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Confidentiality Policy for HIV-Related Information: An Analytical Framework for Sorting Out Hard and Easy Cases

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1989]

**CONFIDENTIALITY POLICY FOR HIV-RELATED
INFORMATION: AN ANALYTICAL FRAMEWORK
FOR SORTING OUT HARD
AND EASY CASES**

RICHARD C. TURKINGTON†

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I. INTRODUCTION

DO the special medical and social facts about AIDS warrant stricter confidentiality policies for health care information that identifies someone as having the disease or as being infected with human immunodeficiency virus (HIV)? Several federal and state governmental entities have answered this question affirmatively.¹ Other states have considered legislative proposals that would increase public access to health care information involving AIDS.² There has been a spate of recently enacted Omnibus

1. Federal agencies expressing a concern for confidentiality have included a Presidential Commission and the Centers for Disease Control. See REPORT OF THE PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC 126 (1988) [hereinafter PRESIDENTIAL COMMISSION] ("Rigorous maintenance of confidentiality is considered critical to the success of the public health endeavor to prevent the transmission and spread of HIV infection."); *Provisional Public Health Service Inter-Agency Recommendations for Screening Donated Blood and Plasma for Antibody to the Virus Causing Acquired Immunodeficiency Syndrome*, 34 MORBIDITY & MORTALITY WEEKLY REP. 1, 3 (1985) ("Physicians, laboratory and nursing personnel, and others should recognize the importance of maintaining confidentiality of positive test results.").

Some states have enacted legislation that strictly protects the confidentiality of health care information pertaining to AIDS. See, e.g., FLA. STAT. ANN. § 381.609(2)(f)(1)-(9) (West Supp. 1989); N.Y. PUB. HEALTH LAW §§ 2780-2787 (McKinney Supp. 1989).

2. See, e.g., 1989 Tex. Sess. Law Serv. 4802 (Vernon). These amendments to the Real Estate License Act include provisions relating to HIV infection. Section I5C provides:

[A] person who has actual knowledge that the previous or current occupant of real property had or has AIDS, HIV-related illness, or HIV infection shall provide that information to a potential purchaser or lessee of the real property on receiving a specific request for the information from the potential purchaser or lessee.

Id. at 4804.

One of the most publicized examples of attempts to expand public access to HIV-related information was Proposition 102, described as the "Reporting Exposure to AIDS Virus Initiative Statute." Sections 10, 11, and 14 of the proposed statute authorized: (1) physicians and health officials to disclose HIV-related information to a broad range of potential contacts, and (2) required persons that have tested positive for HIV to report the names of any person from whom the disease may have been contacted to local health officials within seven days. Proposition 102 was defeated by a 2-1 margin in a referendum in California. See *Californians Split on Referenda Seeking Contact Tracing and Criminal Tests*, AIDS LITIGATION REP. 1802, 1802 (Nov. 29, 1988). See also GA. CODE ANN. § 24-9-47 (Supp. 1989). For the text of this provision, see *infra* note 84.

AIDS legislation.³ Regulation of access to health care information about AIDS has been a central plank of this legislation.⁴ From these laws a consensus is emerging that may be viewed as the "official" public policy on confidentiality and AIDS. With this official public policy as a backdrop, in this article I examine the role that confidentiality should play in governmental responses to the AIDS epidemic.

Initially, I will examine the considerations that are commonly involved in confidentiality issues with respect to general health care information. Secondly, I propose an analytical model for evaluating the soundness of confidentiality policies as applied to health care information related to the diagnosis, testing and treatment of AIDS patients. Finally, I apply this analysis to the resolution of selected confidentiality questions that have been addressed in litigation and in recently enacted legislation. Using this analytical model, I will conclude that some controversial confidentiality issues actually present easy cases and others that appear to be easy cases may present, in fact, hard choices.

II. HEALTH CARE INFORMATION AND CONFIDENTIALITY

A. *General Considerations*

"Health care information" is a term that describes all of the information that is acquired or generated about a patient or client in the course of providing treatment.⁵ "Confidentiality" is a term that reflects a judgment about whether, and to what extent, health

3. See, e.g., CAL. HEALTH & SAFETY CODE, § 199.21 (West 1989); FLA. STAT. ANN. § 381.609 (West Supp. 1989); N.Y. PUB. HEALTH LAW §§ 2780-2787 (McKinney Supp. 1989).

4. See, e.g., FLA. STAT. ANN. § 381.609 (West Supp. 1989). For the text of this statute, see *infra* note 37. See also N.Y. PUB. HEALTH LAW §§ 2780-2787 (McKinney Supp. 1989). The New York statute's statement of legislative intent is typical of this kind of legislation in stating:

In order to retain the full trust and confidence of persons at risk, the state has an interest both in assuring that HIV related information is not improperly disclosed and in having clear and certain rules for the disclosure of such information. By providing additional protection of the confidentiality of HIV related information, the legislature intends to encourage the expansion of voluntary confidential testing for the human immunodeficiency virus (HIV) so that individuals may come forward, learn their health status, make decisions regarding the appropriate treatment, and change the behavior that puts them and others at risk of infection.

Id. § 2780 legislative intent.

5. See generally ADVISORY PANEL ON PRIVACY AND CONFIDENTIALITY OF HOSPITAL RECORDS, AM. HOSP. ASS'N, GUIDELINES ON INSTITUTIONAL POLICIES FOR DISCLOSURE OF MEDICAL RECORD INFORMATION (1979).

care information should be made public. To say that information is confidential is to make a normative statement that such information ought to be non-public—that is, inaccessible to the public.⁶ Health care practitioners, patients and clients expect that information acquired in the course of treatment will be kept confidential.⁷ This expectation about confidentiality reflects two inter-related concerns. One is that confidentiality is essential to protect the privacy of the patient; the other is that confidentiality is necessary to preserve the integrity of the professional-patient relationship. These two concerns are expressions of different intellectual and legal traditions.

B. *The Right to Privacy and the Preservation of the Integrity of the Professional-Patient Relationship*

The right to privacy is the product of our legal system's tradition of appellate courts building upon common law and constitutional law foundations to declare and expound rights that persons have against individuals and governmental entities. This tradition is grounded in evolving concepts of personhood and society's notion of fairness and justice as reflected in everyday discourse and traditional values of Anglo-American society. Rights, like privacy, are viewed as an inextricable part of what it is to be a person in our legal system.⁸ This view holds that privacy is an intrinsic good that stands on its own. Privacy rights stand on

6. See generally Turkington, *Legal Protection for the Confidentiality of Health Care Information in Pennsylvania: Patient and Client Access; Testimonial Privileges; Damage Recovery for Unauthorized Extra-Legal Disclosure*, 32 VILL. L. REV. 259, 265 (1987).

7. These expectations are reflected in the proscription against betrayal of secrets found in the licensing and ethical standards of health professions and medical records professionals. See, e.g., AMERICAN MEDICAL ASS'N, PRINCIPLES OF MEDICAL ETHICS § 9 (1957); *Ethical Principles of Psychologists*, 36 AMERICAN PSYCHOLOGISTS 633, 635-36 (June 1981); AMERICAN HOSPITAL ASS'N, HOSPITAL MEDICAL RECORDS 5 (1972).

The limited research that has been conducted on the attitudes of patients about expectations of confidentiality supports the view that confidentiality is expected and thought of as important for treatment. See, e.g., S. KNAPP & L. VADECREEK, PRIVILEGED COMMUNICATIONS IN THE MENTAL PROFESSIONS 30-33 (1987) (survey of studies about information acquired in psychotherapy).

8. For a useful evaluation of the respect for individual dignity basis for the right to privacy, see PHILOSOPHICAL DIMENSIONS OF PRIVACY: AN ANTHOLOGY (F. Schoeman ed. 1984). This view was first advanced by Warren and Brandeis in their famous article. See Warren & Brandeis, *The Right to Privacy*, 4 HARV. L. REV. 193 (1890). In the article the authors refer to privacy as part of a more general right. The more general right was said to be the "right to the immunity of the person,—the right to one's personality." *Id.* at 207. Dean Bloustein further developed these views several decades later. See Bloustein, *Privacy as an Aspect of Human Dignity: An Answer to Dean Prosser*, 39 N.Y.U. L. REV. 962 (1964).

their own in the sense that the right to privacy has a force in legal argument that ranges from either “trumping” other worthwhile interests that are at stake in the case, or at least requiring that privacy be given important weight in the decision-making process.⁹

The integrity of the professional-patient relationship as a basis for confidentiality reflects a different intellectual tradition. It is the tradition of science, empiricism, utilitarianism, and of the health profession in providing treatment and care. From this perspective, confidentiality is an essential condition for treatment and care because it promotes the unfettered exchange of information between the patient and the professional.

Preserving the integrity of the professional-patient relationship and protecting individual privacy are two positive values that support the idea that there should be legal protection for the confidentiality of health care information. In many instances these positive values which support confidentiality collide with other positive values that are promoted by public access to health care information. Important governmental and private interests may be furthered in particular situations by such access. Some of the most important of these are: the interest in crime control,¹⁰ the interest in truth seeking and the integrity of the fact-finding process in civil and criminal proceedings,¹¹ and the interest in public safety and preserving life.¹² Legal protection for the confidentiality of health care information necessarily involves an accommodation of interests. Public and private interests that would be

9. The “trumping” metaphor is that of Professor Dworkin in his influential work. See R. DWORKIN, *TAKING RIGHTS SERIOUSLY* 22-28 (1978). This section reflects my prejudice that the essence of the right to privacy is grounded in what Dworkin refers to as principle-based arguments that come from society’s sense of justice and morality. This tradition is essentially one of natural law. See *Pavesich v. New England Life Ins. Co.*, 122 Ga. 190, 50 S.E. 68 (1905) (utilizing classic natural law justification for recognition of a common law right to privacy). See generally M. PERRY, *THE CONSTITUTION, THE COURTS AND HUMAN RIGHTS* (1982); D. RICHARDS, *THE MORAL CRITICISM OF LAW* (1977); Wellington, *Common Law Rules and Constitutional Double Standards: Some Notes on Adjudication*, 83 *YALE L.J.* 221, 249-51 (1973).

10. See, e.g., *In re June 1979 Allegheny County Investigating Grand Jury*, 490 Pa. 143, 415 A.2d 73 (1980) (investigation of misappropriation of public funds justified disclosure of information contained in medical records).

11. See, e.g., *In re Lifschutz*, 2 Cal. 3d 415, 467 P.2d 557, 85 Cal. Rptr. 829 (1970) (neither psychiatrist’s nor patient’s right to privacy violated by forced disclosure of patient information in assault case initiated by patient).

12. See, e.g., *Tarasoff v. Regents of University of California*, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976) (therapist has obligation to warn of patient’s violent threats).

furthered by disclosure must be weighed against the interests of patient privacy and the preservation of the integrity of the professional-patient relationship.

C. *HIV-Related Health Care Information*

AIDS is currently described according to the stage of infection with HIV. When the infected individual's immune system is sufficiently suppressed, an opportunity for certain infections is provided, and physical symptoms and specific terminal illnesses follow. A person may be infected for a lengthy period of time before the virus sufficiently damages the immune system and the symptoms which indicate AIDS are manifested. Many infected persons are asymptomatic for long periods of time and may never acquire the full-blown disease.¹³ Damage to the immune system from the virus may facilitate the onslaught of other diseases in the infected person. The focus of confidentiality concerns with AIDS is on health care information that identifies an individual as infected with HIV (seropositive test), or as diagnosed or treated for AIDS or for one of the specific diseases commonly associated with AIDS (Kaposi's sarcoma or *Pneumocystis carinii* pneumonia, for example).

In this article I employ the phrase "HIV-related information" to refer to the generic information that should be considered as the subject for confidentiality policies. This includes information that an individual has been the subject of an HIV test or has HIV infection. It also includes any other information that could reasonably identify an individual as having one or more of the above conditions. That a person had a prescription for AZT, a drug used exclusively to treat AIDS, would be such information. One of the issues that has prompted some disagreement within legislatures is the scope of civil and criminal sanctions for unauthorized disclosure of protected information. One approach, as illustrated by the New York statute, is to focus regulations specifically on information that is acquired during the course of treatment or counseling.¹⁴ To implement this policy New York utilizes the

13. For an explanation of the criteria for and identification of AIDS, see Redfield & Burke, *HIV Infection: The Clinical Picture*, SCI. AM., Oct. 1988, at 90. For a leading statement on the facts of transmission, see Francis & Chin, *The Prevention of Acquired Immunodeficiency Syndrome in the United States: An Objective Strategy for Medicine, Public Health, Business, and the Community*, 257 J. A.M.A. 1357 (1987).

14. See N.Y. PUB. HEALTH LAW § 2783 (McKinney Supp. 1989). The statute provides in pertinent part: "Any person who shall . . . disclose, or compel another person to disclose, or procure the disclosure of, confidential HIV related

concept of "Confidential HIV Related Information."¹⁵ "Confidential" is employed to limit the information to that which is acquired by or is in the possession of a health or social services professional or is acquired by any person pursuant to a valid release. Other statutes do not make this distinction and provide for sanctions if there is unauthorized disclosure by someone who has not acquired the information in a treatment or counseling setting.¹⁶ I find this feature of the New York statute appealing. However, for purposes of the limited issues that are discussed in this article, the broader definition of "HIV-related information" is the appropriate concept.

III. AN ANALYTICAL PARADIGM FOR DETERMINING APPROPRIATE CONFIDENTIALITY POLICIES FOR HIV-RELATED INFORMATION

I propose an analytical structure for evaluating confidentiality policies for HIV-related information. This proposal is normative in that it provides a way for determining what confidentiality policies ought to be when relevant variables are evaluated and weighed. The analysis also comports with many of the features of judicial practices involved in the resolution of analogous confidentiality issues and with legislative practices that are reflected in AIDS legislation providing for confidentiality protection. I refer to this approach as an analytical paradigm because it reflects what I view as the best features of relevant judicial opinions and public policy.

I propose that the scope of legal protection for the confidentiality of health care information ought to be determined by the careful evaluation and accommodation of: (1) the extent of the loss of privacy that would occur if there were to be public disclosure of the specific information; (2) the extent to which the integrity of the professional-patient relationship requires immunity from public access to the information; and (3) the extent to which

information . . . shall be subject to a civil penalty not to exceed five thousand dollars for each occurrence." *Id.* § 2783(1)(b).

15. *Id.*

16. Compare ILL. ANN. STAT. ch. 111½, para. 7309 (Smith-Hurd Supp. 1989) ("No person may disclose . . . the identity of any person upon whom a test is performed, or the results of such a test . . .") (emphasis added) with CAL. HEALTH & SAFETY CODE § 199.219 (West Supp. 1989) (providing for civil penalty up to \$1000 for the disclosure of subject-identifying blood test results by anyone responsible for care and treatment of test subject) (emphasis added).

important governmental and private interests would be furthered by disclosure of such information.

A. HIV-Related Information and Privacy

The first factor to be evaluated is the risk of loss of privacy that would result from a breach of confidentiality of HIV-related information. Most health care information contains much that, if publicly disclosed, would constitute a significant invasion of privacy. Information about someone's physical condition embodies the most basic subject of privacy. Similarly, one's intimate personal and family relationships and sexual experiences, real or fantasized, are recognized as calling forth our most fundamental desires for privacy and secrecy. Nonconsensual publication of such information violates our sense of self-respect, human dignity and personhood.¹⁷ Disclosure of this highly personal and intimate information may damage our reputation and so affect others' perceptions of us that it may cause financial ruin and destroy or permanently alter friendships and other associations.

The extent to which specific types of health care information implicate privacy is a by-product of two interrelated factors: the intrinsic and the consequential features of the information. By intrinsic features, I am referring to the degree of intimacy of the information.¹⁸ "Consequential features" refers to the potential for harmful consequences to the subject if information is dis-

17. In an often quoted passage from a significant privacy case, Judge Hamely of the Ninth Circuit aptly noted: "We cannot conceive of a more basic subject of privacy than the naked body. The desire to shield one's unclothed figure from the view of strangers and particularly strangers of the opposite sex, is compelled by elementary self respect and personal dignity." *York v. Story*, 324 F.2d 450, 455 (9th Cir. 1963), *cert. denied*, 376 U.S. 939 (1964). See also *United States v. Westinghouse Elec. Corp.*, 638 F.2d 570 (3d Cir. 1980) (employee's medical records containing sensitive, personal facts entitled to privacy protection; but upon showing of governmental interest, disclosure may be required); *Woods v. White*, 689 F. Supp. 874 (W.D. Wis. 1988) (constitutional right to privacy in medical records not relinquished by virtue of incarceration).

18. See generally *Rural Hous. Alliance v. Department of Agric.*, 498 F.2d 73 (D.C. Cir. 1974). *Rural Housing* is a federal Freedom of Information Act (FOIA) case in which a U.S. Department of Agriculture report on discrimination in governmental housing in Florida was sought by a public interest group. The Act was enacted in 1966, and generally provides access by any person to information that is in federal governmental agency records. See 5 U.S.C. § 552 (1988). The Act adopts a presumption in favor of disclosure and places the burden on the agency to demonstrate that exemptions under the Act are applicable before the information will be nondisclosable. *Id.* § 552(a)(6)(A)(i). The major vehicle for protecting privacy interests under the Act is § 552(b)(6). Medical records epitomize the type of information that is intended to be protected by this exemption because of the powerful privacy concerns involved. Section 552(b)(6) reads in pertinent part: "This section does not apply to matters that are . . . personnel

closed. Information may not be intimate, yet be "highly personal" in the sense that the subject may choose not to make such information available to the public because of a reasonable fear that disclosure would bring about harmful consequences. One example of highly personal information would be the fact that someone had been arrested or had otherwise encountered the criminal process. Even though such information is, to some extent public, and although it may not say much, if anything, about the health or personal or family relations of the subject, its disclosure could raise serious privacy concerns.¹⁹

Attitudes about health care information influence whether adverse consequences will occur to the subject of the information as a result of disclosure. These attitudes may reflect both rational and irrational concerns about the extent to which a particular condition threatens others. Misconceptions about illness and disease are the product of the social forces that contribute to attitudes generally. Over the last several decades, media accounts have undoubtedly contributed to prevalent attitudes about contemporary contagious and terminal diseases.

Susan Sontag has described the influence of metaphors expressed in public accounts of disease upon the perception by others of victims of those diseases.²⁰ She argues that these metaphors contributed to misperceptions regarding cancer. Sontag initially examined attitudes and perceptions about persons with

and medical files and similar files the disclosure of which would constitute a clearly unwarranted invasion of personal privacy." *Id.*

Because § 552(b)(6) requires courts to sort out information on the basis of privacy values, § 552(b)(6) FOIA cases involve one of the most extensive and valuable discussions on the subject in our legal system. In *Rural Housing* the court noted that the requested report disclosed information about "marital status, legitimacy of children, identity of fathers of children, medical conditions, welfare payments, alcoholic consumption, [and] family fights," and that such information involved "intimate details" of those identified in the report. *Rural Housing*, 498 F.2d at 77. See also *Wine Hobby USA, Inc. v. IRS*, 502 F.2d 133, 137 (3d Cir. 1974) (disclosure of name and address list would constitute clearly unwarranted invasion of privacy in part because disclosure could subject those on list to unsolicited phone calls and perhaps offensive mail).

19. See *U.S. Dep't of Justice v. Reporters Comm.*, 109 S. Ct. 1468 (1989). Section 552(b)(7)(C) of the Freedom of Information Act (FOIA) excludes from disclosure records or information compiled for law enforcement purposes "to the extent that the production of such law enforcement records or information . . . could reasonably be expected to constitute an unwarranted invasion of personal privacy." 5 U.S.C. § 552(b)(7)(C) (1988). In *Reporters Committee*, the Court held that this section precluded disclosure of FBI "rap sheets" under FOIA because the compilation of information in these arrest records implicated significant privacy interests of the subject. *Reporters Committee*, 109 S. Ct. at 1485.

20. See generally S. SONTAG, *AIDS AND ITS METAPHORS* (1989); S. SONTAG, *ILLNESS AS METAPHOR* (1978).

cancer during the time when increased incidence of the disease was receiving much publicity but treatment was less sophisticated and successful than today. Currently, "cancer" is a term that probably does not generate the fear and social stigma that it did a decade or so ago. Sontag suggests that the metaphoric imagery of public accounts of AIDS has now distracted the public somewhat from its cancer phobia. Yet the intrinsic and consequential features of health care information about cancer have produced laws providing for special protection for the privacy of cancer patients.²¹ Similarly, concern over patient privacy with respect to information about treatment for drug and alcohol abuse and mental health problems has produced federal and state laws providing for the most stringent confidentiality for such information.²²

B. *Medical and Social Facts About AIDS*

Intrinsically and consequentially, publication of HIV-related information constitutes the most serious invasion of privacy. This conclusion inescapably follows from both the medical and social facts about the disease.

Numerous claims about AIDS are spoken of as "facts" in the public discourse on AIDS. The nature of these claims differ both in the evidence and methodological reasoning used to support them and in the extent to which there is disagreement or consensus in the scientific community about the conclusions that are to be drawn from the relevant evidence. The claim that HIV causes the disease is supported by purely scientific methodology and laboratory observations and is embraced overwhelmingly in the scientific community. Claims about modes of transmission are based upon general data and the inferences that epidemiologists make from such data by using the methodology of their science. There is now general agreement by epidemiologists that HIV is

21. See, e.g., N.Y. PUB. HEALTH LAW § 2402 (McKinney 1985) ("The reports of cancer cases made pursuant to the provisions of this article shall not be divulged or made public so as to disclose the identity of any person to whom they relate, by any person, except in so far as may be authorized in the sanitary code.").

22. See, e.g., 42 U.S.C. § 290dd-3 (Supp. V 1987). This statute provides:

Records of the identity, diagnosis, prognosis or treatment of any patient which are maintained in connection with the performance of any program or activity relating to alcoholism or alcohol abuse education, training, treatment, rehabilitation, or research, which is conducted . . . by any department or agency of the United States shall . . . be confidential

Id.

not transmitted by casual contact. Claims about the behavior of those who are infected and the behavior of persons toward those who are perceived to be infected are supported by the data and methodology of social scientists. Although these claims about behavior are supported mostly by surveys and indirect observations rather than by the more empirical techniques available to medical science, they are predicates of social policy that are as essential to the formulation of that policy as are claims of medical facts.

Although there is a great deal that is now known about AIDS, some of the epidemiological and medical facts about AIDS are very fluid and uncertain. Two very recent developments illustrate this. One is the preliminary studies that strongly suggest that AZT may be effective in retarding the growth of HIV at early stages of entry into the body.²³ The other is the discovery that in rare instances the body does not seroconvert for as long as thirty-six months after HIV infection.²⁴ Claims about the medical features and social implications of AIDS greatly influence public policy on confidentiality and AIDS. I refer to these claims in a general sense as medical and social facts.

The most basic and stable current medical facts about the disease are: it is incurable, communicable and terminal; it is caused by a virus that may not be eliminated once it is in someone's system; and the virus is primarily transmitted by anal and vaginal sexual intercourse, intravenous drug use with contaminated syringes, transfusions of contaminated blood or blood derivatives, and from mother to child during pregnancy or at birth.²⁵ It is difficult to imagine information more intimate than the fact that someone has become infected with HIV. The fact that someone has an infection that is communicable, incurable and almost certainly fatal, reflects upon that person's most basic sense of identity and security.

AIDS is also a social and cultural phenomenon. Some of the social and cultural features of AIDS are expressed in behavior and

23. See *F-D-C Reports: The Pink Sheet*, Aug. 7, 1989, at T&G2. The National Institute of Allergy and Infectious Disease conducted a double-blind, placebo-controlled study involving 713 HIV-infected persons. Study participants advancing to ARC or AIDS totalled 50 (36 from the placebo group and 14 from the AZT treatment group). *Id.* The study was said to have demonstrated for the first time that AZT is effective against early symptomatic HIV infection. *Id.*

24. See Imagawa, Lee, Wolinsky *et al.*, *Human Immunodeficiency Virus Type 1 Infection in Homosexual Men Who Remain Seronegative for Prolonged Periods*, 320 *NEW ENG. J. MED.* 1458 (1988); *Silent HIV Infections*, 320 *NEW ENG. J. MED.* 1487 (1988).

25. See Francis & Chin, *supra* note 13.

attitudes about the disease. These social facts provide the best evidence of the dramatic consequential feature of HIV-related information.

Commentary in this symposium and in numerous other forums has demonstrated, by pointing to a variety of accumulating evidence, that persons who are infected with the virus or suffer from the full-blown disease have been subjected to intolerance, ostracism, discrimination and violence.²⁶ These are basic and fundamentally important social facts about AIDS. Several factors undoubtedly contribute to the stigmas with which this disease is associated.

AIDS is the first full-blown transnational plague²⁷ of the electronic age. The disease entered our society with stealth and dispatch at a time when world-wide interconnected information technology was maturing. The disease has been identified for less than a decade. It has been known for only six to seven years that HIV may be transmitted by blood transfusions. During the early phases of the public discussion about the disease (the years from 1981 to 1984-85), the fact that HIV was found to survive in a number of body fluids produced a number of alarming, highly publicized theories of transmission. The virus was found in blood, semen, vaginal fluids, breast milk, saliva, tears and urine. While the epidemiological evidence was developing, logical inferences concerning transmission were freely disseminated and became ensconced in the public consciousness. If HIV could live in saliva, then the virus must be transmittable by exchanging saliva

26. Testimony and reports on incidents of adverse actions taken against persons that were perceived to have AIDS have been so often noted that to summarize them would be to repeat what has been said and is found in numerous books, articles, governmental reports and findings. The Report of The Presidential Commission on the Human Immunodeficiency Virus Epidemic encapsulated this by noting that "[a]t virtually every Commission hearing, witnesses have attested to discrimination's occurrence and its serious repercussions for both the individual who experiences it and for this nation's efforts to control the epidemic." See PRESIDENTIAL COMMISSION, *supra* note 1, at 119. In addition to the incidents cited in the symposium article by Mary Dunlap, (see Dunlap, *AIDS and Discrimination in the United States: Reflections on the Nature of Prejudice in a Virus*, 34 VILL. L. REV. 909 (1989)), the following publications contain references that support the position on social facts that the analysis in this article proceeds upon: W. BANTA, *AIDS IN THE WORKPLACE* 4-15 (1988); Brandt, *AIDS: From Social History to Social Policy*, in *AIDS: THE BURDENS OF HISTORY* 147, 152-57 (E. Fee & D. Fox eds. 1988). See also NAT'L GAY & LESBIAN TASK FORCE, *Anti-Gay Violence, Victimization & Defamation in 1986*, attributing part of the increase in reported incidents of violence against gays to the AIDS epidemic.

27. For an illuminating discussion of the concept of plague and its relation to illness and disease and AIDS, see S. SONTAG, *AIDS AND ITS METAPHORS* (1989) at 44-60.

or sharing eating utensils. If HIV were found in tears, than perhaps it was an air-borne transmittable virus. Since it was found in blood, perhaps it could be transmitted by mosquito bites or by an infected toilet seat.²⁸

Considerable epidemiological data has been accumulated since the disease was first recognized in 1981. This data has convinced the mainstream scientific community that the virus is only transmitted by contaminated blood (either in the course of a transfusion or via contaminated drug paraphernalia), perinatally, and by anal or vaginal sexual intercourse. Yet the attention paid to the medical literature's current theory of transmission has not been equal to the early publicity. Like the retraction to a defamatory statement, dissemination of updated, more factually-founded theories of transmission has not debunked the sensational conjectures that still shape the attitudes of many in our society. These lingering and pervasive misconceptions about transmission have coalesced with prejudice against homosexuals, racism, increasing intolerance of illegal drug use, and fear for personal safety to produce hostile and abusive behavior against those with AIDS and those perceived as being likely to contract AIDS.

Given these social facts, the most significant consequential features must be assigned to HIV-related information. While the presence of the virus threatens the physical life of the infected person, public disclosure of the fact of infection may destroy the subject as a "person" by denying that individual those social rights and privileges that are essential to personhood.

C. *Preserving the Integrity of the Professional-Patient Relationship:
The Special Role of Confidentiality in Diagnosis, Treatment
and Disease Prevention*

The second factor to be considered in the proposed analytical framework is the interest in preserving the professional-patient relationship in the context of the AIDS epidemic. One of the purposes of protecting the confidentiality of any health care information is to insure the free flow of information between the parties by preserving the integrity of the professional-patient relationship. Preventing public access to the information acquired during the existence of the professional-patient relationship is considered essential to effective health care. The relative importance of preserving the integrity of the professional-patient rela-

28. See generally W. BANTA, *supra* note 26, at 7-8; Francis & Chin, *supra* note 13.

relationship may vary according to two factors: (1) the role of communications in treatment, and (2) the subjective concerns and expectations of privacy that the patient has about the information. If the information communicated is crucial to effective treatment and the patient has strong concerns and expectations about privacy, the greatest value attaches to preserving the integrity of the relationship. The paradigm would be information about treatment for substance abuse and information related to mental illness. Some of the most stringent confidentiality laws have been enacted for such information.²⁹ These expressions of public policy are based upon the proposition that special legal protection is mandated to protect confidentiality where the free exchange of certain information is essential to diagnosis and treatment and a patient is concerned about the public disclosure of that information.

Because of the previously identified medical and social facts about AIDS, insuring the free flow of information between the patient and the professional plays a special and important role in current efforts to manage the epidemic. The present lack of a cure for AIDS shifts the primary focus of public policy away from treatment to protecting public health through reducing transmission of the virus. The major avenue of transmission appears to be through persons who are asymptomatic and unaware that they are infected. This, combined with the fact that infected persons may avoid transmission by altering their behavior, has caused voluntary testing to become an important piece of national health strategy to reduce transmission of HIV.³⁰ Voluntary testing promotes the policy of reducing transmission and protecting public health by informing infected persons of their infection so they may alter their behavior.

The case of Gaetan Dugas is a highly publicized piece of anecdotal evidence that raises questions as to the soundness of the assertion that positive behavior patterns will result from knowledge of HIV status.³¹ Knowledge of HIV status may be of limited use in altering the behavior patterns of drug addicts. Addiction

29. See, e.g., 42 U.S.C. § 290dd-3 (Supp. V 1987). See also generally Turkington, *supra* note 6, at 346 (discussing Mental Health Procedure and Alcohol Abuse Control Acts).

30. See PRESIDENTIAL COMMISSION, *supra* note 1, at 119-40.

31. Dugas has been depicted as "Patient Zero" for purportedly spreading HIV across North America and for deliberately engaging in high-risk sexual activity with a large number of persons who later became infected, even after he knew that he was infected. Dugas' escapades are graphically narrated in Randy Shilts' popular book, *And The Band Played On* (1988), but may have been of less

may compel persons to continue to share needles or to engage in prostitution as a means of obtaining drugs even though they know themselves to be HIV seropositive.³² On the other hand, studies based upon surveys of homosexual and bisexual men that compared the behavior patterns of those that had been tested for HIV with men that did not know their HIV status provide important support for the claim that knowledge of seropositive HIV status is likely to produce changes in behavior that reduce the risk of transmission.³³

As progress continues toward a cure or effective ways to manage the disease, voluntary testing may provide carriers with an opportunity to seek available treatment by identifying the infection at early stages. Recent studies have strongly suggested that AZT retards replication of the virus in many infected persons if taken at early stages of the infection.³⁴ This important development will undoubtedly result in a greater interest in testing by persons that perceive themselves to be at risk.

The official public policy on confidentiality and AIDS links increasing knowledge of HIV status via voluntary testing with the need to provide strict confidentiality protection. This linkage is made by the assumption that a significant number of persons will be unwilling to be tested unless they believe that the results will be confidential. This is a reasonable assumption about the attitudes and behavior of persons that perceive themselves to be, or that are in fact, at risk of infection. There has been much publicity about breaches of confidentiality of HIV-related information and the social harm that such disclosure has caused to the infected persons. There also has been much publicity on increased violence and discrimination against gays that is tied to fear of AIDS. Given the large number of persons that typically have access to health records in treatment facilities, a concern about breaches of confidentiality is certainly not unwarranted.³⁵

Claims about the effects on behavior of attitudes about confidentiality are difficult to verify. Research does provide support

epidemiological significance than Shilts implies. See Dunlap, *supra* note 26, at 910 n.6, 919 n.35.

32. See *Report of the Workgroup on Prevention: Information, Education, and Behavior Change*, PUB. HEALTH REP., Nov. 1988, at 19.

33. See generally Tauer, *AIDS: Toward an Ethical Public Policy*, 1988 BIOMEDICAL ETHICS REVIEWS 79, 85-87.

34. See *F-D-C Reports: The Pink Sheet*, *supra* note 23.

35. See Tauer, *supra* note 33, at 83 (more than 100 people may have access to medical records in a typical American hospital).

for the proposition that fear of what will happen if the fact of infections is known will inhibit someone from being voluntarily tested. A recent study showed that gay males were more willing to use a totally anonymous testing system than one that was confidential but used the subjects' names.³⁶ On balance, the evidence does support the position that protecting the confidentiality of HIV-related information will encourage voluntary testing and provide individuals with the opportunity to change high-risk behavior.

It is ironic that because of the special medical and social facts about AIDS, a combination of arguments coalesce to support providing strict confidentiality protection for HIV-related health care information. In respect to other kinds of health care information, these same arguments some times face off against each other. Confidentiality not only furthers the intrinsic good of the right to privacy and the pragmatic good of treatment and diagnosis, but also the pragmatic good of protecting the public safety by limiting transmission of the virus.³⁷

36. Fehrs, Fleming, Foster *et al.*, *Trial of Anonymous Versus Confidential Human Immunodeficiency Virus Testing*, *LANCET*, Aug. 13, 1988, at 379. In 1988, the state of Illinois experienced a 25% decline in the number of marriage licenses issued and a mass exodus of couples out of the state to marry during the initial year of its mandatory HIV testing program. Wilkerson, *Illinois Legislature Repeals Requirement for Prenuptial AIDS Tests*, *N.Y. Times*, June 25, 1989, at 12, col. 1. Although factors such as the cost and delay of the test undoubtedly contributed to this phenomena, concern over the risk of public access to test results may have also influenced the behavior of prospective marriage applicants. *Id.* The legislature has since repealed the mandatory testing requirement. *Id.*

37. An example of legislation that reflects this reasoning and promotes confidentiality as a central plank in public policy responses to AIDS is found in the statement of legislative intent in the recently enacted Florida statute which states:

The Legislature finds that the use of tests designed to reveal a condition indicative of human immunodeficiency virus infection can be a valuable tool in protecting the public health. The Legislature finds that despite existing laws, regulations, and professional standards which require or promote the informed, voluntary and confidential use of tests designed to reveal human immunodeficiency virus infection, many members of the public are deterred from seeking such testing because they misunderstand the nature of the test or fear that test results will be disclosed without their consent. The Legislature finds that the public health will be served by facilitating informed, voluntary, and confidential use of tests designed to detect human immunodeficiency virus infection.

FLA. STAT. ANN. § 381.609 (West Supp. 1989).

D. *Governmental and Private Interests Asserted on Behalf of Compromising Confidentiality of HIV-Related Information*

The third factor to be considered in the proposed analytical model for evaluating the treatment of HIV-related information is the strength of the interests asserted, either governmental or private, in favor of compromising confidentiality. A broad range of interests are asserted to justify breaches of confidentiality. In this section I engage in a general discussion of two interests: the interest in preventing physical harm to others and the interest in preventing emotional harm to others. In the last section I discuss a third interest: that of preserving the integrity of the truth-seeking process of courts in civil suits where HIV-related information is sought. A comprehensive evaluation of the whole spectrum of competing interests that may be implicated is beyond the scope of this article. However, I do find it interesting and worthy of mention that much of the public policy that has addressed the important question of the extent to which the interest in research warrants access to information is consistent with the analysis in this article. The importance of protecting personal privacy and in maintaining trust in the professional-client relationship is recognized by requiring the researcher to get the informed consent of the subject or by limiting access to HIV-related information to research that does not identify the subject.³⁸

1. *The Interest in Preventing Physical Harm to Others*

Perhaps the strongest basis for compromising the confidentiality of health care information is when disclosure is essential to the protection of persons against physical harm and loss of life. There is a tradition in moral philosophy traceable at least to John Stuart Mill that views preventing harm to others as having primacy over personal autonomy and privacy rights.³⁹ Considerable precedent exists for requiring disclosure of confidential health

38. See, e.g., WIS. STAT. ANN. § 146.025(5)(a)(10) (West 1989) (HIV test results may be disclosed to researchers affiliated with health care providers if written assurance is given that identity of subject will not be disclosed unless informed consent is obtained from subject).

39. See J. MILL, ON LIBERTY (1859). Mill argued that preventing harm to others is the only basis for coercive actions against mature competent persons. I do not take a position in this article on the question of whether preventing harm is the exclusive justification for breaches of confidentiality. For an interesting discussion of how Mills' harm principle supports imposing duties on infected persons to warn sexual partners, see Steinbock, *Harming, Wronging, and AIDS*, 1988 BIOMEDICAL ETHICS REVIEWS 27.

care information to prevent physical harm. Physicians are routinely required by statutes to report both terminal conditions (like cancer) and contagious diseases (like syphilis and tuberculosis) to health departments.⁴⁰ Health departments in turn engage in "contact tracing"—identifying and informing persons who are at significant risk that they have been exposed to a contagious disease and should be tested. Common law duties have been imposed on physicians to disclose the existence of contagious diseases to spouses and family members.⁴¹

Assuming that in appropriate circumstances the interest in preventing physical harm to others and protecting the life of others ought to outweigh personal privacy and the integrity of the professional-client relationship, the facts about transmission of HIV are crucial to determining whether in a particular case this interest is significantly implicated. As previously discussed, the best evidence demonstrates that HIV is transmitted only by intimate sexual contact, contaminated blood and perinatally.⁴² The

40. See, e.g., CAL. HEALTH & SAFETY CODE § 3125 (West 1979) (physicians, nurses, clergymen, attendants, co-habitants and others required to report fact of infectious or contagious disease to health officer); WIS. STAT. ANN. §§ 143.04, 143.07 (West 1989) (any person, particularly a physician, is required to report communicable diseases, particularly sexually transmitted diseases, to local health officer); see generally Note, *Between a Rock and a Hard Place: AIDS and the Conflicting Physician's Duties of Preventing Disease Transmission and Safeguarding Confidentiality*, 76 GEO. L.J. 169 (1987).

41. See, e.g., *Davis v. Rodman*, 147 Ark. 385, 227 S.W. 612 (1921) (physician has duty to exercise reasonable care when advising family about typhoid fever); *Hofmann v. Blackmon*, 241 So. 2d 752, 753 (Fla. Dist. Ct. App. 1970) (physician has duty to inform patient's family of risks and precautions associated with contagious disease); *Skillings v. Allen*, 143 Minn. 323, 173 N.W. 663 (1919) (physician has duty to inform family of infectious nature of scarlet fever). See generally Note, *supra* note 40, at 176-87.

42. As the previous authors have pointed out, there is a considerable consensus among epidemiologists in the scientific community about modes of transmission for HIV. There is only hard evidence to support the view that HIV is transmitted in three main ways: (1) through intimate sexual contact; (2) through parenteral exposure to contaminated blood (contaminated blood entering the body through breaks in the skin as in IV drug use or in transfusions); and (3) from mother to child in utero or at the time of delivery. Myths that HIV is transmittable by other means, flow, I think, from speculation and unwarranted inferences from the fact that the virus has been isolated from blood, semen, saliva, tears, breast milk and urine. From the fact that HIV is present in these body fluids and excretions, early speculation was that HIV could be transmitted from exchange of body fluids and casual contact.

As more facts about the occurrence and distribution of the disease accumulated, the evidence that transmission does not occur through casual contact became compelling. The major evidence was the absence of any clearly demonstrable cases of transmission to persons living in the household of someone infected with the virus by other than the three modes described above. If the virus were transmittable through casual contact, members of households of

interests in preventing physical harm and protecting life ought not to be regarded as reasonable justification for disclosure of HIV-related information unless the recipient of the information is at significant risk of infection and disclosure will significantly reduce or eliminate that risk.⁴³

2. *The Interest in Preserving Mental Equanimity and Preventing Emotional Harm to Others*

Some legislative proposals for requiring disclosure of HIV-related information appear to be ultimately designed to provide the recipient of the information with peace of mind about the risk of infection. Examples of this are proposals to require the testing and disclosure of HIV status of employees to employers, and of homeowners to prospective buyers. Given the known facts about transmission, these proposals are not justified as efforts to prevent physical harm to others, but only to provide peace of mind. There is neither much precedent nor many persuasive arguments for compromising the values that are furthered by protecting the confidentiality of HIV-related information where the primary justification for doing so is to prevent anxiety or other forms of emotional distress about the possibility of being exposed to HIV. The instances where tort law provides protection for mental equanimity nearly always involve situations where there is affirmative conduct. Where the conduct is deliberate or reckless, it must be demonstrably of no social value and cause serious emotional distress.⁴⁴ Where the conduct is negligent, the conduct must create

infected persons would have been infected because exchange of fluids does occur with kissing, mutual use of toothbrushes, eating utensils and other non-sexual contact. See Fischl, Dickinson, Scott *et al.*, *Evaluation of Heterosexual Partners, Children, and Household Contacts of Adults with AIDS*, 257 J. A.M.A. 640 (1987); Friedland, Saltzman, Rogers *et al.*, *Lack of Transmission of HTLV-III/LAV Infection to Household Contacts of Patients with AIDS or AIDS-Related Complex with Oral Candidiasis*, 314 NEW ENG. J. MED. 344 (1986). In the Friedland study, one household member became infected, but the authors concluded that transmission likely occurred from mother to child during infancy rather than through any casual contact. *Id.*

Several theories have been suggested for explaining the absence of evidence of cases of transmission by exchanging saliva: (1) HIV is not found in the saliva of many infected persons; (2) there is insufficient concentration of HIV particles in saliva for transmission; and (3) chemicals in the saliva inhibit transmission.

43. See J. FEINBERG, HARM TO OTHERS (1988). Feinberg is a leading moral philosopher and commentator on Mills' harm principle. The harm principle comes into play when human action causes harm or creates an unreasonable risk of harm to others. *Id.* at 11.

44. The tort of intentional infliction of emotional distress allows for recovery for purely emotional harm without manifestation of physical injury; however,

clearly defined risks of physical harm, and the emotional distress generally must be accompanied by physical injury.⁴⁵ Marc Christian's successful lawsuit against the estate of Rock Hudson may be an appropriate use of tort remedies for non-disclosure of HIV status.⁴⁶ But in that case, recovery for anxiety over risk of infection was based upon an allegation of wrongful affirmative conduct that involved a serious risk of transmission of the virus to the person claiming to have a right to know of someone's HIV status. Where fear over the risk of infection is irrational because of erroneous assumptions about transmission or because of prejudice about high risk groups, a policy that requires that confidentiality be breached in order to reduce such fears places the imprimatur of society behind these fears and prejudices. Such a policy hinders efforts to manage the epidemic. For these reasons I take the position that the interest in preventing anxiety and mental distress about the risk of being infected with HIV is not a sufficient *per se* justification for requiring the disclosure of the fact of infection.

recovery is only allowed if serious emotional distress was caused by conduct on the part of the defendant that is "outrageous" within the meaning of the tort. Outrageous conduct is that which is beyond what is tolerated in a civilized society. See RESTATEMENT (SECOND) OF TORTS § 46 (1965).

45. Although there have been many changes in the requirements for recovery in negligence actions where the gravamen of the claim is for emotional harm, recovery is still generally denied unless the plaintiff is at risk of physical harm from the defendant's conduct and there is physical manifestation of the emotional distress. See RESTATEMENT (SECOND) OF TORTS §§ 436, 436A (1965); see also *Dillon v. Legg*, 68 Cal. 2d 728, 441 P.2d 912, 69 Cal. Rptr. 72 (1968) (risk of physical harm not necessary, but physical manifestation of harm is required); *Tobin v. Grossman*, 24 N.Y.2d 609, 249 N.E.2d 419, 301 N.Y.S.2d 554 (1969) (no cause of action for unintended harm sustained solely as result of injuries inflicted directly upon another regardless of relationship and proximity to incident).

When there is a duty owed in negligence due to the affirmative conduct of the defendant, it is not necessary for the plaintiff to have been at risk of physical harm. See *Molien v. Kaiser Found. Hosps.*, 27 Cal. 3d 916, 616 P.2d 813, 167 Cal. Rptr. 831 (1980) (allowing cause of action for negligent infliction of severe emotional distress); *Johnson v. State*, 37 N.Y.2d 378, 334 N.E.2d 590, 372 N.Y.S.2d 638 (1975) (recovery for emotional harm allowed to plaintiff subjected directly to the negligent act when evidence shows causation and substantial harm).

This limited precedent does not support general disclosure of health care information to members of the public that have real but unfounded fears of being endangered. This precedent does have some relevance to the question of disclosure to sexual partners discussed later in this article. See *infra* notes 76-84 and accompanying text.

46. See *Christian v. Sheft*, No. C574153, slip op. (Cal. Super. Ct. Apr. 21, 1989) (lover successfully sued estate of late actor on grounds that actor and personal secretary withheld news of actor's AIDS infection while sexual relationship continued).

IV. EASY AND HARD CASES USING THE ANALYTICAL MODEL

To illustrate this analytical model, specific confidentiality questions will now be examined. First, I will examine “easy” cases. Easy cases are those cases where there is not a true conflict between positive interests. These false cases of having to make hard choices may occur in two ways: (1) the important interest furthered by disclosure may be furthered without invading the privacy of the infected person or adversely affecting the integrity of the professional-patient relationship, or (2) disclosure will not in fact further the interest and will seriously invade privacy and compromise the integrity of the professional-patient relationship. I suggest that in such cases the only responsible public policy is to protect the confidentiality of such information. Finally, I look at the issue of notification of known sexual partners and needle-sharing partners. I conclude that this turns out to be a hard case because there is a true conflict between values supporting confidentiality and important governmental and private interests.

A. *Easy Cases*

1. *Disclosure to Subject of HIV Test and to Persons Authorized to Receive Information by the Subject: The Need for Informed Consent and Written Authorization for Release*

The preceding analysis strongly supports the adoption of three policies in the information gathering and dissemination activities involved with testing for HIV: (1) that testing not occur without the informed consent of the subject; (2) that the subject have the right to release testing information to whomever they choose; and (3) that the release be contained in a written document specifically limiting the extent of disclosure and specifically precluding further disclosure.

The common law right to self-determination is the central principle of the evolving law of informed consent.⁴⁷ Legally valid

47. *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir.) (recognizing fundamental concept that every adult of sound mind has right to decide what shall be done with his own body), *cert. denied*, 409 U.S. 1064 (1972). *See also* *Cobbs v. Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972) (informed consent case involving undisclosed potential complication which was not integral part of procedure, but merely a known risk); *Scott v. Bradford*, 606 P.2d 554 (Okla. 1979) (liability for failure to obtain informed consent when adverse consequences not made known to plaintiff do in fact occur and cause injury); *Wilkinson v. Vesey*, 110 R.I. 606, 295 A.2d 676 (1972) (involving informed consent in malpractice action where patient suffered radiation burns); *Trogun v. Fruchtman*, 58 Wis. 2d 596, 207 N.W.2d 297 (1973) (physician has duty to disclose ramifications of a course of conduct, governed by principles of negligence for breach of duty).

consent to medical procedures must be voluntary and fully informed. Physicians now clearly have a duty to fully inform patients of risks and alternatives to proposed medical procedures. The theoretical basis of the right to self-determination is in the notion that autonomy about choices involving fundamental matters is intrinsic to personhood. Fundamental matters about which persons have the privacy of choice include whether to undergo a physically invasive medical procedure and the choice as to who shall have access to intimate and highly personal information about them.⁴⁸ Consent is the manifestation of the right to self-determination because it conclusively demonstrates that persons have decided for themselves. Informed consent is an essential component of the patient's right to privacy.

Whether there has been informed consent to a medical procedure becomes an issue when there has been assent to the procedure by the subject. This assent becomes legally valid consent if fully informed and voluntary. Similarly, the question of informed consent for HIV testing sometimes arises when there has been consent to the drawing of blood for a medical procedure or examination and the test for HIV is performed without first informing the patient.⁴⁹

Under these circumstances some argue that informed individualized consent is not necessary because the consent to perform blood tests and other diagnostic procedures is implied from the general consent required of the patient. This argument relies upon a dis-analogy, namely that testing for HIV is like testing for cholesterol or other conditions in the blood that involve no significant risk of adverse consequences to the subject if the condition is known. Comparing testing for cholesterol with testing for HIV is like comparing firecrackers to the hydrogen bomb. With the potential for discrimination and other adverse social consequences that exist for persons who test positive for HIV, the decision to be tested for the virus is an important one. The decision is more analogous to choosing whether to undergo an invasive

48. For a more philosophical discussion of the theory of informed consent, see generally Shapiro, *Legislating the Control of Behavior Control: Autonomy and the Coercive Use of Organic Therapies*, 47 S. CAL. L. REV. 237 (1974) (discussing coercive elements of prison and psychiatric hospital settings on informed consent to medical experiments); Waltz & Scheuneman, *Informed Consent to Therapy*, 64 NW. U.L. REV. 628 (1970) (discussing evolution of doctrine of informed consent).

49. See *Doe v. Conly*, Civ. No. CV-88-0486, slip op. (M.D. Pa. Mar. 31, 1988) (blood sample, taken for diagnosis of rash, tested for HIV without consent of subject).

medical procedure with inherent risks of permanent physical harm.

The weakness of the implied consent argument is fully exposed when the government requires employees to submit to mandatory testing for HIV. The drawing of a person's blood to test for HIV, like the drawing of blood for alcohol tests or the capturing of urine for drug testing, would seem to clearly be a "search" under both the state and federal constitutions.⁵⁰ As such, either consent to the search or a demonstration of strong overriding governmental interests is necessary for the test to be constitutional. In *Glover v. Eastern Nebraska Community Office of Retardation*,⁵¹ mandatory blood testing of employees of the Eastern Nebraska Human Services Agency (ENHSA) for tuberculosis, hepatitis B, and HIV was found to be an unreasonable search and seizure in violation of the Federal Constitution.⁵²

Following this reasoning, it is difficult to comprehend how a test by the government for HIV may so significantly affect personal privacy as to be considered a fourth amendment search while a test for HIV in the private sector by a health care facility or employer does not involve a sufficiently fundamental matter to trigger the common law right to self-determination and require individualized informed consent. The personal privacy interests of the subject of an HIV test are too significant to test without informed consent. Surreptitious testing for HIV status may also threaten the trust that is essential for the free flow of information between the professional and client; persons may be reluctant to

50. See *Skinner v. Railway Labor Executives' Ass'n*, 109 S. Ct. 1402 (1989) (drug testing program not designed to serve ordinary law enforcement needs requires balancing of public interest in program against individual's privacy concerns); *National Treasury Employees Union v. Von Raab*, 109 S. Ct. 1384 (1989) (collection and subsequent chemical analysis of urine samples are searches that must meet reasonableness requirement of fourth amendment).

51. 686 F. Supp. 243 (D. Neb. 1988), *aff'd*, 867 F.2d 461 (8th Cir. 1989).

52. *Id.* The court found that a policy requiring mandatory testing of the employees for hepatitis B and HIV was not justified at its inception and constituted a search for purposes of the fourth amendment. *Id.* at 250. Regarding HIV testing, the court stated that

[t]he policy was prompted by concerns about the AIDS virus, formulated with little or erroneous medical knowledge, and is a constitutionally impermissible reaction to a devastating disease with no known cure. The risk of transmission of disease from the staff to the clients . . . is minuscule, trivial, extremely low, extraordinarily low, theoretical, and approaches zero. Such a risk does not justify the implementation of such a sweeping policy which ignores and violates the staff members' constitutional rights.

Id. at 251.

interface with the health care professional if they think that secret testing for HIV status may occur.

The doctrine of informed consent presupposes that a competent patient, and not the treating professional, has the right to decide whether it is best for the patient to participate in a medical procedure. The requirement of informed consent is, in this sense, essentially anti-paternalistic. Therefore, surreptitious testing for HIV in order to protect the patient from further physical harm through additional replication of HIV is the kind of excessively paternalistic rationale that does not justify the invasion of privacy that occurs when important medical procedures are performed without informed consent.

There is some evidence that many hospitals and health care providers are currently testing without acquiring the informed consent of the patient.⁵³ This fact and the considerations discussed above have prompted many states to enact legislation that requires informed consent as a prerequisite to testing for HIV.⁵⁴ This is not a universal feature of AIDS legislation.⁵⁵

While the perspective of the analytical model clearly supports a public policy of requiring informed consent, consideration must also be given to the scope of the information disclosed to the subject. The nature of the medical and social facts of AIDS suggest that the subject of the test generally ought to be informed about: the purpose and meaning of the test; the sequential test procedures; the confidentiality policies that apply to the test results; the nature of AIDS and AIDS related illnesses; behavior known to involve risks of transmission and contraction of HIV infection; the benefits of early diagnosis; the availability of counseling; legal remedies available in the state if discrimination occurs; and the availability of anonymous testing where it is a practical alternative.

53. See Henry, Willenbring & Crossley, *Human Immunodeficiency Virus Antibody Testing: A Description of Practices and Policies at US Infectious Disease—Teaching Hospitals and Minnesota Hospitals*, 259 J. A.M.A. 1819 (1988).

54. See, e.g., CAL. HEALTH & SAFETY CODE § 199.22 (West Supp. 1989) (containing informed consent provisions); FLA. STAT. ANN. § 381.609(2)(a) (West Supp. 1989) (“No person . . . shall perform a test designed to identify [HIV] . . . without first obtaining the informed consent of the [subject]”); N.Y. PUB. HEALTH LAW § 2781(1) (McKinney Supp. 1989) (“[N]o person shall order the performance of an HIV related test without first receiving the written, informed consent of the subject”).

55. See, e.g., ILL. ANN. STAT. ch. 111½, para. 7308 (Smith-Hurd Supp. 1989) (provides exception for informed consent in limited circumstances when physician authorizes HIV test of patient that has consented to medical treatment but not to HIV test).

Several states have specified the minimum amount of information that must be communicated to the subject in the AIDS statute itself.⁵⁶ It is quite exceptional for the content of informed consent to be defined in legislation. Specifying the content acknowledges that the test may be ordered and administered by someone other than a physician. It also reflects the judgment that the personal privacy of the subject and the policy of reducing transmission by voluntary testing requires strict regulation of HIV information at the crucial initial information gathering stage of testing.

There is a divergence in state laws that address the content of informed consent. Some states, like Florida, limit required disclosure to medical facts. Those medical facts that must be disclosed are bifurcated by requiring that some facts be communicated before the test and others communicated only when notifying the subject of positive test results.⁵⁷ New York requires disclosure of both medical and social facts and related information including the scope of laws protecting infected persons against discrimination. The New York statute details the information that must be disclosed and requires disclosure before the subject's blood is drawn.⁵⁸ The New York view is more con-

56. See FLA. STAT. ANN. § 381.609(2) (West Supp. 1989). See also N.Y. PUB. HEALTH LAW § 2781 (McKinney Supp. 1989).

57. See FLA. STAT. ANN. § 381.609(2) (West Supp. 1989). This statute provides in pertinent part:

(c) No person shall order a test without making available to the person tested, prior to the test, information regarding measures for the prevention of, exposure to, and transmission of human immunodeficiency virus.

....
(e) No test result shall be revealed to the person upon whom the test was performed without affording that person the immediate opportunity for individual, face-to-face counseling about:

1. The meaning of the test results;
2. The possible need for additional testing;
3. Measures for the prevention of the transmission of the [HIV] infection;
4. The availability in the geographic area of any appropriate health care services, including mental health care, and appropriate social and support services;
5. The benefits of locating and counseling any individual [who may have infected the subject and whom the subject may have infected]; and
6. The availability . . . of the services of public health authorities . . . [for] any individual described in subparagraph 5.

Id.

58. See N.Y. PUB. HEALTH LAW § 2781(3) (McKinney Supp. 1989). The statute provides in pertinent part:

Prior to the execution of a written informed consent, a person or-

sistent with the underlying principles of informed consent.

Once the subject has given informed consent to an HIV test, the results of that test ought to be available to any person that the subject has authorized to have access. Control of who has access to health care information outside of those immediately involved with treatment is generally left to the subject of the information. The right to decide who shall have access to such information is the essence of the personal right to privacy, and if the subject has consented to access no significant privacy interests are implicated, at least in respect to the authorized recipient. Authorized disclosure is also consistent with preserving the interest in the integrity of the professional-patient relationship. Other important interests, such as providing for payment of insurance benefits for treatment, may also be furthered by authorized disclosure.

In order to protect against unauthorized publication of HIV-related information and provide protection for the subject's privacy, authorization should be in writing in non-emergency situations and the written release should contain a specific prohibition against further disclosure, with criminal and civil sanctions if the prohibition is violated. These are the conditions imposed in federal and state legislation for authorized disclosure of health care information acquired in the course of drug or alcohol treatment or treatment for mental illness.⁵⁹ Much of the recently enacted state AIDS legislation imposes similar conditions on the authorized disclosure of HIV-related information.⁶⁰

dering the performance of an HIV related test shall provide to the subject of an HIV related test or, if the subject lacks capacity to consent, to a person authorized pursuant to law to consent to health care for the subject, an explanation of the nature of AIDS and HIV related illness, information about discrimination problems that disclosure of the test result could cause and legal protections against such discrimination, and information about behavior known to pose risks for transmission and contraction of HIV infection.

Id.

59. See 42 C.F.R. § 2.31 (1988) (records of drug and alcohol abuse). For an example of state law imposing similar restrictions on the release form, see 4 PA. CODE § 255.5(a)(7), (b)(1)-(5) (1986) (drug and alcohol abuse records). For redisclosure, the federal regulations require that specific consent be procured. See 42 C.F.R. § 2.32 (1988).

60. See, e.g., COLO. REV. STAT. § 25-4-1409 (Supp. 1988) (penalty of up to \$5000 and imprisonment for up to 24 months); N.Y. PUB. HEALTH LAW §§ 2782, 2783 (McKinney Supp. 1989) (prohibits redisclosure without specific written consent of subject; penalty for unauthorized redisclosure is up to \$5000 per occurrence).

2. *Disclosure of HIV-Related Information in Tort Negligence Actions Brought Against Blood Banks or Physicians*

The screening for the HIV virus in blood donations began when an effective test for the antibody was developed in 1985.⁶¹ Since then, the screening process has substantially reduced, but not totally eliminated, the risk of contaminated blood. Persons who became infected from contaminated whole blood or its components and derivatives through transfusions both prior to and subsequent to 1985 have sued health care facilities, physicians and blood banks in negligence and strict liability in tort or under implied warranty theories.⁶² The vast majority of states have statutorily provided immunity to suppliers of blood and blood products for liability without fault.⁶³ Courts have generally rejected the implied warranty and strict liability claims based upon precedent involving blood contaminated with the hepatitis B virus. Actions for negligence in the performance of a service have been allowed.⁶⁴

61. See Kuritsky, Rastogi, Faich *et al.*, *Results of Nationwide Screening of Blood and Plasma for Antibodies to Human T-Cell Lymphotropic III Virus, Type III*, 26 *TRANSFUSION* 205 (1986). Cases of infection in hemophiliacs who were not members of previously identified high risk groups began to be diagnosed in 1982. See *Kozup v. Georgetown Univ.*, 663 F. Supp. 1048, 1051 (D.D.C. 1987) (citing 31 *MORBIDITY & MORTALITY WEEKLY REP.* 365-67 (1982) and 31 *MORBIDITY & MORTALITY WEEKLY REP.* 652-54 (1982)), *aff'd in part, vacated in part on other grounds*, 851 F.2d 437 (D.C. Cir. 1988).

62. See, e.g., *Doe v. Miles Laboratories, Inc.*, 675 F. Supp. 1466 (D. Md. 1987) (plaintiff brought actions in strict liability and breach of warranty after contracting AIDS-related complex (ARC) when blood-coagulation-factor concentrate was administered during emergency medical procedures); *Hyland Therapeutics v. Superior Court*, 175 Cal. App. 3d 509, 220 Cal. Rptr. 590 (1985) (strict liability action resulting from contaminated Factor VIII blood clotting product used to treat hemophilia).

63. See, e.g., CAL. HEALTH & SAFETY CODE § 1606 (West 1979). This statute provides in pertinent part:

The procurement, processing, distribution, or use of whole blood, plasma, blood products, and blood derivatives for the purpose of injecting or transfusing the same, or any of them, into the human body shall be construed to be, and is declared to be, for all purposes whatsoever, the rendition of a service . . . and shall not be construed to be, and is declared not to be, a sale of such . . . products . . . for any purpose or purposes whatsoever.

Id. *Hyland* interpreted § 1606 to apply to whole blood by-products, finding a "legitimate state interest in manufacturing blood products." *Hyland*, 175 Cal. App. 3d at 516, 220 Cal. Rptr. at 594.

64. See, e.g., *Kozup*, 663 F. Supp. 1048 (granting summary judgment in favor of defendant hospital and blood bank on strict liability and implied warranty claims brought by parents of infant who contracted AIDS from blood transfusion administered at birth); *Roberts v. Suburban Hosp., Inc.*, 73 Md. App. 1, 532 A.2d 1081 (1987) (upholding dismissal of strict liability and breach of implied warranty claims of hemophiliacs who contracted AIDS via transfusions of con-

The theories of lack of reasonable care vary, but in many instances information about the donor is relevant to the issue of whether the health care facility or blood bank was at fault. Prior to the utilization of the test, plaintiffs argued that the negligence arose from the failure to exclude blood donors who were members of high-risk groups—gay males and IV drug users—or from the failure to warn of the risk of infection.⁶⁵ After the use of screening tests began, the claims focused on improper administration of the test or on negligence in handling the information.⁶⁶ These theories are all based upon assessment of the reasonableness of accepting the blood from the donor in the circumstances, given the state-of-the-art in screening. In strict liability, implied warranty and negligence actions, the plaintiff must demonstrate that the defendant's actions caused the plaintiff's infection. Consequently, the identity of the donor may be central to demonstrating cause in a particular case.

Disclosure of the donor's name raises serious confidentiality issues. Information in judicial records is potentially as public as any information in our society.⁶⁷ Courts have registered a broad range of responses to requests for disclosure of donors' names. Most have demonstrated some sensitivity to the confidentiality concerns that are presented by such requests and, by exercising

taminated blood). *But cf. Miles Laboratories*, 675 F. Supp. 1466 (Maryland statute did not preclude claim in strict liability against producer of blood-coagulation-factor).

65. *See Kozup*, 663 F. Supp. at 1055-60 (example of various theories developed to demonstrate negligence prior to development of test and difficulties in prevailing against supplier when transfusion of infected blood occurred before 1985).

66. *See Liability for Transfusion-Transmitted Disease*, 14 WM. MITCHELL L. REV. 141, 148-51 (1988) (discussion of blood bank liability for failure to choose appropriate testing device, incomplete performance of test and inaccurate documentation of test results).

67. Court records generally are open to the public under common law access principles without the benefit of statutory rights to access. State and federal court decisions have granted access to the public and media on the basis of rights granted in the common law and Constitution as well. Publication by the media of health care information that is contained in judicial records is protected by the first amendment. *See Florida Star v. B.J.F.*, 109 S. Ct. 2603 (1989) (first amendment protects newspaper from civil sanctions for publishing rape victim's name when information was obtained lawfully from police report); *Landmark Communications Inc. v. Virginia*, 435 U.S. 829 (1978) (giving first amendment protection to newspaper for publishing confidential information regarding judicial review commission proceedings); *Cox Broadcasting Corp. v. Cohn*, 420 U.S. 469 (1975) (first amendment protects publication of rape victim's name obtained from public judicial records). *Cf. Gilbert v. Medical Economics Co.*, 665 F.2d 305 (10th Cir. 1981) (allowing publication of physician's name, photograph and psychiatric history).

their discretion in granting access to information during the discovery phase, have disclosed general information without disclosing the identity of the individual.⁶⁸ Other courts have disclosed the identity of the donor to the plaintiff and assumed that confidentiality would be adequately protected by appropriate directions to the plaintiff restricting further unnecessary disclosure.⁶⁹

In *Rasmussen v. South Florida Blood Service*,⁷⁰ the Florida Supreme Court responded to the request for disclosure of a blood donor's name in a negligence action with an analysis that has influenced public policy on nonconsensual disclosure of HIV-related information in blood transfusion litigation and in civil and criminal litigation generally. The analysis of the *Rasmussen* court is a mirror image of my analytical paradigm. It dramatically illustrates how assumptions about social and medical facts about AIDS and their implications to values assigned to personal privacy and public health policies drive toward strict confidentiality protection.

In *Rasmussen*, access to the donor list was denied to the civil plaintiff because disclosure would deprive the donors of their constitutional right to informational privacy and chill prospective blood donors from participating in the voluntary blood bank system.⁷¹ In treating the privacy interest of the donor as having a constitutional dimension, the *Rasmussen* court built upon an incipient development in our legal system: high courts in a few states had interpreted the constitutional right to informational privacy under the federal and state constitutions to be violated by govern-

68. See *Doe v. American Nat'l Red Cross*, 125 F.R.D. 646 (D.S.C. 1989) (patient who had contracted HIV from contaminated blood not entitled to discover identity of donor or to take "veiled disposition" of donor in order to establish blood supplier's negligence).

69. See *Tarrant County Hosp. Dist. v. Hughes*, 734 S.W.2d 675 (Tex. 1987) (patient who had contracted HIV from contaminated blood entitled to donor's name but directed not to directly or indirectly contact donor nor undertake further discovery regarding donor until permitted to do so by court). See also *Belle Bonfills Memorial Blood Center v. District Court*, 763 P.2d 1003 (Colo. 1988). In *Belle Bonfills* the court authorized the plaintiff to submit written questions to the donor through the clerk of the court. The clerk was provided with the identity of the donor for purposes of communicating the questions and receiving the written answers. The plaintiff received the written answers but was not provided with the identity of the donor. *Id.* at 1014.

70. 500 So. 2d 533 (Fla. 1987).

71. *Id.* at 537 ("Our analysis of the interests to be served by denying discovery does not end with the effects of disclosure on the private lives of the fifty-one donors implicated in this case. Society has a vital interest in maintaining a strong volunteer blood supply . . .").

mental disclosure of highly personal or intimate information.⁷²

Under this view, the degree of the invasion of privacy that occurs when the court as an agent of the state requires disclosure of highly intimate health care information must be weighed against the interest in truth-seeking that would be furthered by disclosure in the legal proceedings. In this weighing process, if privacy interests are strong, they may trump or override the interest in truth-seeking. At the very least, if the interest in truth-seeking may be furthered by alternative means that do not require that the subject's privacy be invaded, these alternatives must be utilized.⁷³

In a number of instances where the identity of an infected person is sought because it is relevant to issues in litigation, pri-

72. *Id.* ("We conclude, therefore, that the disclosure sought here implicates constitutionally protected privacy interests.").

73. *See Woods v. White*, 689 F. Supp. 874, 875-76 (W.D. Wis. 1988) (tracing evolution of recognition of constitutional right to informational privacy).

Although the Supreme Court has never squarely held that governmental disclosure of highly personal or intimate information violates a right to informational privacy under the Constitution that is independent of the fourth amendment, dicta in several cases has suggested that a right to informational privacy exists as part of "liberty" under the fifth and fourteenth amendments. *See Nixon v. Administrator of Gen. Servs.*, 433 U.S. 425 (1977) (weighing President's expectation of privacy in personal correspondence against public interest in disclosure); *Whalen v. Roe*, 429 U.S. 589 (1977) (discussing constitutionality of collection of patient identification data for persons using prescription medications).

Lower courts have proceeded on the basis of the existence of this independent informational privacy right. *See United States v. Westinghouse Elec. Corp.*, 638 F.2d 570, 577 (3d Cir. 1980) (There is "no question that an employee's medical records, which may contain intimate facts of a personal nature, are well within the ambit of materials entitled to privacy protection.").

When this informational right theory is employed judicially to prevent compelled disclosure of health care information, it creates a constitutionally-based evidentiary privilege. The development of a constitutionally-based privilege has formally occurred primarily in three states: Alaska, California and Pennsylvania. *See Falcon v. Alaska Pub. Offices Comm'n*, 570 P.2d 469 (Alaska 1977) (prohibiting reporting of individual patients' names); *In re Lifschutz*, 2 Cal. 3d 415, 431-35, 467 P.2d 557, 567-70, 85 Cal. Rptr. 829, 839-42 (1970) (no constitutional right allows psychotherapist to assert absolute privilege concerning all psychotherapeutic communications); *In re "B"*, 482 Pa. 471, 394 A.2d 419 (1976) (defining constitutional right to privacy in preventing disclosure of psychotherapist's medical records). A number of other jurisdictions have not formally adopted the constitutional testimonial privilege but have adopted a *de facto* theory by weighing interests. These courts have indirectly adopted the test, citing *Lifshultz* with approval, and have discussed the role of the patient's right of privacy in the determination regarding the privilege. *See, e.g., Yoho v. Lindsley*, 248 So. 2d 187, 190-92 (Fla. 1971) (balancing of rights of parties must occur in light of doctor-patient privilege and nature of judicial proceeding); *Commonwealth v. Kobrin*, 395 Mass. 284, 479 N.E.2d 674 (1985) (notions of psychotherapist are privileged only to extent patient's interest in confidentiality outweighs interest of state in fact finding).

vacancy may be completely protected without compromising the integrity of the truth-seeking process. In the context of negligence actions for transfusion of contaminated blood for example, general information about donors may be sufficient to fully develop the theory of the case. If the identity of the donor is not disclosed or may not be discovered from information that is disclosed, there is no invasion of the privacy of the subject. Where the identity of an infected person is essential to resolution of an issue in a civil or criminal case, the force of the constitutional privacy argument requires that steps be taken to minimize the loss of privacy. These steps might include limiting disclosure of the donor's name to the plaintiff's attorney under an obligation of confidentiality and deleting any identifying data in what information is ultimately placed in the court record.

Many of the state statutes reflect the privacy-weighted balancing of the *Rasmussen* court. The paradigm of this emerging public policy is illustrated by the Florida and New York statutes. These statutes generally require that the party seeking access to protected HIV-related health care information demonstrate both that the interest furthered by disclosure is substantial or compelling and that there is no alternative means to disclosure.⁷⁴ Be-

74. See FLA. STAT. ANN. § 381.609(2)(f) (West Supp. 1989). The statute provides in pertinent part:

No person who has obtained or has knowledge of a test result pursuant to this section may disclose or be compelled to disclose the identity of any person upon whom a test is performed, or the results of such a test in a manner which permits identification of the subject of the test, except to the following persons:

.....
(9) A person allowed access by a court order which is issued in compliance with the following provisions:

a. No court of this state shall issue such order unless the court finds that the person seeking the test results has demonstrated a compelling need for the test results which cannot be accommodated by other means. In assessing compelling need, the court shall weigh the need for disclosure against the privacy interest of the test subject and the public interest which may be disserved by disclosure which deters . . . donation and future [HIV]-related testing or which may lead to discrimination.

Id. See also N.Y. PUB. HEALTH LAW § 2785 (McKinney Supp. 1989). This statute provides in pertinent part:

A court may grant an order for disclosure of confidential HIV related information upon an application showing: (a) a compelling need for disclosure of the information for the adjudication of a criminal or civil proceeding; (b) a clear and imminent danger to an individual whose life or health may unknowingly be at significant risk as a result of contact with the individual to whom the information pertains; (c) upon application of a state, county or local health officer, a clear and imminent danger to the public health; or (d) that the applicant is lawfully

yond that, if the information is disclosed, confidentiality is protected in the ultimate court record by requiring the use of pseudonyms or other methods to prevent identification of the infected person.⁷⁵

These statutes and courts, following the *Rasmussen* approach, reflect the appropriate public policy on judicially compelled disclosure of HIV-related information.

B. *Hard Cases: Contact Tracing, Notification of Sexual Partners, Needle-Sharing Partners and Spouses*

One of the hardest issues involving confidentiality and AIDS is under what circumstances a physician or health department has the duty or discretion to disclose the fact of infection to the spouse, known current sexual partner, or known needle-sharing partner of the infected person. Yet, on the surface it does not seem like a hard case at all. If notification will prevent transmission of HIV to one of these individuals and save his or her life, then disclosure should be mandatory. Since there is some evidence of a correlation between the frequency of sexual contact and transmission of the virus,⁷⁶ notification could prevent transmission to the current sexual partner or spouse in those instances where transmission has not yet occurred. Even where the sexual partner is already infected, further transmission by him or her to others might be avoided by notification. Beyond that, in view of the discovery that AZT may retard replication of HIV in the earliest stages of infection, early notification may be the difference between whether the infection is treatable or not. These factors weigh heavily toward requiring health care professionals to disclose the fact of a patient's infection to known sexual or needle-sharing partners. Such disclosure is warranted as an application of the primacy of the interest in preventing physical harm to others.

entitled to the disclosure and the disclosure is consistent with the provisions of this article.

Id. § 2785(2).

75. See FLA. STAT. ANN. § 381.609(2)(f)(9)(b) (West Supp. 1989) ("Pleadings pertaining to disclosure of test results shall substitute a pseudonym for the true name of the subject of the test."). *Id.*

76. See Jaffe & Lifson, *Acquisition and Transmission of HIV*, in 2 INFECTIOUS DISEASE CLINICS OF N. AM. 299, 300 (June 1988) (Biologic as well as behavioral factors may contribute to HIV transmission. Some infected persons may be more infectious than others, and this infectiousness may vary over time."). See also Francis & Chin, *supra* note 13, at 1360 ("Statistically, the fewer different partners one has, the less likely that one will be exposed [to the HIV virus].").

Legal precedent for requiring disclosure of health care information by physicians to prevent further transmission of contagious diseases and to protect life predated AIDS and provides further arguments for mandatory disclosure in limited circumstances. Many states routinely require physicians to report contagious diseases to health departments. In the case of some of these diseases, like syphilis, contact tracing is performed by health departments for purposes of reducing the incidence of transmission and locating those that are infected so that they may be treated.

Some courts imposed a common law duty in negligence upon a physician to warn family members and health workers of the contagious condition of a client or patient.⁷⁷ These common law precedents were built upon and extended by the California Supreme Court in *Tarasoff v. Regents of University of California*.⁷⁸ The court extended this duty beyond infectious diseases to include mental conditions of the patient that constituted a threat of physical harm to third parties. In *Tarasoff*, the court imposed a common law duty in negligence on psychotherapists to warn third parties of a client's specified threat to harm them if the psychotherapist reasonably believed the threat was likely to be carried out.⁷⁹

77. See *Skilling v. Allen*, 143 Minn. 323, 173 N.W. 663 (1919) (physician had duty to use care in advising patient's parents of risk of contracting scarlet fever from contact with patient). One commentator finds *Skilling* not relevant precedent in the AIDS area because the case involved the affirmative act of the physician telling the mother that there was no risk in contact with the child. See Note, *supra* note 40, at 177-78. See also *Davis v. Rodman*, 147 Ark. 385, 391, 227 S.W. 612, 614 (1921), where the court stated:

It is undoubtedly the duty of physicians who are attending patients afflicted with contagious or infectious diseases not to negligently do any act that would tend to spread the infections. It would likewise be their duty to exercise reasonable care to advise members of the family and others, who are liable to be exposed thereto, of the nature of the disease and the danger of exposure.

Id.

78. 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976).

79. California decisions following the case have limited the duty to warn to the facts of *Tarasoff*. See, e.g., *Thompson v. County of Alameda*, 27 Cal. 3d 741, 614 P.2d 728, 167 Cal. Rptr. 70 (1980). In *Thompson*, a juvenile delinquent, within 24 hours after being released to the custody of his mother, sexually assaulted and murdered the plaintiff's son. *Id.* at 746, 614 P.2d at 730, 167 Cal. Rptr. at 72. The plaintiff's complaint alleged that the county had acted negligently in releasing from its psychiatric care a juvenile delinquent who was known to have "latent, extremely dangerous and violent propensities regarding young children" and who had "indicated that he would, if released, take the life of a young child residing in the neighborhood." *Id.* Despite the complaint's allegations, the California Supreme Court dismissed the plaintiff's case and concluded that the county had no duty to warn since the defendant made no "prior

Are cases involving notification of HIV-related information sufficiently different from infectious disease notification cases and *Tarasoff* to consider adopting policies other than mandatory notification? There is a strong case for treating notification of HIV status differently. Disclosure without consent constitutes a serious invasion of privacy and involves risks of adverse consequences to the patient, such as discrimination or violence, through further publication by the sexual partner. Mandatory disclosure may also exacerbate psychiatric disorders caused by infection.⁸⁰ Unless the patient is informed by the professional that HIV status would be disclosed to known current contacts at risk, disclosure threatens the trust necessary for free communication and the integrity of the professional-patient relationship. If the patient is informed of contact notification, he or she may be deterred from being tested. Third-party notification might save some lives in the short run but, in the long run, if it damages the trust between professional and client, and deters persons from voluntary testing, more transmission and deaths may result.

Also, unlike the *Tarasoff* situation, the health professional is

threat[s] to a specific identifiable victim." *Id.* at 758, 614 P.2d at 738, 167 Cal. Rptr. at 80.

Other courts have somewhat extended the duty to warn. *See, e.g.,* Mavroudis v. Superior Court, 102 Cal. App. 3d 594, 600, 162 Cal. Rptr. 724, 729 (1980) (therapist has duty to protect potential victim from danger presented by patient once therapist determines, or reasonably should have determined victim's identity upon a "moments reflection"). *See also* Lipari v. Sears, Roebuck & Co., 497 F. Supp. 185, 194 (D. Neb. 1980) (doctor's liability extends to those individuals foreseeably endangered by patient, not just those whom patient may have specifically threatened); Hedlund v. Superior Court, 34 Cal. 3d 695, 705-06, 669 P.2d 41, 46-47, 194 Cal. Rptr. 805, 810-11 (1983) (therapist held liable for failing to warn identifiable potential victim and her minor child, since risk of harm to minor was reasonably foreseeable if patient attacked victim); Petersen v. State, 100 Wash. 2d 421, 428-29, 671 P.2d 230, 237 (1983) (psychiatrist who knew of patient's drug-related mental problems and that patient was "potentially dangerous person and that his behavior would be unpredictable," held liable for failing to petition court for 90-day commitment of patient when patient injured plaintiff while driving under influence).

However, courts have generally been restrained in recognizing and defining the scope of the duty, and in most cases adjudicated on the *Tarasoff* theory, the plaintiff has not prevailed against the psychotherapist.

80. For a useful examination of the factors that distinguish disclosure issues in HIV cases from *Tarasoff* and the infectious disease notification cases, see Note, *supra* note 40. *See also* Herman & Gagliano, *AIDS, Therapeutic Confidentiality, and Warning Third Parties*, 48 MD. L. REV. 55 (1989). In this useful article, Herman and Gagliano argue against the imposition of a mandatory duty to disclose on physicians and therapists. They also make the important point that discretionary disclosure provides the flexibility that provides the best opportunity for accommodating the various interests that arise in the broad contexts where notification of HIV status may arise. *Id.* at 69-75.

not the only potential source of notification to the third party. The infected person and the health department are both in the position to notify third parties, and the infected person is arguably in a better position to do so. Only the subject knows who is at risk. The physician may only know that a spouse is at risk. Imposing a duty upon the physician to discover those that may be sexually involved with the patient requires the physician to undertake a police-type activity that many are reluctant to perform and that ought not to be imposed.

Imposing notification duties on the physician also may not be especially efficacious given the medical facts of the disease. Since some infected persons are asymptomatic for up to seven years, notification of potential retrospective contacts and their potential contacts is only theoretically possible and obviously unrealistic. Notification without proper counseling may also result in harm to the contact or further unnecessary disclosure with significant adverse consequences to the infected individual. These differences have resulted in a reluctance on the part of legislatures and health departments to treat AIDS or HIV infection as analogous to other infectious diseases or dangerous health conditions for purposes of notifying current sexual partners or other high-risk contacts. Although all states require that physicians notify health departments of AIDS, most do not require similar notification of HIV infection, and only a few states are treating AIDS like other diseases and requiring contact tracing.

The possibility of significant tort damage awards for disclosure under breach of confidentiality theories⁸¹ and the lack of clarity in the existing law on the duty to disclose to contacts leave the health care professional between a rock and a hard place. The special dimensions of the dilemma of the health professional has produced legislation that specifically deals with the notification

81. There is considerable precedent for allowing a patient or client to recover tort damages for unauthorized extra-legal disclosure by a health care professional of confidential information. The leading cases are: *Hammonds v. Aetna Casualty & Surety Co.*, 243 F. Supp. 793 (N.D. Ohio 1965) (physician liable to patient when physician turned medical records over to attorney without patient's consent); *Horne v. Patton*, 291 Ala. 701, 287 So. 2d 824 (1973) (physician liable to patient for disclosing health care information to patient's employer); *Hague v. Williams*, 37 N.J. 328, 181 A.2d 345 (1962) (physician not liable for revealing confidential information when claim has been made and public interest in honest and just result outweighs patient's right to nondisclosure). Various legal theories are raised in support of recovery in these cases. The most pervasive one is the breach of fiduciary theory. See Note, *Breach of Confidence: An Emerging Tort*, 82 COLUM. L. REV. 1426 (1982); Turkington, *supra* note 6, at 383-86.

question. Many of these laws provide the physician with discretion to disclose in limited circumstances and immunize the physician from liability if they exercise the discretion either to disclose or not to disclose. The circumstances and scope of contacts that may be notified under the various laws differs. The three basic approaches are illustrated by the Florida, New York and Georgia statutes.

Florida limits discretionary notification to the patient's spouse, allowing disclosure only if the patient has refused to notify after the health professional has recommended that the patient does so.⁸² New York provides for discretionary notification to spouses, sex partners or persons identified as having shared hypodermic needles or syringes with the infected person, provided that the physician has counseled the individual about notification but reasonably believes that the individual will not inform the contact. New York requires that notification be accompanied by counseling and gives the infected person the option of having the health department notify without disclosing the identity of the infected person.⁸³ Georgia allows for discretionary disclosure to

82. See FLA. STAT. ANN. § 455.2416 (West Supp. 1989). This statute provides in pertinent part:

(1) A practitioner regulated through the Division of Medical Quality Assurance of the department shall not be civilly or criminally liable for the disclosure of otherwise confidential information under the following circumstances:

- (a) If a patient of the practitioner has tested positive for [HIV] discloses to the practitioner the identity of a spouse;
- (b) The practitioner recommends the patient notify the spouse of the positive test and refrain from engaging in sexual activity in a manner likely to transmit the virus and the patient refuses; and
- (c) If pursuant to a perceived civil duty or the ethical guidelines of the profession, the practitioner reasonably and in good faith advises the spouse of the patient of the positive test and facts concerning the transmission of the virus.

Id.

83. N.Y. PUB. HEALTH LAW § 2782(4)(a) (McKinney Supp. 1989). This statute provides in pertinent part:

A physician may disclose confidential HIV-related information under the following conditions:

- (1) disclosure is made to a contact or to a public health officer for the purpose of making the disclosure to said contact; and
- (2) the physician reasonably believes disclosure is medically appropriate and there is a significant risk of infection to the contact; and
- (3) the physician has counseled the protected individual regarding the need to notify the contact, and the physician reasonably believes the protected individual will not inform the contact; and
- (4) the physician has informed the protected individual of his or her intent to make such disclosure to a contact and has given the protected individual the opportunity to express a preference as to whether disclosure should be made by the physician directly or to a public health of-

the spouse, sexual partner or their children after first attempting to notify the infected person that such disclosure is going to be made.⁸⁴

Many states have not addressed the question of notification of at-risk contacts. In such states, because precedent on disclosure of other health care information may not be controlling, health professionals are at risk of significant liability even if they take action consistent with their professional ethics and judgment as to what is medically and therapeutically correct for their patient. This is an unacceptable situation. The conflicting and important values that face off in notification cases require that: (1) the physician or health professional be provided limited discretion to disclose when there has been an opportunity for the infected person to notify the high-risk contact but there is reason to believe they will not do so; (2) discretionary disclosure to current known high risk contacts, including sexual and needle-sharing partners, be allowed; and (3) notification be accompanied by counseling. The New York statute reflects the policy that best weighs the interest in preventing transmission with that of preserving confidentiality. The imposition on physicians of mandatory duties to disclose does not. The risk of significant disruption of the professional-patient relationship is too great. If mandatory disclosure does occur, the hope of controlling the disease by acquiring pertinent information for research and treatment and by encouraging voluntary testing will be lost.

V. CONCLUSION

The medical and social facts about AIDS have projected the need to protect the confidentiality of HIV-related health care information into a prominent place in current public policy. Confidentiality is needed not only to prevent the risk of serious

ficer for the purpose of said disclosure . . . [and] the physician shall honor such preference.

Id.

84. GA. CODE ANN. § 24-9-47(g) (Supp. 1989). The Georgia statute provides in pertinent part:

When the patient of a physician has been determined to be infected with HIV and that patient's physician reasonably believes that the spouse or sexual partner or any child of the patient, spouse, or sexual partner is a person at risk of being infected with HIV by that patient, the physician may disclose to that spouse, sexual partner, or child that the patient has been determined to be infected with HIV, after first attempting to notify the patient that such disclosure is going to be made.

Id.

invasions of privacy that occur from disclosure, but also as a means for controlling the epidemic by encouraging voluntary testing. In this article I have proposed a general analytical system for determining whether, in particular cases, breaches of confidentiality for HIV-related information are appropriate. This includes identifying the extent to which personal privacy and the trust essential for preserving the integrity of the professional-client relationship are implicated if confidentiality were to be breached, and weighing the extent to which access to HIV-related information is necessary to further important interests. Given the medical and social facts about AIDS, powerful reasons support providing strict confidentiality for HIV-related information in order to protect privacy and preserve trust in professional-client relationships. In some instances important interests like preventing physical harm to others are furthered by disclosing HIV-related information. These hard cases may ultimately require disclosure. I suggest that notification of sexual or needle-sharing partners is such a case, and that providing discretionary disclosure by physicians to third parties in prescribed circumstances constitutes the best accommodation of conflicting values. I also consider cases where confidentiality may be preserved and sufficient information disclosed to protect private interests. Where this occurs the answer is easy: protect confidentiality.