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PUBLIC HEALTH VS. PRIVACY: REBALANCING THE GOVERNMENT INTEREST IN INVOLUNTARY PARTNER-NOTIFICATION FOLLOWING ADVANCEMENTS IN HIV TREATMENT

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I. INTRODUCTION

The discovery of Acquired Immune Deficiency Syndrome (AIDS) and the Human Immunodeficiency Virus (HIV) created a new dilemma for healthcare providers faced with the challenge of knowing that their patients may be putting others at risk of an incredibly serious, and usually fatal, disease.[1] State legislatures responded to this dilemma and the immense

1. *See Basic Information About HIV and AIDS*, CENTERS FOR DISEASE CONTROL, http://www.cdc.gov/hiv/topics/basic/index.htm (last updated Aug. 3, 2011) [hereinafter

public fear of AIDS by enacting statutes that allowed, or even required, notification of sexual and needle-sharing partners of their potential exposure to HIV when a patient refuses to notify them on his or her own.[2]

Despite the importance of preventing the spread of HIV, the need for personal privacy protections imposes limitations on these state partner-notification laws.[3] According to certain circuit courts of appeals, the Due Process Clause of the Fourteenth Amendment covers medical information in its ambit of personal privacy protections.[4]

This Comment argues that partner-notification statutes, in their most common forms, may be unconstitutional as applied to HIV-positive people who regularly comply with their medication and maintain an undetectable viral load, and, by extension, a low level of infectiousness.[5] Part II of this Comment describes the development of the HIV epidemic, as well as the legislative response to it.[6] Part II also discusses the different cases that form the basis for a constitutional right to privacy in personal medical information, with a focus on *United States v. Westinghouse Electric Corp.*[7] Part III then applies the seven-factor test developed in *Westinghouse* to Michigan's and Maryland's partner-notification statutes through the lens of a hypothetical situation.[8] Based on this analysis, Part IV recommends that partner-notification statutes be amended to take infectiousness into account before triggering any notification requirement so that the statutes are narrowly tailored to the purpose of preventing the spread of HIV.[9] Lastly,

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Basic Information] (describing routes of HIV transmission including sexual intercourse and other transfers of bodily fluids).

2. *See* Benjamin F. Neidl, *The Lesser of Two Evils: New York's HIV/AIDS Partner Notification Law and Why the Right of Privacy Must Yield to Public Health*, 73 ST. JOHN'S L. REV. 1191, 1198 (1999) (detailing common forms of partner-notification laws enacted to prevent the transmission of HIV, having initially developed in the 1930s for venereal diseases).

3. *See* Whalen v. Roe, 429 U.S. 589, 597 (1977) (holding that states have latitude in addressing matters of local concern despite potential infringement upon personal privacy interests).

4. *See, e.g.*, United States v. Westinghouse Elec. Corp., 638 F.2d 570, 577 (3d Cir. 1980) (emphasizing the personal nature of medical records).

5. *See* EFFECT OF ANTIRETROVIRAL THERAPY ON RISK OF SEXUAL TRANSMISSION OF HIV INFECTION AND SUPERINFECTION, CENTERS FOR DISEASE CONTROL 1 (2009) [hereinafter *Effect of Antiretroviral Therapy*], *available at* http://www.cdc.gov/hiv/topics/treatment/resources/factsheets/pdf/art.pdf (explaining the correlation between viral load and infectiousness).

6. *See infra* Part II (describing the history of HIV/AIDS and public reaction to the epidemic).

7. *See infra* Part II (explaining the circuit split over the constitutional right to medical privacy and the standards developed by the circuits that recognize it).

8. *See infra* Part III (analyzing the balance between personal interest in medical privacy and government interest in public health as expressed by partner-notification statutes).

9. *See infra* Part IV (recommending that partner-notification statutes take infectiousness into account when establishing parameters for involuntary notification).

Part V concludes that, by taking infectiousness into account, statutes can better balance the government's public health interest against an HIV-positive person's interest in maintaining his or her medical privacy and, therefore, better satisfy the requirements of the Due Process Clause.[10]

II. BACKGROUND

A. History of the HIV Epidemic

1. Discovering and Understanding Transmission

HIV is a virus that, when it infects the human body, destroys CD4+ T cells, blood cells that are vital to defending the body against disease.[11] Doctors first isolated HIV in 1984 in an effort to discover the cause of AIDS.[12] AIDS, a usually fatal condition that weakens the immune system, came to the attention of the medical community in 1981, when most reported cases occurred among homosexuals and intravenous drug users.[13] The prevalence of the disease in these particular communities and a general lack of knowledge regarding the transfer of HIV/AIDS stigmatized HIV infection and marginalized those affected by it.[14]

As early as 1983, the transmission of AIDS was linked to intimate sexual contact and exposure to infected blood.[15] By 1986, the major routes of transmission were identified: (1) sexual contact, (2) exposure to used needles or infected blood, and (3) passage of the virus from infected mothers to their newborns.[16] Because these routes encompass a broad range of behaviors and activities, HIV prevention efforts have varied

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10. *See infra* Part V (concluding that statutes failing to take infectiousness into account do not satisfy constitutional requirements when applied to persons with undetectable viral loads).

11. *See Basic Information*, *supra* note 1 (describing the effects of HIV infection on the immune system).

12. *See History of AIDS Up to 1986*, AVERT, http://www.avert.org/aids-history-86.htm (last visited Feb. 3, 2012) (discussing the study by the Centers for Disease Control that isolated the virus that causes AIDS).

13. *See id.* (recounting the increased incidence of rare diseases such as Kaposi's Sarcoma and Pneumocystis carinii pneumonia amongst patients later discovered to have AIDS).

14. *See* ETHEL KLEIN, GAY MEN'S HEALTH CRISIS, U.S. PUBLIC OPINION TOWARD HIV/AIDS: PERCEPTIONS OF RISK, BIAS, AND GOVERNMENT SPENDING 8-9 (Apr. 2, 2009), *available at* http://www.gmhc.org/files/editor/file/perceptions_klein3.pdf (finding that many Americans believe that those infected by HIV face discrimination).

15. *See Current Trends Acquired Immunodeficiency Syndrome (AIDS) Update—United States*, MORBIDITY & MORTALITY WEEKLY REP. (June 24, 1983), at 24 (identifying intravenous drug users and men who have sex with men as groups at highest risk for HIV infection).

16. *See* Thomas C. Quinn et al., *AIDS in Africa: An Epidemiologic Paradigm*, 21 SCIENCE 955, 958 (1986) (describing documented HIV transmission routes).

widely.[17] Of primary concern in this Comment are legislative efforts to prevent transmission through sexual contact by allowing involuntary partner notification.[18]

2. The Evolution of Treatment

The treatment of HIV has evolved dramatically since its discovery.[19] At the outset of the epidemic, an HIV diagnosis was considered a death sentence due to the likely onset of AIDS shortly thereafter.[20] The development of protease inhibitors in 1995 revolutionized the treatment of HIV.[21] Between 1996 and 2005, the average life expectancy of an HIV-positive person in the United States increased from 10.5 years to 22.5 years after initial infection.[22]

Doctors look to two main markers when monitoring the health of an HIV-positive patient. The first is a patient's viral load, which is the concentration of the virus in a person's bloodstream.[23] The viral load shows the extent of the infection, and the patient's health is better when this number is lower.[24] The second is the patient's CD4 count, the measure of the number of CD4+ T cells in a patient's blood.[25] The CD4 count

17. *See, e.g.*, *What Can States Do to Achieve Safe Community Needle Disposal?*, CENTERS FOR DISEASE CONTROL, http://www.cdc.gov/needledisposal/goals.htm (last updated Sept. 26, 2011) (discussing strategies for safe needle disposal to prevent blood-borne infections); *Condom Distribution as a Structural Level Intervention*, CENTERS FOR DISEASE CONTROL, http://www.cdc.gov/hiv/resources/factsheets/condom_distribution.htm (last updated Oct. 21, 2010) (advocating condom distribution as a strategy to prevent the spread of HIV through sexual contact).

18. Christine E. Stenger, Note, *Taking* Tarasoff *Where No One Has Gone Before: Looking at "Duty to Warn" Under the AIDS Crisis*, 15 ST. LOUIS U. PUB. L. REV. 471, 471 (1996) (describing statutes requiring physicians to inform third parties of the potential risk of the transmission of HIV, despite the obligation of doctor-patient confidentiality).

19. *See Effect of Antiretroviral Therapy*, *supra* note 5, at 1 (detailing the marked advances in antiretroviral therapy medications which have greatly reduced the spread of the HIV virus within the past decade).

20. *See* Neidl, *supra* note 2, at 1196-97 (describing the relative untreatability of HIV/AIDS).

21. *See History of AIDS: 1993-1997*, AVERT, http://www.avert.org/aids-history93-97.htm (last visited Feb. 2, 2012) (noting the promise of saquinavir and similar classes of drugs and their ability to treat HIV).

22. *See* Kathleen McDavid Harrison et al., *Life Expectancy After HIV Diagnosis Based on National HIV Surveillance Data from 25 States, United States*, 53 J. ACQUIRED IMMUNE DEFICIENCY SYNDROME 124, 125 (2009) (documenting the increase in life expectancy for HIV-positive persons treated with antiretroviral therapy, from 10.5 years to 22.5 years, between 1996 and 2005).

23. *See Effect of Antiretroviral Therapy*, *supra* note 5, at 1 (defining viral load as "levels of virus in the bloodstream").

24. *See id.* (explaining that antiretroviral therapy is considered effective when it suppresses viral load).

25. *See Basic Information*, *supra* note 1 (stating that HIV targets and destroys CD4+ T cells).

shows the extent to which HIV infection has damaged the patient's immune system, and the patient is in better health when this number is higher.[26]

Currently, with regular adherence to protease inhibitors, a class of drugs that prevents the replication of viruses, and other antiretroviral medications, an HIV-positive person's viral load may be undetectable.[27] In addition to the benefits to the individual patient's health, an undetectable viral load now has also been linked to a lower rate of transmission through sexual contact.[28]

B. Development of Partner-Notification Laws

1. Medical Privacy and Threats to Third Parties

An individual's health issues may, in certain cases, create a risk to the health of third parties. An overall goal of public health policy is to manage these risks, whether it is through preventing the spread of disease or through other kinds of interventions.[29] However, public health policy may not easily address certain more acute risks through these broader efforts, and may require specific action by individual health care providers in the form of partner-notification.[30]

Since *Tarasoff v. Regents of the University of California*, the legal role of doctors has evolved with regard to their duty to protect third parties affected by the health issues of their patients.[31] In *Tarasoff*, the Supreme Court of California imposed a duty upon therapists to warn third parties when a patient is reasonably believed to be a threat.[32] Other courts have

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26. *See id.* (noting CD4+ T cells are vital to the immune system and that allowing degradation of those cells will lead to poor health).

27. *See Effect of Antiretroviral Therapy*, *supra* note 5, at 1 (specifying an undetectable viral load as an indicator of effective antiretroviral treatment); *Classes of HIV/AIDS Antiretroviral Drugs*, NAT'L INST. ALLERGY & INFECTIOUS DISEASES, http://www.niaid.nih.gov/topics/HIVAIDS/Understanding/Treatment/Pages/arvDrugClasses.aspx (last updated Mar. 26, 2009) (outlining the function of different antiretroviral drugs).

28. *See Effect of Antiretroviral Therapy*, *supra* note 5, at 3 (observing that undetectable viral load should reduce the risk of infecting a partner).

29. *See, e.g.*, *What Is Public Health*, OHIO DEP'T HEALTH, http://www.odh.ohio.gov/landing/about_odh/whatispublichealth.aspx (last updated July 19, 2011) (stating that public health is the actions society takes, collectively, to assure healthy conditions).

30. *See Effect of Antiretroviral Therapy*, *supra* note 5, at 5 (arguing that HIV-positive people with asymptomatic infection pose the greatest risk of transmission).

31. *See* Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334, 342 (Cal. 1976) (noting that previous cases have relied on either a special relationship or a judgment on whether the defendant created a threat to a third party through lack of ordinary care or skill in order to find a duty to warn a third party); *see also* Stenger, *supra* note 18, at 471 (arguing that *Tarasoff* fundamentally changed the doctor-patient relationship).

32. *See Tarasoff*, 551 P.2d at 343 (finding a special relationship between the defendant, a therapist, and the patient who had informed said therapist of an intent to

since extended this duty to cover infectious diseases such as hepatitis and spinal meningitis.[33]

2. HIV-Specific Legislation

Initially, in their legislation governing the treatment of HIV, some states adopted the Supreme Court of California's approach to warning third parties.[34] Due to the acute danger posed by HIV infection in the early 1990s, legislators were able to analogize the homicidal patient of *Tarasoff* to an HIV-positive patient who knowingly engaged in unprotected sex.[35]

Few states still impose an affirmative duty on health care providers to warn the sexual partners of an HIV-positive patient of their potential exposure to the virus.[36] More commonly, statutes instead create guidelines for when notification is permissible and specifically limit liability for those health care providers who act in good faith.[37] Typically, when a doctor knows the identity of the sexual partner of an HIV-positive patient and that the patient has refused to notify that partner of the risk of transmission despite counseling, notifying the partner without the patient's permission is not a breach of doctor-patient confidentiality.[38] While all statutes specify that doctors shall only provide notification where there is a risk of transmission, "risk" is not defined in a way that takes into account actual infectiousness due to viral load.[39]

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harm a specific victim).

33. *See* Stenger, *supra* note 18, at 487-89 (noting cases that found a duty to warn third parties of a patient's medical condition).

34. *See, e.g.*, Neidl, *supra* note 2, at 1212-15 (describing a New York statute imposing an affirmative duty on public health officials to notify individuals of potential exposure to HIV).

35. *See* Stenger, *supra* note 18, at 494 (arguing that the fear of innocent third parties to contract HIV led to legislation allowing for the disclosure of a patient's HIV status).

36. *Compare* MICH. COMP. LAWS SERV. § 333.5131 (LexisNexis Supp. 2011) (imposing an affirmative duty on doctors to warn third parties of their exposure to HIV by one of the doctor's patients), *with* MD. CODE ANN., HEALTH-GEN. § 18-337 (LexisNexis 2009) (precluding liability for doctors acting in good faith in disclosing or not disclosing patient's HIV status to an exposed third party).

37. *Accord* ARIZ. REV. STAT. § 32-1860 (LexisNexis 2008) (requiring a physician to report the name of an HIV-positive patient's sexual partner to the department of health services when patient has refused to disclose his or her status); *see also* HEALTH-GEN. § 18-337 (permitting a physician to directly notify the sexual partners of a patient who has refused to disclose his or her HIV status).

38. *See* ARIZ. REV. STAT. § 32-1860(a) (prohibiting doctors from notifying a patient's spouse or sex partner without first asking the patient to release the information voluntarily).

39. *See* KY. REV. STAT. ANN. § 311.182 (West 2011) (limiting notification to sexual partners cohabitating with an HIV-positive person for more than one year).

C. Establishing a Substantive Due Process Right to Privacy in Medical Information

1. Whalen v. Roe *and the Circuit Split on Medical Privacy Rights*

Whalen v. Roe forms the basis for a constitutional right to privacy in one's medical information.[40] At issue was a New York statute requiring physicians to report a patient's name, address, and age, along with other information, to the State Health Department each time the physician prescribed a Schedule II drug.[41] A group of patients and doctors challenged the law, claiming that it violated the patients' right to privacy.[42] In its analysis, the Supreme Court identified two different kinds of privacy interests protected by the Fourteenth Amendment: (1) the "individual interest in avoiding disclosure of personal matters," and (2) the "interest in independence in making certain kinds of important decisions."[43] The majority of Fourteenth Amendment privacy jurisprudence falls under the latter category and forms the more common conception of protected activities.[44]

Several circuits, however, have extended the privacy interest in avoiding disclosure of personal matters to find a constitutionally protected right to privacy in one's medical information.[45] According to these courts, any law permitting or requiring disclosure of an individual's medical information must be evaluated by balancing the government's interest against the individual's interest in keeping that information private.[46] Though courts

40. *See* Whalen v. Roe, 429 U.S. 589, 605 (1977) (finding a right to privacy in certain types of medical records).

41. *See id.* at 593 (describing the requirement that physicians fill out three copies of an official form each time they prescribe a Schedule II drug).

42. *See id.* at 595 (noting that litigants were patients prescribed Schedule II drugs, prescribing physicians, and two professional physicians' associations).

43. *See id.* at 599-600 (delineating the primary categories of protected personal privacy interests).

44. *See, e.g.*, Doe v. Bolton, 410 U.S. 179 (1973) (invalidating restrictions on the right to seek an abortion); Roe v. Wade, 410 U.S. 113 (1973) (holding that the Fourteenth Amendment protects a woman's privacy interest in the decision to have an abortion); Griswold v. Connecticut, 381 U.S. 479 (1965) (establishing that the Fourteenth Amendment protects the privacy interest of married couples using birth control).

45. *See* Anderson v. Romero, 72 F.3d 518, 522 (7th Cir. 1995) (finding *Whalen v. Roe* to be the strongest Supreme Court precedent for a constitutional right to privacy in medical information); *see also* United States v. Westinghouse Elec. Corp., 638 F.2d 570, 577 (3d Cir. 1980) (stating that medical records definitely fall within the ambit of materials entitled to privacy protection). *But see* J.P. v. DeSanti, 653 F.2d 1080, 1090 (6th Cir. 1981) (holding that the Constitution does not encompass a right to nondisclosure of private information).

46. *See Romero*, 72 F.3d at 522 (noting that the right to medical privacy depends on a balance between privacy and public health).

have upheld statutes requiring the reporting of various kinds of public health information to local and state governments, courts have taken a stricter view of disclosures to members of the public.[47]

2. United States v. Westinghouse *and the Seven-Factor Balancing Test*

The Third Circuit relied on *Whalen* to evaluate a subpoena by the National Institute for Occupational Safety and Health (NIOSH) for the medical records belonging to employees of the Westinghouse Electric Corporation.[48] Westinghouse refused to honor the subpoena, prompting NIOSH to seek an enforcement order, which the District Court granted.[49] On appeal, Westinghouse argued, in part, that the subpoena infringed upon its employees' right to privacy.[50] Though the Third Circuit affirmed the District Court's decision, it acknowledged the constitutional protection of personal medical information, and enumerated seven factors contributing to permissible infringement upon this protection: (1) the type of record involved, (2) the information it contains, (3) the potential for harm due to nonconsensual disclosure, (4) the injury to the relationship that generated the record caused by disclosure, (5) the presence of a public interest articulated by statute or policy militating toward access, (6) the degree of need for access, and (7) the sufficiency of measures to prevent unauthorized disclosures.[51] Courts, both inside and outside the Third Circuit, have since utilized these factors to balance government interests against individual privacy interests when evaluating government disclosures of personal medical information.[52]

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47. *See Westinghouse*, 638 F.3d at 573, 579-80 (describing the extensive measures necessary to ensure that medical information is not disseminated to the public).

48. *See id.* at 577-78 (relying on *Whalen v. Roe* as guiding precedent for medical privacy cases).

49. *See id.* at 573 (discussing the subpoena for medical records of all employees that were currently working, or had previously worked, in a certain part of the Trafford, Pennsylvania plant).

50. *See id.* at 576 (explaining Westinghouse's argument that the NIOSH subpoena infringes upon the employees' constitutional right to privacy).

51. *See id.* at 578 (outlining factors relevant to the weighing of the personal privacy interest in a particular piece of medical information and the government's interest in its disclosure).

52. *See, e.g.*, Doe v. New York, 15 F.3d 264, 267 (2d Cir. 1994) (applying *Westinghouse* factors to public release of conciliation agreement); Borucki v. Ryan, 827 F.2d 836, 846 (1st Cir. 1987) (applying *Westinghouse* factors to disclosure of court ordered psychological evaluation); Faison v. Parker, 823 F. Supp. 1198, 1201 (E.D. Pa. 1993) (applying *Westinghouse* factors to disclosure of presentence report); Doe v. Barrington, 729 F. Supp. 376, 382 (D.N.J. 1990) (applying *Westinghouse* factors to disclosure of arrestee's AIDS diagnosis).

D. Creating a Test Case for Taking Infectiousness into Account

1. Test Case Hypothetical

Jane Smith is a twenty-five-year-old, heterosexual, HIV-positive woman. She was diagnosed with HIV five years ago and, likely, had it transmitted to her by a male sexual partner. She has been on antiretroviral medication since her diagnosis and has a history of regular compliance with her medication regimen.[53] Her viral load is undetectable, and she has no other sexually transmitted infections.[54] She has recently begun seeing a new doctor, Brian Jones. At her first visit, Dr. Jones learns from Ms. Smith that a few months ago she moved in with her boyfriend and that she has not told him about her HIV status. Dr. Jones talks to Ms. Smith about the importance of telling her partner about her status, but she says that she does not want to tell him because she is afraid of what he will think.[55]

2. Test Case Statutes

a. Michigan's Partner-Notification Statute

Under Michigan law, all information regarding a patient's HIV status is confidential, with several exceptions.[56] Among those exceptions is the requirement for disclosure when there is a reasonably foreseeable risk of further transmission of HIV from an individual that a physician or health official knows is HIV-positive.[57] Moreover, if a physician or health official knows that an HIV-positive individual has exposed a third party to HIV, the physician or health official has an affirmative duty to notify that third party of his or her exposure.[58] When making a disclosure to a third party, a doctor or health official may not provide any identifying information regarding the HIV-positive individual to whom the third party has been

53. *See Effect of Antiretroviral Therapy*, *supra* note 5, at 1 (noting regular adherence to antiretroviral therapy is necessary for effective treatment of HIV).

54. *See id.* at 2-3 (stating that concurrent infection with other sexually transmitted infections increases risk of transmission of HIV).

55. *Cf.* Klein, *supra* note 14, at 8 (observing that in 2006, 80% of Americans believed individuals with HIV/AIDS faced discrimination, and 40% believed individuals with HIV/AIDS faced substantial prejudice).

56. *See* MICH. COMP. LAWS SERV. § 333.5131(5) (LexisNexis Supp. 2011) (establishing exceptions to confidentiality including disclosure to local health department, a patient's sexual partners, and the school board).

57. *See id.* § 333.5131(5)(b) (allowing the violation of confidentiality rules when an HIV-positive patient poses a reasonably foreseeable risk of transmission to a known third party).

58. *See id.* (imposing an affirmative duty upon health care providers to warn contacts of an HIV-positive patient where there is a reasonably foreseeable risk of transmission of the virus).

exposed, unless it is necessary to prevent a reasonably foreseeable risk of transmission.[59]

No reported cases have addressed the application of section 333.5131 specifically in the context of notification of a sexual partner.[60] However, the Court of Appeals of Michigan upheld the disclosure of a prisoner's HIV status to a prison guard, in whose face the prisoner spat, on the grounds that the guard constituted a contact of the prisoner.[61]

b. Maryland's Partner-Notification Statute

Unlike Michigan, Maryland does not impose an affirmative duty on physicians or health officials to notify a third party of his or her exposure to HIV.[62] Instead, Maryland law requires that physicians act in good faith when deciding whether to disclose a patient's HIV status to either the local health department or the patient's sexual partner.[63] Besides acting in good faith, a physician must know of a specific contact of an HIV-positive patient, and the patient must have refused to perform partner notification on his or her own.[64] When conducting the notification, a doctor may provide the third party with the HIV-positive individual's identity, as well as the circumstances giving rise to the notification.[65]

The only case to apply section 18-337 is *Lemon v. Stewart*.[66] The Maryland Court of Special Appeals held that section 18-337 does not create a duty for physicians to notify sexual or needle-sharing partners of an HIV-positive patient.[67] By extension, the physicians in the case had no

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59. *See id.* § 333.5131(7) (prohibiting the inclusion of identifying information in any disclosure made to warn a contact of an HIV-positive individual of a potential exposure).

60. *Cf.* Abouhassan v. Detroit Biomed. Labs., Inc., No. 291294, 2010 WL 3928716, at *4 (Mich. Ct. App. Oct. 7, 2010) (allowing the disclosure of a patient's HIV test result from the laboratory that conducted the test to the doctor who requested it); People v. Odom, 740 N.W.2d 557, 560-62 (Mich. Ct. App. 2007) (affirming an inmate's conviction for assault on a prison employee for spitting blood on her).

61. *See Odom*, 740 N.W. at 565-66 (finding no illegal disclosure of inmate's HIV status where prison guard was exposed to an inmate's blood, and was therefore a contact of the inmate).

62. *See* MD. CODE ANN., HEALTH-GEN. § 18-337 (LexisNexis 2009) (including no mention of an affirmative duty to warn third parties of a potential exposure to HIV).

63. *See id.* HEALTH-GEN. § 18-337(b), (e), (f) (providing protection from liability for any doctor acting in good faith, regardless of whether he or she decides to disclose or not).

64. *See id.* HEALTH-GEN. § 18-337(b) (explaining the circumstances necessary for a permissible notification to a third party potentially exposed to HIV infection).

65. *See id.* HEALTH-GEN. § 18-337(b)(1)-(2) (enumerating the information that may be provided when making a disclosure to a third party).

66. *See* Lemon v. Stewart, 682 A.2d 1177, 1178 (Md. Ct. Spec. App. 1996) (dismissing complaint alleging negligence on the part of doctors who did not inform the patient's family of the patient's HIV status).

67. *See id.* at 1184 (finding that liability protections for physicians precluded the

obligation to notify the patient's family of his positive HIV status.[68]

III. ANALYSIS

The personal privacy interest in medical information is not absolute, and when there is a strong public interest in certain medical information, limited disclosures may be allowed.[69] The *Westinghouse* factors articulate a balancing test that weighs the personal privacy interest at stake against the government's interest in allowing the disclosure of the medical information at issue.[70]

A. The Personal Privacy Interest in HIV Status Is Great, Regardless of a Person's Adherence to Treatment, and Therefore Should Be Strongly Protected by the Constitution.

Ms. Smith, as well as all HIV-positive persons, has an extremely great privacy interest in her HIV status that must be balanced against the government's interest in disclosure. This privacy interest does not change simply because of Ms. Smith's regular adherence to treatment. The first four *Westinghouse* factors—the type of record involved, the information it contains, the potential for harm due to nonconsensual disclosure, and the injury to the relationship that generated the record caused by disclosure—speak to the weight of the privacy interest at issue.[71] Taken together and applied to Ms. Smith's situation, they demonstrate an important and sensitive privacy interest at stake. Because a privacy interest protected by the Fourteenth Amendment does not vary by state, it does not require a state-specific analysis.[72]

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establishment of an affirmative duty to warn third parties of a patient's HIV status).

68. *See id.* (arguing that if no duty exists to inform sexual or needle-sharing partners, no duty can exist to inform family members who are much less likely to acquire the virus).

69. *See* United States v. Westinghouse Elec. Corp., 638 F.2d 570, 578 (3d Cir. 1980) (stating that an individual does not have an absolute right to control access to his or her medical history).

70. *See id.* at 578 (observing that courts allow intrusion into medical privacy only when the societal interest in disclosure outweighs the privacy interest); *see also* Faison v. Parker, 823 F. Supp. 1198, 1201 (E.D. Pa. 1993) (specifying that protected information shall be disclosed only after a showing of proper governmental interest).

71. *See* Murray v. Pittsburgh Bd. of Educ., 759 F. Supp. 1178, 1181 (W.D. Pa. 1991) (translating the *Westinghouse* factors into a traditional balancing test).

72. *Cf.* U.S. CONST. amend. XIV (extending included rights to all persons within the jurisdiction of the United States and restricting certain conduct by state governments).

1. The Information That Dr. Jones Would Disclose to Ms. Smith's Boyfriend Is Highly Sensitive and Therefore Necessitates a Highly Protected Privacy Interest.

The first two *Westinghouse* factors are the type of record involved in the disclosure and the information contained in the record.[73] Unlike the records involved in *Westinghouse*, information related to Ms. Smith's HIV status is extremely sensitive.[74] Several courts have noted the particular sensitivity of information related to HIV status.[75] In large part based on the behaviors associated with it, an HIV diagnosis may imply sensitive personal details, in addition to simple medical information.[76] Therefore, HIV-positive individuals have a greater privacy interest in their HIV status than HIV-negative individuals have in more routine medical information.

While Dr. Jones informing Ms. Smith's boyfriend of her HIV status would not involve providing access to any particular medical record, it would involve the disclosure of highly sensitive personal information.[77] A significant portion of the American public continues to associate HIV infection with high-risk behaviors that are often linked with highly personal conduct.[78] Therefore, disclosure may communicate additional personal information that falls within the ambit of privacy protections.[79]

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73. *See Westinghouse*, 638 F.2d at 578 (identifying factors relevant to measuring privacy interest in specific information).

74. *See id.* at 579, 580-81 (noting that records contained results of routine testing not generally regarded as sensitive, but that individual employees may raise a personal claim of privacy regarding particular information); *see also Faison*, 823 F. Supp. at 1201-02 (observing that certain kinds of medical information are more sensitive than others).

75. *See* Doe v. New York, 15 F.3d 264, 267 (2d Cir. 1994) (stating that HIV status differs from other medical conditions due to the common negative perception of HIV-infected individuals); Doe v. Barrington, 729 F. Supp. 376, 384 (D.N.J. 1999) (arguing that medical information about AIDS is sensitive due to its association with certain behaviors and the accompanying public stigma).

76. *See Barrington*, 729 F. Supp. at 384 (noting society's moral judgments about and association of high-risk behaviors with AIDS).

77. *See* MICH. COMP. LAWS SERV. § 333.5131 (LexisNexis Supp. 2011); MD. CODE ANN., HEALTH-GEN. § 18-337 (LexisNexis 2009) (specifying only that doctors may perform disclosure under certain circumstances and not how disclosure should be performed).

78. *See* Klein, *supra* note 14, at 8-9 (finding that survey respondents associated discrimination against HIV-positive persons with discrimination against gays and lesbians).

79. *See* Woods v. White, 689 F. Supp. 874, 876 (W.D. Wis. 1988) (stating that AIDS is closely related to sexual activity).

2. The Potential for Harm if Dr. Jones Discloses Ms. Smith's HIV Status to Her Boyfriend Is Great, Which Increases the Significance of the Privacy Interest at Stake.

The third *Westinghouse* factor is the potential for harm in nonconsensual disclosure of the information.[80] If Dr. Jones decides to disclose Ms. Smith's HIV status to her boyfriend, she is at risk of significant discrimination and stigma, which is the primary concern of courts regarding potential harm due to a nonconsensual disclosure of medical information.[81] Courts confronted with unauthorized disclosures of individuals' HIV status have cited the potential for discrimination in all areas of daily life.[82]

If Dr. Jones discloses Ms. Smith's HIV status to her boyfriend, Ms. Smith faces the risk of severe adverse effects in her personal and professional life. Though the actual amount of discrimination against HIV-infected individuals has decreased as public understanding of the virus has increased, Ms. Smith and other persons living with HIV continue to face a significant public stigma.[83] Moreover, the adverse impact of disclosure may last indefinitely. Because HIV remains incurable, Ms. Smith has no guarantee that she will be able to repair any damage to her reputation or prevent future discrimination.[84] Therefore, there is a great potential for harm if Dr. Jones discloses Ms. Smith's HIV status without her consent.

3. By Disclosing Ms. Smith's HIV Status to Her Boyfriend, Dr. Jones May Greatly Harm Their Doctor-Patient Relationship Because It May Severely Damage Her Trust in Doctors and Discourage Her from Continuing Treatment.

The fourth *Westinghouse* factor is the injury that disclosure may cause to

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80. *See* United States v. Westinghouse Elec. Corp., 638 F.2d 570, 578 (3d Cir. 1980) (explaining that the gravity of potential harm from disclosure increases the weight of the personal privacy interest in specific medical information).

81. *See* O'Donnell v. United States, 891 F.2d 1079, 1086 (3d Cir. 1989) (noting damage to public image and loss of employment as potential results of disclosure of psychiatric information).

82. *Compare Westinghouse*, 638 F.2d at 579 (arguing that the disclosures were unlikely to have any adverse effects on Westinghouse employees), *with* Doe v. Barrington, 729 F. Supp 376, 384-85 (D.N.J. 1999) (citing instances of discrimination against HIV-positive individuals and their families, including eviction, firing, and harassment).

83. *Cf.* Klein, *supra* note 14, at 9 (stating that only 41% of Americans surveyed in 2006 would feel very comfortable working with an HIV-positive person, only 25% would feel very comfortable living with an HIV-positive person, and only 29% would feel very comfortable if their child's teacher was HIV-positive).

84. *See* Doe v. New York, 15 F.3d 264, 267 (2d Cir. 1994) (emphasizing the incurability of HIV).

the relationship that generated the record.[85] If Dr. Jones chooses to disclose Ms. Smith's HIV status to her boyfriend, Dr. Jones's and Ms. Smith's relationship may suffer significant injury and change drastically.[86] While the third *Westinghouse* factor is concerned with the harm to the individual whose medical information is disclosed to a third party, the fourth factor asks whether the disclosure could damage the relationship in which the information was originally generated.[87] For instance, medical records generated through the employer-employee relationship require a court to determine whether the employee suffers any economic deprivation or harassment by the employer due to the disclosure.[88]

In Ms. Smith's case, the relationship at risk is that between her and Dr. Jones. Though the major motivation to protect sensitive medical information is a person's general privacy interest, doctor-patient confidentiality also helps doctors to perform their jobs by increasing the level of trust between doctor and patient.[89] If Dr. Jones chooses to disclose Ms. Smith's HIV status, the loss of trust could damage her future health care. If Ms. Smith chooses to continue seeing Dr. Jones, she may stop informing him about aspects of her personal life.[90] Some of these aspects, such as Ms. Smith's relationship status, can be extremely important for effective management of not only her HIV care, but also other health care decisions she might make.[91] At worst, however, Ms. Smith may stop visiting Dr. Jones altogether.[92] Decreasing the regularity of her doctor visits would hurt Ms. Smith's health by making it more difficult for her to monitor her infection and adherence to treatment.[93]

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85. *See Westinghouse*, 638 F.2d at 578 (listing injury from disclosure to the relationship that generated the record as a factor to be weighed in evaluating the personal privacy at stake).

86. *Cf.* Doe v. Se. Pa. Transp. Auth., 72 F.3d 1133, 1141 (3d Cir. 1995) (finding no injury where the relationship between a customer and pharmacy did not change).

87. *See Westinghouse*, 638 F.2d at 578 (listing "injury from disclosure to the relationship in which the record was generated" as a factor to be considered, but not explicitly addressing its application in the present case).

88. *See Se. Pa. Transp. Auth.*, 72 F.3d at 1141 (noting the particular injuries that may arise in the context of the employer-employee relationship).

89. *See* Carrie Gene Pottker-Fishel, *Improper Bedside Manner: Why State Partner-Notification Laws Are Ineffective in Controlling the Proliferation of HIV*, 17 HEALTH MATRIX 147, 174-75 (2007) (noting fears surrounding confidentiality have discouraged individuals from seeking HIV testing).

90. *See id.* at 175 (contending that confidentiality concerns may deter patients from sharing all potentially relevant information with their physicians).

91. *See* K. E. Kearley et al., *An Exploration of the Value of the Personal Doctor-Patient Relationship in General Practice*, 51 BRITISH J. GEN. PRACT. 712, 712 (2001) (arguing that knowledge of patient's personal life improves a physician's diagnoses).

92. *See id.* (emphasizing the importance of continuity of care for primary care physicians).

93. *See* Pottker-Fishel, *supra* note 89, at 174 (stating that respecting confidentiality and preventing the spread of HIV are interrelated goals).

B. The Government Interest in Allowing Health Care Providers to Disclose a Person's HIV Status to Third Parties Diminishes as That Person's Adherence to Treatment Improves.

The last three *Westinghouse* factors—the existence of an articulated public policy supporting the disclosure, the degree of need for access, and the sufficiency of measures to prevent unauthorized disclosures—facilitate balancing the government interest in allowing disclosure against the personal privacy interest of an HIV-infected person.[94] Applying them to Ms. Smith's case shows how infectiousness affects the weight of the government interest by decreasing the actual risk of transmission. Specifically, an analysis of these factors shows that, in a case such as Ms. Smith's, minimal infectiousness diminishes the government interest so much that nonconsensual disclosure to a third party is no longer permissible under the Fourteenth Amendment.[95]

1. Ms. Smith's Undetectable Viral Load Means That She Does Not Pose a Serious Public Health Risk, and Therefore May Not Fall Under the Stated Purpose of Partner-Notification Laws.

The fifth *Westinghouse* factor is whether there is a recognized public interest militating towards disclosure of the information.[96] Allowing Dr. Jones to disclose Ms. Smith's HIV status serves only a broad government interest in preventing the spread of HIV, and not the specific interest in warning third parties where there is a significant risk of HIV transmission.[97] Ways of demonstrating recognition of the public interest include statutory mandates and other articulations of public policy.[98] Generally, when a statute requires disclosure to a government agency for a government program or activity, the court weighs the government's interest in disclosure against the individual's interest in privacy.[99] When a statute instead requires disclosure to a non-governmental party, courts look to

94. *See* Murray v. Pittsburgh Bd. of Educ., 759 F. Supp. 1178, 1181 (W.D. Pa. 1991) (translating the *Westinghouse* factors into a traditional balancing test).

95. *See Effect of Antiretroviral Therapy*, *supra* note 5, at 4 (finding significant reductions in community transmission rates after introduction of antiretroviral treatment).

96. *See* United States v. Westinghouse Elec. Corp., 638 F.2d 570, 578 (3d Cir. 1980) (specifying "express statutory mandate, articulated public policy, or other recognizable public interest militating towards access" as one factor of the balancing test).

97. *See Effect of Antiretroviral Therapy*, *supra* note 5, at 5 (describing the high level of infectiousness of an HIV-positive person with a high viral load).

98. *See Westinghouse*, 638 F.2d at 578 (stating that courts should look for an express statutory mandate or articulated public policy).

99. *See, e.g.*, Faison v. Parker, 823 F. Supp. 1198, 1202 (E.D. Pa. 1993) (noting important government interest in the administration of sentencing and prison policy).

whether there is an acute public health risk necessitating the disclosure.[100] In Ms. Smith's case, this acute public health risk does not exist because of her low viral load and attendant low level of infectiousness.[101]

a. The Reasonably Foreseeable Risk of Transmission Requirement in Michigan's Partner Notification Statute Sufficiently Articulates the Government's Interest in Preventing the Transmission of HIV, and Therefore May Provide a Permissible Standard for Dr. Jones to Disclose Ms. Smith's HIV Status to Her Boyfriend.

Though Michigan's partner-notification statute risks encouraging doctors to err on the side of notification, even when it is not reasonably necessary to prevent transmission, by imposing an affirmative duty on doctors, the statute's foreseeable risk requirement tempers this risk.[102] Under Michigan law, a physician has an affirmative duty to disclose a patient's HIV status when there is a reasonably foreseeable risk of transmission to a third party whom the patient refuses to warn.[103] However, the affirmative duty provides less discretion for health care providers to make a determination of what course of action will yield the best public health result.[104] Moreover, an affirmative duty injects a degree of self-interest into the doctor's rationale when considering a decision that should focus instead on the patient and the third party potentially exposed to HIV.[105] If Dr. Jones focuses on his own liability more than on the well-being of either Ms. Smith or her boyfriend, then his rationale conflicts with the purpose of the law, namely to protect third parties from a known risk of HIV-infection.[106]

However, the requirement of a reasonably foreseeable risk of

100. *See* Doe v. Barrington, 729 F. Supp. 376, 385 (D.N.J. 1990) (finding that disclosure of an individual's confidential medical records to a third party did not advance the government's compelling interest in preventing the transmission of HIV when the third party would come into only casual contact with that individual).

101. *See Effect of Antiretroviral Therapy*, *supra* note 5, at 4 (noting the effect of regular antiretroviral treatment on likelihood of transmission).

102. *See* MICH. COMP. LAWS SERV. § 333.5131(5)(b) (LexisNexis Supp. 2011) (requiring a reasonably foreseeable risk of transmission for making notification without the permission of the patient).

103. *See id.* (specifying when disclosure of a patient's HIV status to a third party is permissible).

104. *See* Neidl, *supra* note 2, at 1215 (noting that New York state's partner notification law, which imposes an affirmative duty to disclose, "elevates partner notification to a more aggressive degree than nearly any state in the United States").

105. *See* Edmund D. Pellegrino, *The Internal Morality of Clinical Medicine: A Paradigm for the Ethics of the Helping and Healing Professions*, 26 J. MED. & PHILOSOPHY 559, 576 (2001) (noting that controlling self-interest is essential to professional practice).

106. *See* § 333.5131(5)(b) (stating that preventing foreseeable risk of transmission is the crux of the law).

transmission actually articulates the primary interest motivating the law.[107] It also approximates a consideration of infectiousness and therefore allows for disclosure primarily in those cases where there is an actual risk.[108] Section 333.5131 of the Michigan Code therefore creates a permissible standard by which a doctor could decide to make a disclosure because it limits the application to the specific government interest at stake.[109] While Ms. Smith may not pose a major risk of transmission, the statute does provide Dr. Jones with discretion to evaluate the actual risk at issue. Following a consideration of Ms. Smith's level of infectiousness, Dr. Jones may then decide whether he needs to notify Ms. Smith's boyfriend of his potential exposure to HIV.

b. Maryland's Partner Notification Statute Does Not Sufficiently Articulate the Government Interest Because It Does Not Incorporate a Specific Evaluation of the Risk of Transmission Before Allowing for Disclosure.

Section 18-337 of the Maryland Health Code benefits from granting doctors discretion to determine when partner notification is necessary, but is vague by failing to explicitly require any consideration of infectiousness.[110]

Maryland's partner-notification statute has only two requirements for health care providers who decide to disclose a patient's HIV status to a third party: the patient refuses to notify his or her sexual or needle-sharing partner, and the doctor acts in good faith in making the decision to disclose.[111]

While the risk of transmission that Ms. Smith poses to her boyfriend is more significant than the risk she would pose to someone with whom she only had casual contact, the risk does not rise to the level where Ms. Smith poses a severe risk of harming her boyfriend because of her undetectable

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107. *See* Stephen P. Clifton et al., *HIV-Related Laws in the Michigan Public Health Code*, 73 MICH. B.J. 156, 156 (1994) (determining the focus of HIV-related laws in Michigan to be on persons at "special risk" for HIV infection).

108. *See* Efrén A. Acosta, Comment, *The Texas Communicable Disease Prevention and Control Act: Are We Offering Enough Protection to Those Who Need It Most?*, 36 HOUS. L. REV. 1819, 1862-63 n.321 (1999) (describing many state statutes' limitation of disclosure to specific at-risk individuals (citing MICH. COMP. LAWS ANN. § 333.5131)).

109. *See* § 333.5131(5)(b) (limiting permissible notifications to where a foreseeable risk of transmission exists).

110. *See* MD. CODE ANN., HEALTH-GEN. § 18-337 (LexisNexis 2009) (incorporating no evaluation of actual infectiousness into the determination of when partner notification is permissible).

111. *See id.* HEALTH-GEN. § 18-337(b), (e) (prohibiting disclosure of a patient's HIV status unless certain requirements are met).

viral load.[112] The question then becomes what constitutes a good faith decision on Dr. Jones's part.[113] According to the plain meaning of good faith, Dr. Jones should do what he feels is honest and faithful to his obligations as a physician.[114] Though a good faith standard is an improvement upon imposing an affirmative duty to disclose in that it provides for discretion on the part of the doctor, it still does not include an account of the actual risk of transmission posed.[115] Therefore, Maryland's partner-notification law is not sufficiently narrowly tailored and would allow for notification even when no major risk of transmission exists.

2. Ms. Smith's Undetectable Viral Load Mitigates Her Boyfriend's Need for Access to Information Regarding Her HIV Status to Effectively Protect Himself Against Infection Because the Risk of Transmission Is Significantly Reduced.

The sixth *Westinghouse* factor is the degree of need for access to the particular medical information.[116] Ms. Smith's boyfriend's general need for access to information about Ms. Smith's health is substantial due to his personal interest in protecting his own health.[117] However, in Ms. Smith's case, the need for access is not so substantial that it creates a high degree of necessity for Dr. Jones to provide that information to Ms. Smith's boyfriend without Ms. Smith's consent.[118] Determining the degree of need for access requires an inquiry into whether the interest may be achieved by means besides disclosure of the specific information.[119] The fact that Ms.

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112. *Compare* Doe v. Barrington, 729 F. Supp. 376, 385 (D.N.J. 1990) (finding no compelling government interest where third parties would only come into casual contact with HIV-infected person), *with* Anderson v. Romero, 72 F.2d 518, 524 (7th Cir. 1995) (finding disclosure to an inmate whose HIV-positive cellmate had a propensity for rape justifiable).

113. *See* HEALTH-GEN. § 18-337(e) (creating good faith requirement in performance of partner-notification).

114. *See id.* HEALTH-GEN. § 18-337(e), (f) (including no definition of good faith in the context of partner notification); Bond v. Messerman, 873 A.2d 417, 432 (Md. Ct. Spec. App. 2005) (stating that when there is no statutory definition, good faith shall be interpreted by its plain meaning); BLACK'S LAW DICTIONARY 337 (4th pocket ed. 2011) (defining "good faith" as "honesty in belief or purpose" and "faithfulness to one's duty or obligation").

115. *Cf.* HEALTH-GEN. § 18-337 (including no criteria related to actual risk of transmission).

116. *See* United States v. Westinghouse Elec. Corp., 638 F.2d 570, 578 (3d Cir. 1980) (holding that the degree of need for access is a necessary factor in weighing the government interest in disclosure against the personal privacy interest at stake).

117. *See* R.L. Sowell et al., *Disclosure of HIV Infection: How Do Women Decide to Tell?*, 18 HEALTH EDUC. RES. 32, 33 (2003) (describing disclosure of HIV status to sexual partners as essential to stopping the spread of HIV completely).

118. *See* Anderson v. Romero, 72 F.3d 518, 524 (7th Cir. 1995) (noting the high risk of transmission between cellmates).

119. *See* Doe v. Se. Pa. Transp. Auth., 72 F.3d 1133, 1141-42 (3d Cir. 1995)

Smith has an undetectable viral load significantly lessens the degree of need for access because the degree of need for access is linked to, not only the severity of the potential harm, but also the likelihood of that harm occurring.[120]

In *Westinghouse*, NIOSH could not achieve the objective of a thorough evaluation of workplace safety without access to employee medical records.[121] In comparison, Ms. Smith's boyfriend has other means available to protect himself from HIV infection.[122] Moreover, the government may also pursue other strategies to protect him and others in a similar position from HIV infection.[123] Unlike situations where the risk of transmission is so high that transmission can only be effectively prevented through disclosure, Ms. Smith's case allows the government to pursue its public health interests without impinging upon her right to personal privacy.[124] Therefore, the degree of need for access to information about Ms. Smith's HIV status is not so substantial that it justifies allowing disclosure without her permission.

a. While the Reasonably Foreseeable Risk of Transmission Requirement in the Michigan Statute Limits Disclosures to Where the Degree of Need for Access Is Highest, the Affirmative Duty to Disclose Risks Creates an Overbroad Requirement for Disclosure.

Because Michigan's partner-notification statute specifically limits its use to instances in which there is a reasonably foreseeable risk of transmission,

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(finding disclosure of employees' prescription records to employer necessary to monitor health costs).

120. *Cf.* Faison v. Parker, 823 F. Supp. 1198, 1202-03 (E.D. Pa. 1993) (explaining that there was a need for access to a prisoner's medical history during her sentencing because of the likelihood of potential harm that would arise if the information was withheld).

121. *See Westinghouse*, 638 F.2d at 576, 579 (finding that access to the entire medical record is reasonably necessary for NIOSH to effectively monitor workplace safety).

122. *See Condoms and STDs: Fact Sheet for Public Health Personnel*, CENTERS FOR DISEASE CONTROL (Sept. 13, 2011) [hereinafter *Condoms and STDs: Fact Sheet*], http://www.cdc.gov/condomeffectiveness/latex.htm (advocating use of male condoms as a highly effective method of preventing the transmission of HIV).

123. *See, e.g.*, *Advancing HIV Prevention: New Strategies for a Changing Epidemic—United States, 2003*, 52 MORBIDITY & MORTALITY WEEKLY REP. 329 (2003) (describing counseling and awareness programs as ways to improve HIV prevention).

124. *Compare* Anderson v. Romero, 72 F.3d 518, 524 (7th Cir. 1995) (noting the difficulty of preventing HIV transmission between cellmates without disclosure of HIV-positive cellmate's status to the HIV-negative cellmate), *with* Lemon v. Stewart, 682 A.2d 1177, 1184-85 (Md. Ct. Spec. App. 1996) (finding no need to inform the family members of an HIV-positive man's status due to the low risk of transmission of HIV to them).

it intrinsically identifies those instances where the degree of need for access will be highest.[125] The degree of need for access is directly related to whether other means exist for accomplishing the government interest at stake.[126] Where the interest is limited to a specific set of circumstances, the degree of need for access will increase accordingly.[127]

Under Michigan's partner-notification statute, Dr. Jones's notification of Ms. Smith's boyfriend may not be permissible because, as stated above, Ms. Smith may not pose a reasonably foreseeable risk of transmission.[128] Such a determination would depend on other facts that Dr. Jones must obtain from Ms. Smith, including whether she and her boyfriend regularly use condoms.[129] Still, Dr. Jones should seek out more facts and avoid allowing the imposition of an affirmative duty to sway his decision of whether disclosure is appropriate.[130] Therefore, while the Michigan statute provides a permissible standard in terms of identifying where the degree of need for access is highest, it may not be applicable to Ms. Smith's case.[131]

b. Maryland's Good Faith Requirement for Disclosure of a Patient's HIV Status Does Not Establish a High Degree of Need for Access Because It Does Not Adequately Define When Disclosure Is Necessary.

Section 18-337 of the Maryland Health Code only requires that a doctor act in good faith when deciding to disclose a patient's HIV status to a sexual partner that the patient has refused to notify.[132] As previously

125. *See* MICH. COMP. LAWS SERV. § 333.5131(5)(b) (LexisNexis Supp. 2011) (limiting disclosure to cases where there is a reasonably foreseeable risk of transmission).

126. *See, e.g.*, Murray v. Pittsburgh Bd. of Educ., 759 F. Supp. 1178, 1183 (W.D. Pa. 1991) (finding high degree of need for access to teacher's psychiatric records to reliably determine possible dangers that teachers could pose to students).

127. *See* United States v. Westinghouse Elec. Corp., 638 F.2d 570, 579 (3d Cir. 1980) (finding that a review of an entire medical file was the only reasonable way for NIOSH to compile necessary data).

128. *See Effect of Antiretroviral Therapy*, *supra* note 5, at 1 (noting the decreased risk of sexual transmission of HIV when the HIV-positive partner has an undetectable viral load).

129. *See Condoms and STDs: Fact Sheet*, *supra* note 122, at 2 (describing the high degree of protection from HIV transmission provided by consistent and correct use of male condoms).

130. *See* Woods v. White, 689 F. Supp. 874, 876 (W.D. Wis. 1988) (observing personal nature of information related to HIV diagnosis that cautions against disclosure); *see also* Neidl, *supra* note 2, at 1212-15 (noting the aggressive nature of statutes that impose an affirmative duty upon health care providers to disclose a patient's status to at-risk third parties).

131. *See* Clifton et al., *supra* note 107, at 158-59 (stating that one intent of the original Michigan disclosure provision was to prevent transmission of HIV).

132. *See* MD. CODE ANN., HEALTH-GEN. § 18-337(e) (LexisNexis 2009) (removing liability for breach of confidentiality for any doctor who performs partner notification

stated, this standard does not state clearly the government's interest in allowing for partner notification in all instances that fall under the law.[133] The statute also does not establish a high degree of need for third parties, such as Ms. Smith's boyfriend, to have access to the information.[134] Unlike the Michigan statute, the Maryland statute does not limit the use of partner-notification to a specific set of circumstances defined by the amount of risk posed to third parties.[135]

Based on the facts available, Dr. Jones would not be able to make a good faith determination as to whether to disclose Ms. Smith's status to her boyfriend.[136] However, Dr. Jones has all of the information that the statute requires before he can make a disclosure: whether Ms. Smith has a sexual partner and whether she refuses to inform him of her HIV status.[137] While the Michigan statute at least requires the determination of a foreseeable risk of transmission, the Maryland statute does not provide any clear impetus for Dr. Jones to discover more details that would help him evaluate the actual need for giving Ms. Smith's boyfriend access to information regarding her HIV status.[138] Therefore, Maryland's partner-notification law allows for disclosure even when a doctor has not even considered in detail whether an actual risk of transmission exists.

3. Disclosure to Ms. Smith's Boyfriend Would Create a Great Risk to Her Continued Medical Privacy Because There Are No Safeguards Against Further Disclosures.

The final *Westinghouse* factor is the adequacy of safeguards to prevent

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in good faith and in accordance with the rest of the section).

133. *See id.* (providing no guidance beyond a good faith standard for when to perform notification).

134. *See id.* HEALTH-GEN. § 18-337 (b) (requiring only that a doctor be aware of the patient's HIV status and the patient's refusal to inform his or her sexual partner for disclosure to be permissible).

135. *Compare* MICH. COMP. LAWS SERV. § 333.5131(5)(b) (LexisNexis Supp. 2011) (requiring a reasonably foreseeable risk of transmission before a doctor may make a disclosure of a patient's HIV status), *with* HEALTH-GEN. § 18-337 (requiring no assessment of infectiousness or other risk behaviors that would affect likelihood of transmission).

136. *See* BLACK'S LAW DICTIONARY, *supra* note 114, at 337 (maintaining that good faith requires acting with faithfulness to one's duty or obligation); *Condoms and STDs: Fact Sheet*, *supra* note 122, at 2 (explaining the vast difference in rates of transmission between heterosexual couples who use condoms during sexual intercourse and those who do not).

137. *See* HEALTH-GEN. § 18-337(b) (limiting the requirements for permissible disclosure to instances where the doctor is aware of an HIV-positive patient's sexual partner and the patient has refused to perform notification independently).

138. *See id.* (imposing no specific requirement that doctors investigate factors contributing to actual risk of transmission from patient to patient's sexual partner).

unauthorized disclosure.[139] Because no partner-notification law addresses what a third party may do with the information once warned about a sexual partner's HIV status, Ms. Smith's boyfriend may share the fact of Ms. Smith's HIV status with whomever he wishes.[140] These safeguards are crucial after the initial disclosure is made to ensure that the information is used only for the stated purpose of the law requiring the disclosure.[141] The lack of safeguards in partner-notification laws poses a major risk to Ms. Smith's medical privacy, and also highlights the primary issues surrounding HIV infection that make Ms. Smith's privacy interest in information regarding her HIV status so strong.[142]

While partner-notification laws may not be able to control the independent conduct of third parties, other precautions may be taken to limit the likelihood of further disclosures and violations of a patient's medical privacy.[143] These precautions may, in certain instances, balance the need for disclosure to protect a third party from likely infection against the privacy interest of the HIV-positive person.[144] However, in Ms. Smith's case, more than simple precautions may be warranted.

a. The Michigan Statute Does Not Have Adequate Safeguards to Prevent Unnecessary Disclosures Because It Does Not Speak to the Third Party's Conduct Once the Initial Disclosure Is Made.

Michigan's partner-notification statute does not address what a partner may do with the information regarding the potential HIV exposure after being notified.[145] Therefore, if Dr. Jones decides to notify Ms. Smith's

139. *See* United States v. Westinghouse Elec. Corp., 638 F.2d 570, 578 (3d Cir. 1980) (holding that adequate safeguards against unauthorized disclosure are an important factor in judging the constitutionality of a particular law requiring disclosure of personal medical information).

140. *See* MICH. COMP. LAWS SERV. § 333.5131 (LexisNexis Supp. 2011) (imposing no duty upon the sexual partner of an HIV-positive person to keep that person's HIV status confidential); HEALTH-GEN. § 18-337 (declining to address what a third party may do with information regarding a sexual partner's HIV status after being notified).

141. *Cf.* Whalen v. Roe, 429 U.S. 589, 605 (1977) (expressing concern about unwarranted use of personal information gathered by government); *see also Westinghouse*, 638 F.2d at 580 (finding that NIOSH would only disclose Westinghouse employee medical information to third parties when necessary for process of analysis).

142. *See, e.g.*, Doe v. New York, 15 F.3d 264, 267 (2d Cir. 1994) (finding that a positive HIV status carries an additional public stigma that does not accompany other medical diagnoses).

143. *See* § 333.5131(7) (prohibiting providing identifying information of an HIV-positive person when making a disclosure unless necessary to prevent a foreseeable risk of transmission).

144. *See* Pottker-Fishel, *supra* note 89, at 174, 176 (arguing that statutes like Texas's partner-notification statute are exemplary because they prohibit the inclusion of identifying information as well as any information regarding the time period in which the partner was exposed).

145. *See* § 333.5131 (declining to address what should happen after disclosure

boyfriend of his potential exposure to HIV, Ms. Smith's personal information regarding her HIV status may be disclosed further without her consent.[146] Such a lack of protections for sensitive personal information goes against the principle that a law may require disclosure only in limited circumstances that serve a legitimate government interest.[147]

However, section 333.5131 of the Michigan code protects the privacy of HIV-positive persons to a certain extent by prohibiting a doctor or health official from including identifying information while making a disclosure.[148] The only exception is where identifying information is necessary to prevent a foreseeable risk of transmission of HIV.[149] While this is an important safeguard for Ms. Smith's privacy, its effectiveness may be undermined by the fact that she is in a monogamous relationship, making the source of the potential exposure more obvious to her boyfriend.[150] If Ms. Smith's boyfriend then decides to share his knowledge of Ms. Smith's HIV status with someone else, he will be using the information in a way not envisioned by the purpose of the law, which was only to protect him.[151]

b. The Maryland Statute Has Inadequate Safeguards to Prevent Unnecessary Disclosures Because It Does Not Speak to the Third Party's Conduct Once the Initial Disclosure Is Made and Also Increases the Danger of Further Disclosures by Allowing Ms. Smith's Doctor to Disclose Her Identifying Information in Addition to the Potential Exposure.

Maryland's partner-notification statute does not help to limit the potential for further disclosures without Ms. Smith's consent, and therefore

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occurs).

146. *See id.* (including no provision regarding the conduct of a sexual partner who is notified of a patient's HIV status pursuant to the statute); *see also* MICH. COMP. LAWS SERV. § 333.5114a (LexisNexis Supp. 2011) (describing requirements for partner-notification but including no guidance on respecting confidentiality of sources of potential HIV exposure).

147. *See* United States v. Westinghouse Elec. Corp., 638 F.2d 570, 577-78 (3d Cir. 1980) (stressing that any disclosures should be warranted by a societal interest in disclosure that outweighs the individual's privacy interest).

148. *See* § 333.5131(7) (prohibiting inclusion of any identifying information during the partner-notification process except in certain circumstances).

149. *See id.* (allowing inclusion of identifying information only when necessary to prevent foreseeable risk of HIV transmission).

150. Roger Doughty, *The Confidentiality of HIV-Related Information: Responding to the Resurgence of Aggressive Public Health Interventions in the AIDS Epidemic*, 82 CALIF. L. REV. 111, 169 (1994) (finding that notification of an exclusive sexual partner may result in constructive notification of the HIV-positive person's identity).

151. *See* § 333.5131(5)(b) (specifying that partner-notification without a patient's consent is permissible where there is a foreseeable risk of transmission of HIV to a third party who is unaware of that risk).

is not sufficient to protect her privacy beyond the disclosure necessary to achieve the purpose of the law.[152] Section 18-337 of the Maryland Health Code lacks even the basic protection of Michigan's statute because it does not impose any limitations on the ability of a doctor or health care official to share identifying information when making a disclosure to warn a third party.[153] While this risk of further disclosure may be warranted in cases where an HIV-positive person is highly infectious and engaging in high-risk behavior, Ms. Smith does not pose so much danger that such a risk should be taken without her consent.[154]

IV. POLICY RECOMMENDATION

The foregoing analysis highlights several deficiencies in current partner-notification laws, making them ill-suited for dealing with the new realities of HIV treatment.[155] In particular, the lack of accounting for infectiousness in many partner-notification statutes creates an overbroad standard that allows for violations of personal privacy even where the government interest will not be substantively promoted.[156] The reality of HIV today, when a person regularly adheres to treatment and maintains an undetectable viral load, is vastly different from the highly dangerous levels of infectiousness that typified the virus in the past that made drawing comparisons to *Tarasoff*'s mentally unstable murderer much simpler for lawmakers.[157] By taking account of infectiousness when establishing requirements for permissible notification, partner-notification statutes will better balance the government interest in preventing the reckless transmission of HIV with the privacy interests of persons infected with HIV.[158]

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152. *See* MD. CODE ANN., HEALTH-GEN. § 18-337 (LexisNexis 2009) (lacking a provision governing the conduct of a third party notified pursuant to the statute).

153. *See id.* HEALTH-GEN. § 18-337(b)(1) (permitting a doctor or health official performing partner notification to include the HIV-positive individual's identity when making the disclosure).

154. *See, e.g.*, *Effect of Antiretroviral Therapy*, *supra* note 5, at 1, 4 (stating that the risk of transmission is reduced when the HIV-positive partner has an undetectable viral load and that effective antiretroviral treatment reduces sexual transmission of HIV).

155. *See supra* Part III.B (describing ways in which the government interest in partner notification weakens in the case of HIV-positive patients adhering to treatment and maintaining an undetectable viral load).

156. *See supra* Part III.B.1 (finding that HIV-positive patients like Ms. Smith do not clearly fall into the area of government interest described by partner-notification laws).

157. *Compare* Stenger, *supra* note 18, at 494 (observing the particular deadliness of AIDS as instrumental in motivating legislatures to pass partner-notification laws), *with Effect of Antiretroviral Therapy*, *supra* note 5, at 4 (noting the demonstrated decreased rates of transmission related to effective antiretroviral treatment).

158. *See* United States v. Westinghouse Elec. Corp., 638 F.2d 570, 580 (3d Cir. 1980) (holding that disclosure must serve specific interest); *see also, e.g.*, MICH. COMP. LAWS SERV. § 333.5131(5)(b) (LexisNexis Supp. 2011) (balancing governmental

Michigan's partner-notification law provides an excellent starting point upon which to build a new infectiousness standard.[159] The reasonably foreseeable risk of transmission requirement not only gives doctors and health officials discretion as to when to make a notification without a patient's consent, but also emphasizes the actual purpose of the law, which is to reduce the risk of transmission.[160] Conversely, Maryland's good faith standard, while providing discretion, gives less specification as to when it will be most important to perform notification without a patient's consent.[161]

Still, Michigan does not provide the perfect example because it imposes an affirmative duty on doctors to warn a third party of potential HIV exposure.[162] The unpopularity of such a provision is demonstrated by the number of states that do not include it, as well as the many states that provide specifically that their partner-notification statutes shall not be interpreted to create an affirmative duty to notify.[163]

V. CONCLUSION

The governmental role in encouraging disclosure of HIV status, while still great, diminishes as HIV treatment continues to develop and allow HIV-positive persons to reduce their risk of transmission.[164] If partner-notification statutes include an evaluation of infectiousness, they will be more narrowly tailored to the government's interest in preventing the further spread of HIV while also giving more respect to the personal privacy interest of HIV-positive persons.

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interest in HIV prevention with patient privacy by requiring a reasonably foreseeable risk of transmission for disclosure); Anderson v. Romero, 72 F.3d 518, 524 (7th Cir. 1995) (allowing disclosure of HIV status due to the high likelihood of transmission).

159. *See* § 333.5131(5)(b) (describing requirements for permissible partner-notification).

160. *See id.* (establishing a foreseeable risk of transmission as the primary requirement for permissible partner notification without giving a specific definition of foreseeable risk).

161. *See* MD. CODE ANN., HEALTH-GEN. § 18-337(e) (LexisNexis 2009) (providing a good faith standard for partner notification but providing no further guidance).

162. *See* § 333.5131(5)(b) (creating an affirmative duty to warn known sexual partners of an HIV-positive patient who are unaware of the person's HIV status); *supra* Part III.B.1.a (explaining why affirmative duty statutes can undermine the best public health result).

163. *See When, If Ever, Can You Divulge Your ED Patient's HIV Status?*, ED LEGAL LETTER (AHC Media, Atlanta, Ga.), Oct. 1, 2008, at 119, *available at* http://www.dgslaw.com/images/materials/Eiselein_patient_HIV_status.pdf (stating that only a few states require doctors to disclose HIV status to sexual partners and that Michigan is therefore in the minority).

164. *See* United States v. Westinghouse Elec. Corp., 638 F.2d 570, 578 (3d Cir. 1980); *Effect of Antiretroviral Therapy*, *supra* note 5, at 1 (describing the change in rates of transmission related to the development of antiretroviral therapies).