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# Improper Bedside Manner: Why State Partner Notification Laws Are Ineffective in Controlling the Proliferation of HIV

Carrie Gene Pottker-Fishel

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## NOTE

# IMPROPER BEDSIDE MANNER: WHY STATE PARTNER NOTIFICATION LAWS ARE INEFFECTIVE IN CONTROLLING THE PROLIFERATION OF HIV

*Carrie Gene Pottker-Fishel, R.N.*<sup>†</sup>

## INTRODUCTION

The Centers for Disease Control (CDC) estimates that up to 280,000 people in the United States are unaware that they have human immunodeficiency virus (HIV).<sup>1</sup> Today, fifteen percent of Americans consider themselves “very concerned” about becoming infected with HIV; this percentage has decreased steadily since 1995.<sup>2</sup> However, the number of people infected with HIV and acquired immunodeficiency syndrome (AIDS) continues to rise at a devastating rate,<sup>3</sup> while pre-

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<sup>†</sup> J.D. Candidate 2007, Case Western Reserve University School of Law; B.S. 2004, University of Pennsylvania; Registered Nurse, Pennsylvania. I would like to thank my family and friends for their support. I am grateful for the influence of Professors Jessie Hill, Arthur D. Austin, and Jonathan Gordon.

<sup>1</sup> Rochelle P. Walensky et al., *Effective HIV Case Identification Through Routine HIV Screening at Urgent Care Centers in Massachusetts*, 95 AM. J. PUB. HEALTH 71, 71 (2005). Other reports state that as many as 500,000 people in the United States have undiagnosed and/or untreated HIV or AIDS. *See, e.g.*, Jennifer Kates et al., *Critical Policy Challenges in the Third Decade of the HIV/AIDS Epidemic*, 7 AM. J. PUB. HEALTH 1060, 1060 (2002) (discussing how the United States domestic and international AIDS policy is affected by cost, technological development, and “AIDS fatigue”).

<sup>2</sup> KAISER PUB. OPINION SPOTLIGHT, PUBLIC OPINION ON THE HIV/AIDS EPIDEMIC IN THE UNITED STATES (2006), [http://www.kff.org/spotlight/hivus/upload/Spotlight\\_Aug06\\_US.pdf](http://www.kff.org/spotlight/hivus/upload/Spotlight_Aug06_US.pdf) (finding that fifty-five percent of African-Americans in 1995 considered themselves “very concerned” about contracting HIV, as opposed to forty-three percent in 2004).

<sup>3</sup> *See* David Brown, *Why the U.S. Has Not Stemmed HIV: Activists Blame Infection Rate, Unchanged Since 1990, on Policies and Funding*, WASH. POST, Aug.

vention efforts funded by the government continue to decline.<sup>4</sup> Although state and federal programs have attempted to combat the spread of HIV through partner notification requirements, many of the statutes are ineffective due to their construction, which requires health care providers (HCPs)<sup>5</sup> to take on the role traditionally assigned to a public health official to combat the spread of HIV. This Note will discuss why HIV notification efforts would be more effective if the HCP of an HIV-positive patient does not have the legal responsibility to investigate and notify third parties about their risk of contracting HIV. Instead, this Note suggests that public health officials can most effectively carry out partner notification responsibilities.

Part I of this Note explains the history and disease pathology of HIV and AIDS as it is relevant to this discussion. Part II provides an overview of the types of HIV testing, the different approaches to partner notification, and what information HCPs submit to health departments regarding newly diagnosed HIV infections. Part III examines case law, federal statutes, and state statutes and discusses how they attempt to balance the competing interests of protecting public health while keeping an individual's medical records confidential. Part IV shows that many states' HIV prevention laws are ineffective and burdensome, and therefore frustrate the purpose of the HIV prevention effort because the laws place too much responsibility on HCPs. Part V discusses why an exemplary approach to partner notification programs should emphasize patient confidentiality while utilizing public health officials instead of HCPs.

## I. BACKGROUND OF HIV

To recognize the importance and impact of HIV or AIDS, one needs to understand the origins of this disease in the United States, its effect on afflicted individuals, and how people spread HIV to others.

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13, 2006, at A7 (noting that the increase in people living with HIV or AIDS is also due to the scientific advances in pharmacology that allow for longer longevity after an HIV diagnosis). Prevention efforts cut the infection HIV rate in the mid-1980's. *Id.* Since then, further decreasing the number of newly infected persons has not come to fruition, despite efforts by prevention groups. *Id.*

<sup>4</sup> See KAISER FAMILY FOUND., HIV/AIDS POLICY FACT SHEET: U.S. FEDERAL FUNDING FOR HIV/AIDS: THE FY 2006 BUDGET REQUEST (2005), <http://www.kff.org/hiv/aids/upload/Fact-Sheet-U-S-Federal-Funding-for-HIV-AIDS-The-FY-2006-Budget-Request.pdf> [hereinafter KAISER 2006 BUDGET] (from 2004 to 2006, federal funding requests for HIV went down approximately 1.5 percent, from \$738 million in 2004 to \$727 million in the 2006 fiscal year request).

<sup>5</sup> For the purpose of this Note, "health care provider" is anyone licensed by the state licensing board to care for the medical treatment of people and required by the state statute to follow the state reporting laws regarding HIV or AIDS.

### A. History of HIV

On June 5, 1981, HCPs in California were the first to officially report an AIDS infection in the United States,<sup>6</sup> and, “by the end of 1981, there were only 189 documented AIDS cases.”<sup>7</sup> A more recent estimate by the CDC posits that somewhere from 1.04 to 1.19 million people in the United States have HIV or AIDS.<sup>8</sup>

The disease came to the forefront of the national media as a disease that affected Caucasian gay males; however, currently a disproportionate number of racial minorities have HIV.<sup>9</sup> In addition, women’s rates of HIV have nearly doubled: women made up twenty-seven percent of the HIV population in the United States in 2003, as compared to fourteen percent in 1992.<sup>10</sup> Both the large increase in the number of HIV cases over the course of the past twenty-five years and the expansion in the demographics infected by HIV make the virus an important contagious disease that demands public concern and state government intervention. Quite possibly the most alarming statistic regarding HIV is that twenty-four to twenty-seven percent of Americans infected with HIV are completely unaware of their infection.<sup>11</sup>

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<sup>6</sup> *First Report of AIDS*, 50 MORBIDITY & MORTALITY WKLY. REP. 429, 429 (2001), available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5021a1.htm>.

<sup>7</sup> Jake Taylor, Comment, *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*, 26 N.M. L. REV. 481, 483 (1996).

<sup>8</sup> CTRS. FOR DISEASE CONTROL & PREVENTION, BASIC STATISTICS, <http://www.cdc.gov/hiv/stats.htm> [hereinafter BASIC STATISTICS] (information based on the newly released 2003 national statistics).

<sup>9</sup> Note, *Name Brands: The Effects of Intrusive HIV Legislation on High-Risk Demographic Groups*, 113 HARV. L. REV. 2098, 2099-2100 (2000) [hereinafter *Name Brands*] (commenting on the weakness of HIV legislation as it affects minorities in the United States). In 2003, African-Americans made up only twelve percent of the population in the United States but comprised fifty percent of the HIV and AIDS infected population. CTRS. FOR DISEASE CONTROL & PREVENTION, CDC HIV/AIDS FACT SHEET: A GLANCE AT THE HIV/AIDS EPIDEMIC (2005), <http://www.cdc.gov/hiv/PUBS/Facts/At-A-Glance.pdf> [hereinafter GLANCE]. African-Americans are seven times more likely to have HIV or AIDS than Caucasians, and Hispanics are three times more likely to have HIV or AIDS than Caucasians. *Id.* While African-American and Hispanic women represented twenty-five percent of the women in the United States, they had eighty-three percent of AIDS diagnoses in 2003. *Id.* In addition, two-thirds of the women and children with AIDS in 2003 were African Americans. NAT’L INST. OF ALLERGY & INFECTIOUS DISEASES, HIV INFECTION AND AIDS: AN OVERVIEW (2005), <http://www.niaid.nih.gov/factsheets/hivinf.htm> [hereinafter OVERVIEW]. See also CTRS. FOR DISEASE CONTROL & PREVENTION, HIV/AIDS AMONG WOMEN (2004), <http://www.cdc.gov/hiv/pubs/facts/women.pdf> [hereinafter AMONG WOMEN].

<sup>10</sup> GLANCE, *supra* note 9. Eighty percent of women who have HIV infections contract the disease through heterosexual contact. AMONG WOMEN, *supra* note 9.

<sup>11</sup> BASIC STATISTICS, *supra* note 8.

Not only will this lack of knowledge prevent an infected person from seeking HIV therapy, but it will act as an absolute bar to effective communication to others regarding their risk of contracting HIV. It is dismaying that so many people are unsuspectingly living with HIV or AIDS because AIDS kills more people each year than cancer, accidental death, or stroke.<sup>12</sup>

### B. Symptoms

It is necessary to understand the pathology of HIV in order to understand why so many people infected with HIV do not know they are infected. The signs and symptoms of an initial HIV infection are the same as influenza.<sup>13</sup> These flu-like symptoms resolve completely while the person's immune system is subject to an incubation period of the virus.<sup>14</sup> At this time, HIV antibodies (which show the presence of an HIV infection) are not present.<sup>15</sup> Therefore, if someone were concerned about having an HIV infection, clinical testing of blood or tissue samples would not show HIV antibodies; however, the person still will develop HIV in the future.<sup>16</sup> Within six months of the infection, and more commonly in only three months, the infected person would test positive for HIV antibodies in clinical HIV testing. However, since the person is asymptomatic, or lacks clinical indicators of HIV, he may not be aware of his HIV infection.<sup>17</sup> During these initial stages of HIV infection, a person is contagious and may unknowingly spread the virus to others.<sup>18</sup>

The virus then progresses, usually undetected, and, eventually, the infected person becomes symptomatic. The common signs and symptoms of an HIV infection are night sweats, lethargy, diarrhea, weight loss, dementia, tuberculosis, and neurological complications, as well as skin rashes and oral lesions unique to HIV.<sup>19</sup> Stated simply, HIV attracts and kills important immune cells (CD4 lymphocytes, or

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<sup>12</sup> NAT'L INST. OF ALLERGY & INFECTIOUS DISEASES, THE RELATIONSHIP BETWEEN THE HUMAN IMMUNODEFICIENCY VIRUS AND THE ACQUIRED IMMUNODEFICIENCY SYNDROME (Sept. 1995), <http://www.niaid.nih.gov/publications/hiv aids/all.htm>.

<sup>13</sup> MOSBY'S MEDICAL, NURSING & ALLIED HEALTH DICTIONARY 830 (6th ed. 2002) [hereinafter MOSBY'S].

<sup>14</sup> *Id.* (charting the CDC's classification of an HIV infection based on pathophysiology of the disease as immune function deteriorates).

<sup>15</sup> *Id.*

<sup>16</sup> *Id.*

<sup>17</sup> *Id.*

<sup>18</sup> *See id.* (the incubation period of the disease can last for as long as ten years).

<sup>19</sup> *Id.* at 830.

“helper T cells”) and weakens the body’s immune system, making its victim prone to opportunistic infections and cancers.<sup>20</sup> AIDS is clinically diagnosed once the helper T cell count is below 200 cells/mm<sup>3</sup>.<sup>21</sup>

### C. Transmission

Casual contact (such as holding hands, or touching the sweat, tears, or saliva of someone with HIV) and environmental contact (such as coming into contact with surfaces that have been touched by someone with HIV, or being bitten by a mosquito that had bitten an HIV-infected person) do not transmit HIV or AIDS.<sup>22</sup> Unprotected sexual contact with a person who has HIV is the most common way to transmit HIV.<sup>23</sup> People also spread HIV through their blood—for instance, by sharing contaminated needles. For the purpose of this Note, a “contact” means an infected person’s prior or current sexual partners or people with whom he has shared needles.<sup>24</sup>

## II. HIV TESTING AND REPORTING

In order to understand the public prevention efforts related to HIV, one must understand the types of HIV tests from which patients can choose and what is required once an HCP determines the results of a test. First, this Note will explore the differences between anonymous and confidential testing. Then, this Note will discuss HCPs’ role in identifying contacts and their obligations to notify their state health department of a patient’s positive HIV status.

### A. Anonymous and Confidential Testing

Voluntary HIV testing is either anonymous or confidential. Anonymous HIV testing occurs when a person is tested and given a patient identification number that is not based on such personal identifiers as the patient’s name, social security number, or medical record

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<sup>20</sup> *Id.* at 830-31.

<sup>21</sup> TABER’S CYCLOPEDIA MEDICAL DICTIONARY 59 (20th ed. 2005).

<sup>22</sup> CTRS. FOR DISEASE CONTROL & PREVENTION, HIV AND ITS TRANSMISSION (July 1999), <http://www.cdc.gov/hiv/pubs/facts/transmission.htm> (explaining the basic pathology of HIV and how people can avoid becoming HIV-positive).

<sup>23</sup> OVERVIEW, *supra* note 9.

<sup>24</sup> Women who pass HIV to their children during pregnancy, birth, or through breast milk are outside of the scope of this Note. By using medications during pregnancy and delivering by a cesarean section, the transmission rate of HIV from mother to baby is reduced to only one percent, as compared to the previous transmission rate of thirty-three percent. MOSBY’S, *supra* note 13, at 830.

number.<sup>25</sup> Based on the results of the blood or tissue sample associated with the identification number, the patient who gave the sample has either a follow-up appointment or telephone call with his HCP to learn of his HIV status.

Confidential HIV testing, by contrast, matches the patient's testing identification to his identity. These test results are recorded in the patient's permanent medical record if the testing took place at a hospital or at a private health practice.<sup>26</sup> Sometimes with confidential testing, a person's health insurance provider is notified of the patient's HIV infection.<sup>27</sup> Also, if the patient is tested confidentially in a jurisdiction that requires HCPs to notify the state of newly diagnosed HIV cases, the patient's history, risk factors, and even name may be reported to the state health department.<sup>28</sup>

In 2005, forty states and the District of Columbia allowed both confidential and anonymous HIV testing.<sup>29</sup> However, ten states offered only confidential testing, excluding the possibility of anonymous testing within state lines.<sup>30</sup> Regardless of the testing method people use, one-third of the people who test positive for HIV will never follow up to learn their test results.<sup>31</sup>

## B. Notification to Contacts and Public Health Departments

After a medical provider compiles a careful patient history, a patient who shares common risk factors with those infected with HIV

<sup>25</sup> See Ctrs. for Disease Control & Prevention, *Guidelines for National HIV Case Surveillance, Including Monitoring for HIV Infection and AIDS*, 48 MORBIDITY & MORTALITY WKLY. REP. 1, 9 (1999), available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/tr4813a1.htm> [hereinafter *Guidelines*] (detailing the types of HIV testing and how people choose testing based on their demographic information). See also OHIO REV. CODE ANN. § 3701.24(A)(9) (West 2005) (defining anonymous test).

<sup>26</sup> See, e.g., OHIO REV. CODE ANN. § 3701.24(A)(10) (West 2005) (defining confidential test); see also *Guidelines*, *supra* note 25.

<sup>27</sup> See, e.g., A.R.S. § 20-448.01(D) (2006). Although the Arizona statute requires a patient to sign a release form to allow HIV results to be shared with his insurance company, in other situations "[t]est results and application responses may be shared with the underwriting departments of the insurer and reinsurers, or to those contractually retained . . . [who] are involved in underwriting decisions regarding the individual's application." *Id.*

<sup>28</sup> See OHIO REV. CODE ANN. § 3701.24(B) (West 2005).

<sup>29</sup> KAISER FAMILY FOUND., HIV/AIDS POLICY FACT SHEET: HIV TESTING IN THE UNITED STATES (2005), <http://www.kff.org/hiv/aids/upload/Updated-Fact-Sheet-HIV-Testing-in-the-United-States.pdf> [hereinafter KAISER HIV TESTING] (documenting which states use anonymous and/or confidential HIV tests).

<sup>30</sup> *Id.*

<sup>31</sup> *Id.* (based on information gathered at testing sites funded by the Centers for Disease Control).

should be encouraged to seek HIV testing promptly. Risk factors (in order of prevalence rates) are: men who have sex with men; a person of either sex who has had multiple sexual partners; a history of injection drug use; a history of providing sex in exchange for money or drugs; or a past or present sexual partner who had HIV or AIDS, was bisexual, or shared needles.<sup>32</sup> However, the largest study of its kind, which used a sample set of more than 1.28 million subjects, found that twenty to twenty-six percent of people who were HIV-positive did not report any of these risk factors.<sup>33</sup> This underscores the importance of investigating the contacts of a person who was recently diagnosed with HIV in order to ensure that contacts are alerted of their possible infection even when neither they nor the medical community may consider them at risk of contracting HIV.

### 1. Partner Notification

In the context of this Note, “partner notification” means gathering information from a person who is newly diagnosed with HIV in order to identify and notify the person’s contacts of their risk of contracting HIV. Under partner notification, the infected person and the HCP or the public health officer then informs the contacts that they are at risk of having or developing HIV.<sup>34</sup>

The purpose of partner notification, aside from warning contacts of their possible infection, is to encourage HIV testing, to protect the public from future HIV spread, and to acknowledge the contact’s right to know that he may be infected with HIV.<sup>35</sup> The partner notification

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<sup>32</sup> Roger Chou et al., *Screening for HIV: A Review of the Evidence for the U.S. Preventive Services Task Force*, ANNALS INTERNAL MED., July 5, 2005, at 55, 57 (noting that while screening tests themselves are very accurate, medical practitioners often miss opportunities to screen potential HIV carriers due to the subjectivity of selective screening).

<sup>33</sup> *Id.*

<sup>34</sup> Lawrence O. Gostin & James G. Hodge, *Piercing the Veil of Secrecy in HIV/AIDS and Other Sexually Transmitted Diseases: Theories of Privacy and Disclosure in Partner Notification*, 5 DUKE J. GENDER L. & POL’Y 9, 63 (1998) (discussing the origin of partner notification, and its progeny, contact tracing). The idea of contact tracing originated around 1918 when the federal government used its spending power to influence states to control and maintain sexually transmitted disease surveillance. *Id.* at 53. Then, the syphilis outbreak in the 1930s pushed contact tracing into the mainstream. *Id.* at 21-23.

<sup>35</sup> See Edward H. Kaplan & Michael H. Merson, *Allocating HIV-Prevention Resource: Balancing Efficiency and Equity*, 92 AM. J. PUB. HEALTH 1905, 1905 (2002) (analyzing the feasibility of a system where, unlike the current system where a state is awarded federal funds based on the number of its citizens that have AIDS, a state that prevents new HIV infections would receive increased funding in order to encourage effective HIV prevention programs).



theory argues that “1) knowledge empowers individuals to avoid continuing risks; 2) knowledge of infection allows for early treatment; and 3) knowledgeable partners can adapt their behavior to prevent further transmission of infection to others.”<sup>36</sup> There are two types of partner notification: patient referral and provider referral.<sup>37</sup> To increase the chance of effective notification, sometimes both types of notification are utilized.

#### a) Patient Referral

Patient referral (also known as self-referral or client referral) requires the HCP to ask the patient to take responsibility to notify everyone whom the patient may have exposed to HIV.<sup>38</sup> HCPs must first counsel patients about the proper way to notify others.<sup>39</sup> A significant drawback to this approach is that there is no reliable method to determine whether the infected patient actually warned his contacts that they are at risk of contracting HIV.

#### b) Provider Referral

Provider referral programs typically require that the patient’s HCP notify the patient’s contacts about their exposure to HIV. Usually the providers inform<sup>40</sup> contacts that they have been exposed to HIV but do not name the person who may have infected the contact.<sup>41</sup> However, a discrepancy exists as to the definition of provider referral programs. Unlike in the first example of a provider referral program, many state statutory laws on provider referral programs only require the HCP to notify public health officers of the newly diagnosed HIV infection. The public health officers then have the responsibility to notify the necessary contacts.<sup>42</sup>

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<sup>36</sup> Gostin & Hodge, *supra* note 34, at, 65.

<sup>37</sup> Sharron Salmon, *The Name Game: Issues Surrounding New York State’s HIV Partner Notification Law*, 16 N.Y.L. SCH. J. HUM. RTS. 959, 967 (2000).

<sup>38</sup> *Id.*

<sup>39</sup> Nancy E. Kass & Andrea Carlson Gielen, *The Ethics of Contact Tracing Programs and Their Implications for Women*, 5 DUKE J. GENDER L. & POL’Y 89, 91 (1998).

<sup>40</sup> *Id.*

<sup>41</sup> See Thomas Bradley et al., *Legal Issues Associated with Disclosure of Patient’s HIV-Positive Status to Third Parties*, NEXUS, Summer 2002, <http://www.thebody.com/aahivm/summer02/disclosure.html> (stating that existing statutes either expressly forbid, allow, or are silent on the subject of disclosing patients’ identity when notifying contacts).

<sup>42</sup> Salmon, *supra* note 37, at 967.

## 2. The Duty of HCPs to Report to the State Health Departments

Every state requires HCPs to report newly diagnosed AIDS cases to the state health department.<sup>43</sup> HIV causes AIDS,<sup>44</sup> yet in contrast to mandatory requirements that HCPs report AIDS infections to the department of health, only recently have states required the parallel reporting of newly diagnosed HIV infections.<sup>45</sup> The current statutes regarding HIV allow at least one of three methods for HCPs to report HIV cases to the state health department.

In the first method, name reporting entails collecting a patient's personal contact information and reporting it along with the patient's name to the state health department.<sup>46</sup> Thirty-eight states use name-reporting procedures for some or all of their HIV reporting requirements.<sup>47</sup> This is an increase from thirty-three states and two territories in 2001.<sup>48</sup>

The second method, code reporting, occurs in seven states and Washington, D.C.<sup>49</sup> Code reporting is a process in which code identifiers (such as a date of birth or part of a social security number<sup>50</sup>) replace the infected person's name before the HCPs report the person's HIV-positive status to the state.<sup>51</sup>

<sup>43</sup> Anthony Simones, *The Right to Suffer as Individuals or the Necessity to Survive as a Society: HIV Status and the Constitutional Right of Privacy*, 68 UMKC L. Rev. 195, 196 (1999) (discussing the role of public health authorities in tracing contagious diseases, including HIV and AIDS).

<sup>44</sup> OVERVIEW, *supra* note 9.

<sup>45</sup> Simones, *supra* note 43, at 196. In 1998, the number of states that required HIV reporting to the health department was as low as thirty-one. Sonia Bhatnager, *HIV Name Reporting and Partner Notification in New York State*, 26 FORDHAM URB. L.J. 1457, 1458 (1999). Today, all states require HIV reporting to the state health department. KAISER HIV TESTING, *supra* note 29.

<sup>46</sup> *Name Brands*, *supra* note 9, at 2101.

<sup>47</sup> KAISER HIV TESTING, *supra* note 29. The practice of name reporting is the most traditional reporting method; it was used to control and trace diseases as far back as colonial times. Salmon, *supra* note 37, at 960-61.

<sup>48</sup> CTRS. FOR DISEASE CONTROL & PREVENTION, HIV/AIDS SURVEILLANCE TECHNICAL REPORT: HIV INFECTION IN AREAS CONDUCTING HIV REPORTING USING CODED PATIENT IDENTIFIERS, 2000 3 (2000), <http://www.cdc.gov/hiv/stats/hastr1100/commentary.htm> [hereinafter TECHNICAL REPORT].

<sup>49</sup> KAISER HIV TESTING, *supra* note 29. See also Jose Antonio Vargas, *Once a Pioneer in AIDS Battle, District is Now Fighting Blind*, WASH. POST, Mar. 26, 2006, at A1 (describing why Washington D.C., with the "highest rate of new AIDS cases in the country," continues to have difficulty tracking, and thus preventing, HIV infections).

<sup>50</sup> TECHNICAL REPORT, *supra* note 48, at 3.

<sup>51</sup> Laura Lin & Brian A. Liang, *HIV and Health Law: Striking the Balance Between Legal Mandates and Medical Ethics*, VIRTUAL MENTOR: AM. MED. ASS'N J. ETHICS, Oct. 2005, <http://www.ama-assn.org/ama/pub/category/15549.html>.

Finally, five states use name-to-code reporting.<sup>52</sup> Name-to-code reporting occurs when HCPs report the name of a person newly diagnosed with HIV to the public health department; however, after a public health official follows up and collects the newly infected patient's epidemiological data, the patient's name is replaced by a code and is stored as such in the health department's registry.<sup>53</sup> The state reporting methods are important to partner notification because the method the HCP must use affects (1) privacy issues of the patients and their contacts and (2) the ability and effectiveness of states to seek out and warn contacts.

### III. COMPETING INTERESTS TO BALANCE: PUBLIC HEALTH AND RIGHT TO CONFIDENTIALITY

Without the guarantee of confidentiality,<sup>54</sup> the HIV "epidemic would be driven underground, putting individuals at risk and frustrating entirely the epidemic control efforts of the state."<sup>55</sup> Therefore, one can conclude that without the cooperation of the people most at risk for becoming HIV positive, prevention efforts would be frustrated because epidemic control rests on the willingness of infected people to utilize the health system for testing, partner notification, and treatment.<sup>56</sup> This shows that while the public health aspect is important, protecting patient confidentiality to the greatest extent possible is "complementary to, rather than in conflict with, protection of public health."<sup>57</sup> While the government's interest in public health may appear to be in conflict with a patient's right to confidentiality, the courts and legislatures have tried to protect confidentiality as much as possible.<sup>58</sup> Specifically, the trend in case law, federal statutes, and state statutes clearly shows that public health interests are the dominant concern but

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<sup>52</sup> KAISER HIV TESTING, *supra* note 29 (describing the approach to partner notification and state documentation of HIV and AIDS).

<sup>53</sup> Lin & Liang, *supra* note 51.

<sup>54</sup> Here, confidentiality refers to the privacy of one's medical records from parties other than the patient's HCP. It does not refer specifically to confidential HIV testing as opposed to anonymous HIV testing.

<sup>55</sup> Roger Doughty, Comment, *The Confidentiality of HIV-Related Information: Responding to the Resurgence of Aggressive Public Health Interventions in the AIDS Epidemic*, 82 CAL. L. REV. 113, 126 (1994) (describing how the AIDS virus is dissimilar from any previous disease that has been under the surveillance of state health agencies and how this affects the strategies used for AIDS prevention).

<sup>56</sup> *Id.* at 125.

<sup>57</sup> *Id.* at 127.

<sup>58</sup> See V.I. CODE ANN. tit. 19, § 32a(c) (1995).

that confidentiality and privacy issues are still critical to decision-making regarding how to improve HIV-related laws.

### A. Case Law

There are two highly recognized types of privacy interests: “[o]ne is the individual interest in avoiding disclosure of personal matters, and another is the interest in independence in making certain kinds of important decisions.”<sup>59</sup> The former interest is the privacy interest that is pertinent to this discussion. Although the Constitution does not explicitly state that a right to privacy exists, the right exists based on other rights explicitly stated in the Constitution.<sup>60</sup> The court system in the United States, however, has quite clearly and quite often made exceptions to the right of privacy and has permitted disclosure of medical information when the competing concern is public health.

As far back as 1899, physicians could be found liable for failing to warn a third party of the danger posed by their patient’s contagion.<sup>61</sup> In 1920, the Nebraska Supreme Court held in *Simonsen v. Swenson*<sup>62</sup> that although the relationship between the patient and physician is otherwise unquestionably confidential, if a disease is highly contagious and others may become infected unless warned, the physician may warn third parties to prevent the spread of the disease.<sup>63</sup> The doctor-defendant in *Simonsen* was not liable for “the betrayal of a professional secret,” or wrongful disclosure, when he alerted others in the patient’s hotel that the patient had a “contagious disease.”<sup>64</sup> The court’s rationale in *Simonsen* was that a doctor’s duty falls not only to

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<sup>59</sup> *Whalen v. Roe*, 429 U.S. 589, 599-600 (1977) (permitting a New York statute that requires physicians to report to the state health department each time they prescribe Schedule II drugs and to identify to whom they prescribe the drug).

<sup>60</sup> *See Griswold v. Connecticut*, 381 U.S. 479, 500 (1965) (upholding a right to privacy from intrusion into one’s personal life); *see also Doughty*, *supra* note 55, at 148.

<sup>61</sup> *See Edwards v. Lamb*, 45 A. 480 (N.H. 1899) (holding a physician liable for not explaining to the patient’s wife how to avoid infecting herself with her husband’s contagious disease, and for giving her false information that she was not at risk of infection while changing her husband’s bandages); *see also Skillings v. Allen*, 173 N.W. 663 (Minn. 1919) (holding a physician liable for his failure to warn the patient’s parents that scarlet fever was highly contagious; however, the physician was not liable for the death of the patient’s brother because the plaintiff did not meet the burden of proving that the brother caught scarlet fever from the patient or that the brother’s infection was a consequence of the negligent performance of the defendant’s duties as a physician).

<sup>62</sup> 177 N.W. 831 (Neb. 1920).

<sup>63</sup> *Id.* at 831.

<sup>64</sup> *Id.* at 831-32 (noting that the doctor did not say that the disease was syphilis).

the patient, but also to the public and individuals identified as at risk.<sup>65</sup> The court's reasoning depended on state statutes.<sup>66</sup> The statutes allowed the disclosure of a potential harm to surpass the importance of laws and ethical codes relating to the confidential doctor-patient relationship.<sup>67</sup> Specifically, the court cited state statutes that delegated power to the state board of health to create, disseminate, and enforce HCP procedural rules relating to contagious diseases. Therefore, it was the statutes, via the board of health, that required HCPs to report such diseases.<sup>68</sup> Lastly, the court in *Simonsen* held that there was no betrayal of confidence since the patient knew that by submitting to an examination by a doctor, he waived his right to confidentiality if the physician needed to disclose his disease in order to protect others.<sup>69</sup>

It is important to note that shortly after *Simonsen*, the United States Supreme Court established that the state's police powers give it wide latitude in which to enforce those health measures that it deems necessary. In *Jacobson v. Massachusetts*,<sup>70</sup> the Court held that a mandatory vaccination program by the state was legal and within the state's police powers.<sup>71</sup> The Court stated that not only does the state have the right to create and enforce such laws, but it also has the duty to protect the interest of the majority against the interest of the minority.<sup>72</sup>

A decision by the California Supreme Court in *Tarasoff v. Regents of California*,<sup>73</sup> fifty-six years after *Simonsen*, was instrumental in changing the way HCPs and patients view confidentiality. *Tarasoff*

<sup>65</sup> *Id.* at 832 (explaining that "[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.").

<sup>66</sup> *See id.*

<sup>67</sup> *Id.* at 832. The court stated that when an HCP's "report is made in the manner prescribed by law, he of course has committed no breach of duty toward his patient and has betrayed no confidence, and no liability could result." *Id.* This seemingly rejects the concept that patient confidentiality continues if a competing public health issue exists.

<sup>68</sup> *Id.*

<sup>69</sup> *Id.*

<sup>70</sup> 197 U.S. 11 (1905).

<sup>71</sup> *Id.* at 12. The Supreme Court also held that a state was within its constitutional rights to mandate and enforce a vaccination for an entire town and fine those who refused to be vaccinated regardless of a person's rationale behind the refusal. *Id.* at 25-26.

<sup>72</sup> Doughty, *supra* note 55, at 121.

<sup>73</sup> *See generally* *Tarasoff v. Regents of the Univ. of Cal.*, 551 P.2d 334, 340 (Cal. 1976) (holding that a psychiatrist who knows a patient could be dangerous to a specific victim not only may break confidentiality with the patient but has a duty to get a warning to the victim).

increased the duties of HCPs beyond what was required in *Simonsen*. In *Tarasoff*, a psychologist's relationship with his patient created a special duty for the psychologist to exercise reasonable care to protect a third (and identifiable) party from harm by the patient. *Tarasoff* held that "protective privilege ends where public peril begins."<sup>74</sup> While breaching confidentiality was not always necessary to protect the public, the heightened duty imparted upon HCPs in *Tarasoff* is accepted as a way to protect third parties from harm.<sup>75</sup> In jurisdictions that continue to follow the *Tarasoff* rule, an HCP has an absolute duty to warn contacts of their potential HIV infection.<sup>76</sup> The HCP may be liable for negligence to a third party who was infected by the HCP's patient due to the HCP's "failure to warn the infected patients of the potential to infect others."<sup>77</sup>

The duty imposed in *Tarasoff* goes further than it may seem at first glance. The court in *Tarasoff* made it clear that HCPs not only have a duty to warn the victim of potential harm, but HCPs also have a duty to warn any pertinent party in order to alleviate a dangerous situation.<sup>78</sup> Therefore, an HCP's duty is not necessarily to warn the potential victim directly. Using this rationale, an HCP satisfies the *Tarasoff* duty to warn if the provider informs the state health department of a person's HIV infection and the health department then communicates with the infected person and that person's contacts.

In the United States Supreme Court case *Whalen v. Roe*<sup>79</sup>, the Court held that medical records could fall within the established zone of privacy.<sup>80</sup> *Whalen* set the standard that, while protecting one's privacy interest is desirable, this interest is not absolute,<sup>81</sup> and it confirmed that the Court may balance a person's privacy interest against the state interest of disclosure.<sup>82</sup> Specifically, the New York State

<sup>74</sup> *Id.* at 347.

<sup>75</sup> Roger S. Magnusson, *The Changing Legal and Conceptual Shape of Health Care Privacy*, 32 J.L. MED. & ETHICS 680, 681 (2004) (balancing the right of privacy versus the public health concern as it relates to contagious diseases such as AIDS).

<sup>76</sup> Gostin & Hodge, *supra* note 34, at 42, 45. However, this duty to warn would be difficult to apply in the real world if an HCP is unaware of a patient's contacts.

<sup>77</sup> *Id.* at 42.

<sup>78</sup> *Tarasoff*, 551 P.2d at 431 (stating that, in order to warn a potential victim, an HCP may "warn the intended victim or others likely to apprise the victim of the danger . . . or to take whatever other steps are reasonably necessary under the circumstances.").

<sup>79</sup> 429 U.S. 589 (1977).

<sup>80</sup> *See id.* at 605-06.

<sup>81</sup> *Id.* at 602-04.

<sup>82</sup> *Id.* at 601 n.27 (citing *Buckley v. Valeo*, 424 U.S. 1, 71-72 (1976)). Other

Controlled Substances Act of 1972 required doctors to submit to representatives of the state the names of patients who received prescriptions of Schedule II drugs. The Court's ruling held that such laws do not "automatically amount to an impermissible invasion of privacy."<sup>83</sup> *Whalen* also noted that sometimes disclosure of private information (which is typically confidential) might occur against the patient's wishes and that such personal or embarrassing information may be disclosed to public health agencies for public purposes.<sup>84</sup>

Applying the holding in *Whalen* to HIV-reporting laws, courts will uphold partner notification laws for HIV infection as long as confidentiality is preserved because the states' interest in reducing HIV infections trumps the concern of privacy. However, the states need to ensure that information disclosed to contacts remains confidential and that the infected person's identity is not disclosed to the contact.<sup>85</sup> But the states may still require name reporting to health departments if it furthers the process of contact tracing. In general, a court may "strike down a public health measure only if it stems from an illegitimate motivation [such as discrimination] or is demonstrably irrational and unrelated to its public health rationales."<sup>86</sup> While a state must have a legitimate purpose and reasonably related means to achieve this purpose, it is not difficult to concede that preventing the further spread of HIV is legitimate. In addition, providing the least amount of information possible to potential contacts is a reasonably related means to achieve the stated purpose.<sup>87</sup>

A similar privacy issue surfaced in *United States v. Westinghouse Electric Corp.*<sup>88</sup> *Westinghouse* focused on the right of workers to keep their medical records private against the government's interest in regulating occupational safety. As in *Whalen*, in *Westinghouse* the court used a broad balancing test to decide whether a public health concern may dominate over an individual's interest of keeping his medical information private.

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statutory reporting requirements, such as reporting venereal disease and child abuse, have been upheld as not amounting to "impermissible invasion[s] of privacy." *Id.* at 602.

<sup>83</sup> *Id.*

<sup>84</sup> *Id.*

<sup>85</sup> N.Y. PUB. HEALTH LAW § 2782(4)(a)(1) (McKinney 1999). *But see* MD. CODE ANN., HEALTH-GEN § 18-337 (West 2005).

<sup>86</sup> Doughty, *supra* note 55, at 122.

<sup>87</sup> *Id.* at 121.

<sup>88</sup> 628 F.2d 570, 573-74 (3rd Cir. 1980) (protecting medical records as private from the state because the administrative subpoena did not (1) fall within the agency's authority, (2) specifically demand items for production, and (3) have a reasonable relation to the inquiry).

Unlike *Whalen*, *Westinghouse* established specific factors for the court to use in balancing a privacy interest against the state's interest of public health. *Westinghouse* held that

[t]he factors which should be considered in deciding whether an intrusion into an individual's privacy is justified are the type of record requested, the information it does or might contain, the potential for harm in any subsequent nonconsensual disclosure, the injury from disclosure to the relationship in which the record was generated, the adequacy of safeguards to prevent unauthorized disclosure, the degree of need for access, and whether there is an express statutory mandate, articulated public policy, or other recognizable public interest militating toward access.<sup>89</sup>

The Third Circuit held the same interest was at issue in *Westinghouse* as in *Whalen*: "the right not to have an individual's private affairs made public by the government."<sup>90</sup> The court in *Westinghouse* agreed with *Whalen* and stated that "the right of an individual to control access to her or his medical history is not absolute."<sup>91</sup> The "courts and legislatures have determined that public health . . . may support access to facts an individual might otherwise choose to withhold."<sup>92</sup>

Although remanded for further review on the workers' privacy claim, *Westinghouse* generally held that a medical record could fall within a person's zone of privacy and that the government may not use the medical records for investigatory purposes without patient consent. The court also found that the medical records under consideration obliged more privacy protection than *Whalen* required in the statewide recording of prescription drug use. The *Westinghouse* court stated, "[t]he medical information requested in this case is more extensive than the mere fact of a prescription drug usage . . . and may be more revealing of intimate details."<sup>93</sup> Hence, the records in *Westinghouse* were more eligible for protection.

Serious risks could result from disclosing the information in a patient's medical record if the specific factors in the *Westinghouse* balancing test are applied to monitoring and recording HIV infection. For instance, patients may fear discrimination due to their seropositive

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<sup>89</sup> *Id.* at 578.

<sup>90</sup> *Id.* at 577.

<sup>91</sup> *Id.* at 577-78.

<sup>92</sup> *Id.* at 578.

<sup>93</sup> *Id.* at 577.



status.<sup>94</sup> The stigma alone of having AIDS may discourage people from seeking testing if they find their results will not be held private and they fear discrimination by the public.<sup>95</sup> The fears of negative public attitudes towards people with HIV are valid.<sup>96</sup> The fear of losing confidentiality will be magnified with the populations that already have a distrust of medical providers<sup>97</sup> or government record keeping, and, unfortunately, these demographic groups are the ones most likely to suffer from an HIV infection.<sup>98</sup> However, a patient's name or other identifying information need not be disclosed to the public during partner notification, and, as in many states, the basis of reporting to the state need not include names either.<sup>99</sup>

The 1988 opinion in *Doe v. Attorney General of the United States*<sup>100</sup> goes to the root of how stigma can have a grave effect on those with HIV. This court stated "that an AIDS diagnosis was extremely sensitive medical information."<sup>101</sup> Therefore, this information deserved constitutional protection.<sup>102</sup> However, as with its predecessors, the court in *Doe* stated that "the privacy protection afforded medical information is not absolute; rather, it is a conditional right

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<sup>94</sup> See generally *Doe v. Borough of Barrington*, 729 F. Supp. 376 (D.N.J. 1990). In a case where police officers disclosed the plaintiff's HIV status to his neighbors, the court found that

[s]ociety's moral judgments about the high-risk activities associated with the disease, including sexual relations and drug use, make the information of the most personal kind. Also, the privacy interest in one's exposure to the AIDS virus is even greater than one's privacy interest in ordinary medical records because of the stigma that attaches with the disease. The potential for harm in the event of a nonconsensual disclosure is substantial; plaintiff's brief details the stigma and harassment that comes with public knowledge of one's affliction with AIDS.

*Id.* at 384 (citation omitted).

<sup>95</sup> Ronald O. Valdiserri, *HIV/AIDS Stigma: An Impediment to Public Health*, 92 AM. J. PUB. HEALTH 341, 341 (2002) (concluding that stigma substantially interferes with HIV-prevention efforts because investigations show that a "fear of receiving a positive test result remains a potent disincentive to seek HIV testing").

<sup>96</sup> Gregory M. Herek et al., *HIV-Related Stigma and Knowledge in the United States: Prevalence and Trends, 1991-1999*, 92 AM. J. PUB. HEALTH 371, 374 (2002) (surveying over 1,300 people and finding that many surveyed feel that people with AIDS are "[r]esponsible for their illness"). In addition, one-fifth of those surveyed actually feared people with AIDS, and one-sixth felt disgust or supported public naming of people with AIDS. *Id.* at 374.

<sup>97</sup> *Id.* at 374-75. Of those living with HIV, many consider their infection shameful and keep it a secret. Vargas, *supra* note 49.

<sup>98</sup> See *Name Brands*, *supra* note 9, at 2099.

<sup>99</sup> Doughty, *supra* note 55, at 126.

<sup>100</sup> 941 F.2d 780 (9th Cir. 1991).

<sup>101</sup> *Id.* at 796.

<sup>102</sup> *Id.*

which may be infringed upon a showing of proper governmental interest.”<sup>103</sup> The culmination of case law leads to the conclusion that reporting HIV infections (and maybe even an infected person’s name and contacts) may be permissible.

### B. Federal Statutes

Federal statutes delineate the federal government’s interest in public health. These statutes try to protect public health, while also maintaining confidentiality of medical information. Two important statutes to examine in the context of HIV and public health are the Health Insurance Portability and Accountability Act of 1996<sup>104</sup> (HIPAA) and the Ryan White Comprehensive AIDS Resources Emergency Act of 1990<sup>105</sup> (CARE Act). These statutes were enacted after the following proposed federal policy failed to become law.

In an attempt to unify HIV notification laws, Congress considered but did not pass the AIDS Federal Policy Act of 1988 (Federal Act).<sup>106</sup> The Federal Act states that HCPs could disclose identifying information about a person who tested positive for HIV if: the disclosure is made to the tested person’s spouse, sexual partner, or needle-sharing partner; the health care provider reasonably believes that the tested person would not voluntarily inform those at risk; and the disclosure of identifying information is medically appropriate.<sup>107</sup>

Although this legislation did not become law,<sup>108</sup> it still set the standard for how states should legislate partner notification.<sup>109</sup> It is noteworthy that the Federal Act would have required an HCP to make “reasonable efforts” to find the contact and disclose that he is at risk

<sup>103</sup> *Id.*

<sup>104</sup> Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (1996).

<sup>105</sup> Ryan White Comprehensive AIDS Resources Emergency Act of 1990, Pub. L. No. 101-381, 104 Stat. 576 (1990).

<sup>106</sup> H.R. 5142, 100th Cong., 134 CONG. REC. H8041, H8076 (1998).

<sup>107</sup> H.R. 5142, 100th Cong. § 2329, 134 CONG. REC. H8041, H8077 (1988); H.R. 5142 § 2302.

<sup>108</sup> H.R. 5142, 100th Cong., 134 CONG. REC. H8041, H8076 (1998). The bill passed in the House but not in the Senate and was not included in the Health Omnibus Programs Extension of 1988. *See* Pub. L. No. 100-607, 102 Stat. 3045 (1998).

<sup>109</sup> Rhode Island’s law states that the health care provider [m]ay inform third parties with whom an HIV-infected patient is in close and continuous contact, including but not limited to a spouse, if the nature of the contact, in the physician’s opinion, poses a clear and present danger of HIV transmission to the third party, and if the physician has reason to believe that the patient, despite the physician’s strong encouragement, has not and will not warn the third party . . . .

R.I. GEN. LAWS § 23-6-17(2)(v) (1956).

of contracting HIV.<sup>110</sup> The opponents of the Federal Act believed that a “reasonable effort”<sup>111</sup> by HCPs to identify and warn contacts was too vague when left undefined.<sup>112</sup> Also, there was no uniform penalty for noncompliant doctors, possibly making some states’ penalties significantly more severe than other states’ penalties.<sup>113</sup> These two problems—the vagueness of “reasonable effort” and a lack of a uniform penalty—exist in many of the current state statutes on HIV partner notification.

HIPAA is the first national standard to protect the privacy of medical records and personal health information.<sup>114</sup> HIPAA balances the public’s “need to know” and a person’s right to privacy. HIPAA allows disclosure, to the proper party, of some information from a private medical record if there is a valid public health concern.<sup>115</sup> Therefore, HIPAA does not preclude states from enacting laws that authorize public health surveillance or reporting; instead, it allows HCPs to report even confidential health information to the necessary public health authorities to satisfy various public health purposes.<sup>116</sup> Specifically, HIPAA gives the United States Department of Health and Human Services authority to promulgate privacy regulations, such as the Privacy Rule.<sup>117</sup> However, the Privacy Rule paradoxically provided many exceptions, allowing a covered entity to lawfully disclose information from a patient’s medical record. One pertinent example of a significant exception to the Privacy Rule is that personal medical information may be released for the purpose of preventing or controlling disease.<sup>118</sup>

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<sup>110</sup> Donald H.J. Hermann & Rosalind D. Gagliano, *AIDS, Therapeutic Confidentiality, and Warning Third Parties*, 48 MD. L. REV. 55, 73 (1989) (describing the federal legislative acts to try to control the spread of the HIV virus).

<sup>111</sup> *Id.*

<sup>112</sup> *Id.* at 74.

<sup>113</sup> *Id.*

<sup>114</sup> Health Insurance Portability and Accountability Act, Pub. L. No. 104-191, 110 Stat. 1936 (1996); U.S. DEP’T OF HEALTH & HUMAN SERVS., FACT SHEET: PROTECTING THE PRIVACY OF PATIENT’S HEALTH INFORMATION (2003), <http://www.hhs.gov/news/facts/privacy.html> (stating that HIPAA gives patients control over their health information by setting boundaries on the use and release of medical records; HIPAA also establishes the safeguards that HCPs must comply with, or be subject to civil and criminal penalties).

<sup>115</sup> *Id.*

<sup>116</sup> Magnusson, *supra* note 75, at 686.

<sup>117</sup> 45 C.F.R. § 160.103 (2005).

<sup>118</sup> See 45 C.F.R. § 164.514(e)(3) (2005). For further discussion of privacy issues, see Nathan J. Wills, Note, *A Tripartite Threat To Medical Records Privacy: Technology, HIPAA’s Privacy Rule and the USA Patriot Act*, 17 J.L. & HEALTH 271, 277 (2002-03) (recalling a California Healthcare Foundation national survey).

Another relevant law that balances privacy versus public health concerns is the CARE Act.<sup>119</sup> The CARE Act significantly changed the way the federal government approached the HIV epidemic. The CARE Act is “specifically dedicated to providing HIV/AIDS health care for low-income and uninsured Americans.”<sup>120</sup> The CARE Act is the largest federal discretionary program for HIV and AIDS<sup>121</sup>; its budget contains more than \$787 million for the Drug Assistance program and \$731 million for the CDC’s HIV and AIDS prevention programs.<sup>122</sup> Pertinent to this Note, the CARE Act requires any state that receives federal grants must have a law “to require that a good faith effort be made to notify a spouse of a known HIV-infected patient.”<sup>123</sup> Of course, there are many other federal statutes that affect HIV and AIDS policy. Nonetheless, the major authority and control of HIV statutes still rests with the states, and, therefore, the rest of this Note will focus on the state statutes and how they can be strengthened.

### C. State Statutes

Many partner notification laws try to prevent an invasion of privacy by the government into one’s personal life, and the laws provide “legal protections” for an HIV-infected person who refuses to cooperate in partner notification.<sup>124</sup> A majority of the states have laws regu-

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<sup>119</sup> See 42 U.S.C. § 300ff-27a(a) (2000) (requiring states that receive federal grants under Title XXVI of the Public Health Service Act make a good faith attempt “to notify a spouse of a known HIV-infected patient that such spouse may have been exposed to the human immunodeficiency virus and should seek testing”).

<sup>120</sup> HRSA Fact Sheet, HRSA’s Fiscal Year 2005 Budget – Foundation of American Health Care Safety Net, <http://newsroom.hrsa.gov/factsheets/HRSA-budget-FY05.htm> (last visited Feb. 10, 2006). This governmental program, which gives provisions to HCPs who serve HIV- or AIDS-infected patients unable to afford health care, improves infected persons’ quality of life. Press Release, Health Resources and Services Administration, HRSA Report Finds Federal HIV/AIDS Programs Slow Spread of Disease, Help People Live Longer, Healthier Lives (Aug. 23, 2004), available at <http://newsroom.hrsa.gov/releases/2004/CAREreport.htm>.

<sup>121</sup> KAISER 2006 BUDGET, *supra* note 4.

<sup>122</sup> *Id.*

<sup>123</sup> Ryan White Care Act Amendments of 1996, Pub. L. No. 104-146, § 8(a), 110 Stat. 1346, 1372 (1996); 42 U.S.C. § 300ff-27a(a) (2000). Interestingly, a “spouse” is defined as a person who has been married to the infected person within the last ten years. The law did not mention other contacts, such as needle sharers. 42 U.S.C. § 300ff-27a(b). Due to the requirement for federal funding under this Act, the states’ contract programs follow the CDC’s guidelines for partner notification. Gostin & Hodge, *supra* note 34, at 54.

<sup>124</sup> N.Y. PUB. HEALTH LAW § 2781(3) (McKinney 1999); see also Bhatnager, *supra* note 45, at 1468. It is unclear, and probably unlikely, that this protection provides this infected person with complete criminal or civil immunity from their future

lating the disclosure of HIV by an HCP to a contact; however, these statutes vary greatly in what they permit or require HCPs to do.<sup>125</sup> Some states place the burden of investigating and informing the contacts on the infected person,<sup>126</sup> some place this burden on the HCP,<sup>127</sup> and others place the burden on state health officials.<sup>128</sup> Many state statutes disperse the responsibility to more than one party. In addition, the states differ regarding whom the statute protects. Some statutes explicitly protect spouses,<sup>129</sup> some are broader and protect contacts,<sup>130</sup> and others cover anyone who may have been exposed to HIV.<sup>131</sup> The statutes naturally differ by permissiveness of HCP reporting to public health departments and by whom the statutes protect. Therefore, this section will analyze three categories of statutes—weak statutes, intermediate statutes, and strong statutes—that take the most effective approach to partner notification and disease prevention.

### 1. Weak Statutes

“Permissive statutes authorizing disclosure to a spouse or known sexual partners do not facially create a legal duty to warn,”<sup>132</sup> and, without this duty, many HCPs may not take the effort upon themselves to notify contacts for the good of public health. A majority of states have statutes that do not require an HCP to inform a contact that the contact is at risk of becoming HIV positive. These permissive statutes allow partner notification programs to be ignored, as HCPs are not mandated to notify contacts or the public health department. In addition, there is no penalty for the HCPs’ inaction. Maryland, Arizona, Louisiana, Rhode Island, and Georgia have similar optional statutes.

For example, some statutes declare that HCPs “may” inform public health officials of an infected person so the official can follow

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contacts.

<sup>125</sup> Not all states, however, require HIV contact reporting by HCPs. Pennsylvania statutes list exceptions to the confidentiality of HIV-related information. However, there are no exceptions that allow HCPs to notify the infected person’s contacts. The exceptions mostly relate to release of the information to insurers. 35 PA. CONS. STAT. ANN. § 7607 (West 2003).

<sup>126</sup> See, e.g., N.Y. PUB. HEALTH LAWS § 2781 (McKinney 1999).

<sup>127</sup> See, e.g., MICH. COMP. LAWS ANN. § 333.5131(c) (2006) (imposing an “affirmative duty” on physicians to notify their patients’ contacts). The duty in Michigan, however, may be discharged by notifying the local health department. *Id.*

<sup>128</sup> See, e.g., W. VA. CODE § 16-3c-3(d)-(e) (West 2001).

<sup>129</sup> See, e.g., KAN. STAT. ANN. § 65-6004 (West 2002).

<sup>130</sup> See, e.g., LA. REV. STAT. ANN. § 32-2556 (2006).

<sup>131</sup> See, e.g., TENN. CODE ANN. § 68-10-115 (West 2001).

<sup>132</sup> Hermann & Gagliano, *supra* note 110, at 68.

through with partner notification procedures.<sup>133</sup> In addition, these states may allow HCPs to notify the contacts of an infected person, as well. However, since the HCP has no duty to disclose this information, if the HCP chooses to warn neither the contact nor the public health officer, then the HCP is not liable to contacts who become infected after the HCP diagnoses the patient with HIV. This is true even though contacts otherwise would have been notified, and possibly protected from acquiring HIV had the HCP made an effort to communicate with the contact.

Under this type of statute, HCPs have no obligation to identify or locate contacts.<sup>134</sup> All the weak statutes use a permissive approach of notification. These laws state that an HCP *may* disclose an HIV or AIDS infection to the infected person's spouse or sexual partner.<sup>135</sup> As ineffectual as these statutes are, there are statutes that do even less to protect contacts and fail to secure public health by not requiring that a contact is notified of the risk of becoming HIV positive.

In regard to who is protected under the statute, in some states an HCP is only permitted to notify a "spouse" or "sexual partner," but not permitted to notify needle-sharing partners.<sup>136</sup> Conversely, some states permit HCPs to disclose an HIV infection to a "contact"<sup>137</sup> or any "identifiable third party"<sup>138</sup> who is a sexual or needle-sharing partner with the recently diagnosed patient. Many states give discretionary power to the HCP to inform a patient's contact but do not further require the HCP to notify a public health official of the need to continue partner notification.<sup>139</sup> Therefore, HCPs have the option of whether to inform a patient's spouse or sexual partner of a patient's HIV status, and also control whether the local health department is notified to initiate, or continue, partner notification. Regardless of their choice of whether to disclose, HCPs will not be held liable to any civil or criminal lawsuits.<sup>140</sup> With ambiguity regarding when an HCP

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<sup>133</sup> MD. CODE ANN., HEALTH-GEN § 18-337(b) (West 2005). *See also* LA. REV. STAT. ANN. § 32-2556 (2006). Other states, such as Rhode Island, have similarly lackadaisical laws that health care providers are not specifically required to inform contacts but "may" report to the contact as they find necessary. R.I. GEN. LAWS § 23-6-17(2)(v) (1956).

<sup>134</sup> *Id.*

<sup>135</sup> *Id.*

<sup>136</sup> *Id.*

<sup>137</sup> N.Y. PUB. HEALTH LAW § 2780(10) (McKinney 2002).

<sup>138</sup> IOWA CODE § 141A.5(1)(3)(c) (2005).

<sup>139</sup> MD. CODE ANN., HEALTH-GEN § 18-337(b) & (f) (West 2005).

<sup>140</sup> *See, e.g.*, TEX. HEALTH & SAFETY CODE ANN. § 81.051(h) (Vernon 2001) (requiring "[a] health care professional who fails to make the notification [to contacts] required by Subsection (g) is immune from civil or criminal liability for failure to

should take action to notify contacts, and without punishment for those who do not follow the guidelines, this type of statute will stand as a roadblock to further partner notification.

The Ohio Revised Code establishes a permissive rule for partner notification. In Ohio, an HCP “may” disclose to the “spouse or any sexual partner” of the person who was tested the results of the HIV test, the person’s AIDS status, or the presence of an AIDS-related condition.<sup>141</sup> The duty to disclose the HIV or AIDS status of a spouse or sexual partner trumps the competing concern of patient confidentiality.<sup>142</sup>

It is important to note that the Ohio law does not specify how to determine if a person is a sexual partner because the statute refers to a patient’s partner by using the present tense. Even though the person’s past sexual partners may be infected, if the relationships are over and the infected person does not intend to have future sexual conduct with these people, the law may not require that past partners be notified. Nor does the statute in Ohio mandate that an HCP must investigate, or inform the state health department in order for its officers to investigate, who may be a current contact. The result is that there is no duty for the HCP to make any efforts to locate or communicate with potential contacts.

HCPs in Ohio who try in good faith to comply with the laws regarding nonconsensual HIV or AIDS status disclosure will not be liable for civil damages.<sup>143</sup> An HCP who illegally divulges HIV or AIDS information must be aware that he is improperly disclosing this information in order for a court to hold the HCP accountable.<sup>144</sup> An HCP who unlawfully discloses a patient’s HIV or AIDS status in Ohio could be liable in a civil action and may incur compensatory damages, attorney’s fees, and equitable or injunctive relief.<sup>145</sup>

## 2. Intermediate Statutes

The New York Partner Notification Law<sup>146</sup> requires New York HCPs to report those people with HIV, HIV-related illnesses, and

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make that notification.”).

<sup>141</sup> OHIO REV. CODE ANN. § 3701.243(B)(2) (West 2006).

<sup>142</sup> *State v. Gonzalez*, 796 N.E.2d 12, 31 (Ohio Ct. App. 2003) (discussing the proper felony assault conviction of a defendant who did not inform his sexual partner that he was HIV-positive).

<sup>143</sup> OHIO REV. CODE ANN. § 3701.244(D) (West 2006).

<sup>144</sup> § 3701.244(B).

<sup>145</sup> *Id.*

<sup>146</sup> N.Y. PUB. HEALTH LAW § 2130-39 (McKinney 2002).

AIDS to the state.<sup>147</sup> The timely report must contain the name of spouses, sexual partners, or needle-sharing partners known to the HCP, *or* the contacts whom the infected person wishes to notify.<sup>148</sup> This law is effective because it requires reporting to the state health department and includes all varieties of contacts, however it places a large burden on the HCPs to research and notify contacts.

This burden on HCPs to seek out and potentially communicate with the patient's contacts constitutes a problem with the New York law and laws similar to it. In New York, for instance, the HCP shall report to the public health commission the name of the infected patient and his contacts, if known to the HCP or if provided by the patient.<sup>149</sup>

Another flaw of the New York law is that the disclosure of contacts by the infected person to the HCP is completely voluntary. Failing to identify possible contacts does not create a risk of civil or criminal liability to the infected person.<sup>150</sup> Thus, the statute allows an infected person to avoid disclosure in two ways: a patient who does not want to notify any of his contacts of their risk of HIV infection may opt for anonymous HIV testing, or the patient may choose simply not to disclose his contacts.<sup>151</sup> The second situation demonstrates that it is legal for a person to undergo a confidential HIV test with a doctor who does not know the patient's personal history; then the patient legally may refuse to disclose the contacts' identities. These two legal loopholes are substantial and may negate the law's preventative effects. In addition, the law's practical significance in some situations is that it requires HCPs or the health department to investigate the identity of at-risk contacts.

In New York, the HCP has the option to disclose the information to the contact or to a public health officer, who will then take over the contact reporting.<sup>152</sup> Many states allow the option for an HCP to pass off the duty to notify contacts to the public health officer,<sup>153</sup> but for

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<sup>147</sup> Amendment changes to section 2784(4) of the Public Health Law read "[a] physician may disclose confidential HIV related information . . . [if] the physician has counseled or the protected individual [about notification] . . . [and] the physician has informed the protected individual of his or her intent to make such a disclosure to a contact ." Bhatnager, *supra* note 45, at 1488.

<sup>148</sup> New York State Department of Health, HIV Reporting and Partner Notification: Summary, <http://www.health.state.ny.us/diseases/aids/regulations/notification/summary.htm> (last visited on Sept. 26, 2006).

<sup>149</sup> See N.Y. PUB. HEALTH LAW § 2782(4)(a) (McKinney 1999).

<sup>150</sup> *Id.*

<sup>151</sup> *Id.*

<sup>152</sup> *Id.* § 2782(4)(a)(1).

<sup>153</sup> See, e.g., MD. CODE ANN., HEALTH-GEN. § 18-337(b) (West 2005).



the statute to be effective, this condition should be mandatory. In some cases, a public health worker may contact the HCP to verify information.<sup>154</sup> In New York, good-faith reporting by an HCP trying to comply with the law bestows civil and criminal immunity upon the HCP.<sup>155</sup>

### 3. Strong Statutes

At least three states have enacted strong reporting statutes. The New Mexico legislature recognized the great burden on physicians regarding partner notification and placed the duty to locate and inform contacts on public health agents.<sup>156</sup> Public health officials are also experienced and trained in both patient behavior and counseling, so extending their duty from reporting syphilis, tuberculosis, and AIDS, to reporting HIV exposure will not be burdensome to the state.<sup>157</sup> Furthermore, if the state finds that HIV-contacting is burdensome and, for this reason, does not want its officials taking this role, then it is inherently unfair to make private citizens enforce the law that the state will not require its own officials to enforce.

Another example of a strong statute dealing with partner notification and the role of a physician lies in a Texas statute that states: “[A] health care professional shall notify the partner notification program when the health care professional knows the HIV+ status of a patient and the health care professional has actual knowledge of possible transmission of HIV to a third party.”<sup>158</sup>

If an individual informed of the individual's HIV positive status under § 18-336 of this subtitle refuses to notify the individual's sexual and needle-sharing partners, the individual's physician may inform the local health officer and/or the individual's sexual and needle-sharing partners of: (1) The individual's identity; and (2) The circumstances giving rise to the notification.

*Id.* Kansas law states that a physician may disclose to “a spouse or partner” of the person diagnosed with HIV of their risk of infection. KAN. STAT. ANN. § 65-6004 (2002). However, nothing in the statute creates “a duty to warn any person of possible exposure to HIV.” *Id.*

<sup>154</sup> N.Y. PUB. HEALTH LAW § 2782(4)(a)(1) (McKinney 1999).

<sup>155</sup> See N.Y. PUB. HEALTH LAW § 2783(3) (2007).

<sup>156</sup> See Taylor, *supra* note 7, at 508-09.

<sup>157</sup> *Id.* But see Leslie M. Beitsch et al., *Structure and Functions of State Public Health Agencies*, 96 AM. J. PUB. HEALTH 167, 170 (2006) (discussing how the state public health system's infrastructure does not alleviate the overburdening of public health systems).

<sup>158</sup> TEX. HEALTH & SAFETY CODE ANN. § 81.051(g)(2) (Vernon 2001). See also MICH. COMP. LAWS ANN. § 333.5114a (West 2006). The Michigan statute states: (1) A person or governmental entity that administers a test for HIV or an antibody to HIV to an individual shall refer the individual to the appropriate

Similarly, West Virginia enacted laws to inform the “spouse, sex partners or contacts, or persons who have shared needles” of their exposure to HIV.<sup>159</sup> Not only does the West Virginia code keep the initial infected person’s identity confidential from the contact, but it also makes it solely the bureau’s duty to inform contacts.<sup>160</sup> The law allows HCPs to notify third party contacts; however, there is no explicit legal duty to do so.<sup>161</sup> The duty simply is that the HCP should notify the bureau if the HCP does not personally perform partner notification.<sup>162</sup> This law properly takes the responsibility out of the hands of the physician and passes the responsibility onto the state health department in every case of HIV infection.

#### IV. PROBLEMS ASSOCIATED WITH STATE STATUTES

Numerous limitations exist in the state statutes that attempt to prevent the spread of HIV. One important issue is that many HCPs are either unaware of, or noncompliant with, the current HIV partner notification laws and state health department reporting procedures. Another limitation of the statutes is that legislatures may not have comprehended the burden that these laws cause HCPs who try to comply with the law.

##### A. Ineffectiveness Due to HCP Noncompliance

Unfortunately, inaction by the medical community has reduced the success of both notification programs and accurate reporting statistics. In 2002, researchers were startled by the responses of 7,300

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local health department for assistance with partner notification if both of the following conditions are met:

- (a) The test results indicate that the individual is HIV infected.
- (b) The person or governmental entity that administered the test determines that the individual needs assistance with partner notification.

*Id.*

<sup>159</sup> W. VA. CODE § 16-3c-3(d) (West 2001).

<sup>160</sup> *Id.* (stating “the bureau shall make a good faith effort to inform spouses, sex partners, contacts or persons who have shared needles that they may be at risk of having acquired the HIV infection as a result of possible exchange of body fluids”).

<sup>161</sup> *Id.* § 16-3c-3(e).

<sup>162</sup> *Id.*

There is no duty on the part of the physician or health care provider to notify the spouse or other sexual partner of, or persons who have shared needles with, an infected individual of their HIV infection and a cause of action will not arise from any failure to make such notification. However, if contact is not made, the bureau will be so notified.

*Id.*; accord, MICH. COMP. LAWS ANN. § 333.5114(a) (2006).

physicians who participated in a mail survey regarding their reporting practices with sexually transmitted diseases, including HIV.<sup>163</sup> About forty percent of the physicians self-reported that they *never* report HIV or AIDS to the health department.<sup>164</sup> In those states where it was mandatory to report HIV and AIDS infections, about thirty percent of physicians were uncertain whether reporting was mandatory.<sup>165</sup> Of the physicians who knew that they were required to report HIV and AIDS, only fifty-three percent (for HIV) and fifty-six percent (for AIDS) actually reported required information to the state.<sup>166</sup> Physicians may not be fulfilling their role in reporting HIV and AIDS because about seventy-seven percent of physicians incorrectly assumed that their laboratories always report this information to the state, hence relieving their burden of reporting.<sup>167</sup>

Aside from the low proportion of physicians who report HIV cases to the health department, many physicians are noncompliant with laws that require them to inform contacts or educate the infected person on how to inform contacts. For example, the overall trend shows that, nationwide, only thirty percent of physicians always follow up to see if a patient actually referred his partners for treatment.<sup>168</sup> Furthermore, while almost ninety percent of physicians always teach patients how to prevent the spread of HIV to their partners, only around one-third of this number (thirty-four percent) instruct HIV-positive patients to notify the health department and even fewer (sixteen percent) send the contact information to the health department.<sup>169</sup> With such low statutory compliance by physicians, either physicians are not aware of or do not understand the statutes, or perhaps physicians are choosing to ignore a law that they consider a violation of the patient's confidentiality, or the penalties of violating reporting laws are not great enough to create an incentive for physicians to adhere to the law. Whatever the underlying reason may be, it is clear that the HIV reporting statutes that rely on HCPs are ineffective. Ineffective HIV policies that remain unchanged allow infections to occur that

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<sup>163</sup> Janet S. St. Lawrence et al., *STD Screening, Testing, Case Reporting, and Clinical and Partner Notification Practices: A National Survey of US Physicians*, 92 AM. J. PUB. HEALTH 1784, 1784 (2002).

<sup>164</sup> *Id.* at 1786.

<sup>165</sup> *Id.*

<sup>166</sup> *Id.*

<sup>167</sup> *Id.*

<sup>168</sup> *Id.*

<sup>169</sup> *Id.*

could otherwise be avoided; this is the price that the United States will pay if the current approach to HIV prevention continues.<sup>170</sup>

### B. Burden and Expense to HCPs

State policies that require medical providers to collect and report patients' personal information place a great burden on HCPs.<sup>171</sup> In addition, patients' trust in their HCPs may wane if the state requires HCPs to act as counselors, social workers, and informants.<sup>172</sup> Therefore, forcing the privatized health industry to "take title" of partner notification costs is a flawed solution to the problem. Taking title could potentially disable the health industry, which cannot control how many people seek treatment. In response to high costs, the health industry may decrease services available for HIV testing and counseling. HCPs may reject an incentive, but they have no choice but to accept the law mandated to them by the state.

Even if the state does pay for a medical provider's expenses, the lines are not clear as to how much effort by an HCP who must investigate the personal life of the patient is considered "reasonable." What level of investigation about identities of possible contacts is enough? We must also consider that during patient interviews the stress of possibly being HIV positive or the panic of being newly diagnosed with HIV may not allow the patient to think clearly and remember all of his contacts.

Furthermore, even if the patient does know his contacts, he may not want to disclose this information if it is potentially embarrassing, harmful, or illegal. This may preclude honest reporting by patients if their contacts were potentially exposed to HIV during an extramarital affair, prostitution, or while using illegal drugs.<sup>173</sup> Furthermore, people at risk of violence or domestic abuse may not disclose a contact if they fear further abuse or violence.

If the patient discloses his contacts but the contacts are, for example, homeless drug users, do we really expect physicians to walk down dark alleys to notify them? Considering that many people with HIV live in poverty, or are mentally ill,<sup>174</sup> we cannot assume the potential contacts will even have permanent addresses or telephone

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<sup>170</sup> Kaplan & Merson, *supra* note 35, at 1906.

<sup>171</sup> See *Name Brands*, *supra* note 9, at 2106.

<sup>172</sup> *Id.*

<sup>173</sup> Doughty, *supra* note 55, at 172.

<sup>174</sup> See Nancy P. Hanrahan, *How to Help Those with HIV and Serious Mental Illness*, 8 PENN. NURSING 22, 22 (2005).

numbers that a medical provider can obtain.<sup>175</sup> Furthermore, once an HCP identifies and warns all a patient's contacts, is the physician then responsible for finding the contact person's contacts as well? If so, where would this duty end?<sup>176</sup> These problems illustrate the need to remove the burden of notification from the HCP.

## V. THE EXEMPLARY APPROACH

This section advocates that the exemplar statutes mentioned above should be used by all states in developing their HIV and AIDS partner notification policies. Although the states can be relied upon to collect the names and contacts of people with HIV, there should continue to be an emphasis on the continuing confidentiality of this information. Also, by virtue of placing the responsibility on public health officers to investigate, notify, and follow up with an infected person's contacts, the state can alleviate an overburdened health system and ensure that its laws are properly and effectively enforced.

### A. Maintain Confidentiality to Alleviate Fears of Stigma

Confidentiality is a necessary requirement for protecting individual rights and preventing the spread of HIV. Even in the beginning of the HIV epidemic, these two goals were "to a large extent, seen as complementary and mutually reinforcing."<sup>177</sup> Early in the epidemic, concerns led to public health policies that reflected "a commitment to rely on prevention measures that were non-coercive—that respected the privacy and social rights of those who were at risk."<sup>178</sup>

By the end of the century, many public health advocates had abandoned the philosophy characterized as "AIDS exceptionalism" where the government "allowed the politics of the disease to stand in the way of public health, putting civil liberties before lives."<sup>179</sup> However, given the public's fear of people who have HIV, it is under-

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<sup>175</sup> Doughty, *supra* note 55, at 172 (describing hindrances to partner notification, such as when drug users do not know any, or the true, identity of their partners).

<sup>176</sup> Furthermore, no law clearly states which HCP, of the numerous HCPs that are involved to test and diagnose a patient for HIV, is ultimately responsible for notifying the patient's contacts of their exposure to HIV. Cf. V.I. CODE ANN. tit. 19, § 32a(a) (1995) (establishing the vague, but mandatory, state reporting requirement that "[e]ach physician who diagnoses and/or treats a person for [HIV or AIDS] . . . , and each laboratory which concludes with a result diagnostic of HIV infection or AIDS" shall inform the state of such an outcome).

<sup>177</sup> Doughty, *supra* note 55, at 114.

<sup>178</sup> Herek et al., *supra* note 96, at 371 (quoting R. Bayer, *Clinical Progress and Future of HIV Exceptionalism*, 159 ARCH INTERN MED. 1042-48 (1999)).

<sup>179</sup> Salmon, *supra* note 37, at 969.

standable that HIV-positive patients worry that others will improperly learn of their diagnosis.

As sociological studies point out, the public distrusts confidential HIV testing because of worries that medical information will be improperly disclosed. Once people understand their need for HIV testing, it takes those who will use confidential testing sites twice as long to go in for testing as it takes those who use anonymous testing sites.<sup>180</sup> In addition, those who use anonymous testing are more likely to return to the diagnostic center for their test results than those who use confidential testing centers; presumably, the delay seen in confidential testing sites is due to the fear that HIV status, once known, will be disclosed to contacts or to the public.<sup>181</sup> The real concerns of people who want to be tested for HIV will cause “detrimental effects on . . . the success of programs and policies intended to prevent HIV transmission.”<sup>182</sup>

Those who fear that their HIV results will not be held confidential may withhold information from an HCP, provide inaccurate information, avoid a consolidated medical record by “doctor-hopping,” or pay out of pocket for costs that insurance would normally cover.<sup>183</sup> The worst result of HIV-related stigma is forgoing HIV testing and treatment altogether.<sup>184</sup>

Confidentiality is crucial to HIV testing: people must be tested for HIV. This not only will help the infected person receive treatment but will also assist epidemiological studies that focus on how to curb or prevent further HIV infection.<sup>185</sup> The CDC, the American Hospital Association, and the American Medical Association (AMA) aver that the continuation of testing lies on the premise that confidential testing will actually remain confidential.<sup>186</sup> Keeping HIV tests confidential will encourage people to receive HIV tests and, in return, enable “state public health officials to accumulate data necessary for prevention and education.”<sup>187</sup>

<sup>180</sup> Bhatnager, *supra* note 45, at 1478.

<sup>181</sup> *Id.*

<sup>182</sup> Herek et al., *supra* note 96, at 376. *See also* Valdiserri, *supra* note 95, at 342.

<sup>183</sup> Wills, *supra* note 118, at 277.

<sup>184</sup> *Id.* *See also* Michael Adams, ACLU AIDS Project Testifies Against the Proposals, Feb. 28, 2002, <http://www.aclu.org/hiv/gen/11533res20020228.html>.

<sup>185</sup> Hermann & Gagliano, *supra* note 110, at 59.

<sup>186</sup> Taylor, *supra* note 7, at 487. The CDC also recommends that HCPs involved in provider referral programs actually hand off the responsibility of notification to public health officials. *See* Salmon, *supra* note 37, at 967.

<sup>187</sup> Taylor, *supra* note 7, at 488-89.

An example of a statute that retains the confidentiality of a patient is found in the Texas Health Code. It states that when notifying contacts "[t]he employee may not disclose: (1) the name of or other identifying information concerning the identity of the person who gave the partner's name; or (2) the date or period of the partner's exposure."<sup>188</sup>

#### B. Give Public Health Officials the Responsibility for Partner Notification

Since a significant number of HIV-positive people choose not to notify their contacts of their risk of infection, and if the goal of HIV prevention is to warn contacts of their possible HIV infection, then patient referral should at the least be supplemented with other means of notification, such as provider notification.<sup>189</sup>

Those who argue that physicians and other HCPs are exactly the people who should intervene and counsel patients about HIV contact tracing overestimate the bond that most patients have with their HCPs in today's large and impersonal health care system.<sup>190</sup> A patient who refuses to notify his sexual or needle-sharing contacts of their possible exposure to HIV places before an HCP the choice of breaking confidentiality to warn the third party or protecting confidentiality and letting HIV cases go undiagnosed.<sup>191</sup> Allowing a physician simply to report the case to the local health department for follow up with partner notification will alleviate both of these problems. Public health officers more regularly deal with partner notification and have specialized training in the area as well.

A disproportionate amount of media attention will occur in instances when a single infected person puts many contacts at risk of contracting HIV.<sup>192</sup> In these situations, HCPs may not be the best in-

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<sup>188</sup> TEX. HEALTH & SAFETY CODE ANN. § 81.051 (Vernon 2001).

<sup>189</sup> Doughty, *supra* note 55, at 170-71. A general problem with partner notification is that sometimes the contacts are not willing to participate in HIV testing, are not at the same address, or are no longer living; but the majority of contacts who are notified of their potential HIV infection find the program helpful. Even the HIV-negative contacts change their lifestyle habits in the future. Kass & Gielen, *supra* note 39, at 93-94.

<sup>190</sup> For instance, seventy-seven percent of 7,300 physicians surveyed each have an average caseload of ninety-eight patients a week. St. Lawrence et al., *supra* note 163, at 1785.

<sup>191</sup> Judith C. Ensor, Comment, *Doctor-Patient Confidentiality Versus Duty to Warn in the Context of AIDS Patients and Their Partners*, 47 MD. L. REV. 675, 687 (1988).

<sup>192</sup> Nushawn Williams, for example, sent the media, and hence the New York State Legislature, into action to create HIV reporting laws. In 1997, Williams, a New York resident, was diagnosed with HIV and voluntarily alerted authorities of thirteen

dividuals to inform infected patients discretely and also deal with the media without disclosing confidential information. Similarly, in states with domestic violence exceptions<sup>193</sup> to partner notification laws, the state may want to defer these evaluations and judgments to “those professionally-trained in such matters, rather than give just any physician or testing facility such important discretionary power.”<sup>194</sup> It would also be less arduous to train state health authorities on proper ways to screen for domestic violence in HIV, as they are already involved in disease notification and they have training in crisis management. In addition, it is less strenuous for administrative agencies to oversee public health authorities as compared to overseeing all the HCPs in the state who may be notifying contacts of their HIV risk.<sup>195</sup> For these reasons, it appears to be preferable for HCPs to defer partner notification to public health officials.

Although the majority of sexually transmitted disease testing occurs in a private doctor’s office, those people who are most likely to be HIV-positive will be tested at public health clinics or in-patient hospital settings.<sup>196</sup> This further supports that public health officers, versus overwhelmed clinic and hospital employees, may have the most time as well as the best access to patient data.

Placing responsibility on public health officials to warn contacts is the best approach to resolving the burdens that otherwise fall to HCPs.<sup>197</sup> In fact, the AMA suggests that physicians who practice in states that do not require them to report HIV infections to contacts should try to persuade the patient to do so.<sup>198</sup> Next, the AMA suggests notifying the pertinent state health authorities.<sup>199</sup> Only if the state health authorities do not take any action, the AMA states that, as a last

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women who he possibly infected in the past. Williams then continued to have unprotected sex after his HIV diagnosis. Williams was convicted under criminal charges of statutory rape and reckless endangerment for having unprotected sex and not warning his sexual partners after his HIV diagnosis. The court sentenced him to prison for four to twelve years. Note that the 1998 New York Partner Notification law would not have altered the actions taken in the Williams case, as he had already voluntarily disclosed his prior sexual partners as required by the law. Richard Perez-Pena, *Drifter Gets 4 to 12 Years in H.I.V. Case*, N.Y. TIMES, Apr. 6, 1999, at B1.

<sup>193</sup> N.Y. PUB. HEALTH LAW § 2782(4)(e)(2)(A) (McKinney 1999).

<sup>194</sup> Bhatnager, *supra* note 45, at 1487.

<sup>195</sup> *Id.*

<sup>196</sup> KAISER HIV TESTING, *supra* note 29. See also St. Lawrence et al., *supra* note 163, at 1784 (reporting seventy-one percent of people who are diagnosed with sexually transmitted diseases receive care from a private practice, community health center clinic, emergency room, or family planning clinic).

<sup>197</sup> Hermann & Gagliano, *supra* note 110, at 72.

<sup>198</sup> *Id.* at 73.

<sup>199</sup> *Id.*



resort, the physician should notify the third parties who are at risk of infection.<sup>200</sup>

Utilizing public health authorities to report the names of HIV-infected persons, along with their contacts' names, will enhance the ability of scientists and epidemiologists to study the disease.<sup>201</sup> Any new information learned from these studies—such as the presence of HIV, its direction of spread, or its most common modes of transmission—will assist in reforming prevention programs to continually target, educate, and prevent those people most at risk from becoming infected. In addition, if states begin to report HIV to local health authorities, this may allow for early treatment of those who are already infected, prevent them from infecting others, or even prevent the infection altogether if the contact is given sufficient notice of his potential risk.<sup>202</sup> The CDC states that using name-based reporting throughout the United States is critical to tracking the HIV epidemic effectively (and thereby lessen infection) and that name-based reporting does not deter HIV testing or even increase anonymous HIV testing.<sup>203</sup>

## CONCLUSION

While the medical treatment of those who are afflicted with HIV is improving with better patient care and scientific advances, HIV infection rates are still rising in the United States. Partner notification is essential to prevent the further spread of HIV. While patient confidentiality is an important part of the right to privacy, it is well established that one's medical information is never absolutely private, hence reinforcing the legitimacy of partner notification programs. Partner notification programs, however, should emphasize confidentiality so people do not avoid HIV testing.

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<sup>200</sup> *Id.*

<sup>201</sup> See Simones, *supra* note 43, at 196; see also Bhatnager, *supra* note 45, at 1478 (finding that name-based reporting may deter people from getting HIV tested). But see Amy Lensky et al., *Changes in HIV Testing After Implementation of Name-Based HIV Case Surveillance in New Mexico*, 92 AM. J. PUB. HEALTH 1767, 1767 (2002) (allaying concerns that name-based HIV surveillance deters HIV testing by finding that “[o]verall, reporting policies seemed to be a minor factor in the HIV testing decisions of individuals at risk”).

<sup>202</sup> Simones, *supra* note 43, at 196.

<sup>203</sup> David Brown, *D.C., Md. Face Cut In AIDS Funding: Grants to Be Linked to Use of Patients' Names to Track HIV*, WASH. POST, Mar. 13, 2006, at A1 (defending the potential federal requirement for HIV grants to require jurisdictions to use name-based reporting systems; citing both the high cost of code-based reporting and the effectiveness of name-based reporting in lowering the rate of people newly infected with HIV).

Furthermore, the current partner notification laws frustrate the HIV prevention effort because they are too permissive, and they place the burden on HCPs who are unable to handle such a large primary prevention responsibility. However, public health officials are both skilled and experienced in partner notification procedures. In addition, the government has a responsibility to assure the effective implementation of the partner notification laws that it creates and enforces. Therefore, public health officials are better suited than private HCPs to administer partner notification programs.

State and federal statutes aimed at reducing the spread of HIV should utilize the most effective means to achieve this goal. In order to be effective, a partner notification statute should: broadly define "contacts;" encourage patients to provide contact information; require an HCP to report the identifying information of a patient recently diagnosed with HIV or AIDS to public health officials; mandate that the responsibility to research a patient's contacts and notify the contacts of their risk of becoming infected with HIV or AIDS is the responsibility of the public health officials; utilize name-to-code reporting; and prevent disclosure to the contact of the identity of the person diagnosed with HIV or AIDS.

While medical science continues to pursue a way to prevent and cure HIV and AIDS, it is incumbent on all levels of government to do everything possible to limit exposure to this disease. Following the principles described above will dramatically improve the certainty that state governments utilize the best practices in HIV and AIDS prevention.

