify this situation, most states have passed legislation specifically pro-

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54. *See* American Medical Ass'n, *Prevention and Control of Acquired Immunodeficiency Syndrome: An Interim Report*, 258 JAMA 2097 (1987).

55. *See supra* note 1 and accompanying text.

56. *See, e.g.*, CAL. CIV. CODE § 56.10 (West Supp. 1996); MASS. GEN. LAWS ANN. ch. 111, § 70E(b) (West 1996); R.I. GEN. LAWS § 5-37.3-4 (1995); TENN. CODE ANN. § 10-7-504 (1992).

57. *See, e.g.*, CAL. CIV. CODE § 56.10(a) (prohibiting disclosure of "medical information"); MASS. GEN. LAWS ANN. ch. 111 § 70E(b) (mandating confidentiality of "all records and communications"); R.I. GEN. LAWS § 5-37.3-4(a) (requiring a "patient's health care information" remain confidential); TENN. CODE ANN. § 10-7-504(a)(1) (mandating confidentiality of "the medical records of patients").

58. *See, e.g.*, CAL. CIV. CODE § 56.10(a) (extending duty to "provider of health care"); MASS. GEN. LAWS ANN. ch. 111, § 70E (extending duty to patients of any hospital, institution for the care of unwed mothers, clinic, infirmary, convalescent or nursing home, rest home or charitable home for the aged); R.I. GEN. LAWS § 5-37.3-3 (extending duty to any "health care provider"); TENN. CODE ANN. § 10-7-504 (extending duty to state, county and municipal hospitals and medical facilities).

59. *See, e.g.*, FLA. STAT. ANN. § 90.503 (Harrison Supp. 1994) (psychotherapist-patient); LA. REV. STAT. ANN. § 13:3734 (West 1991) (physician-patient); NEB. REV. STAT. § 27-504 (Supp. 1994) (physician-patient); N.J. STAT. ANN. § 2A:84A-22.2 (West 1994) (physician-patient); OR. REV. STAT. § 40.235 (1988) (psychologist-patient); TENN. CODE ANN. § 24-1-207 (Supp. 1995) (psychiatrist-patient).

60. *See supra* note 59.

61. *See, e.g.*, ALA. CODE § 11A-22 (1992); CAL. HEALTH & SAFETY CODE § 120705 (West Supp. 1996); COLO. REV. STAT. ANN. § 25-4-402 (West Supp. 1995); DEL. CODE ANN. tit. 16, § 711 (1995); 35 PA. CONS. STAT. ANN. § 521.15 (1993).

tecting the confidentiality of HIV-related information.[62] HIV confidentiality statutes broadly protect the identity of individuals seeking an HIV test, their seropositive status, and their medical records.[63] Accordingly, confidentiality statutes encourage people to participate in voluntary testing, which, in turn, enables state public health officials to accumulate data necessary for prevention and education.

2. Common Law Recognition

Although the United States Supreme Court has recognized an implied constitutional right to privacy,[64] under which a patient's right to confidentiality would seemingly fall, the concept of a constitutional right to privacy still remains largely undefined. The Supreme Court has held that a person's medical records fall within the constitutional zone of privacy.[65] Additionally, a federal court in Missouri, citing earlier state cases, held that the right to privacy includes the right to have medical information kept confidential from the general public.[66] Even though the Supreme Court has not explicitly held that the constitutional right to privacy protects an individual from unlimited disclosure of personal information, individual state courts have long recognized a common law right to physician-patient confidentiality.[67]

Cases awarding damages as a result of a physician's disclosure of information illustrate the existence of a legally recognized duty of physician-patient confidentiality at common law. Courts have based

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62. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 120820 (West Supp. 1996); FLA STAT. ANN. § 381.004(3)(f) (Harrison Supp. 1994); GA. CODE ANN. §24-9-47(b)(1) (Supp. 1994); ILL. ANN. STAT. ch. 410, para. 305, § 9 (Smith-Hurd Supp. 1995); N.Y. PUB. HEALTH LAW § 2782(1) (McKinney 1993).

63. *See supra* note 62.

64. *See* Griswold v. Connecticut, 381 U.S. 479, 485 (1965) (holding that the use of contraceptives between married couples lies "within the zone of privacy created by several fundamental constitutional guarantees"); Mapp v. Ohio, 367 U.S. 643, 656 (1961) (holding the Fourth Amendment to create a "right to privacy, no less important than any other right carefully and particularly reserved to the people").

65. *See* Whalen v. Roe, 429 U.S. 589, 605-06 (1977).

66. *See* Mikal v. Abrams, 541 F. Supp. 591, 597 (W.D. Mo. 1982), *aff'd mem.*, 716 F.2d 907 (8th Cir. 1983) (although a person is entitled to know the medical status of his or her spouse).

67. *See* Hammonds v. Aetna Casualty & Surety Co., 237 F. Supp. 96 (E.D. Ohio 1965), *aff'd on reh'g*, 243 F. Supp. 793 (E.D. Ohio 1965) (holding that patient stated a cause of action against an insurance company who allegedly induced physician to divulge medical information of the patient); Simonsen v. Swenson, 177 N.W. 831 (Neb. 1920) (holding that a physician had a duty not to divulge information concerning treatment of patient's syphilis, but allowed a narrow exception to prevent spread of disease to identifiable individuals); Hague v. Williams, 181 A.2d 349 (N.J. 1962) (holding that physician who obtained information about a patient's new infant had a duty not to disclose frivolously the information); Doe v. Roe, 400 N.Y.S.2d 668 (N.Y. Sup. Ct. 1977) (holding that physician's descriptions of patient information in a book of case studies, although anonymous, is actionable); Clark v. Geraci, 208 N.Y.S.2d 564 (N.Y. Sup. Ct. 1960) (holding that patient stated a cause of action against armed forces physician who divulged patient's alcoholism, but disallowed recovery because patient had authorized partial disclosure); Humphers v. First Interstate Bank of Oregon, 696 P.2d 527 (Or. 1985) (holding that a mother had a cause of action against her physician after he divulged her identity to her biological daughter put up for adoption at birth); Berry v. Moench, 331 P.2d 814 (Utah 1958) (holding that a physician's disclosure of a patient's medical information to another physician for nonmedical reasons was actionable).

recovery against physicians for breach of patient confidentiality on a variety of theories. Patients have asserted a variety of causes of action against physicians for unauthorized disclosures of information, including implied statutory law,[68] breach of implied contract,[69] and invasion of privacy.[70] Courts are more willing to recognize a duty to maintain this confidentiality when there are state laws which indicate the public policy behind the duty.[71] Additionally, courts have also begun to recognize an emerging tort, breach of confidentiality,[72] which specifically allows a patient a cause of action for a physician's breach of confidentiality. The establishment of the distinct tort of breach of patient confidentiality indicates the state courts' willingness to recognize a duty of confidentiality and demonstrates just how far the courts will go to find a physician liable for a breach.

In *Simonsen v. Swenson*,[73] for example, the Nebraska Supreme Court relied on the theory of implied statutory law when it recognized that the "relation of physician and patient is necessarily a highly confidential one."[74] In *Simonsen*, after treating his patient for syphilis, a physician disclosed the information to the owners of the hotel where his patient was staying.[75] The court sustained a cause of action against a doctor for wrongful divulgence and based its decision upon that portion of a state medical licensing statute.[76] According to the statute, a physician's license could be revoked, under the terms of the statute, for any unauthorized or unprivileged betrayal of communication.[77] The *Simonsen* court noted that the statute at issue constituted a sufficient expression of public policy to support a cause of action against a physician who betrayed a patient's confidences.[78]

Additionally, in *Berry v. Moench*,[79] parents, distraught over their daughter's plans to marry plaintiff, asked their family doctor to investigate

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68. *See Hammonds*, 237 F. Supp. at 101-02 (stating that requirement in state medical licensing statute precluding disclosure of confidential information implied duty of confidentiality); Simonsen v. Swenson, 177 N.W. 831 (Neb. 1920) (holding that state statute mandating professional conduct of physician implied duty of confidentiality); *Geraci*, 208 N.Y.S.2d at 567 (holding that duty of secrecy was implied by state statutory law).

69. *See Hammonds*, 237 F. Supp. at 98 (recognizing a breach of contract cause of action after physician stopped treating patient following disclosure of patient's prior medical information); *Hague*, 181 A.2d at 349 (holding that after patient contracts with defendant for services, the physician is under a duty not to disclose information regarding the services); Doe v. Roe, 400 N.Y.S.2d 668, 674 (N.Y. Sup. Ct. 1977) (holding that a relationship between a physician and patient establishes a contractual relationship with a duty to maintain confidence); *Humphers*, 696 P.2d at 536 (recognizing that a contract claim may be adequate where the breach of confidence causes financial loss).

70. *See* Horne v. Patton, 287 So.2d 824, 831-32 (Ala. 1973). *See also Humphers*, 696 P.2d 527, 531 (identifying plaintiff's interest in confidentiality as a privacy interest).

71. *Hammonds*, 237 F. Supp. at 101 (N.D. Ohio 1965) ("statutes of Ohio contain both basic expressions of public policy which have persuaded these other courts [*Simonsen*, *Berry*, and *Clark*]").

72. *See Roe*, 400 N.Y.S.2d at 670-71; *cf. Humphers*, 696 P.2d at 533.

73. 177 N.W. 831 (Neb. 1920).

74. *Id.* at 832.

75. *Id.*

76. *Id.* (relying on NEB. REV. ST. § 2721 (1913)).

77. *Id.* (citing NEB. REV. STAT. § 2721 (1913)).

78. *See id.*

79. 331 P.2d 814 (Utah 1958).

plaintiff's background.[80] The doctor contacted the defendant, a psychiatrist who had treated plaintiff seven years earlier.[81] Defendant's response disclosed the details of plaintiff's therapy, which included electric shock treatment, and advised the daughter to "run as fast and far as she possibly could in any direction away from him."[82] The Utah Supreme Court held that a cause of action existed against the doctor for the wrongful disclosures. The court based its decision on a public policy of non-disclosure implied in Utah's privileged communication statute.[83]

Courts also have recognized a physician's duty to maintain confidentiality based on an implied contract between the physician and the patient,[84] or based on a general duty not to disclose.[85] In *Hammonds v. Aetna Casualty & Surety Co.*,[86] for instance, a federal district court in Ohio stated that even if there is no statute creating a duty of confidentiality, public policy implies a duty of "implied secrecy" in the physician-patient relationship.[87] The court went on to find three theories for holding physicians liable for the unjustified disclosure of confidential information, even without a statute: breach of contract, breach of a fiduciary relationship, and breach of an implied promise of secrecy or confidentiality.[88]

A more recent example involved a book of case studies that a psychiatrist and her psychologist husband published for popular as well as scientific consumption.[89] The book contained biographical details and verbatim disclosures of a former patient including descriptions of her thoughts, emotions, and intimate fantasies.[90] The patient was a university professor, whom friends, colleagues, and students were able to identify from the material in the book. In searching for a theory of liability, the court discussed implied statutory cause of action, tort, and implied contract, but ultimately held that this disclosure was an actionable breach of confidence based in tort.[91]

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80. *Id.* at 816.
81. *Id.*
82. *Id.*
83. *Id.* at 817 (citing UTAH CODE ANN. § 78-24-8 (1953) (providing that a physician cannot be examined as to any information acquired in attending his patient)).
84. *See, e.g.*, Hammonds v. Aetna Casualty & Surety Co., 237 F. Supp. 96, 98 (N.D. Ohio 1965)(recognizing a breach of contract cause of action after physician stopped treating patient following disclosure of patient's prior medical information); Hague v. Williams, 181 A.2d 345, 349 (N.J. 1962) (holding that after patient contracts with defendant for services, the physician is under a duty not to disclose information regarding the services); Doe v. Roe, 400 N.Y.S.2d 668, 674 (N.Y. Sup. Ct. 1977) (holding that a relationship between a physician and patient establishes a contractual relationship with a duty to maintain confidence); Humphers v. First Interstate Bank of Oregon, 696 P.2d 527, 527-29 (Or. 1985) (recognizing that a contract claim may be adequate where the breach of confidence causes financial loss).
85. A physician is "under a *general duty* not to disclose frivolously the information received from [the patient] or from an examination of the patient." *Hague*, 181 A.2d at 349 (emphasis added).
86. 237 F. Supp. 96 (N.D. Ohio 1965).
87. *Id.* at 102.
88. *Id.* at 98.
89. *See* Doe v. Roe, 400 N.Y.S.2d 668 (N.Y. Sup. Ct. 1977).
90. *See id.* at 671.
91. *Id.* at 676.

More recently, the Oregon Supreme Court recognized the physician-patient confidentiality by establishing the tort of breach of confidential relationship.[92] In *Humphers v. First Interstate Bank of Oregon*,[93] a mother who had given up her daughter for adoption just after her birth brought an action against the physician who had delivered her daughter, and subsequently helped reveal the mother's identity to the daughter.[94] The mother sought relief under two different theories: breach of a confidential or privileged relationship and invasion of privacy.[95] The court held that the mother had no cause of action under the invasion of privacy theory, but she could proceed against the physician for breach of confidence in a confidential relationship.[96]

Physician-patient confidentiality has only recently been applied in the context of AIDS.[97] In *Behringer v. Medical Center at Princeton*,[98] the estate of a surgeon diagnosed with AIDS at a hospital later brought a cause of action against the hospital for breach of the AIDS information.[99] At the time of the diagnosis, the plaintiff was also a member of the surgical staff of the hospital.[100] After discovering that he had AIDS, the plaintiff decided to have treatment administered at home in an effort to prevent his diagnosis from becoming public.[101] However, upon returning home, the plaintiff received many phone calls from practitioners inquiring about both his health and the health of his companion.[102] A month after diagnosis, plaintiff returned to his office practice.[103] Although plaintiff took steps to minimize disclosure to his patients, he began receiving patient cancellations, requests for records, and resignations from long-time employees.[104] During the next two years, until his death, plaintiff's office practice diminished at a very high rate.[105]

At trial, plaintiff could not identify specifically the actual sources of the disclosure of his diagnosis. However, plaintiff argued that the medical center's failure to implement meaningful restrictions on access to his medical records was sufficient to establish liability.[106] The court stated that it "makes little difference to identify those who 'spread the news,'"

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92. *See* Humphers v. First Interstate Bank of Oregon, 696 P.2d 527, 536 (Or. 1985).
93. *Id.*
94. *Id.* at 527-28.
95. *Id.* at 528.
96. *Id.* at 533.
97. *See e.g.*, Estate of Behringer v. Medical Ctr. at Princeton, 592 A.2d 1251 (N.J. Super. Ct. Law Div. 1991) (recognizing duty of health care providers to maintain confidentiality of AIDS-infected surgeon); Doe v. Borough of Barrington, 729 F. Supp. 376 (D.N.J. 1990) (recognizing violation of Fourteenth Amendment after police officer disclosed AIDS infection of family members).
98. 592 A.2d 1251 (N.J. Sup. Ct. 1991).
99. *Id.* at 1257.
100. *Id.* at 1256.
101. *Id.* at 1256.
102. *Id.*
103. *Id.*
104. *Id.* at 1257.
105. *Id.*
106. *Behringer*, 592 A.2d at 1268.

when such sensitive information was made so readily available.[107] The court held that the hospital's failure to take reasonable steps to maintain the confidentiality of plaintiff's medical records was a breach of the medical center's duty and obligation to keep such records confidential.[108]

Based on the *Behringer* decision, it appears that the public's perception of AIDS will be an integral factor towards a determination of a duty of physician-patient confidentiality in the context of AIDS.[109] Because of the stigma and discrimination surrounding AIDS, courts will possibly be more critical of normal protocols attempting to ensure confidentiality.[110] As a result, physicians treating patients suffering from AIDS could be scrutinized more closely in actions brought by patients for a breach of confidential information.

III. EXCEPTIONS TO PHYSICIAN-PATIENT CONFIDENTIALITY

Courts generally agree that a physician's duty to maintain the confidentiality of information acquired through the physician-patient relationship is not absolute.[111] Disclosure of information by physicians has been approved in situations in which strict confidentiality conflicts with the "supervening interests of society."[112] Under such circumstances, a physician has a qualified privilege to disclose confidential information. Circumstances that qualify as supervening interests of society, however, have been narrowly interpreted.[113]

It is clear that society views AIDS with significant concern. It is not certain, however, whether AIDS would qualify as a supervening interest enabling a doctor to override the physician-patient confidentiality in favor of disclosure to a third party. Proponents of requiring a physician to warn third parties argue that because AIDS is incurable, the failure to

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107. *Id.* at 1273.

108. *Id.* at 1274.

109. *See Behringer*, 592 A.2d at 1269-74 (discussing the implications of AIDS in a determination of duty to maintain confidentiality).

110. *See id.* at 1271-72 (analyzing hospital's normal record keeping procedures).

111. *See, e.g.*, Simonsen v. Swenson, 177 N.W. 831, 832 (Neb. 1920) ("[n]o patient can expect that if his malady is found to be of a dangerously contagious nature he can still require it to be kept secret from those to whom, if there was no disclosure, such disease would be transmitted"); Hague v. Williams, 181 A.2d 345, 349 (N.J. 1962) ("not to say that the patient enjoys an absolute right"); Estate of Behringer v. Medical Ctr. at Princeton, 592 A.2d 1251, 1268 (N.J. Sup. Ct. 1991) ("[n]otwithstanding the strong policy in favor of the physician-patient privilege and the ensuing obligation of confidentiality, exceptions to the privilege have been widely recognized"); Clark v. Geraci, 208 N.Y.S.2d 564, 567 (N.Y. Sup. Ct. 1960) ("[t]he delicate balance of conflicting duties must thus be weighed . . . to determine the doctor's paramount duty"); Humphers v. First Interstate Bank of Oregon, 696 P.2d 527, 535 (Or. 1985) ("[p]hysicians . . . also may be legally obliged to report medical information to others . . ."); Berry v. Moench, 331 P.2d 814, 817 (Utah 1958) ("the responsibility of the doctor to keep confidence may be outweighed by a higher duty to give out information . . . if there is a sufficiently important interest to protect").

112. Hague v. Williams, 181 A.2d 345, 349 (N.J. 1962) (stating that patient possesses a limited right against such disclosure, subject to exceptions prompted by the supervening interest of society).

113. Case law that has allowed for breaches of doctor-patient confidentiality has done so after determining that the release of the information would be an overall public benefit. *See supra* notes 64-110 and accompanying text.

warn far outweighs the physician's duty of confidentiality to the patient.[114] However, the question of whether the existence of AIDS rises to the level of supervening public interest, should be considered in the context of current exceptions to physician-patient confidentiality.

A. Legal Basis

In an effort to protect physicians from unlimited liability, courts and legislatures began to recognize exceptions to physician-patient confidentiality. Statutes granting physicians the ability to disclose patient information largely derive from a state's need to protect its citizens. Common law exceptions range from a narrow duty to disclose in the context of contagious diseases to a broader duty in the context of mental illness.

1. Statutory Exceptions to Confidentiality

In the early 20th century, state legislatures began to recognize exceptions to physician-patient confidentiality through mandatory disclosure or "reporting" statutes. Reporting statutes actually require physicians to breach the confidentiality of patients by reporting certain diagnosed conditions to a designated authority.[115] Such statutes direct physicians to report a variety of medical treatments ranging from evidence of child abuse[116] to communicable diseases.[117] Failure to report these conditions may result in criminal sanctions against the physician.[118]

Because reporting statutes conflict with the requirement of physician-patient confidentiality, the United States Supreme Court has had the opportunity to address the constitutionality of medical reporting laws.[119] In *Whalen v. Roe*,[120] the Court held that a New York statute, which required physicians to report to the state the names and addresses of all persons receiving prescriptions for various drugs, was not a violation of privacy or liberty guaranteed by the Fourteenth Amendment.[121] In upholding the legislation, the Court applied the rational basis test, according

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114. *See, e.g.*, Sten L. Gustafson, *No Longer the Last to Know: A Proposal for Mandatory Notification of Spouses of HIV Infected Individuals*, 29 HOUS. L. REV. 991, 1023 (1992).

115. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 120980(i) (West Supp. 1996) (mandating compliance with federal reporting requirements regarding AIDS, HIV, and their probable causative agents).

116. *See, e.g.*, N.M. STAT. ANN. § 32A-4-3 (Repl. Pamp. 1995) (mandating disclosure when a physician has a reasonable suspicion that a child is an abused or a neglected child).

117. *See, e.g.*, N.M. STAT. ANN. § 24-1-15 (Repl. Pamp. 1994) (requiring physician to promptly notify the district health officer whenever he knows that any person is sick with any disease dangerous to the public health); FLA. STAT. ANN. ch. 381.0031 (Harrison 1993) (requiring physicians to immediately report the existence of a disease of public health significance to state health department); TEX. HEALTH & SAFETY CODE ANN. § 81.042 (West 1992) (requiring disclosure of a suspected case of a reportable disease and all information known concerning the person who has or is suspected of having the disease).

118. *See, e.g.*, FLA. STAT. ANN. §§ 384.24, 384.34 (Harrison 1993) (failing to report a case of AIDS, ARC, or HIV is punishable by a maximum fine of $500 and notification of the physician's state licensing agency); TEX. HEALTH & SAFETY CODE ANN. § 34.07 (West 1992) (failing to report a "reportable disease or health condition" is punishable as a Class B misdemeanor).

119. *See* Whalen v. Roe, 429 U.S. 589, 603 (1977).

120. *Id.*

121. *Id.* at 596-97.

to which laws are to be upheld if they are reasonably related to a legitimate state interest.[122] The Court pointed out that "disclosures of private medical information to doctors, to hospital personnel, to insurance companies, and to public health agencies are often an essential part of modern medical practice . . . ."[123] The Court relied on the statutory reporting requirements concerning venereal disease as a specific example. Thus, subject to an overriding provision that the statutes provide safeguards against the improper disclosure of confidential information, the constitutionality will be upheld.[124]

As a result, some states have attempted to meet the need for public health information by enacting mandatory reporting statutes for sexually transmitted diseases and AIDS, while also attempting to protect confidentiality by including extensive confidentiality provisions.[125] Such statutes allow physicians, or other authorities having the confidential information, to disclose the information only to certain listed individuals and agencies.[126] Such states ensure enforcement of confidentiality provisions by mandating criminal sanctions.[127]

California and New York have the most progressive HIV reporting statutes. Similar to other states' reporting statutes, New York and California statutes provide a list of individuals and agencies that may receive AIDS-related information about a patient.[128] Both states also allow physicians to warn spouses or sexual partners of a patient with AIDS if the physician reasonably believes such third parties to be in danger of contracting the disease. Unlike other states with this specific exception,

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122. *See id.*

123. *Id.* at 602.

124. *See Whalen* 429 U.S. at 598-600.

125. *See id.*

126. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 1603.1 (West 1990); FLA. STAT. ANN. ch. 384.25(3) (Harrison Supp. 1994); GA. CODE ANN. § 31-22-9.2 (1991); ILL. ANN. STAT. ch. 410, para. 310, § 4(b) (Smith-Hurd 1993); N.Y. PUB. HEALTH LAW § 2782 (McKinney Supp. 1996).

127. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 120980 (West Supp. 1996) (negligent violation results in civil penalty not to exceed $1000, while willful violation results in penalty not to exceed $10,000 or a year in jail or both); FLA. STAT. ANN. ch. 381.004(6)(b) (Harrison Supp. 1994) (violation is a 2nd degree misdemeanor); GA. CODE ANN. § 31-22-9.2(o) (1991) (violation results in misdemeanor); ILL. ANN. STAT. ch. 410, para. 305, § 12 (Smith-Hurd 1993) (intentional or reckless violation is a Class A misdemeanor punishable between $1000-$5000); N.Y. PUB. HEALTH LAW § 2783(2) (McKinney 1993)(willful violation is a misdemeanor).

128. *See* CAL. HEALTH & SAFETY CODE §§ 120985-121015 (West Supp. 1996) (listing the patient's spouse, sexual partner, needle sharer, and the county health officer as authorized recipients of test results); N.Y. PUB. HEALTH LAW § 2782 (McKinney 1993) (listing those eligible to receive confidential HIV-related information as including the health facility or health care provider administering health care to the infected individual, a health officer, and an authorized agency in connection with foster care or adoption of a child); *accord* FLA. STAT. ANN. ch. 381.004(3)(f) (Harrison Supp. 1990) (listing health care providers, health facilities providing organ transplant and semen donor services, and other persons allowed access by court order as eligible to receive HIV information); ILL. ANN. STAT. ch. 111½, para. 7309 (Smith-Hurd Supp. 1992) (listing health care providers, health facilities providing organ transplant and semen donor services, and law enforcement officials coming in direct contact with the individual's blood or bodily fluids as eligible to receive HIV information); VA. CODE ANN. § 32.1-36.1 (Michie Supp. 1992) (listing health care providers, health facilities providing organ and semen donor services, and persons allowed access by court order as eligible to receive HIV test information).

however, New York and California make the exception optional, with explicit shielding provisions for physicians who choose not to warn a third party in danger of infection from the physician's patient.[129] The New York statute states that "no criminal sanction or civil liability" can be imposed against a physician for failing to disclose or for disclosing in good faith.[130] The California statute provides the same protection, but extends this authorization to county health officers as well.[131] Other states have provided physicians with the authorization to disclose to a spouse or sexual partner, but have not extended explicit immunization from liability.[132]

The Supreme Court has not dealt with the constitutionality of laws requiring the reporting of AIDS or HIV infection. Given the Court's use of the rational basis test in *Whalen v. Roe*, it is probable that state laws requiring the reporting of AIDS and even HIV infection will be upheld as long as confidentiality is preserved. While reporting statutes may not be necessary for stemming the spread of AIDS, such laws are reasonably related to slowing the spread of AIDS.

2. Common Law Exceptions to Confidentiality

Courts have also recognized exceptions to physician-patient confidentiality based upon a duty to protect public health. Courts have found an affirmative duty to act for the protection of non-patients of a physician in two contexts: where a patient with a contagious disease is likely to spread the disease to others[133] and where a mental health patient threatens harm to another person.[134] The contagious disease cases recognize a

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129. *See* CAL. HEALTH & SAFETY CODE § 121015(c) (West Supp. 1996); N.Y. PUB. HEALTH LAW § 2782(4)(a)(2) (McKinney 1993).

130. N.Y. PUB. HEALTH LAW § 2783(3)(a)-(b) (McKinney 1993).

131. CAL. HEALTH & SAFETY CODE § 121015 (West. Supp. 1996).

132. *See, e.g.*, FLA. STAT. ANN. ch. 381.703 (Harrison Pamp. 1994); GA. CODE ANN. § 31-22-9.2(g) (Michie 1991); ILL. ANN. STAT. ch. 410, para. 305, § 9(a) (Smith-Hurd 1993).

133. *See* Gammill v. United States, 727 F.2d 950 (10th Cir. 1984) (recognizing a duty towards specific persons at specific risk of infection); Smith v. Baker, 20 F. 709 (C.C.S.D.N.Y. 1884) (holding a physician liable for the negligent spreading of a contagious disease); Davis v. Rodman, 227 S.W. 612 (Ark. 1921) (holding that physicians attending patients afflicted with contagious diseases have a duty to exercise reasonable care to advise family members likely to be exposed); Skillings v. Allen, 173 N.W. 663 (Minn. 1919) (holding that physician had a duty to warn parents of possibility of infectious transmission); Edwards v. Lamb, 45 A. 480 (N.H. 1899) (holding that physician had a duty to warn spouse of danger of infection); Jones v. Stanko, 160 N.E. 456 (Ohio 1928) (holding physician liable to a third party in proximity to his contagious patient).

134. *See* Thompson v. County of Alameda, 614 P.2d 728 (Cal. 1980) where court recognized duty towards intended victims who were readily identifiable); Tarasoff v. Regents of University of California, 551 P.2d 334 (Cal. 1976) (holding that a patient's psychotherapist had a duty to exercise reasonable care to protect an identifiable victim from harm); Lipari v. Sears Roebuck & Co., 497 F. Supp. 185 (D. Neb. 1980) (holding relationship between psychotherapist and his patient gives rise to affirmative duty to initiate whatever precautions are reasonably necessary to protect potential victims of his patient); McIntosh v. Milano, 403 A.2d 500 (N.J. Super. Ct. 1979) (holding that a therapist had a duty to protect an intended or potential victim of his patient); Petersen v. State, 671 P.2d 230 (Wash. 1983) (where psychiatrist of a diagnosed schizophrenic had a duty to take reasonable precautions to protect a person foreseeably at danger).

narrower exception to physician-patient confidentiality,[135] while the more recent mental health cases seem to support a broader exception.[136]

a. Contagious Disease Cases

As early as 1884, a federal circuit court heard a case concerning the negligent spreading of a contagious disease.[137] In *Smith v. Baker*,[138] the defendant took his children to a boarding house when they had the contagious disease whooping cough.[139] The children ended up exposing the plaintiff's child and children of other boarders to the disease.[140] At that time, the accusation that someone was infected with a contagious disease could be actionable as slander; yet the negligent spread of a disease among animals could also result in liability.[141] The *Smith* court held that the plaintiff's suit could be actionable and upheld the jury's decision of negligence on the defendant's part.[142]

Soon thereafter, *Edwards v. Lamb*[143] became the first case to recognize a physician's potential liability for failing to warn a non-patient of the danger posed by a patient. In *Edwards*, a wife employed a physician to treat her husband for a wound, which became an infectious sore. During the treatment, the physician asked the wife to assist in dressing the wound.[144] The physician, knowing that there was danger of infection, nonetheless assured the wife that she was perfectly safe.[145] The wife relied on his advice and subsequently became infected.[146] The court stated that "the fact that [the physician's] duty, as to [the wife], was merely to advise, and not administer treatment, is immaterial," and held the physician negligent.[147] By doing so, the court recognized that the lack of physician-patient relationship was not necessarily a bar to recovery.

Similarly, in *Skillings v. Allen*,[148] a mother alleged that a physician had wrongfully advised her that she might safely visit her child, who was hospitalized with scarlet fever, with no risk of infection.[149] Not only was the child at the most infectious stage when she visited, but the physician also told the mother that she could safely return to her home without risk of spreading the infection.[150] The Minnesota Supreme Court

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135. *See, e.g.*, Gammill v. United States, 727 F.2d at 954 (refusing to expand duty beyond special relationship).
136. *See, e.g.*, McIntosh v. Milano, 403 A.2d at 511-12 (holding that physician had broad duty to protect foreseeable victim).
137. *See* Smith v. Baker, 20 F. 709 (C.C.S.D.N.Y. 1884).
138. *Id.*
139. *Id.* at 709.
140. *Id.*
141. *Id.* at 709-10.
142. *Id.* at 710.
143. 45 A. 480 (N.H. 1899).
144. *Id.* at 480.
145. *Id.*
146. *Id.*
147. *Id.* at 480.
148. 173 N.W. 663 (Minn. 1919).
149. *Id.* at 663.
150. *Id.*

stated that a person "is responsible for the direct consequences of his negligent acts whenever he is placed in such a position with regard to another that it is obvious that if he does not use due care in his own conduct he will cause injury to that person."[151] Because both parents eventually contracted scarlet fever as a result of the exposure, the court held that the physician breached his duty to use due care in telling the patient's mother about the possibility of an infectious transmission.[152]

Shortly thereafter, the Arkansas Supreme Court sustained a dismissal of a complaint alleging negligence in the treatment of typhoid patients.[153] In *Davis v. Rodman*,[154] the court found for the physicians involved because the complaint did not allege specific acts and facts showing proximate cause; yet the court did find that a duty to prevent the spread of infection existed. The court held that a physician owes a duty to those persons who do not know that the patient's disease is contagious, and to those who are likely to come in contact with the patient, to instruct and advise them of the character of the disease.[155] Like the *Skillings* court, the *Davis* court recognized the physician's duty to immediate family members of the patient. However, the *Davis* court went further, in that it acknowledged the existence of an affirmative duty of physicians to warn patients.[156] Unlike *Skillings*, where the physician was liable for his negligent advice, in *Davis* the court recognized the potential liability of a physician who negligently fails to warn.

New York recognized a physician's liability to family members in 1959.[157] In *Wojcik v. Aluminum Co. of America*,[158] a wife brought an action against a physician, who was employed by her husband's employer, for failing to inform her that her husband was suffering from tuberculosis.[159] The court held that the physician "could have reasonably anticipated that the [husband], without knowledge of his contagious disease, would not take the precautionary measures necessary to prevent infecting others, including his wife, with the germs of the disease."[160] The court relied on a treatise which extended "the duty of a physician who is attending a patient afflicted with a contagious disease to exercise care in advising and warning members of the family and others who are liable to exposure . . . from the disease."[161] Although the court relied on language that expanded the duty to those outside the immediate family,[162] the court did not have the opportunity to decide whether that language applied.

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151. *Id.* at 663-64.
152. *Id.*
153. *See* Davis v. Rodman, 227 S.W. 612 (Ark. 1921).
154. *Id.*
155. *Id.* at 612.
156. *See id.* at 613.
157. *See* Wojcik v. Aluminum Co. of America, 183 N.Y.S.2d 351 (N.Y. Sup. Ct. 1959).
158. *Id.*
159. *Id.* at 352.
160. *Id.* at 358.
161. *Id.* (quoting 70 C.J.S. PHYSICIANS AND SURGEONS 48, at 970).
162. *Id.*

The facts of the case apparently limited the physician's duty to warn only to the patient's wife, because she was the only one likely to become infected from the disease.

Some time later, in *Hofmann v. Blackmon*,[163] a minor who lived with his father brought an action against a physician for failure to warn him of the nature of his father's contagious disease and advise him of the precautionary steps necessary to prevent contracting the disease. The physician attempted to distinguish previous cases finding a duty to warn immediate family members because, unlike physicians in those cases, he failed to correctly diagnosis his patient with a contagious disease.[164] The Florida District Court of Appeals held that once a doctor diagnoses a patient as having a contagious disease, the doctor has the duty to use reasonable care in advising and warning family members of the contagious nature of the patient's illness.[165] This duty to warn was not negated by the physician's failure to correctly diagnose the disease, because to apply such logic would "reward the doctor for failing to discover that which . . . [may have been] his duty to discover."[166] Thus, even if a physician fails to determine that a contagious disease exists, she may still owe a duty to immediate family members if a reasonable physician would have diagnosed the contagious disease.[167]

Some jurisdictions have considered whether to expand a physician's liability beyond immediate family members. In *Jones v. Stanko*,[168] the estate of a neighbor brought an action against the physician of a smallpox patient after the neighbor contracted the disease and died.[169] The Ohio Supreme Court held that when a physician holds himself out as qualified concerning a matter, he must exercise ordinary skill and care relative to that matter.[170] Ordinary care necessarily included giving notice of the contagious nature of a patient's disease to those persons who are in proximity to the patient.[171] Additionally, a doctor could be held liable to a third party for any injury to the third party resulting from the doctor's failure to notify.[172] Thus, the court not only recognized an affirmative duty to warn, they also expanded that duty to those in close proximity to the patient.[173]

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163. Hofmann v. Blackmon, 241 So. 2d 752 (Ct. App. 1970), *cert. denied*, 245 So. 2d 257 (Fla. 1971).

164. *Id.* at 753.

165. *Id.*

166. *Id.*

167. *See id.*; *accord* Fosgate v. Corona, 330 A.2d 355 (N.J. 1974) (holding that a physician may be liable to the relatives who contract a disease from the patient following the physician's failure to diagnose the disease).

168. 160 N.E. 456 (Ohio 1928).

169. *Id.* at 456.

170. *Id.* at 458.

171. *Id.*

172. *Id.*

173. *See id.*; *accord* Simonsen v. Swenson, 177 N.W. 831 (holding that a breach of confidentiality outside the family to those in reasonable danger and likely to contract the disease from the patient was justified).

More recently, third parties have attempted to expand a physician's duty even further to those who are reasonably foreseeable. In *Gammill v. United States*,[174] the friends of a hepatitis patient who subsequently contracted hepatitis as well brought a cause of action against the patient's physician for failure to report the disease to public health.[175] The Tenth Circuit Court of Appeals relied on the previous contagious disease cases to support the fact that "[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."[176] However, the court declined to extend the duty any further and suggested a special relationship must exist between the physician and those to be warned. This special relationship required that "at the bare minimum the physician must be aware of the specific risks to specific persons before a duty to warn exists."[177]

The contagious disease cases clearly support a physician's duty to warn a patient's immediate family of the dangers of contacting the patient's contagious disease. The duty extends to a physician even if the physician fails to correctly diagnosis the disease as contagious. Moreover, after *Stanko* and *Simonsen*, it was unclear whether this duty extends only to "those who are in proximity to a patient's contagious disease,"[178] or to anyone who is reasonably foreseeable. After *Gammill*, however, it is clear that a physician's duty extends only to immediate family members or specific persons in close proximity to the patient.

b. Cases Involving the Mentally Ill

In 1976, the California Supreme Court took steps toward expanding the duty derived from the contagious disease cases when it decided *Tarasoff v. Regents of University of California*.[179] The case involved a voluntary out-patient who informed his therapist that he was going to kill "an unnamed girl, readily identifiable as Tatiana [Tarasoff], when she returned home from spending the summer in Brazil."[180] The therapist failed to take any action to warn Ms. Tarasoff or the campus police. Shortly after Tatiana's return from Brazil, the patient went to her residence and stabbed her to death.[181] Her estate brought an action against the therapist and the university, his employer, for breach of duty to warn a foreseeable victim of the danger posed by a threatening patient.

In its decision, the California Supreme Court recognized the duty of a psychotherapist to use reasonable care to protect a third party from harm when the therapist has notice that his patient presents a serious

174. 727 F.2d 950 (10th Cir. 1984).
175. *Id.* at 952.
176. *Id.* at 954.
177. *Id.*
178. *Stanko*, 160 N.E.2d at 458.
179. 551 P.2d 334 (Cal. 1976).
180. *Id.* at 341.
181. *Id.*

danger of violence to that intended victim.[182] The court relied on the Restatement (Second) of Torts to impose a duty upon a professional to act where a "special relationship" exists with another person, imposing either a duty to control the other party or to protect that party from a known danger.[183] Previous California cases, however, involved defendants who were in a special relationship with both the victim and the person who created the danger. Thus, the court cited to the string of contagious disease cases for the contention that the physician-patient relationship "is sufficient to support the duty to exercise reasonable care to protect others against the dangers emanating from the patient's illness."[184] Applying this contention, the court held that although the therapist had no "special relationship" to the victim, the therapist's relationship to his patient was sufficient under the circumstances to create a duty to use reasonable care to protect the known intended victim.[185] In the words of the court, "[s]uch a relationship [psychotherapist-patient] may support affirmative duties for the benefit of third persons."[186]

The *Tarasoff* court acknowledged that its holding extended then-existing precedent. The court noted that the foreseeability of harm to the third person was the most important consideration in establishing the existence of a duty to warn.[187] The court, however, failed to define the parameters of this duty. After *Tarasoff*, it is unclear whether the duty extends only to warn readily identifiable victims or more broadly to prevent harm to those reasonably foreseeable. Consequently, other jurisdictions have attempted to clarify the ambiguities as to whom and when a therapist owes duty to warn.[188]

In 1979, New Jersey became the first state to expand the *Tarasoff* duty to warn.[189] *McIntosh v. Milano*[190] involved a patient who disclosed his possessive feelings toward a young woman to his therapist.[191] On one occasion, the patient disclosed that he had fired a B.B. gun at the woman's (or her boyfriend's) car, because he was upset that she was going on a date with her boyfriend.[192] The patient eventually shot the young woman.[193]

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182. *Id.* at 340.
183. *Id.* at 343.
184. *Id.* at 344.
185. *Tarasoff*, 551 P.2d at 343.
186. *Id.*
187. *Id.* at 342.
188. *See* Thompson v. County of Alameda, 614 P.2d 728, 738 (Cal. 1980) (limiting the duty to a named or readily identifiable victim or group of victims); Lipari v. Sears, Roebuck & Co., 497 F. Supp. 185, 194 (D. Neb. 1980) (adopting a duty on a therapist to any person foreseeably endangered by the negligent treatment of a psychiatric patient); McIntosh v. Milano, 403 A.2d 500, 511-12 (N.J. Sup. Ct. 1979) (expanding duty to protect an intended or potential victim of the patient); Petersen v. State, 671 P.2d 230, 237 (Wash. 1993) (establishing a duty to take reasonable precautions to protect a person foreseeably at danger).
189. *See* McIntosh v. Milano, 403 A.2d 500 (N.J. Sup. Ct. 1979).
190. *Id.*
191. *Id.* at 503.
192. *Id.*
193. *Id.* at 504.

The *McIntosh* court held that a "therapist may have a duty to take whatever steps are reasonably necessary to protect an intended or potential victim of his patient."[194] The duty arises when the therapist knows, or should have known, in accordance with the standards of the profession, that the patient may pose a danger to the victim.[195] The court said that the relationship giving rise "to [this] duty may be [based] either [on the special relationship which exists] between the therapist and [his] patient . . . or [on the broader duty a physician] may have to protect the welfare of the community, which is analogous to the [duty] to warn" in contagious disease cases.[196] Thus, the court expanded the therapist's obligation from a narrow duty to warn to a broad duty to take whatever measures are necessary to protect the foreseeable victim.[197]

A 1980 federal district court case, *Lipari v. Sears Roebuck & Co.*,[198] applying Nebraska law, extended a therapist's duty to warn far beyond those persons who may be identifiable to the therapist. In *Lipari*, an ex-psychiatric patient fired a shotgun into a crowded night club, killing one person and wounding another.[199] Even though the victims were not identifiable to the therapist, the court held the therapist's employer liable because the harm was foreseeable.[200] Like the *Tarasoff* and *McIntosh* courts, the *Lipari* court drew an analogy to contagious diseases.[201] Thus, under *Lipari*, where a therapist knows or should know that a patient's dangerous propensities pose an unreasonable risk of harm to others, he must take whatever precautions are reasonably necessary to protect potential victims.

During the same year, in *Thompson v. Alameda*,[202] the California Supreme Court attempted to put limitations on the ambiguous *Tarasoff* interpretations.[203] The court read *Tarasoff* to require that intended victim be "readily identifiable" as a precondition to liability.[204] The narrow interpretation of *Tarasoff* restricted the duty to warn to those instances in which protection was appropriate for specifically named or readily identifiable victims. The court found no liability because no specific child was threatened.

Unlike the contagious disease cases, which refused to extend a physician's liability beyond specific, readily identifiable people, the mental illness cases suggest that a duty is owed to anyone who is reasonably foreseeable. Thus, it appears that two entirely different theories have

194. *McIntosh*, 403 A.2d at 511-12.
195. *Id.*
196. *Id.* at 512.
197. *See id.*; *see also* Peterson v. State, 671 P.2d 230, 238-39 (Or. 1983).
198. 497 F. Supp. 185 (D. Neb. 1980).
199. *Id.* at 187.
200. *Id.* at 195.
201. *See id.* at 190.
202. 614 P.2d 728 (Cal. 1980).
203. *See supra* note 188 and accompanying text (setting forth disparaging interpretations of *Tarasoff*).
204. *See Thompson*, 614 P.2d at 734.

developed establishing a physician's duty to third parties. The contagious disease cases support the proposition that a physician may only be held to a duty to warn specific people in close proximity to the patient. Thus, the contagious disease cases could provide support for a duty to warn a spouse or sexual partner in the context of HIV. The mental illness cases, however, support a broader duty to warn anyone who foreseeably may be injured. Thus, under the mental illness cases, a physician could potentially be held liable to any person whom the patient may expose to the virus.

IV. NEW MEXICO LAW

New Mexico currently recognizes a duty to maintain physician-patient confidentiality.[205] Additionally, like other jurisdictions, the New Mexico legislature as well as New Mexico courts have provided specific exceptions to physician-patient confidentiality.[206] Exceptions to physician-patient confidentiality, however, are especially broad or ill-defined in New Mexico.[207] The question of whether a physician in New Mexico could be liable for disclosures of HIV related information to foreseeable third parties requires an analysis of the exceptions to physician-patient confidentiality in the state.

A. Physician-Patient Confidentiality in New Mexico

New Mexico, like other jurisdictions, has recognized a duty to maintain a patient's confidentiality concerning medical information.[208] In New Mexico, the Public Health Act (PHA) states that the "files and records of the department giving identifying information about individuals who have received or are receiving from the department, treatment, diagnostic services or preventive care for disease, disabilities, or physical injuries, are confidential and are not open to inspection."[209] Further, violation of the PHA is a petty misdemeanor subject to a fine, jail sentence, or both.[210] As written, the PHA implies a broad duty of confidentiality. The statute fails to specifically define what comprises diseases, disabilities or physical injuries. Presumably, AIDS would fall within the definition of diseases for the purposes of this statute.

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205. *See* N.M. STAT. ANN. § 24-1-20 (Repl. Pamp. 1994) (establishing disclosure of information relating to individuals who have received medical services as a misdemeanor).

206. *See* N.M. STAT. ANN. § 24-1-15(A) (Repl. Pamp. 1994) (mandating reporting to public health officials of individuals "sick with any disease dangerous to the public health"); N.M. STAT. ANN. § 24-2B-6 (A)-(H) (Repl. Pamp. 1994) (excepting various disclosures of test results from confidentiality); Wilchinsky v. Medina, 108 N.M. 511, 775 P.2d 713 (1989) (mandating disclosure of confidential patient information to third parties foreseeably at risk by patient's behavior).

207. *See* N.M. STAT. ANN. § 24-2B-6 (A)-(H) (permitting potential disclosure to the health and environment department, various qualifying health care providers, and insurance agents among others).

208. *See* Public Health Act, N.M. STAT. ANN. § 24-1-20.

209. N.M. STAT. ANN. § 24-1-20(A).

210. *See* N.M. STAT. ANN. § 24-1-20(F); N.M. STAT. ANN. § 24-1-21 (Repl. Pamp. 1994).

The New Mexico legislature has also recognized the heightened importance of confidentiality in the context of HIV by specifically enacting a statute relating to HIV information and testing.[211] The Human Immunodeficiency Virus Tests Act (HIV Act) states that "no person or the person's agents or employees who require or administer the [HIV] test shall disclose the identity of any person upon whom a test is performed, or the result of such a test in a manner which permits the identification of the subject of the test."[212] Because HIV-related information clearly falls within the confidential medical information statute, the same criminal sanctions apply.

Through both the PHA and the HIV Act, the New Mexico legislature has recognized the importance of protecting the privacy of AIDS-related information. Additionally, the state health department has recognized the importance of patient confidentiality by providing for anonymous testing in New Mexico. Because a patient's identity is never disclosed, anonymous testing ensures the highest level of confidentiality during testing. Insurance of confidentiality, in turn, helps alleviate fears of discrimination and ostracism, which affect the state's ability to provide effective HIV testing and preventative services.

B. Exceptions to Physician-Patient Confidentiality in New Mexico

Like other jurisdictions, New Mexico has codified exceptions to physician-patient confidentiality, both generally and in the context of HIV.[213] Although the HIV Act provides for many disclosures, the statute is silent concerning whether a physician can disclose information to spouses or sexual partners. Moreover, New Mexico courts have not had much opportunity to interpret the HIV Act. New Mexico has, however, adopted a *Tarasoff* duty.[214] Currently physicians in New Mexico are subject to a balancing test to determine whether a duty towards third parties exists.[215]

1. New Mexico Statutory Law

Although both sexually transmitted diseases and AIDS presumably fall within the ambit of New Mexico's broad medical records statute, the legislature has allowed specific exceptions for both of these diseases that allow for reporting to public health officials.[216] For example, the PHA requires any physician, superintendent or manager of a clinic or penal institution that makes a diagnosis or treats a case of a sexually transmitted disease to report the information to the district health officer in the

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211. *See* Human Immunodeficiency Virus Tests Act, N.M. STAT. ANN. §§ 24-2B-6 to -8 (Repl. Pamp. 1994).
212. N.M. STAT. ANN. § 24-2B-6.
213. *See* N.M. STAT. ANN. § 24-2B-6 (A)-(H).
214. *See* Wilchinsky v. Medina, 108 N.M. 511, 775 P.2d 713 (1989).
215. *Id.* at 515, 775 P.2d at 717.
216. *See* N.M. STAT. ANN. § 24-1-7 (Repl Pamp. 1994); N.M. STAT. ANN. § 24-2B-6.

district in which they are located.[217] Similarly, New Mexico's HIV Act mandates disclosure to the Public Health Department.[218]

Unlike the PHA, however, the HIV Act provides an extensive list of individuals and other agencies that may also receive information concerning HIV.[219] Most of these exceptions recognize the public policy interest in acquiring additional epidemiological data. To prevent further disclosure, whenever a disclosure is made pursuant to the HIV Act, a written statement must accompany the disclosure. The statement must indicate the confidential nature of the information.[220]

Although the PHA does not contain an extensive list of exceptions, it does provide physicians with an important exception that the HIV Act does not.[221] The PHA expressly permits a physician to breach confidentiality when the physician believes that the patient may act in such a way as to harm third parties.[222] The statute states that:

> any attending physician [who] knows or has good reason to suspect that a person having a sexually transmitted disease may conduct himself so as to expose other persons to infection, [the physician] shall notify

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217. N.M. STAT. ANN. § 24-1-7.

218. N.M. STAT. ANN. § 24-2B-6(D).

219. *See* N.M. STAT. ANN. § 24-2B-6. The HIV Act allows exceptions to the following persons:

> A. the subject of the test or the subject's legally authorized representative, guardian or legal custodian;
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> B. any person designated in a legally effective release of the test results executed prior to or after the test by the subject of the test or the subject's legally authorized representative;
>
> C. an authorized agent, a credentialed or privileged physician or employee of a health facility or health care provider if the health care facility or health care provider itself is authorized to obtain the test results, the agent or employee provides patient care or handles or processes specimens of body fluids or tissues and the agent or employee has a need to know such information;
>
> D. the health and environment department . . . and the centers for disease control of the United States public health service in accordance with reporting requirements for a diagnosed case of acquired immune deficiency syndrome;
>
> E. a health facility or health care provider which procures, processes, distributes or uses:
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> (1) a human body part from a deceased person, with respect to medical information regarding that person;
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> (2) semen provided prior to the effective date of the Human Immunodeficiency Virus Test Act for the purpose of artificial insemination;
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> (3) blood or blood products for transfusion or injection; or
>
> (4) human body parts for transplant with respect to medical information regarding the donor or recipient;
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> F. health facility staff committees or accreditation or oversight review organizations which are conducting program monitoring, program evaluation or service reviews so long as any identity remains confidential;
>
> G. authorized medical or epidemiological researchers who may not further disclose any identifying characteristics or information; and
>
> H. for purposes of application or reapplication for insurance coverage, an insurer or reinsurer upon whose request the test was performed.

Id.

220. N.M. STAT. ANN. § 24-2B-7.

221. *See* N.M. STAT. ANN. § 24-1-8 (Repl. Pamp. 1994).

222. *See id.*

> the district health officer of the name and address of the diseased person and the facts of the case.[223]

By using the word "shall" in the statute, the legislature required physicians to warn of suspicious conduct.

Although a physician is required to disclose suspicious conduct of a patient under the PHA, the legislature removed some of the burden upon physicians by requiring them to notify only the public health officer of suspicious conduct. Thus, the PHA does not require a physician to determine whether the suspicious conduct will, in fact, endanger others or to determine who specifically may be in danger by the conduct. The statute places the burden on the district health officer, who presumably has sufficient education and training to determine the level of dangerousness involved with certain conduct.[224]

Unlike the PHA, the HIV Act does not contain a provision that requires a physician to report patients whom the physician feels may be acting unethically. In fact, the HIV Act specifically states that "no person . . . may disclose the test results to another person except as authorized by [the HIV Act]."[225] By not explicitly including exceptions to confidentiality, it appears that the legislature intentionally decided not to impose a duty towards third parties, permissive or otherwise, on physicians in the context of HIV or AIDS.

2. New Mexico Common Law

The New Mexico Supreme Court has only recently addressed the question of whether a physician has a duty to third persons who foreseeably may be harmed as a result of a physician's negligent treatment.[226] *Wilchinsky v. Medina*[227] involved a physician who administered drugs to a patient in his office.[228] The drugs were narcotics, which cloud a person's judgment and physical abilities and create a risk to that person if he or she drives a car.[229] Shortly after receiving the drugs, the patient left the office and was involved in a serious car accident involving a third party.[230] The third party suffered injuries from the accident and brought suit against the physician.[231] The court held that the physician owed a duty to the driving public when he administered drugs to his patients.[232]

Like the California Supreme Court in *Thompson*,[233] the New Mexico Supreme Court interpreted the holding of *Tarasoff* narrowly by stating that a physician has a duty to warn when a specific, identifiable third

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223. *Id.*
224. *See id.*
225. N.M. STAT. ANN. § 24-2B-7.
226. *See* Wilchinsky v. Medina, 108 N.M. 511, 775 P.2d 713 (1989).
227. *Id.*
228. *See id.* at 511, 775 P.2d at 713.
229. *Id.* at 512, 775 P.2d at 714.
230. *Id.*
231. *Id.*
232. *Id.* at 515, 775 P.2d at 717.
233. *See supra* notes 202-204 and accompanying text.

party is known to the physician.[234] Thus, when the *Wilchinsky* court recognized a physician's duty towards third parties who may be foreseeably injured, the court not only adopted the *Tarasoff* rationale, but expanded it.[235] In its determination, the New Mexico Supreme Court relied on a balancing test set forth in an Illinois case.[236] The factors to be balanced are: "the likelihood of injury, the reasonableness of the burden of guarding against it, and the consequences of burdening the defendant."[237] The balancing of the factors in this case indicated that the physician owed a duty towards third parties.

New Mexico courts have yet to decide a cause of action brought by a third party against a patient's physician in the context of AIDS. After *Wilchinsky*, it is likely courts will extend the balancing test to all suits involving a physician's duty towards third parties, including HIV/AIDS related cases. However, given the increased implications in the context of AIDS, it is unclear how courts will interpret a physician's duty towards third parties.

V. A PHYSICIAN'S DUTY TO THIRD PARTIES IN NEW MEXICO IN THE CONTEXT OF HIV/AIDS

Under New Mexico law, physicians who fear their HIV-infected patient may expose third parties to the disease are forced to chose between two alternatives: 1) breaching physician-patient confidentiality and 2) failing to warn third parties potentially at risk from the patient's behavior. However, each alternative could potentially lead to liability. On the one hand, spouses and sexual partners are not specifically included under exceptions to confidentiality in the HIV Act, which implies that physicians must maintain strict confidentiality even if confronted with a patient who the physician feels may endanger third parties. As a result, a physician who warns a spouse or sexual partner of a HIV-infected person will likely be held liable to the patient for breach of confidentiality under the HIV Act.

On the other hand, because New Mexico has already applied the *Wilchinsky* balancing test to determine a physician's duty towards a third party after administering drugs to a patient, it is likely that the courts will extend the balancing test to a case involving a physician who breaches a patient's confidential serological status in favor of warning a third party. However, it is unclear what the result will be if courts do apply the test. The legislature's failure to specifically address the conflict between confidentiality and duty to warn creates ambiguities as to whether the physician could be equally liable to the spouse or sexual partner for failing to warn.

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234. *Wilchinsky*, 108 N.M. at 515, 775 P.2d at 717.

235. *See id.*

236. *Id.* (citing Kirk v. Michael Reese Hosp. & Medical Ctr., 513 N.E.2d 387, 396 (Ill. 1987), *cert. denied*, 485 U.S. 905 (1987)).

237. *Id.*

A. Expansion of Tarasoff-type Duty in New Mexico

Cases in other jurisdictions lead to the conclusion that a physician may be held liable for failing to warn those in close proximity to a patient with a contagious disease[238] or to those who may be foreseeably injured by a patient's conduct.[239] New Mexico recently indicated that physicians may have a duty to warn those who may be foreseeably injured based upon a balancing test.[240] A determination of a physician's duty to warn a foreseeable third party of a patient's HIV status, then, requires a balancing of the factors set forth in Wilchinsky.

The first factor is the likelihood of injury to a third party. The likelihood of HIV transmission depends on how broadly the term "third parties" is interpreted. Because the only serious and immediate risk of HIV transmission occurs through exchange of blood or sexual conduct, only those third parties who share sexual relationships or who are exposed to the blood of the patient have any likelihood of injury. Furthermore, only those third parties who practice unsafe sex or share needles are at risk. Thus, in the absence of flagrantly unscrupulous behavior, the likelihood of injury to a third parties in general is low. However, the likelihood of injury increases as the third party becomes more identifiable.

The second factor is the reasonableness of the burden of guarding against the likelihood of injury. Guarding against transmission of HIV is fairly routine in that it only requires a physician to inform a patient's sexual partners or intravenous needle sharers of the dangers associated with HIV and their potential risk of exposure through the patient. However, in order for a physician to inform third parties, the physician must first ascertain the identities of a patient's sexual and drug partners. Accordingly, this factor also depends on the classification of third parties. A physician who treats one HIV-positive patient is known in the community for treating HIV and, thus, often has many HIV-positive patients. All of these patients could have any number of sexual partners. Moreover, patients are more likely to keep extramarital affairs, especially homosexual affairs, and drug use hidden. The latency period of AIDS also causes problems in that physicians are not able to narrow time frames significantly. The burden on the physician to guard against exposure to all of these people is clearly high.

A definition of "third parties" limited to identifiable spouses, monogamous sexual partners or specific, identifiable needle sharers, decreases the burden on physicians substantially. A physician can easily determine the identity of a patient's spouse or monogamous sexual partner. Personal information is often disclosed during treatment or is indicated on the record. Once the burden of determining specific third parties is limited, the physician can easily guard against transmission to third parties by

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238. *See supra* notes 133-169 and accompanying text.

239. *See supra* notes 171-195 and accompanying text.

240. *See* Wilchinsky v. Medina, 108 N.M. 511, 775 P.2d 713 (1989). *See also supra* notes 191-197 and accompanying text.

notifying them about the possibility of exposure and risk of infection.

The third factor involves the consequences of burdening physicians. Imposing the entire burden upon physicians to locate potential sexual partners or needle sharers is extremely unrealistic. To effectively warn the required third parties, a physician would have to determine when the patient first became infected.[241] Next, the physician must determine exactly who the patient has potentially exposed to the virus over that time span including the latency period before the patient realized that he or she might be infected.

Finally, the physician would have to locate the required third parties. This would often include tracking down one-night-stands, out-of-town encounters, and, especially in the case of intravenous drug users, homeless people. Such a rule would also put the physician in a potentially dangerous situation by forcing him to confront people whose drug-use, sexuality, or extramarital affairs are not public knowledge. Moreover, the physician may then be responsible for ascertaining whom these third parties have exposed, in order to protect himself from other third parties. Additionally, there is the consideration that a patient may fail to disclose certain information which may lead to a third party, causing a high rate of error outside the physician's control.

Physicians required to locate third parties, especially when more than one of their patients is HIV-positive, would spend all of their time trying to warn third parties. A patient's ethical behavior is also extremely subjective. Moreover, physicians may feel differently about certain behavior. Furthermore, most physicians are untrained in how to approach the subject of confrontation, both with their patient and potential third parties.

Balancing the three *Wilchinsky* factors indicates that the burden on the physician is too high to impose a duty toward third parties, generally, in the context of HIV/AIDS. The low likelihood of transmission is greatly outweighed by the burden that would be imposed on the physician. The balance is more even, however, when the class of third parties is narrowed to specific, identifiable persons. The deciding factor, therefore, is the unreasonableness of placing such a high burden on physicians, especially when dealing with a complex, personal disease such as AIDS.

The New Mexico legislature recognized this burden when it provided physicians with the ability to disclose unethical behavior concerning sexually transmitted diseases to the public health office.[242] Because public health agents are neutral, and have experience and training in patient behavior and counseling, they are better able to handle the burden. Without such a procedure for AIDS physicians, the burden on physicians would be too heavy to justify a duty to warn even specific, identifiable third parties.

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241. Determining the date of seroconversion creates difficulties, however, because often people overlap into many high-risk groups.

242. *See* N.M. STAT. ANN. § 24-1-8 (Repl. Pamp. 1994).

B. Limits to Contagious Disease Expansion

The New Mexico courts have not had the opportunity to determine whether a physician owes a duty to third parties in the context of contagious diseases. Cases from other jurisdictions have determined that a duty may be owed to third parties by a physician in the context of contagious diseases.[243] This duty is narrow and extends to family members or other specific, identifiable third parties, which would necessarily only include spouses or monogamous sexual partners in the context of AIDS.

HIV/AIDS, however, can be distinguished from the other contagious diseases involved in these cases. The contagious disease cases are generally characterized by the inability of the patient either to adapt his conduct so as to avoid or minimize the risk of infection or to communicate adequately to third parties the nature of the risk. Persons with AIDS or people at risk for AIDS, on the other hand, have the ability to adapt their behavior and either abstain from sex or engage in protected sex.

Additionally, all of the diseases that were the subject of these cases were highly contagious. Such diseases involved airborne pathogens, which allowed transmission through casual contact. HIV is only transmitted through blood or bodily secretions resulting from particular types of conduct. Thus, the diseases involved in the contagious disease cases created a higher risk of transmission to a wider class of individuals than does AIDS.

Furthermore, in *Wojcik v. Aluminum Co. of America*[244] and *Hofmann v. Blackmon*,[245] the sufferers were actually unaware of their conditions. Often, as in *Wojcik*, the real complaint of the third party was that a cure for the disease might have been sought in a timely fashion, had the party been informed of the contagious condition of the patient.[246] Yet, with no cure for AIDS, a central traditional purpose of warning disappears when it is likely that the third person has already contracted the virus at the relevant point in time.

The diagnosis of HIV is less accurate, even after confirmatory testing, than the diagnosis of most contagious diseases.[247] The existence of significant numbers of false positives, the spreading of unnecessary alarm, and the resulting ostracism of the supposed sufferers are material factors in the AIDS context.

These distinctions suggest that AIDS cannot easily and simply be considered just another contagious disease for these purposes. People exposed to many of the traditional forms of contagious diseases seek help because of the highly debilitating effects of their illness. Their disease status is more obvious and identifiable. By contrast, HIV positive people may not be easily identifiable and may not even be aware of their own

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243. *See supra* text accompanying notes 132-169.
244. 183 N.Y.S.2d 351 (N.Y. Sup. Ct. 1959).
245. 241 So. 2d 752 (Fla. Ct. App.), *cert. denied*, 245 So.2d 257 (Fla. 1970).
246. *See Wojcik*, 183 N.Y.S.2d at 355.
247. *See supra* note 24 and accompanying text.

illness. These differences, combined with the need for essential testing necessary to track the spread of the disease and to encourage more responsible types of behavior from high risk groups, support the fact that New Mexico courts will not predicate a duty towards third parties based on the contagious disease cases.

CONCLUSION

Physicians in New Mexico have been left in limbo by uncertainties in the law. On the one hand, if they breach confidentiality about an HIV-positive or AIDS patient's serological status, they face legal liability for breach of confidentiality. On the other hand, if they maintain confidentiality, they risk liability for failure to warn an endangered third party.

Possible causes of action against physicians for failing to warn in the HIV/AIDS context will be predicated upon two grounds: 1) the *Tarasoff*-type duty to foreseeable third parties who may be in danger; or 2) the narrower duty based on the string of contagious disease cases. By applying the balancing test set forth in *Wilchinsky*, it is clear that a *Tarasoff*-type duty is unreasonable to impose upon a physician in the context of AIDS in New Mexico. Moreover, the significant differences between contagious diseases and AIDS, combined with the need to safeguard against discrimination and to encourage volunteer testing, indicates that the New Mexico courts will probably not recognize a physician's duty towards third parties in general, or even specific, identifiable third parties, in the context of AIDS.

Although New Mexico courts will probably not recognize a physician's duty towards third parties in the context of AIDS, the New Mexico legislature should take steps to clarify professional responsibilities in an effort to provide direction and avoid potential litigation. The legislature should continue to provide strong confidentiality safeguards because they are advantageous to the public health. To clarify ambiguities, however, the legislature should supplement safeguards with an authority, not a duty, to breach patient confidence, but only if there is an identifiable third party at serious and immediate risk of transmission by a sexual or needle-sharing partner. Moreover, the physician should be authorized to disclose suspicious conduct only to a trained public health official with the experience to interpret and resolve potential conflicts. Narrowly limiting the class and removing the physician from the burden of disclosure to third parties not only satisfies the *Wilchinsky* balancing approach, but might also provide enough weight to impose a duty on physicians towards to specific, identifiable third parties.

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