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MANDATORY AIDS TESTING AND PRIVACY: A PSYCHOLEGAL PERSPECTIVE

EMILY CAMPBELL*

I. INTRODUCTION

The disease known as AIDS¹ is rapidly spreading across this nation and the world,² causing much concern in both the medical and legal communities.³ Although much remains unknown about AIDS, scientists do know that it is contagious, incurable, and nearly always fatal.⁴ The AIDS virus attacks the immune system, leaving the body defenseless — vulnerable to opportunistic diseases which ultimately kill the individuals who become infected with the virus.⁵

Many commentators have called for strict measures designed to combat the spread of AIDS.⁶ What should America do when as

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1. The acronym AIDS is short for Acquired Immunodeficiency Syndrome. See THE MERCK MANUAL OF DIAGNOSIS AND THERAPY 288 (R. Berkow ed. 1987) [hereinafter MERCK MANUAL]. More recently, the disease has been referred to as the HIV infection (human immunodeficiency virus). *Id.* However, this article will continue to use the older term "AIDS" and the acronym "HTLV-III" for the virus itself because they are more commonly understood.

2. See Booth, *CDC Paints a Picture of HIV Infection in U.S.*, 239 SCI. 253 (1988); *CDC Report Reflects Trends of HIV Infection in the United States*, AM. FAM. PHYSICIAN, Feb. 1988, at 454. See also Laumann, Gagnon, Michaels & Coleman, *Monitoring the AIDS Epidemic in the United States: A Network Approach*, 244 SCI. 1186 (1989); *Update: Acquired Immunodeficiency Syndrome—United States: 1981-1988*, 261 J. AM. MED. A. 2609 (1989).

3. See S. PANEM, THE AIDS BUREAUCRACY (1988); Aiken, *AIDS—Pushing the Limits of Scientific and Legal Thought*, 5 JURIM. J. 1 (1986); Booth, *AIDS Policy in the Making*, 239 SCI. 1087 (1988); Dickens, *Legal Rights and Duties in the AIDS Epidemic*, 239 SCI. 580 (1988); Costin, *Public Health Strategies for Confronting AIDS: Legislative and Regulatory Policy in the United States*, 261 J. AM. MED. A. 1621 (1989); Ingraham, *AIDS Epidemic: How Can Biologists Respond?*, 38 BIOSCIENCE 41 (1988); Koshland, *Epidemics & Civil Rights*, 235 SCI. 729 (1987); Lewis, *Acquired Immunodeficiency Syndrome: State Legislative Activity*, 258 J. AM. MED. A. 2410 (1987); Marco, *AIDS 1986: A Medical-Legal Explosion*, 36 MED. TRIAL TECH. Q. 360 (1986); Osborn, *AIDS: Politics and Science*, 318 NEW ENG. J. MED. 444 (1988); Palca, *US Congress Debates Legislation in Response to AIDS*, 328 NATURE 566 (1987); Quinn, Zacarias & St. John, *AIDS in the Americas: An Emerging Public Health Crisis*, 320 NEW ENG. J. MED. 1005 (1989).

4. Duncan, *Public Policy and the AIDS Epidemic*, 2 J. CONTEMP. HEALTH L. & POL. 169 (1986).

5. See *infra* notes 14-26 and accompanying text.

6. See, e.g., Elsberry, *AIDS Quarantine in England and the United States*, 10 HASTINGS INT'L & COMP. L. REV. 113 (1986).

many as three million people may be carrying the virus?⁷ Certainly, some action must be taken soon; delay only multiplies the numbers of people who are exposed to the virus.⁸ Some have suggested quarantining the carriers for life,⁹ others have suggested that laws be enacted to prohibit infected individuals from engaging in sexual contact,¹⁰ the primary means of transmission.¹¹ However, this article will not consider such drastic measures, but will consider universal AIDS screening coupled with educational efforts.¹² One commentator has argued that health officials should:

[i]dentify the carriers of AIDS by screening the entire population for the disease. [Although] such a mass screening will be difficult to implement . . . and some AIDS carriers will slip through unobserved [while the] policy . . . [would] impact on the liberty of every man, woman, and child in America . . . such costs . . . are outweighed greatly by the benefits resulting from the identification of AIDS carriers. At a minimum, AIDS carriers themselves should know they are contagious so that they can make the appropriate adjustments in their lives and in their relationships with others.¹³

Would such a program be unduly invasive of individuals' privacy? Would such a program be constitutionally permissible? This article will explore the psychological concept of privacy and will examine the constitutionality of such a universal testing program, balancing the privacy interests of the individuals subjected to testing against the state interests involved. Furthermore, less intrusive means of education without testing and voluntary testing will

7. *AIDS Infection in U.S. is Double Official Estimates, Hudson Institute Study Says*, HUDSON INSTITUTE REP. (Fall 1988).

8. Duncan, *supra* note 4, at 169 (1986).

9. See Gleason, *Quarantine: An Unreasonable Solution to the AIDS Dilemma*, 55 U. CIN. L. REV. 217 (1986). However, in November 1986, California voters defeated Proposition 64 by a two to one margin; the measure was designed to legally declare AIDS an infectious disease and force public health officials to establish camps to quarantine AIDS patients and anyone who carried the AIDS virus. R. LEE, *AIDS IN AMERICA: OUR CHANCES, OUR CHOICES* 84 (1987).

10. See Robinson, *AIDS and the Criminal Law: Traditional Approaches and a New Statutory Proposal*, 14 HOFSTRA L. REV. 91 (1985). Since 1985, more than two hundred AIDS-related bills were introduced in a majority of the states. See R. LEE, *supra* note 9, at 85. For instance, West Virginia heard a proposal to make the transmission of AIDS first-degree murder. *Id.*

11. See *infra* notes 27-46 and accompanying text.

12. For a similar proposal, see generally R. LEE, *supra* note 9. See also Rhame & Maki, *The Case for Wider Use of Testing for HIV Infection*, 320 NEW ENG. J. MED. 1248 (1989).

13. Duncan, *supra* note 4, at 170.

be examined to determine whether such programs would be as effective in combating the spread of AIDS.

II. MEDICAL FACTS

A. WHAT CAUSES AIDS?

Among the scientific community, it is now nearly unanimous that a necessary cause of AIDS is infection by the human T-cell lymphotropic retrovirus/lymphadenopathy-associated virus (HTLV-III).¹⁴ This virus is not like the virus producing the common cold.¹⁵ Rather, it is an extremely virulent retrovirus that attacks the T-4 lymphocytes of the immune system.¹⁶ T-4 cells are commonly known as a type of white blood cells and are responsible for warding off infection by activating other cells which produce antibodies that attack invading organisms.¹⁷ When the AIDS virus invades these cells, their ability to defend against infection becomes impaired.¹⁸ Instead of fighting infection, the T-cells essentially become AIDS virus factories, reproducing the AIDS virus and spreading it throughout the body.¹⁹ In the process, the T-4 cells are gradually weakened, and they are eventually destroyed in a person with full-blown AIDS, leaving the body helpless to protect itself against other crippling infections.²⁰ Generally, the AIDS patient becomes ill from opportunistic diseases which invade the body when its defenses are suppressed.²¹

14. Broder & Gallo, *A Pathogenic Retrovirus (HTLV-III) Linked to AIDS*, 311 NEW ENG. J. MED. 1292-97 (1984). See also Fauci, *The Human Immunodeficiency Virus: Infectivity and Mechanisms of Pathogenesis*, 239 SCI. 617 (1988); Ho, Pomerantz & Kaplan, *Pathogenesis of Infection with Human Immunodeficiency Virus*, 317 NEW ENG. J. MED. 278 (1987); Levy, *Human Immunodeficiency Virus and the Pathogenesis of AIDS*, 261 J. AM. MED. A. 2997 (1989).

15. "Many viruses cause the common cold, including rhino-influenza, parainfluenza, respiratory syncytial, corona, adeno-, certain echo- and coxsacksieviruses." See MERCK MANUAL, *supra* note 1, at 169.

16. As a retrovirus, HTLV-III's genetic material becomes integrated into human chromosomes. See A. FETTNER & W. CHECK, *THE TRUTH ABOUT AIDS* 172 (rev. ed. 1985). As the virus reproduces, it mutates, changing the genetic structure of the virus and making the development of a vaccine extremely difficult. *Id.*

17. See MERCK MANUAL, *supra* note 1, at 288.

18. *Id.* at 288-89.

19. *Id.*

20. See *infra* note 26.

21. See *The Syndrome Captures More Diseases*, 115 NEW SCI. 29 (1987). Among the most common diseases that a full-blown AIDS patient could contract would be Pneumocystis carinii Pneumonia, a rare lung infection; Kaposi's Sarcoma, a rare skin cancer; Candidiasis, a fungal infection in the mouth, more commonly known as thrush or yeast; Cytomegalovirus, another lung infection that can spread throughout the body and can cause blindness; Herpes Simplex, which can cause severe ulcers around the mouth and perianal areas; Herpes zoster, which causes skin eruptions commonly known as "shingles," leading to oozing blisters and black scabs over infected areas such as the mouth, nose, and rectum; Toxoplasmosis, an infection of the brain caused by a parasite commonly found in cat feces; Cryptosporidiosis, an intestinal disease leading to severe diarrhea, dehydration,

However, the AIDS virus can kill by causing brain diseases without any opportunistic infection and without immune system suppression.²² The AIDS virus per se destroys brain cells and causes AIDS virus encephalopathy, a progressively debilitating brain disease.²³

Whether the virus acts upon the brain or the immune system, it takes time for it to produce deadly effects. This time period varies among individuals, thus producing three basic stages of infection: asymptomatic infection,²⁴ AIDS-related complex (ARC),²⁵ and full-blown AIDS.²⁶

and drastic weight loss, caused by a protozoan associated with in farm livestock, dogs, cats, and other animals; and Cryptococcosis, a fungal infection which may cause diffuse meningitis. See generally ACQUIRED IMMUNE DEFICIENCY SYNDROME & OTHER MANIFESTATIONS OF HIV INFECTION: EPIDEMIOLOGY, ETIOLOGY, IMMUNOLOGY, CLINICAL MANIFESTATIONS, PATHOLOGY, CONTROL, TREATMENT & PREVENTION, (G. Wormser ed. 1987). For more information on Kaposi's Sarcoma, see Biggar, *AIDS-Related Kaposi's Sarcoma in New York City in 1977*, 318 NEW ENG. J. MED. 252 (1988). For more information on the related lung diseases and AIDS, see Chaisson & Hopewell, *Empiric Diagnosis of Pneumocystic Pneumonia*, 258 J. AM. MED. A. 3385 (1987); Macher, Bardenstein, Zimmerman, *Pneumocystis Carinii Choroiditis in A Male Homosexual with AIDS and Disseminated Pulmonary and Extrapulmonary P. Carinii Infection*, 316 NEW ENG. J. MED. 1092 (1987); *Spontaneous Pneumothroax in P. Carinii Infection*, AM. FAM. PHYSICIAN, Mar. 1987, at 323.

For the relationship between other diseases and AIDS, see List, *Metastatic Giant-Cell Bone Tumor in a Man Positive for HIV*, 318 NEW ENG. J. MED. 517 (1988); *Metastatic Basal Cell Carcinoma in AIDS-Related Complex*, AM. FAM. PHYSICIAN, June 1987, at 262.

22. Elder & Sever, *AIDS and Neurological Disorders: An Overview*, 23 ANNALS NEUROLOGY s4-s6 (1988); Seale, *AIDS Virus Infection: Prognosis and Transmission*, 78 J. ROYAL SOC'Y MED. 613, 614 (1985). See also Clifford, *AIDS and the Brain*, AM. FAM. PHYSICIAN, Dec. 1987, at 101; Grabbe & Brown, *Identifying Neurologic Complications of A.I.D.S.*, 19 NURSING, May 1989, at 66.

23. The AIDS virus travels into the cerebrospinal fluid and the tissues of the brain. See Armstrong, Gold, Dryjanski, Estella, Whimby, Polsky, Hawkings, Brown, Banan & Kishn, *Treatment of Infections in Patients with the Acquired Immunodeficiency Syndrome*, 103 ANNALS INTERNAL MED. 738 (1985). Once inside the brain, the virus reproduces, killing infected brain cells. *Id.* at 739. The resulting progressive brain tissue destruction affects the thought processes (leading to dementia) and coordination of vital bodily functions. *Id.* at 741. See also *Dementia May be the First Sign of AIDS*, 50 R.N. 77 (1987); Kingman, *Dementia May Strike Before Other Symptoms*, 116 NEW SCI. 20 (1987); *Know the Early Signs of HIV Dementia Complex*, NURSING, Mar. 1988, at 18.

24. The first stage of AIDS is an asymptomatic carrier stage. MERCK MANUAL, *supra* note 1, at 290. Although the individual is infected, he or she shows no visible signs or symptoms of the disease. *Id.* Because the individual may appear in good health, the AIDS virus is deceptive. *Id.* Individuals who are infected with the AIDS virus but who are asymptomatic are just as capable of spreading AIDS as patients with the full-blown syndrome. *Id.* at 293. See generally SLAFF & BRUBAKER, *THE AIDS EPIDEMIC* (1985).

25. AIDS related complex (ARC) or pre-AIDS syndrome is the second stage of the progressive AIDS infection. MERCK MANUAL, *supra* note 1, at 290. It occurs when an infected person begins to manifest symptoms that include unexplained weight loss, drenching night sweats, persistent diarrhea, swelling of the lymph nodes in the armpits and groin, and chronic fatigue. *Id.* at 291. As the AIDS virus begins to invade cells in the brain and central nervous system, the AIDS victim will begin to exhibit signs of dementia including chronic memory loss, loss of muscular control, seizures, and psychiatric disturbances. SLAFF & BRUBAKER, *supra* note 24, at 142.

26. MERCK MANUAL, *supra* note 1, at 291. The distinction between persons having ARC and what is officially defined as AIDS has become blurred because of the progressive nature of the AIDS infection. *Id.* Generally, at the final stage of the AIDS infection, the immune system is suppressed, allowing the individual to become infected with

B. HOW AIDS IS SPREAD

Epidemiologists do not completely understand how the virus spreads from one individual to another. The virus has been isolated in a variety of bodily fluids, including blood, semen, saliva, tears, urine, and breast milk.²⁷ Further, it is also present in feces.²⁸ Thus far, researchers have implicated blood and semen as the primary modes of transmission.²⁹

Principally, the virus has been transmitted via direct injections of the virus into the bloodstream, *i.e.*, from a transfusion,³⁰ needle exchange among intravenous drug users,³¹ intimate sexual conduct including but not limited to anal intercourse,³² and

opportunistic diseases. *Id.* Under normal conditions the immune system protects against the damaging effects of parasites, protozoan, fungi, and other viruses the body would come in contact with; however, AIDS breaks down the body's defenses, giving the infections the freedom to spread throughout the body. *Id.* Ultimately, such infections are what is responsible for the death of the individual. *Id.* at 292. Nevertheless, the AIDS virus per se destroys brain cells independent of its effect upon the immune system resulting in dementia and the loss of coordination of bodily functions. *Id.* at 291. *See also* G. ANTONIO, *THE AIDS COVER-UP: THE REAL AND ALARMING FACTS ABOUT AIDS* 9 (1987).

27. *See generally* G. ANTONIO, *supra* note 26. However, transmission by tears, saliva, and fomites (material that absorbs or transfers infection such as soiled bandages) has not been reported. MERCK MANUAL, *supra* note 1, at 289.

28. *Id.*

29. *Id.* *See also* A. CANTWELL, *AIDS: THE MYSTERY & THE SOLUTION* (rev. ed. 1986).

30. *See, e.g.*, Medley, *Incubation Period of AIDS in Patients Infected Via Blood Transfusion*, 328 NATURE 719 (1987); Zuck, *Transfusion-Transmitted AIDS Reassessed*, 318 NEW ENG. J. MED. 511 (1988).

31. *See, e.g.*, *Acquired Immunodeficiency Syndrome Associated With Intravenous-Drug Use—United States, 1988*, 261 J. AM. MED. A. 2314 (1989); Booth, *AIDS and Drug Abuse: No Quick Fix*, 239 SCI. 717 (1988); Brown, Murphy & Primm, *Needle Sharing and AIDS in Minorities*, 258 J. AM. MED. A. 1474 (1987).

32. MERCK MANUAL, *supra* note 1, at 289. In the United States male homosexuals have comprised the majority of all full-blown AIDS cases. *Id.* The prevalence of AIDS in the gay community is not accidental. Biological and social factors have been linked with the spread of AIDS among homosexuals. *See* Darrow, Echenberg, Jaffe, O'Malley, Byers, Getchell & Curran, *Risk Factors For Human Immunodeficiency Virus (HIV) Infections in Homosexual Men*, 77 AM. J. PUB. HEALTH 479 (1987); McCusker, Stoddard, Mayer, Cowan & Groopman, *Behavioral Risk Factors for HIV Infection among Homosexual Men at a Boston Community Health Center*, 78 AM. J. PUB. HEALTH 68 (1988). Among male homosexuals, sodomy is commonly substituted for heterosexual penile-vaginal coitus, and it is this practice which provides an efficient means of transmission. G. ANTONIO, *supra* note 26, at 34.

The rectum is physiologically designed for the expulsion of feces. *Id.* When sodomy is performed, the inward expansion of the anal canal results in a tearing of the lining as well as bleeding and fissures. *Id.* The damage to the rectal wall facilitates access to the bloodstream of AIDS-infected sperm. *Id.* In New York City, it was found that receptive anal intercourse was the specific sexual activity most highly correlated with reduced levels of helper T-cells. Goedert, *Determinants of Retrovirus (HTLV-III) Antibody and Immunodeficiency Conditions in Homosexual Men*, LANCET, Sept. 29, 1984, at 711-15. Further, the active partner may be infected during anal intercourse. *Id.* at 712. The opening of the urethra, along with penile abrasions and lesions permit infected bloody secretions issuing from the damaged rectal tissues to enter the bloodstream of the active partner. *Id.* at 715.

In addition to anal intercourse, other traumatic acts facilitate the spread of AIDS. One practice known as "fisting" involves the insertion of the hand, fist, and forearm into the rectum and lower colon. THE COMPLETE GUIDE TO SAFE SEX 32 (T. McIvenna ed. 1987). "Fisting causes bleeding lacerations of the intestine and tearing of the sphincter muscle."

mother-infant contact before, during, and after childbirth.³³ In

G. ANTONIO, *supra* note 26, at 41. Similarly, sadomasochism, which involves bondage and discipline, may provide a means for transmission. During bondage, a partner may be bound, whipped, sodomized, and beaten. *Id.* Lighted cigarettes may be used to burn sensitive parts of the body, especially the genitals, causing ulcers. *Id.* Sores and blisters left on the sex organs facilitate the entrance of infectious agents into the bloodstream. *Id.* at 42.

"Water sports" or "golden showers" refers to urinating in or on someone. THE COMPLETE GUIDE TO SAFE SEX 179 (T. McIvenna ed. 1987). Because urine contains the AIDS virus, this type of behavior is hazardous. *Id.* "Safe sex" guidelines published by the Gay Men's Health Center advised that water sports were "considered safe so long as urine does not enter the body." G. ANTONIO, *supra* note 26, at 42 (*citing* Tanne, *The Last Word on Avoiding AIDS*, NEW YORK MAGAZINE, Oct. 7, 1985, at 29).

The social behavior patterns of certain male homosexuals/bisexuals have been a causal factor in the spread of AIDS. Bath houses which facilitate random, promiscuous contact have come under severe criticism as the number of AIDS casualties have multiplied:

[T]he baths . . . exist primarily to facilitate impersonal sexual encounters among homosexual men. The major function of the bath is to provide an inexpensive place where homosexual men can engage in frequent, anonymous sexual activities without fear of social or legal reprisal. . . . [While there] a patron might have nearly a dozen sexual encounters. . . .

A. BELL & M. WEINBERG, *HOMOSEXUALITIES: A STUDY OF DIVERSITY AMONG MEN AND WOMEN* 239 (1978).

Further, in a 1983 study, homosexuals diagnosed with full-blown AIDS admitted that fifty percent of their previous sexual partners had been in bathhouse/club encounters. Jaffee, *National Case Control Study of Kaposi's Sarcoma and Pneumocystis Carinii Pneumonia in Homosexual Men: Part 1*, 99 ANNALS INTERNAL MED. 145 (1983).

Coitus (sexual intercourse between men and women) is also an effective way to transmit the HTLV-III virus. MERCK MANUAL, *supra* note 1, at 289. In Africa, the incidence of HIV infection is nearly equal between men and women. *Id.* However, African heterosexual couples routinely engage in anal intercourse as a means of birth control. *Id.*

33. See Booth, *CDC Paints a Picture of HIV Infection in U.S.*, *supra* note 2. For a more complete discussion of the risks of transmission from mother to infant, see *Breast Milk is Best, But Milk May Pass on the Virus*, 115 NEW SCI. 19 (1987); Brown, Mitchell, DeVore & Primm, *Female Intravenous Drug Users and Perinatal HIV Transmission*, 320 NEW ENG. J. MED. 1493 (1989); Jabovson, *HIV-Infected Kids in NYC: An Invisible Emergency*, 89 AM. J. NURSING 643 (1989); Katz & Wilfert, *Human Immunodeficiency Virus Infection of Newborns*, 320 NEW ENG. J. MED. 1687 (1989); Landesman & Willoughby, *HIV Disease in Reproductive Age Women: A Problem of the Present*, 261 J. AM. MED. A. 1326 (1989); Maynard & Indacochea, *HIV Infection in Pregnant Women in Rhode Island: 1985 to 1988*, 320 NEW ENG. J. MED. 1626 (1989); Norvick, Berns, Stricot, Stevens, Pass & Wethers, *HIV Seroprevalence in Newborns in New York State*, 261 J. AM. MED. A. 1745 (1989).

Although rare, transmission of HIV is possible from AIDS patients to health care workers. In order for such infection to occur, the employee would have to cut himself or herself during a medical procedure and contaminate the wound with blood or other body fluids from the patient. *Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus in the Workplace*, 34 MORBIDITY & MORTALITY WEEKLY REP. 681, 691 (1985). See also *AIDS Infects Health Workers*, 131 SCI. NEWS 326 (1987); *Centers for Disease Control, Recommendations for Prevention of HIV Infections in Health-Care Workers Exposed to Blood of Infected Patients*, reprinted in 36 MORBIDITY & MORTALITY WEEKLY REP. 285 (1987); Gerberding, Bryant-LeBlanc & Nelson, *Risk of Transmitting the Human Immunodeficiency Virus, Cytomegalovirus, & Hepatitis B Virus to Health Care Workers Exposed to Patients with AIDS and AIDS Related Conditions*, 156 J. INFECTIOUS DISEASE 1 (1987); Gerberding, *Recommended Infection-Control Policies for Patients with Human Immunodeficiency Virus Infection: An Update*, 315 NEW ENG. J. MED. 1562 (1987); *AIDS Infects Health Workers*, 131 SCI. NEWS 326 (1987); *Labor, HHS Urge Health Care Employers to Protect Workers Against Hepatitis B and AIDS*, 103 PUB. HEALTH REP. 99 (1988); McCray, *Occupational Risk of the Acquired Immunodeficiency Syndrome Among Health Care Workers*, 314 NEW ENG. J. MED. 1127 (1986); Merritt, *How to Avoid Needle Stick Injury*, 259 J. AM. MED. A. 353 (1988); *Update: Human Immunodeficiency Virus Infections in Health-Care Workers Exposed to Blood of Infected Patients*, 257 J. AM. MED. A. 3032 (1987); Palca, *AIDS Virus Infects Another Lab Worker*, 329 NATURE 571 (1987);

the United States, it is estimated that seventy-three percent of individuals with full-blown AIDS are homosexual or bisexual men, intravenous drug users, persons with hemophilia or other coagulation disorders, recipients of blood transfusions, heterosexual partners of members of these groups, or children with parents in one of these groups.³⁴

The Public Health Service has continually asserted that "AIDS is a bloodborne, sexually transmitted disease that is not spread by casual contact."³⁵ However, several medical researchers have warned that it may be too early to make such absolute statements about the risk of transmitting the AIDS virus in casual contexts.³⁶

Weiss, Goedert, Gartner, Popobic, Waters, Markham, Veronese, Gail, Barkley, Givvons, Gill, Levther, Shaw, Gallo & Blattner, *Risk of Human Immunodeficiency Virus (HIV-1) Infection Among Laboratory Workers*, 239 SCI. 68 (1988).

Surgeons and dentists have occasionally transmitted hepatitis B to their patients. Polakoff, *Acute hepatitis B in patients in Britain related to previous operations and dental treatment*, 293 BRIT. MED. J. 33, 34 (1986). Although there has been no documentation of any case of AIDS transmitted in this manner, the absence of reported cases is not unexpected given that patients probably do not know whether the health care workers who treated them were infected with AIDS, and likewise, doctors do not often know in advance of a blood test whether the patient is infected. See Klein, Phelan, Freeman, Schable, Friedland, Trieger & Steigbigel, *Low Occupational Risk of Human Immunodeficiency Virus Infection Among Dental Professionals*, 318 NEW ENG. J. MED. 86 (1988).

Researchers have not conducted detailed studies of the incidence of AIDS infection among patients exposed to infected health care workers. Merritt, *Communicable Disease and Constitutional Law: Controlling AIDS*, 61 N.Y.U. L. REV. 739, 749-50 n.47 (1986). For a discussion of physicians' attitudes toward treating AIDS patients, see Keller, *Reflections on Hippocrates in a Plague Year*, 9 DISCOVER 26 (1988); Kelly, St. Lawrence, Smith, Hood & Cook, *Stigmatization of AIDS Patients by Physicians*, 77 AM. J. PUB. HEALTH 789 (1987); Wertz, Soronson, Liebling, Kessler & Heeren, *Knowledge and Attitudes of AIDS Health Care Providers Before and After Education Programs*, 102 PUB. HEALTH REP. 248 (1987); Zuger & Miles, *Physicians, AIDS, and Occupational Risk: Historic Traditions and Ethical Obligations*, 258 J. AM. MED. A. 1924 (1987). For a discussion of nurses' attitudes towards AIDS, see Orrock & Jackson, *Nurses Worry About Contracting AIDS*, 50 R.N. 9 (1987).

Similarly, acupuncturists, tattoo artists, and other personal service workers who use needles or sharp instruments could transmit the AIDS virus to clients. However, such transmission could only occur if the personal service worker cut himself or herself and blood from the wound entered a portal of entry on the client's body or equipment was not adequately cleaned between clients. See *Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus in the Workplace*, *supra*, at 693. Nonetheless, transmission of AIDS in this manner has yet to be documented and even hepatitis B, which is much more infectious than the AIDS virus, is rarely transmitted in these settings. *Id.*

34. See Bayer, Levine & Wolf, *HIV Antibody Screening: An Ethical Framework for Evaluating Proposed Programs*, 256 J. AM. MED. A. 1768 (1986). See also Peterman, Stoneburne, Allen, Jaffe & Curran, *Risk of Human Immunodeficiency Virus Transmission From Heterosexual Adults with Transfusion-Associated Infections*, 259 J. AM. MED. A. 55 (1988).

However, heterosexuals are a small but growing number of infected individuals in the United States and Europe. See Joyce & Kingman, *Heterosexual AIDS Comes to Britain*, 114 NEW SCI. 27 (1987); Edwards, *Heterosexuals and AIDS: Mixed Messages*, 132 SCI. NEWS 60 (1987); Joyce, *Mystery of Heterosexual Transmission*, 117 NEW SCI. 35 (1988).

35. *Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus in the Workplace*, *supra* note 33, at 681.

36. Merritt, *supra* note 33. Recently, doctors in West Germany reported a case in which a six-year-old boy may have contracted the AIDS virus through casual household

Further, few studies have been conducted on individuals living in households with AIDS victims.³⁷ The majority of such studies have demonstrated no transmission among family members who have hugged, kissed, and shared razors, toothbrushes, and other items likely to be soiled with bodily secretions.³⁸ However, those studies have included relatively few subjects and cannot prove that no risk exists.³⁹

Regardless of how an individual becomes infected there is no way for him or her to become disinfected.⁴⁰ Thus, a person remains infected for the rest of his or her life. Most importantly, once infected a person is infectious, and it is not safe to assume otherwise.⁴¹ In practical terms, this means that once a person becomes infected with the AIDS virus, that individual would never be able to engage in intimate sexual activity without endangering the life of another person.⁴² Indeed, the Center for Disease Control⁴³ has drafted regulations stating that: "Each person . . . would have to be told . . . that they cannot engage in sexual intercourse, kiss someone, or seek medical or dental care without exposing their partner or health care provider to this possibly deadly virus."⁴⁴

It has been conservatively speculated that twenty-five to fifty percent of the persons initially infected with the AIDS virus will develop full-blown AIDS.⁴⁵ What awaits the remainder of those

contact with his younger brother. *Id.* at 752. While the parents remained free from infection, the older brother repeatedly tested positive for AIDS antibodies and had developed some clinical signs of AIDS infection. *Id.* at 753. Doctors looked for other possible sources of infection. *Id.* They discovered that the younger brother had bitten the older brother earlier, but the bite was relatively superficial and caused no bleeding. *Id.* Because the older brother had never received a blood transfusion himself and was never sexually abused, researchers concluded that the "most plausible explanation" for the child's infection was "horizontal transmission" of the virus from his sibling. *Id.*

37. *Id.* at 751 (reviewing relevant research).

38. *Id.* For specific studies see Fischl, Dickinson, Scott, Klimas, Fletcher & Parks, *Evaluation of Heterosexual Partners, Children and Household Contacts of Adults with AIDS*, 257 J. AM. MED. A. 640 (1987); Friedland, Saltzman & Rodgers, *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).

39. Redfield, Markham, Salahuddin, Sarnagadharan, Bodner, Folks, Ballou, Wright & Gallo, *Frequent Transmission of HTLV-III Among Spouses of Patients with AIDS-Related Complex & AIDS*, 253 J. AM. MED. A. 1571, 1572-1573 (1985).

40. See MERCK MANUAL, *supra* note 1, at 292.

41. Gelman, *AIDS*, NEWSWEEK, Aug. 12, 1985, at 22.

42. G. ANTONIO, *supra* note 26, at 11.

43. For a discussion of the responsibility of the Center for Disease Control, see S. PANEM, *THE AIDS BUREAUCRACY* 39-44 (1988).

44. G. ANTONIO, *supra* note 26, at 11 (citing draft federal regulations in 34 MORBIDITY & MORTALITY WEEKLY REP. 1-5 (1985)).

45. See Coedert & Blattner, *The Epidemiology of AIDS & Related Conditions*, in *AIDS: ETIOLOGY, DIAGNOSIS, TREATMENT, & PREVENTION* 23 (1985). Doctors are uncertain how many people, who are infected but presently asymptomatic, will eventually develop full-blown AIDS. *Id.* Early studies suggested that the cumulative incidence of

infected is unknown. The lengthy incubation period of the virus has made it difficult to determine their ultimate prognosis, but it is always important to remember that all infected persons have the potential to transmit the disease and infect others.⁴⁶

C. WHAT MEDICAL TECHNOLOGY HAS TO OFFER AIDS PATIENTS

At present, medical treatment for people with AIDS is confined to treating the "opportunistic diseases" that take advantage of the deficient immune response and enter these individuals' bodies.⁴⁷ Goals for the medical community include the following: 1) destroying the AIDS virus within the body, 2) rebuilding the immune system, and 3) immunizing against any further infection.⁴⁸ However, at the present time, medical science is incapable of accomplishing these goals.⁴⁹ The mutability of the virus creates severe problems for the development of a vaccine that would provide full protection from all strains.⁵⁰ Furthermore, knowledge of how to rebuild the immune system does not currently exist.⁵¹ Thus, many scientists believe that the best that can be hoped for is

AIDS in people infected with the virus ranged from four to twenty-nine percent. *Id.* Others suggest higher figures, perhaps thirty percent developing AIDS within seven years. See Hessel, Rutherford & O'Malley, *The Natural History of Human Immunodeficiency Virus Infection in a Cohort of Homosexual and Bisexual Men: A 7-Year Prospective Study*, ABSTRACTS, III International Conference on AIDS, Washington, D.C., June 1-5, 1987, cited in Allen & Curran, *Prevention of AIDS and HIV Infection: Needs and Priorities for Epidemiologic Research*, 78 AM. J. PUB. HEALTH 381 (1988). A committee of the National Academy of Sciences recently predicted that as many as fifty percent of all people infected with the AIDS virus could develop acute AIDS within ten years. *Federal Efforts on AIDS Criticized as Gravely Weak*, N.Y. Times, October 30, 1986, at A1, col. 1. An even more recent German study placed the number even higher, estimating that seventy-five percent of those infected will develop full-blown AIDS within seven years. *German survey's gloomy outlook*, 324 NATURE 199 (1986).

46. Coolfont Report: *A PHS Plan for Prevention & Control of AIDS & the AIDS Virus*, 101 PUB. HEALTH REP. 341, 342 (1986). See also *AIDS Incubation Time Longer Than Expected*, AM. FAM. PHYSICIAN, May 1989, at 392.

47. Ford & Quam, *AIDS Quarantine: The Legal and Practical Implications*, 8 J. LEGIS. MED. 353, 360 (1987). There is no drug to combat the AIDS virus yet, but doctors are working toward finding one. See *Clinical Trials begin for Promising Antibiotic*, 116 NEW SCI. 33 (1987); *Combination of Drugs May be More Effective*, 114 NEW SCI. 24 (1987); Cooper, *Controlled Clinical Trials of AIDS Drugs: The Best Hope*, 261 J. AM. MED. A. 2445 (1989); Marx, *AIDS Drugs—Coming But Not Here*, 244 SCI. 287 (1989); Newmark, *AIDS drug trials to start amid controversy*, 327 NATURE 449 (1987).

48. Ford & Quam, *supra* note 47, at 360. See also Barnes, *AIDS Vaccine Trial Expanded*, 239 SCI. 457 (1988); Bloom, *AIDS Vaccine Strategies*, 327 NATURE 193 (1987); Edwards, *Human Test of AIDS Vaccine Approved*, 132 SCI. NEWS 116 (1987); *Human Trials of AIDS Vaccine Leapfrog Animal Tests*, 115 NEW SCI. 16 (1987); Kingman, *The Quest for an AIDS Vaccine*, 115 NEW SCI. 24 (1987); Weisburd, *AIDS Vaccines: The Problems of Human Testing*, 131 SCI. NEWS 329 (1987); Weisburd, *AIDS Vaccine: Time for Human Tests?*, 131 SCI. NEWS 213 (1987); Weiss, *AIDS Vaccine: Preliminary but Promising*, 135 SCI. NEWS 375 (1989).

49. Ford & Quam, *supra* note 47, at 360.

50. Weisburd, *Will There Be an AIDS Vaccine?*, 131 SCI. NEWS 297-99 (1987).

51. *Id.*

to keep additional individuals from becoming infected and to learn to treat the opportunistic diseases more efficiently in order to keep those people with AIDS alive.⁵²

III. TESTING FOR EXPOSURE TO HTLV-III

A simple test has been developed to detect the presence of antibodies formed in response to exposure to HTLV-III.⁵³ This test is called the enzyme-linked immunosorbent assay test (ELISA).⁵⁴ ELISA is primarily used for screening donated blood as a means of preventing the transmission of the virus through medically supervised blood transfusions.⁵⁵ This test may be useful if made available through individual physicians and health departments for individuals interested in voluntary screening.⁵⁶ ELISA is intended only for screening purposes and has no diagnostic or predictive value in determining who will develop full-blown AIDS.⁵⁷

The ELISA test is not 100% accurate. There is, however, a second test known as the Western Blot which is nearly 100% accurate in detecting antibodies to HTLV-III.⁵⁸ In blood bank

52. Ford & Quam, *supra* note 47, at 360-61. See also *New Hope for AIDS Patients with Pneumocystis Pneumonia*, NURSING, Feb. 1988, at 14. AZT and other drugs now give AIDS positive clients a chance to prolong life. See *Number of N.D., Minnesota AIDS Cases Will Increase*, Grand Forks Herald, Jan. 21, 1990, at 4B, col. 1.

53. As a viral infection, HTLV-III triggers an immune response which includes the production of antibodies which attempt to destroy the virus. MERCK MANUAL, *supra* note 1, at 292. Rather than directly detecting the presence of the virus, the AIDS blood tests detect the presence of antibodies and by inference the person testing positive would have been exposed to the virus. *Id.* See generally ACQUIRED IMMUNE DEFICIENCY SYNDROME & OTHER MANIFESTATIONS OF HIV INFECTION: EPIDEMIOLOGY, ETIOLOGY, IMMUNOLOGY, CLINICAL MANIFESTATIONS, PATHOLOGY, CONTROL, TREATMENT & PREVENTION, *supra* note 21.

The length of time required before the presence of antibodies to the HTLV-III virus can be detected is uncertain but is estimated to be at between six days to eight weeks. Closen, Conner, Kaufman & Wojick, *AIDS: Testing Democracy—Irrational Response to the Public Health Crisis and the Need for Privacy in Serologic Testing*, 19 J. MARSHALL L. REV. 835, 871-72 (1986). Thus, antibodies will not be present early in the course of exposure to HTLV-III. *Id.* See also *AIDS Virus May Lie Hidden*, 122 NEW SCI. 27 (1989); Hazeltine, *Silent HIV Infections*, 320 NEW ENG. J. MED. 1487 (1989); Imagawa, Moon, Lee, Wolisky, Sano, Morales, Kwok, Sninsky, Nishanian, Giorgi, Fahey, Dudley, Visscher & Detis, *Human Immunodeficiency Virus Type 1 Infection in Homosexual Men who Remain Seronegative for Prolonged Periods*, 320 NEW ENG. J. MED. 1458 (1989); *Time from Infection to AIDS Computed*, 132 SCI. NEWS 136 (1987); Weiss, *HIV Can Linger Years with No Antibodies*, 135 SCI. NEWS 340 (1989).

54. See Closen, Conner, Kaufman & Wojick, *supra* note 53, at 872.

Further, a new test exists that takes approximately five minutes, but its uses may be somewhat more restricted than the ELISA test. See *Five-Minute HIV Test Now Available*, 39 AM. FAM. PHYSICIAN, Mar. 1989, at 403; *Quick HIV Test Has Limited Uses*, 52 R.N. 137 (1989).

55. Closen, Connor, Kaufman & Wojick, *supra* note 53, at 872.

56. See *id.*

57. *Id.* at 871.

58. Closen, Connor, Kaufman & Wojick, *supra* note 53, at 873.

screening, any strongly positive ELISA test is first repeated and then followed by a Western Blot for confirmation.⁵⁹

However, because no test is absolutely perfect, either due to accidental positivity produced by structurally similar but unrelated antibodies, difference in test kits, or lab technician error,⁶⁰ false positive results are possible with either test.⁶¹ A false positive result occurs when the person tests positive but in fact is not carrying the virus.

Moreover, the ELISA test loses its accuracy when applied to a population with a low reservoir of infection.⁶² Accordingly, the application of the ELISA test to a general population would create a high ratio of false positives.⁶³ Thus, effective screening programs should take place in a setting where there is a high reservoir of infection as well as a high likelihood of transmission.⁶⁴ However, the groups with a high reservoir of infection are difficult to identify, as all homosexuals and bisexuals cannot be identified by simply looking at them. Nor can IV drug users be readily identified, as many are not even detected in employment situations by observation alone.⁶⁵ Although the test may have a high false positive rate when applied to the general population, this problem could be

59. *Id.* The Western Blot is more expensive than the ELISA test and is therefore not used for initial screening purposes. *Id.* For more information on blood bank screening, see Stankaitis & Bigos, *HTLV III/LAV Screening and Blood Banking*, 77 AM. J. PUB. HEALTH 239 (1987).

60. Closen, Connor, Kaufman & Wojick, *supra* note 53, at 874.

61. See *Alarm Over False Positives*, 117 NEW SCI. 25 (1988). The reliability of the Western Blot has also been challenged, as it too has the possibility of yielding false positive results. Saag & Britz, *Asymptomatic Blood Donor with a False Positive HTLV-III Western Blot*, 314 NEW ENG. J. MED. 118 (1986). See also Zolla-Pazner, Gorny, Itonnen & Pinter, *Reinterpretation of Human Immunodeficiency Virus Western Blot Patterns*, 320 NEW ENG. J. MED. 1280 (1989).

A false negative result is also possible. See Closen, Connor, Kaufman & Wojick, *supra* note 53, at 874. Such a result would occur when the person had been in fact exposed to the virus, but the test does not so indicate. *Id.* False negatives are rare (about 1%). *Id.* Explanations for false negative results include error in administration of the test, as well as the time differential between exposure and development of antibodies. *Id.* at 875. See also Church, *False-Negative HIV Antibody Tests Occur in Children*, AM. FAM. PHYSICIAN, Mar. 1987, at 255.

62. See *False-Positive HIV Tests in Low-Risk Populations*, AM. FAM. PHYSICIAN, Mar. 1989, at 353. "Screening programs in large populations with a predictably low frequency of infection, such as pre-marital screening, have a number of disadvantages: a large number of people will have their privacy unnecessarily invaded; procedures will have to be adopted to keep a large amount of health care data confidential; and a significant amount of scarce resources will be expended." Gostin, Curran & Clark, *The Case Against Compulsory Casefinding in Controlling AIDS—Testing, Screening, & Reporting*, 12 AM. J. L. & MED. 7, 21 (1986).

63. Gostin, Curran & Clark, *supra* note 62.

64. *Id.*

65. See generally *id.* Furthermore, to identify these high risk populations by selectively testing them would stigmatize them, automatically labeling them as being "at risk," whereas testing them along with everyone else would not single them out as "in danger" or a "threat" to others. *Id.*

minimized by doing a follow-up Western Blot test for those testing positive with the ELISA.

Nevertheless, some amount of false positives may be acceptable because medical science would prefer to err on the side of caution and, to the fullest extent possible, prevent the continuing spread of the virus.⁶⁶ In contrast, the legal system may not be able to give deference to this medical caution. It is important to remember that the general population may perceive testing as privacy invasive and implicate the constitution to protect their privacy from governmental interference.⁶⁷

IV. REPORTABILITY OF RESULTS OF VOLUNTARY TESTING

Currently all that has been done on a national scale is surveillance of full-blown AIDS cases.⁶⁸ Surveillance provides data on the prevalence, incidence, and distribution of infection in the population.⁶⁹ In all states, AIDS cases must be reported promptly to local and state health authorities under guidelines from the Center for Disease Control.⁷⁰

Statistical and research techniques used by epidemiologists make it possible to gauge trends in the spread of disease without the need to report each case.⁷¹ However, in order to understand the spread of HTLV-III into the population, it is desirable to have a more complete reporting scheme so more can be learned about the epidemiology of the disease.⁷² Some states have taken steps to

66. In light of such caution, the Center for Disease Control has recommended that a positive antibody test be interpreted under the following assumptions: the virus is present and is transmissible to others, and in the absence of any effective treatment to destroy the presence of the virus in the body, the individual remains infected and capable of transmitting the disease for life. G. ANTONIO, *supra* note 26, at 11.

67. See generally Comment, *Protecting Confidentiality in the Effort to Control AIDS*, 24 HARV. J. ON LEGIS. 315 (1986).

68. There are criteria that physicians look for in order to classify a patient as having full-blown AIDS. For such criteria see *Centers for Disease Control, Revision of the Case Definition of Acquired Immunodeficiency Syndrome for National Reporting—United States, reported in* 34 MORBIDITY & MORTALITY WEEKLY REP. 373-75 (1985). See also *Survey Shows HIV Reporting Practices in 50 States*, 79 J. PUB. HEALTH 581 (1989); Weiss, *Tabulating the Numbing Numbers . . . And Applying Them to Public Policy*, 135 SCI. NEWS 382 (1989).

69. Weiss, *supra* note 68, at 382.

70. Comment, *supra* note 67, at 338.

71. INSTITUTE OF MEDICINE & NATIONAL ACADEMY OF SCIENCES, *CONFRONTING AIDS: DIRECTIONS FOR PUBLIC HEALTH, HEALTH CARE, AND RESEARCH* 118 (1986) [hereinafter *CONFRONTING AIDS*].

72. Comment, *supra* note 67, at 317-18.

require the reportability of positive test results.⁷³

Colorado has lead the way in AIDS control regulation. In 1985, the State Board of Health made it a requirement that a positive AIDS antibody test result be reported to the local departments of health.⁷⁴ Under that regulation, the local health department must convey the information to the Epidemiology Division of the Department of Health.⁷⁵ The purpose of the regulation was:

a) to alert responsible health agencies to the presence of persons likely to be infected with a highly dangerous virus;

b) to allow responsible health agencies to ensure that such persons are properly counseled as to the significance of their laboratory test, and as to what they need to do to prevent further transmission of the virus;

c) to allow responsible health agencies to monitor the occurrence and spread of infection with this virus in the population of Colorado;

d) to allow responsible health agencies to identify and contact persons with likely or proven HTLV-III infection when specific anti-viral treatment becomes available.⁷⁶

The following year, the Board of Health and the Denver Department of Health and Hospitals instituted regulation of the operation of bath houses and similar establishments.⁷⁷ Finally, the Colorado Legislature codified the antibody test reporting requirements and implemented the requirement of confidentiality in

73. See, e.g., 17 N.J. ADMIN. REG. 784-85 (April 1, 1985), as a proposed amendment to N.J. ADMIN. CODE tit. 8 § 57 (1.2)(this bill was tabled); N.J. S. 3104 (pending).

A reporting requirement for positive HTLV-III antibody tests would enable public health officials to keep records of those who are infected, and therefore, capable of transmitting HIV. Gostin, Curran & Clark, *supra* note 62, at 52. Infected individuals are at least as (if not more) likely to engage in behavior leading to the spread of the virus than are individuals with full-blown AIDS. *Id.* An asymptomatic carrier is often more physically able to enter into sexual relationships than is a person who actively exhibits AIDS-related symptoms. *Id.*

74. 6 COLO. CODE REGS. § 1009-1 (1988). For a discussion of Denver's program, see Judson & Vernon, *The Impact of AIDS on State and Local Health Departments: Issues and a Few Answers*, 78 AM. J. PUB. HEALTH 387 (1988).

75. 6 COLO. CODE REGS. § 1009-1 (1988).

76. COLO. DEPT. OF HEALTH, STATEMENT OF BASIS AND PURPOSE OF THE COLORADO HTLV-III REPORTING REGULATION.

77. Rules and Regulations to Minimize Transmission of the HTLV-III Virus in Certain Establishments within the City and County of Denver, DENVER, COLO. REV. MUN. CODE Ch. 24, § 16(6) (1986).

1987.⁷⁸ Further, the confidentiality protections of the Colorado legislation was based on a suggested model of the Centers for Disease Control.⁷⁹ According to the legislation, the reports of positive test results may not be released, shared, or made public "upon subpoena, search warrant, discovery proceedings, or otherwise."⁸⁰

Colorado and other states with this type of reporting scheme are obtaining data about the incidence of the infection in their respective states.⁸¹ However, data obtained from these reporting schemes do not necessarily reflect the extent of infection across the country.⁸² As long as states have different policies, some people might choose a jurisdiction offering the test on an anonymous basis, skewing the results.⁸³

V. PROPOSALS FOR MANDATORY SCREENING

One way to insure the availability of data to more accurately monitor the spread of the disease would be to require individuals to undergo testing and to keep track of their test results for scientific purposes. Mandatory screening for exposure to the virus is most often mentioned by those calling for stronger measures to protect the public from the spread of AIDS.⁸⁴ Some compulsory screening for exposure to the virus has already been initiated.⁸⁵ To date, the largest scale implementation of mandatory AIDS testing has been in the military.⁸⁶

78. COLO. REV. STAT. § 25-4-1401 to § 25-4-1410 (Supp. 1987).

79. Vernon, *Colorado's Promising "Model" for AIDS Control*, 65 DENVER U. L. REV. 109, 113 (1988).

80. COLO. REV. STAT. § 25-4-1404 (Supp. 1987).

81. Colorado has justified its requirement that names be included in official reports as necessary to track incidence and patterns of the disease. See N.Y. Times, Sept. 30, 1985, at B8, col. 3. North Dakota's testing program is similar to Colorado's. Interview with Del Streitz, Epidemiologists, North Dakota State Health Department, in Grand Forks, N.D. (Dec. 10, 1989). Names of tested individuals and their results are recorded at the state level. *Id.* There are ten testing sites throughout the state. *Id.* No records besides a consent form is maintained at the ten testing sites. *Id.* These records are nonsubpoenable. *Id.*

82. CONFRONTING AIDS, *supra* note 71, at 119.

83. *Id.*

84. In 1987, thirty-two states considered bills on mandatory HTLV-III testing. Breo, *States Swamped with AIDS Bills*, AM. MED. NEWS, June 26, 1987, at 1, 25. The Soviet Union adopted strict new measures against the spread of AIDS, including mandatory testing of anyone officials suspect of carrying the AIDS virus. The guidelines include prison terms for carriers who knowingly infect others. *AIDS in the Soviet Union*, HUM. RTS., Fall 1987 at 15.

85. The city of Nashville requires screening of all potential massage parlor employees. *Illinois to Set Up Sites for AIDS Tests*, AM. MED. NEWS, Oct. 25, 1985, at 43. Further, Nevada requires monthly screening of all prostitutes. *Prostitutes to Undergo HTLV-III Testing*, AM. MED. NEWS, April 4, 1986, at 34.

86. *Plebes to be Tested for AIDS Antibody*, AM. MED. NEWS, Mar. 14, 1986, at 42. The federal government has also initiated mandatory screening programs for foreign service applicants, officers, and their dependents. Berke, *State Department to Begin AIDS Testing*, N.Y. Times, Nov. 29, 1986, at 49, col. 1.

A. MILITARY TESTING

Screening is required by the military for all recruits and enlisted personnel.⁸⁷ Although no recruit is forced to submit to the test, since he or she may simply decide not to join the military rather than allow the extraction of blood, military personnel who refuse to take the antibody test are subject to being court-martialed.⁸⁸ Further, military personnel who test positive are discharged.⁸⁹ Occasionally, the individual's seropositivity is even listed on the discharge, and thus, may subject the individual to discrimination.⁹⁰

Even though the penalties may be high for some of the individuals who are unfortunate enough to test positive for the HTLV-III virus, the extraction of blood and its laboratory examination is not unreasonable in comparison to the military's goals: to maintain a healthy fighting force⁹¹ and to ensure that all members of the military are capable of providing blood transfusions in times of combat.⁹² By excluding all who have been exposed, those likely to develop and spread the disease by transfusion are excluded.

B. NORTH DAKOTA'S TESTING LAWS

Beyond the military, the application of mass testing has been questioned.⁹³ North Dakota recently implemented mandatory testing laws in cases with certain convicted individuals⁹⁴ and those testing positive for sexually transmitted diseases.⁹⁵

1. *Prisoners, Sex Offenders, and Those Convicted of Crimes Involving the Use of Controlled Substances*

North Dakota recently passed a statute providing for AIDS testing of inmates and certain individuals convicted of sex offenses

87. *Plebes to be Tested for AIDS Antibody*, *supra* note 86, at 42. For information on the incidence of AIDS among civilian applicants in the military, see Burke, Brundage, Herbold, Bemer, Gardner, Gunzenhauser, Voskovitch & Redfield, *Human Immunodeficiency Virus Infections Among Civilian Applicants for United States Military Service, October 1985 to March 1986: Demographic Factors Associated with Seropositivity*, 317 NEW ENG. J. MED. 131 (1987).

88. Punishment may range from a discharge for improper conduct to a six month prison term. See *Sailor Refuses to Take Antibody Test*, *ADVOC.*, June 10, 1986, at 20, col. 1.

89. See *Pentagon Bars 66 After AIDS Test*, *N.Y. Times*, Nov. 27, 1985, at 11, col. 2.

90. Byron, *The Hidden Risks of Antibody Screening: This is Not Only a Test*, *Village Voice*, May 27, 1986, at 29, col. 1, 2.

91. *Plebes to be Tested for AIDS Antibody*, *supra* note 86, at 42.

92. *Id.*

93. See, e.g., Bayer, Levine & Wolf, *HIV Antibody Screening: An Ethical Framework for Evaluating Proposed Programs*, 256 J. AM. MED. A. 1768 (1986).

94. N.D. CENT. CODE § 23-07-07.5 (Cum. Supp. 1989).

95. N.D. CENT. CODE § 23-07-07 (Cum. Supp. 1989).

or offenses involving the use of controlled substances.⁹⁶ Every individual convicted of a crime who is imprisoned for fifteen days or more in a grade one or grade two jail, a regional correctional facility, or the state penitentiary is to be tested.⁹⁷ Testing of inmates is supported because of the high levels of homosexual activity and intravenous drug use in the inmate population.⁹⁸ Moreover, testing may help prevent transmission of the AIDS virus by identifying inmates who require special services, *e.g.*, health care, isolation, or other precautionary measures.⁹⁹ Although voluntary testing may be effective, it is thought to pose the risk of missing those who are infected and may refuse to submit to voluntary testing.¹⁰⁰

In addition to incarcerated prisoners, North Dakota requires those who are accused of certain sexual offenses, *e.g.*, sexual assault, deviate sexual acts, adultery, and incest, although not jailed to be tested.¹⁰¹ The report of the North Dakota Legislative Council reasoned that sex offenders may force themselves on other unwilling individuals and may be a population at risk.¹⁰²

Finally, North Dakota law requires HIV testing for those convicted of a crime involving controlled substances and the use of any type of syringe or hypodermic needle¹⁰³ because intravenous drug users have been shown to be a population at risk.¹⁰⁴ These individuals may spread the AIDS virus to others either through their sexual behavior or needle sharing.¹⁰⁵

2. *Persons with Sexually Transmitted Diseases*

In addition to testing the criminal population, other individuals may be subject to AIDS testing under North Dakota law.¹⁰⁶

96. N.D. CENT. CODE § 23-07-07.5(1)(a-c) (Cum. Supp. 1989). The results of the tests must be reported to the state department of health. *Id.*

97. For a review of prisoner testing and the constitutional issues involved in this type of testing, see Gostin, Curran & Clark, *supra* note 62, at 39-45; Closen, Connor, Kaufman & Wojick, *supra* note 53, at 835, 912-15.

98. LEGISLATIVE COUNCIL REPORT OF NORTH DAKOTA: JUDICIARY COMMITTEE, *Study of Legal Issues Associated with AIDS in North Dakota*, 143, 145-46 (1989) [hereinafter COUNCIL REPORT].

99. COUNCIL REPORT, *supra* note 98, at 145-46.

100. *Id.* at 145.

101. N.D. CENT. CODE § 23-07-07.5(1)(b) (Cum. Supp. 1989).

102. COUNCIL REPORT, *supra* note 98, at 145-46.

103. N.D. CENT. CODE § 23-07-07.5(1)(c) (Cum. Supp. 1989).

104. See *supra* note 31 and accompanying text.

105. See, *e.g.*, Joyce & Kingman, *Shared Needles Spread AIDS to Heterosexuals*, 114 NEW SCI. 27 (1987).

106. North Dakota has also passed statutes dealing with testing blood for the AIDS virus. See N.D. CENT. CODE § 23-07-02.1 to 23-07-07.5 (Cum. Supp. 1989). In addition, anatomical parts testing is authorized. See N.D. CENT. CODE § 23-06.2-11.1 (Cum. Supp.

North Dakota requires those individuals testing positive for other sexually transmitted diseases such as syphilis or herpes to be tested for the presence of the AIDS virus.¹⁰⁷

In cases where contact tracing is thought to be appropriate, the known sexual partners of an individual infected with the disease may be notified.¹⁰⁸ Further, individuals who either have been or may be exposed to this individual in a manner that creates a risk of transmission may be notified.¹⁰⁹ What that appears to mean is notification not only covers sexual partners, but also potential needle sharers, as needle-sharing also creates an "epidemiologically demonstrated risk of transmission."¹¹⁰ Testing such individuals is felt to be appropriate because the number of AIDS cases is expected to increase in groups at risk for other sexually transmitted diseases.¹¹¹

This North Dakota statute also has specific implications for prostitutes because it authorizes the examination of "any person reasonably suspected of being infected with a sexually transmitted disease."¹¹² Once these individuals test positive for a sexually transmitted disease, they may then be tested for the presence of the AIDS virus.¹¹³ Moreover, prostitutes may be a conduit for spreading AIDS into the heterosexual population¹¹⁴ by engaging

1989). For information regarding tissue testing, see, e.g., *Semen Banking, Organ and Tissue Transplantation, and HIV Antibody Testing*, 259 J. AM. MED. A. 131 (1988).

107. N.D. CENT. CODE § 23-07-07(3) (Cum. Supp. 1989). However, this law contains no enforcement provision for those with a positive STD test who refuse HIV testing. *Id.* For further discussion of this type of testing, see Gostin, Curran & Clark, *supra* note 62, at 33-4.

108. N.D. CENT. CODE § 23-07-07(3)(a) (Cum. Supp. 1989). For a discussion of privacy issues implicated with contact tracing, see *infra* notes 228-51 and accompanying text. See also Kegeles, Catania & Coates, *Intentions to Communicate Positive HIV-Antibody Status to Sex Partners*, 1259 J. AM. MED. A. 216 (1988).

109. N.D. CENT. CODE § 23-07-07(3)(b) (Cum. Supp. 1989).

110. *Id.*

111. COUNCIL REPORT, *supra* note 98, at 145. For further information regarding the relationship between other sexually transmitted diseases and AIDS, see Brandt, *The Syphilis Epidemic and its Relation to AIDS*, 239 SCI. 375 (1988); Holmberg, Stewart, Gerber, Byers, Lee, O'Malley & Nehmias, *Prior Herpes Simplex Virus Type 2 Infection as a Risk Factor for HIV Infection*, 259 J. AM. MED. A. 1048 (1988); Poterat, *Does Syphilis Facilitate Sexual Acquisition of HIV?*, 258 J. AM. MED. A. 473 (1987); Raben, Kucera, Lyer, Kicafdo, Leate, Heise & Myrvik, *Transformed Human T-Cells Coinfected with Herpesvirus Type 2 and Human Immunodeficiency Virus*, 261 J. AM. MED. A. 1359 (1989); Tramont, *Syphilis in the AIDS Era*, 316 NEW ENG. J. MED. 1600 (1987); Weiss, *AIDS May Affect Course of Syphilis*, 131 SCI. NEWS 391 (1987); Wilkerson, Jordan & Kerkerling, *Herpes Zoster as a Sign of AIDS-Related Complex*, AM. FAM. PHYSICIAN, Oct. 1987, at 233.

112. N.D. CENT. CODE § 23-07-07(1) (Cum. Supp. 1989). Further, it authorizes the state health officer to use "every proper means for the repression of prostitution." *Id.* § 23-07-07(5).

113. N.D. CENT. CODE § 23-07-07(3) (Cum. Supp. 1989).

114. COUNCIL REPORT, *supra* note 98, at 146. See also *Antibody to Human Immunodeficiency Virus in Female Prostitutes*, 257 J. AM. MED. A. 2011 (1987); *Prostitutes Asked Not to Give Blood*, 114 NEW SCI. 23 (1987).

in high-risk sexual behavior or IV drug use.¹¹⁵

C. UNIVERSAL TESTING

North Dakota has taken an important step in controlling the spread of AIDS by selecting populations known to be at risk for contracting or transmitting the AIDS virus for testing.¹¹⁶ However, a mandatory screening program for the entire population could be implemented.

Every individual who becomes infected with HTLV-III has anywhere from a twenty-five to fifty percent chance of developing full-blown AIDS.¹¹⁷ Any additional infection is a horrible loss of human life. However, it is debatable whether a universal screening program is necessary to protect the uninfected population.

A universal screening program would seek to identify all infected individuals in order to educate them about how to prevent transmission to uninfected persons and to identify those who are not presently infected in order to educate them how to avoid behaviors that could place them at risk. Under this proposal, states would need to enact statutes to protect the confidentiality of sensitive information obtained during testing, counselling, and contact tracing.¹¹⁸ Only the establishment of trust in the privacy of public health programs could foster cooperation from vulnerable groups.¹¹⁹

Laws currently exist in some jurisdictions which provide the necessary authority to screen.¹²⁰ For example, Massachusetts allows public health officials to authorize mandatory public health measures.¹²¹ The Public Health Council and the Commissioner of Public Health are given the power to define what diseases shall be deemed "dangerous to the public health."¹²² Further, the council and commissioner are to "make such rules and regulations consistent with law for the control and prevention of such diseases as . . .

115. COUNCIL REPORT, *supra* note 98, at 146.

116. Other states have selected other groups to be tested. For example, Illinois had implemented a premarital screening program. See ILL. ANN. STAT. ch. 40, para. 204 (Smith-Hurd 1988). This statute no longer remains on the books, possibly because the cost to the couples seemed to influence their decisions to go out of the state to get their marriage licenses.

117. See *supra* note 45 and accompanying text.

118. Comment, *supra* note 67, at 315.

119. *Id.*

120. See, e.g., MASS. GEN. LAWS ANN. Ch. 111, § 6 (West 1983) (department of public health has power to define and control disease seemed dangerous to public health). See also N.D. CENT. CODE § 23-07.4-01 (Cum. Supp. 1989) (power of state health office to deal with HIV).

121. MASS. GEN. LAWS ANN. Ch. 111, § 6 (West 1983).

122. *Id.*

[are] advisable for the protection of the public health."¹²³

State courts have repeatedly upheld provisions for the mandatory testing of those reasonably suspected of having a contagious disease. For example, statutes providing for the mandatory testing of prostitutes for venereal disease have been repeatedly sustained.¹²⁴ Such measures have been tested against a reasonableness standard.¹²⁵

The United States Supreme Court has not addressed the issue of mandatory testing, but it has considered another compulsory public health measure once just as controversial but now readily accepted: vaccination. In *Jacobsen v. Massachusetts*,¹²⁶ the Supreme Court reviewed the constitutionality of a Massachusetts statute requiring a smallpox vaccine for all residents.¹²⁷ The Court upheld the state's rights to enact mandatory vaccination laws based upon its inherent police power, which "must be held to embrace, at least, such reasonable regulations established directly by legislative enactment as will protect the public health and safety."¹²⁸ However, such regulations could not "contravene the Constitution of the United States, or infringe any right granted or secured by that instrument."¹²⁹

The Court found that the Massachusetts vaccination statute applied to everyone and was based upon the informed judgment of the appropriate health officials.¹³⁰ The Court was unwilling to second guess the judgment of state officials as to the need for the regulation, and stated:

Upon the principle of self-defense, of paramount necessity, a community has the right to protect itself against an epidemic of disease which threatens the safety of its members. . . . Smallpox being prevalent and increasing . . . the court would usurp the functions of another branch of government if it adjudged, as a matter of law, that the mode adopted under the sanction of the State, to protect

123. *Id.*

124. *See, e.g.*, *Ex Parte Woodruff*, 210 P.2d 191 (Okla. 1949) (holding that statutes requiring physical examination of person arrested for sex crimes are reasonable). Based upon health authorities experience, courts have found it probable that prostitutes might be infected with such diseases for the nature of their occupation implies that they would indulge in repeated sexual acts with various partners. *Id.*

125. *See infra* notes 126-132 for a discussion of *Jacobsen v. Massachusetts* and a definition of reasonableness standards.

126. 197 U.S. 11 (1905).

127. *Jacobsen v. Massachusetts*, 197 U.S. 11, 12 (1905).

128. *Id.* at 25 (citations omitted).

129. *Id.*

130. *Id.* at 27.

the people at large, was arbitrary and not justified by the necessities of the case. We say necessities of the case, because it might be that an acknowledged power of a local community to protect itself against an epidemic threatening the safety of all, might be exercised in particular circumstances and in reference to particular persons in such an arbitrary, unreasonable manner, or might go so far beyond what was reasonably required for the safety of the public, as to authorize or compel the courts to interfere for the protection of such persons.¹³¹

The Supreme Court noted that although some renowned physicians believed that vaccination was not a proper measure to fight smallpox, the majority of citizens, as well as many members of the medical profession, believed that such legislation was appropriate:

The fact that the belief is not universal is not controlling, for there is scarcely any belief that is accepted by everyone. The possibility that the belief may be wrong, and that science may yet show it to be wrong, is not conclusive; for the legislature has the right to pass laws which, according to the common belief of the people, are adapted to prevent the spread of contagious diseases. In a free country, where the government is by the people, through their chosen representatives, practical legislation admits of no other standard of action; for what the people believe is for the common welfare must be accepted as tending to promote the common welfare, whether it does in fact or not.¹³²

The *Jacobsen* Court applied a rational basis test, simply looking for a rational relationship between the vaccination and the legislature's goal of decreasing the incidence of smallpox. Since that decision, courts have generally required a more exacting standard than simply reasonableness when fundamental rights have been implicated.¹³³ Moreover, some commentators have indicated that

131. *Id.* at 27-28 (citations omitted).

132. *Id.*

133. See G. GUNTHER, CONSTITUTIONAL LAW 587 (1985) (an individual's guarantee of equal protection may also be implicated for the fourteenth amendment guarantees that similarly situated persons will not be treated differently under the law).

Traditional equal protection analysis requires only minimal judicial intervention and great deference to the states. See *id.* Under this minimal scrutiny, classifications are permitted so long as the state's means are rationally related to the legitimate state end. *Id.* However, when a state creates a suspect classification, e.g., based on race or national origin, or classification that impairs a fundamental right, e.g., the right to privacy, courts apply

now courts should apply strict scrutiny to such health measures because of the important privacy interests at stake.¹³⁴

VI. CONSTITUTIONAL ANALYSIS

Privacy rights have often been the subject of legal disputes. Because the constitution does not explicitly guarantee citizens the right to privacy, the Supreme Court has searched the penumbras of the constitution to find a way to protect what to many seems to be a fundamental or natural right "to be let alone."¹³⁵ Emanations from the first, fourth, fifth, sixth, and ninth amendments have provided the Court with a basis for finding a privacy right,¹³⁶ as well as the fourteenth amendment's guarantee of due process.¹³⁷ Some commentators have suggested that the Supreme Court would apply the highest level of scrutiny to a state's testing program because of the importance of the individual rights affected by such program — one being the right to informational privacy.¹³⁸ Further, if strict scrutiny were applied, it would require a state prescribing mandatory AIDS testing to prove a compelling interest justifying the measure and that no less intrusive means exist that would combat the spread of the disease as effectively as mandatory testing.¹³⁹

A. STATE INTERESTS

The underlying goal of any legislation requiring mandatory testing and reporting to the Center of Disease Control is to reduce the possible incidence of AIDS. However, there are at least five specific objectives that may be articulated in favor of mandatory

strict scrutiny. *Id.* at 588. Strict scrutiny requires that the classification be necessary to satisfy a compelling state interest. *Id.*

Many have argued that the emergence of AIDS has created a discrete and insular minority. *See, e.g.,* Comment, *Reportability of Exposure to the AIDS Virus: An Equal Protection Analysis*, 7 CARDOZO L. REV. 1103, 1115-1129 (1986). Any mandatory testing would divide the population into two groups, *e.g.,* those who have tested positive for the HTLV-III and those who have not. As a consequence, a burden is placed upon the HTLV-III positive group that is not placed on the second group. *Id.* However, the Supreme Court has been reluctant to extend suspect or semi-suspect classification to other groups, such as the aged or to the mentally retarded; thus, it is unlikely that the Supreme Court would consider gays, hemophiliacs, or intravenous drug users (members of the groups considered to be at high risk for contracting AIDS) to be members of a suspect classification.

134. *See* Note, *The Constitutional Rights of AIDS Carriers*, 99 HARV. L. REV. 1274, 1282-84 (1986) (discussing the level of scrutiny applicable to public health regulations).

135. *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting).

136. *Griswold v. Connecticut*, 381 U.S. 479, 484-485 (1965).

137. *Griswold v. Connecticut*, 381 U.S. 479, 502 (1965) (White, J., concurring).

138. *See* Comment, *supra* note 133, at 1124.

139. *Id.*

testing.¹⁴⁰ First, the state would want to alert responsible health agencies to the presence of persons likely to be infected with the virus.¹⁴¹ This reflects the state's need to keep a running list of all those infected in order to form an accurate picture of just how many of its citizens are infected. Because a person who tests positive has the capacity to transmit the virus, such a list would be useful in predicting just how many people could be expected to become infected if the disease were to be allowed to spread without restriction.

Second, such legislation would ensure that persons who were infected were properly counseled as to the significance of the results of their laboratory tests.¹⁴² Educational information should be given to individuals who test positive,¹⁴³ as well as to those who test negative, as everyone plays a significant role in eliminating the spread of the disease.

140. This discussion is based on the objectives of the Colorado legislation adopted to make it compulsory for positive blood tests to be reported to the appropriate health officials. See *supra* notes 74-80 and accompanying text. See also Comment, *supra* note 133, at 1131 (discussing four purposes of the Colorado legislation requiring health officials to report the results of those who test positive for exposure to the virus).

141. Comment, *supra* note 133, at 1131.

142. *Id.*

143. Little is known about individuals' short and long term adjustments to learning that they are seropositive. The ability to handle such information depends upon an individual's personality and social support network, as well as on the social and political context. See BAUMGARTNER, AIDS: PSYCHOSOCIAL FACTORS IN THE ACQUIRED IMMUNE DEFICIENCY SYNDROME (1985); Mandel, *Psychosocial Challenges of AIDS & ARC: Clinical & Research Observations*, in WHAT TO DO ABOUT AIDS: PHYSICIANS & MENTAL HEALTH PROFESSIONALS DISCUSS THE ISSUES (L. McKusick ed. 1986); Frierson & Lippmann, *Psychologic Implications of AIDS*, AM. FAM. PHYSICIAN, Mar. 1987, at 109; *Psychologic Effects of HIV Infection*, AM. FAM. PHYSICIAN, Mar. 1989, at 392; Tross & Hirsch, *Psychological Distress and Neuropsychological Complications of HIV Infection and AIDS*, 43 AM. PSYCHOLOGIST 929 (1988).

One study documented individuals' reactions to their diagnoses of AIDS or ARC. See Mandel, *supra*. Affective reactions to AIDS or ARC among the study participants soon after diagnosis were contrasted with reactions of a matched group of men diagnosed with cancer. All groups showed mean clinical levels of distress, anxiety, and depression. *Id.* See also Glass, *AIDS and Suicide*, 259 J. AM. MED. A. 1369 (1988); Marzuk, Tierney, Tarfeff, Gross, Morgan, Hsu & Mann, *Increased Risk of Suicide in Persons with AIDS*, 259 J. AM. MED. A. 1333 (1988).

However, few would argue with the idea that persons should know their antibody status, especially in light of the increased support for sharing a terminal diagnosis with competent, adult patients. See CONFRONTING AIDS, *supra* note 71, at 122. Furthermore, it is presumed that testing will lead to reductions in high risk behavior. Beneficial effects of informing individuals of their antibody status have been observed in experiments. For a discussion of such research, see Coates, Stall, Kegeles, Lo, Morin & McKusick, *AIDS Antibody Testing: Will It Stop the AIDS Epidemic? Will It Help People Infected with HIV?*, 43 AM. PSYCHOLOGIST 859, 860 (1988) [hereinafter *AIDS Antibody Testing*].

One study of homosexual men was conducted to determine attitude toward testing. See generally CONFRONTING AIDS, *supra* note 71. Seven hundred twenty-eight men in San Francisco were questioned about antibody testing. *Id.* Although contrary to the advice of leaders in the local community, who raised concerns about the potential emotional damage from testing, the possible breach of confidentiality, and the ambiguity of the test, 69.2% indicated that they would like to receive the test, because knowing whether they were infected would reduce anxiety or help them make decisions about behavior changes. *Id.*

Third, the health agencies would be allowed to monitor the occurrence and spread of infection within the population.¹⁴⁴ By testing a number of people and following them for a long period of time, the state may be able to discern the disease's patterns and to use that information in developing a vaccine and a cure for AIDS.

Fourth, responsible health agencies could identify and contact persons with HTLV-III infection when specific anti-viral treatment would become available.¹⁴⁵ Although currently there is no means to cure AIDS victims, there are ways to treat the opportunistic diseases which infect full-blown AIDS patients and to control the development of AIDS.¹⁴⁶ Thus, a list of such persons would be useful in getting medical health care to such individuals. In addition, although those affected with AIDS would become aware of the "ultimate cure" once the media publicized its development, experimental drugs could be made available and offer hope to such individuals.¹⁴⁷

Finally, a state could make estimates of the resources it would need to expend in the future by keeping track of the number of infected individuals.¹⁴⁸ Each AIDS case for which the state would become responsible would cost taxpayers approximately \$150,000¹⁴⁹ and would take a toll on hospital and other state health care resources.

The state has the "right to protect itself against an epidemic of disease which threatens the safety of its members."¹⁵⁰ However, a strong health objective alone does not guarantee that mandatory testing would be upheld. Although the Court upheld a statute prescribing vaccination for smallpox in *Jacobsen v. Massachusetts*,¹⁵¹ it also recognized that protection of the public health might "contravene the Constitution of the United States or infringe any right

144. Comment, *supra* note 133, at 1107 (discussion of the distribution of AIDS).

145. *Id.* at 1115.

146. See Brook, *Approval of Zidovudine (AZT) for Acquired Immunodeficiency Syndrome: A Challenge to the Medical and Pharmaceutical Communities*, 258 J. AM. MED. A. 1517 (1987) (discussing the use of AZT to control onset of AIDS-related syndrome).

147. For example, therapies such as zidovudine (AZT) therapy could be provided for persons with indications of extreme immunodeficiency. See Coates, Stall, Kegeles, Lo, Morin & McKusick, *supra* note 143, at 861. See also PHILOSOPHICAL DIMENSIONS OF PRIVACY: AN ANTHOLOGY (F. Schoeman ed. 1984); PRIVACY & HUMAN RIGHTS (A. Robertson ed. 1973); Fischl, *The Efficacy of Azidothymidine (AZT) in the Treatment of Patients with AIDS and AIDS-Related Complex*, 317 NEW ENG. J. MED. 185 (1987); Lane, *AIDS Patients with Kaposi's Sarcoma May Benefit from Zidovudine*, AM. FAM. PHYSICIAN, Sept. 1987, at 251.

148. See *infra* note 274 and accompanying text.

149. See *id.*

150. *Jacobsen v. Massachusetts*, 197 U.S. 11, 27 (1905).

151. *Jacobsen*, 197 U.S. at 11.

granted or secured by that instrument."¹⁵²

Thus, the health regulations and state objectives must be directly related. Although these five goals are admirable, a public health law must protect the health of the community with as few restrictions on the rights of individuals as possible. Individuals' privacy rights will certainly be implicated.¹⁵³ Therefore, such invasions would only be found permissible to the extent to which the Court would evaluate the importance of individual privacy rights and the quality of potentially less intrusive means available to ameliorate the spread of AIDS.

B. PSYCHOLOGICAL PRIVACY CONSIDERATIONS

The state's first step in justifying such an invasion is to articulate an important objective.¹⁵⁴ Protection of the public health would be an important objective. However, to uphold such a testing program, the Court would have to balance the important state objectives against important personal, privacy interests.¹⁵⁵ Those privacy interests are two-fold. First, the individual has an interest in preventing the state from learning whether or not he or she is seropositive, and second, once the state has obtained that information, the individual has an interest in to whom that information might be disclosed in the future.

There has been considerable social and legal concern about the informational aspect of privacy.¹⁵⁶ Today, individuals experi-

152. *Id.* at 25.

153. See generally Mawdsley, *Privacy Rights of AIDS Victims*, 31 W. EDUC. L. REP. 697 (1986).

154. See generally, G. GUNTHER, *supra* note 133, at 586-593.

155. *Id.*

156. For discussion of the informational aspect of privacy, see FREUND, *PRIVACY: ONE CONCEPT OR MANY IN PRIVACY* (J. Pennock & J. Chapman eds. 1971); JOURARD, *SELF DISCLOSURE: AN EXPERIMENTAL ANALYSIS OF TRANSPARENT SELF* (1971); RULE, MCADAM, STEARNS & UGLOW, *THE POLITICS OF PRIVACY: PLANNING FOR PERSONAL DATA SYSTEMS AS POWERFUL TECHNOLOGIES* (1980); Rovere, *The Invasion of Privacy: Technology and the Claims of Community*, 27 AM. SCHOLAR 416 (1968); Schwartz, *The Social Psychology of Privacy*, 73 AM. J. SOCIOLOGY 741 (1968); Silver, *Future of Constitutional Privacy*, 21 ST. LOUIS U. L. J. 211 (1977). See also Adams, *The Right to be Alone*, 17 U. FLA. L. REV. 597 (1965); Alshuler, *A Different View of Privacy*, 49 TEX. L. REV. 872 (1971); Altman, *Privacy: A Conceptual Analysis*, 8 ENVIR. & BEHAV. 7 (1976); Anastoplo, *Public Interest in Privacy: On Becoming & Being Human*, 26 DE PAUL L. REV. 767 (1977); Askin, *Surveillance: The Social Science Perspective*, 4 COLUM. HUM. RTS. L. REV. 59 (1972); Artigliere, *Privacy vs. Free Expression in Public Areas*, 28 U. FLA. L. REV. 588 (1976); Baistow, *Privacy Versus Freedom*, 79 NEW STATESMAN 108 (1970); Baker, *Posner's Privacy Mystery and the Failure of Economic Analysis of Law*, 12 GA. L. REV. 475 (1978); Barron, Warren & Brandies, *The Right to Privacy* 4, HARV. L. REV. 193 (1890); Demystifying a Landmark Citation, 13 SUFFOLK U. L. REV. 875 (1979); Bates, *Privacy—A Useful Concept?*, 42 SOC. FORCES 429 (1964); Bazelon, *Probing Privacy*, 12 CONZ. L. REV. 587 (1977); Beaney, *The Right to Privacy & American Law*, 31 LAW & CONTEMP. PROBS. 253 (1966); Beardley, *Privacy: Autonomy and Selective Disclosure*, in *PRIVACY* (J. Pennock & J. Chapman eds. 1971); Becker, *Human Being: The Boundaries of the Concept*, 4 PHIL.

ence an increasing loss of control over the circulation of personal information about themselves¹⁵⁷ because surveillance techniques have become more sophisticated.¹⁵⁸ What used to be respected as private has become public information:¹⁵⁹

Consider, for example, the vast amount of personal information one surrenders every time one is asked to fill out some form or another. That it is typically provided in a written form clearly involves a considerable loss of control over the circulation of such information, since writing necessarily entails — at least in theory — infinite reproducibility.¹⁶⁰

Whether an individual experiences such surveillance techniques as privacy invasive depends on a great many factors, some of which are inherent in the definition of privacy.¹⁶¹

Various definitions of privacy have been given.¹⁶² One defini-

PUB. AFFAIRS, 334 (1975); Behr, *Privacy: To Be Or Not To Be, That Is The Question*, 10 PAC. L. J. 663 (1979); Heckscher, *The Invasion of Privacy: The Reshaping of Privacy*, 28 AM. SCHOLAR 13 (1959); Jourard, *Some Psychological Aspects of Privacy*, 31 LAW & CONTEMP. PROBS. 307 (1966); Lee, *Individual Autonomy & Social Structure*, in FREEDOM & CULTURE (1959); Lusk, *Invasion of Privacy: A Clarification of Concepts*, 87 POL. SCI. Q. 192 (1972); Madge, *Privacy and Social Interaction*, 8 SOC. SCI. INFORM. 87 (1969); Marcell, *Privacy & the American Character*, 66 S. ATL. Q. 1 (1967); Symms & Hawks, *The Threads of Privacy: The Judicial Evolution of a "Right to Privacy" and Current Legislative Trends*, 11 IDAHO L. REV. 11 (1974); Verle, *The Protection of Privacy*, 79 POL. SCI. Q. 162 (1964); Willy, *Right to Privacy in Personal Medical Information*, 24 MED. TRIAL TECH. Q. 164 (1977).

For selected bibliographies of articles dealing with the concept of privacy, see LATIN, PRIVACY: A SELECTED BIBLIOGRAPHY AND TOPICAL INDEX OF SOCIAL SCIENCE MATERIALS (1976) and O'BRIEN, THE RIGHT OF PRIVACY—ITS CONSTITUTIONAL & SOCIAL DIMENSIONS: A COMPREHENSIVE BIBLIOGRAPHY (1980).

157. See generally Warren & Brandeis, *The Right to Privacy*, 4 HARV. L. REV. 193 (1890).

158. See generally A. WESTIN, PRIVACY & FREEDOM (1968).

159. See generally *id.*

160. Zerubavel, *Personal Information & Social Life*, 5 SYMBOLIC INTERACTION 97, 104 (1982).

161. See, e.g., Laufer & Wolfe, *Privacy as a Concept and a Social Issue*, 33 J. SOC. ISSUES 22 (1977).

162. In the psychological literature, privacy is often discussed in the context of self-disclosure. Self-disclosure is a member of a broader class of categories of self-reference. Fisher, *A Conceptual Analysis of Self-Disclosure*, 14 J. THEORY SOC. BEHAV. 277, 282 (1984). Self-reference also includes: self-presentation, self-misrepresentation, self-description, self-revelation, and repetition of information about oneself. *Id.*

Self-disclosure, the sharing of information about oneself with others, is a specific form of information management. *Id.* Over forty definitions of self-disclosure have appeared in the literature. *Id.* at 285. However, a core of attributes have been exemplified by the following definition of self-disclosure: "Self-disclosure may be defined as any information about himself [or herself] which person A communicates verbally to person B." *Id.* at 277.

Self-disclosure is composed of six attributes: truth, sincerity, intentionality, novelty, privacy, and choice. *Id.* at 285-88. Researchers have stated that truth is essential to self-disclosure. *Id.* at 285. Further, the truth of the subject matter distinguishes self-misrepresentation from self-disclosure. *Id.* Moreover, the motives must be honest and sincere. *Id.* Rather than simply trying to gain attention, an individual should be committed to being an open person in order to be perceived as being sincere in what he or she chooses to disclose. *Id.* Thus, the information is "disclosed" when it involves novel information

tion states that privacy is "an interpersonal boundary process by which a person or group regulates interaction with others."¹⁶³ Another definition maintains that privacy is "the selective control of access to the self or to one's group."¹⁶⁴

However, regardless of its precise definition, privacy is said to be a developmental process that focuses on developing the individual's sense of autonomy and personal dignity.¹⁶⁵ Further, functioning independently adds to the autonomy of the self, an important aspect of the western personality.¹⁶⁶

1. *The Self*

An important concept to the understanding of privacy is the concept of the self.¹⁶⁷ Developmental theorists agree that the development of the self is "the process of the separation of the individual from the social and physical environment."¹⁶⁸ One model of the self has been one of "concentric circles" with successive, inner circles referring to increasingly intimate layers of self-information.¹⁶⁹ Moreover, the consequences of a person's success at controlling other's interactions with him or her is central to the formation of the self.

[T]he ability or failure to regulate self/other boundaries is an important contributor to self-definition because it is a source of self-knowledge based directly on overt ongoing interaction. That is, if I see that I cannot control interaction with others in ways that I desire, then I am provided with important negative information about my competence to deal with the world. If I fail to implement my

from the perspective of the addressee. *Id.* The privacy aspect of self-disclosure is tied in with this aspect. *Id.* at 286. Self-disclosure differs from other types of self-referent speech in that the information is of a private nature. *Id.* Self disclosure implies that the individual is relating information that is ordinarily private rather than information that is ordinarily public. *Id.* at 286-87.

One additional aspect of self-disclosure has been asserted by some authors: the voluntary nature of self-disclosure. *Id.* at 286-88. However, choice is not always inherent in self-disclosure, as people may be forced to disclose the same information when it is required of them. *Id.*

163. I. ALTMAN, *THE ENVIRONMENT & SOCIAL BEHAVIOUR: PRIVACY, PERSONAL SPACE, TERRITORY & CROWDING* 6 (1975).

164. *Id.* at 18.

165. Laufer & Wolfe, *supra* note 161, at 22.

166. *Id.*

167. See, e.g., Foddy, *A Critical Evaluation of Altman's Definition of Privacy as a Dialectical Process*, 14 J. THEORY SOC. BEHAV. 297, 298-300 (1984).

168. Laufer & Wolfe, *supra* note 161, at 26.

169. I. ALTMAN & D. TAYLOR, *SOCIAL PENETRATION: THE DEVELOPMENT OF INTERPERSONAL RELATIONSHIPS* (1973); LEWIN, *PRINCIPLES OF TOPOLOGICAL PSYCHOLOGY* 101 (1936).

desired contact repeatedly and in many situations, then I gradually will develop a self-definition quite different (and probably more negative) than if I were reasonably successful in regulating interaction with others.¹⁷⁰

In the context of AIDS testing, the individual loses control over information and may experience an invasion of privacy as he or she moves from the choice of going to take a test and the choice of facing the results of a positive test, to being forced to take an AIDS test and having to disclose personal information to society through intensive data collection.

2. *Information Management*

Individuals may experience the inability to manage personal information in the AIDS testing situation as doubly invasive. Initially, the individual may be reluctant to disclose the information contained in the blood, *i.e.*, whether or not he or she is seropositive. However, once the information is disclosed to the health authority, the individual may fear what could happen to the information in the future, especially with the potential for discrimination if it fell into the wrong hands.¹⁷¹

Information management begins early in an individual's development.¹⁷² An individual's claim of control over personal information is similar to a territorial claim.¹⁷³ As people protect their personal space, an individual may protect and control information relating to him or her, a power which is essential to maintaining social relationships and personal freedom.¹⁷⁴ In fact, the violation of one's reserve of personal information may be experienced as more invasive than a simple intrusion into one's personal space. Unlike the penetration of one's personal space, those having access to the individual's antibody status may be quite extensive, especially in light of the computer systems used to store such personal information. Thus, the individual may be unable to know who is invading his or her privacy at any given moment.

Three significant aspects underlie the management of infor-

170. I. ALTMAN, *supra* note 163, at 46-47.

171. There is certainly a great potential for discrimination when the public or even a person's family discovers that he or she has AIDS. See Herek & Glunt, *An Epidemic of Stigma: Public Reactions to AIDS*, 43 AM. PSYCHOLOGIST 886 (1988).

172. Cozby, *Self-Disclosure: A Literature Review*, 79 PSYCHOLOGY BULL. 73 (1973); Laufer & Wolfe, *supra* note 161, at 35.

173. Zerubavel, *supra* note 160, at 103.

174. A. MILLER, *THE ASSAULT ON PRIVACY* (1971).

mation.¹⁷⁵ First, information management involves an individual refraining from an act because of his or her inability to predict what the consequences of that action would be.¹⁷⁶ The act may be ambiguously defined or have no immediate consequences but may have future consequences.¹⁷⁷ For example, people may not go to be tested for AIDS at the present time because they may not be able to predict how they would handle a positive test result. Further, they may fear that somehow the information they disclose or the test results themselves might be disclosed to someone else or that the information would be used against them in some way.

Second, information management involves the emergence of new technologies and their future impact in the person's life.¹⁷⁸ The individual has to decide the probable future consequences of current behavior in terms of the type of recording and communication devices potentially available.¹⁷⁹

The presence of computerized data banks and the use of social security numbers as personal identifiers for all sorts of transactions mean that at some point a mass of information about an individual can be compiled by unknown persons for unknown purposes. Furthermore, experience with record-keeping and communication technologies during the early stages [of a person's life] seems to affect [information management]. Regardless of when one grows up in a technological society, there is the inevitability of new forms of record keeping. . . .

The crucial element of information management in terms of the calculus of behavior is that the individual is often unable to predict the nature of that which has to be managed. Changes in the sociohistorical context and in technology are often unpredictable: in fact, in advanced industrial societies there is a growing certainty about the unknowableness of the future.¹⁸⁰

Individuals may fear what will happen to the information regarding their antibody status once it is placed in a main computer system. Could some "computer whiz" tap into the system from his or her home computer and gain access to the private

175. Laufer & Wolfe, *supra* note 161, at 36.

176. *Id.*

177. *Id.*

178. Laufer & Wolfe, *supra* note 161, at 36.

179. *Id.*

180. *Id.* at 37.

information?¹⁸¹ Certainly absolute protection from invasion cannot be guaranteed, but the possibility of improper access only reduced to a minimum.¹⁸²

Finally, individuals must determine their ability to manage information in future situations with minimal adverse consequences.¹⁸³ When they are certain they can manage the information, they are likely to disclose that information.¹⁸⁴ However, under certain other circumstances, the individual may be torn between disclosing the information and suffering disastrous consequences. The following example demonstrates the importance attached to managing personal information, but also the difficulty in determining what should be managed:

Some therapeutic endeavors support total sharing of one's feelings and other information and, in fact, may insist on this mode; yet, the revelation of personal information by a patient in a psychiatric institution may give the staff reason to continue institutionalizing him/her. Thus, the patient must learn what to disclose or not disclose based on the institution's definition of appropriate behavior.¹⁸⁵

The same problem would occur in AIDS testing clinics where individuals are forced to disclose information about their sexual history and drug use. Where criminal activity is necessarily implicated, as with homosexual sodomy and the use of illegal substances, persons testing seropositive might confound the research by failing to disclose the correct information about how they were exposed to the virus. A bisexual man might prefer to say he got it from a prostitute than to say that he got it from a bathhouse, or a

181. One survey indicated that 54% of Americans consider the present uses of computers an actual threat to personal privacy. HARRIS & ASSOCIATES, INC., & A. WESTIN, *THE DIMENSIONS OF PRIVACY: A NATIONAL OPINION RESEARCH SURVEY OF ATTITUDES TOWARD PRIVACY* 8 (1981).

182. Those in favor of anonymous testing systems have argued that only when such schemes are in place will those in high-risk groups come forward to receive the test. Further, it is claimed that even where confidential systems have been set up to protect names and identities, it is the low level of "confidence in confidentiality" that is the critical factor. For a discussion of the problems of confidentiality in storing data, see the discussion of *Whalen v. Roe*, *infra* notes 221-27 and accompanying text.

Confidentiality can be undermined by future legislation. For a court's discussion of such problems and the psychological "jeopardy" such schemes place an individual in, see *Peninsula Counseling Center v. Rahm*, 719 P.2d 926, 930-36 (Wash. 1986) (Pearson, J., dissenting) (stating that required disclosure of intimate information to governmental agencies is permissible if carefully tailored and not greater than reasonably necessary).

183. Laufer & Wolfe, *supra* note 161, at 36-37.

184. *Id.* at 36.

185. *Id.*

drug addict might prefer to say he got it from anything but sharing needles.

People will usually act to protect their own interests in constrained situations. Some forms of self-presentation are likely. In psychological terms, external pressure to give private information militates *self-disclosure*. However, when people perceive they have the freedom to choose what information they give, any inclination to disclose private information will not be impaired. However, it should not be assumed that private information will be given under conditions of free choice.¹⁸⁶

Only if the individual believes the testing is beneficial would he or she disclose the information in such an ambiguous situation. It is likely that a willing disclosure would not be perceived as invasive.¹⁸⁷ However, what would make one person perceive AIDS testing as beneficial and another perceive the procedure as invasive is unknown; certainly, such perceptions do vary from individual to individual. Further, some researchers have proposed that although an individual will disclose personal information, he or she nonetheless may find the process invasive.¹⁸⁸

3. *Mechanisms Developed to Protect Privacy*

Sometimes individuals believe that their privacy is being invaded. They employ certain mechanisms to protect themselves from having to disclose personal information. Such mechanisms define the boundaries and limits of the self.¹⁸⁹

There are three defensive strategies an individual may employ to preserve the privacy of information: 1) discretion, 2) concealment, and 3) fabrication.¹⁹⁰ Discretion is the simplest way

186. Fisher, *supra* note 162, at 288 (emphasis in original) (citations omitted).

187. See Simons, *Invasions of Privacy & Judged Benefit of Personality Test Inquiry*, 79 J. GEN. PSYCHOLOGY 77 (1965).

188. For example, a person applying for welfare is required to disclose a large amount of personal information. Although the individual may answer such questions, he or she may be hostile to the interviewer because of the invasiveness of the questions. See Laufer & Wolfe, *supra* note 161, at 22, stating:

[O]ne must understand the individual and social-historical basis of expressed desires for privacy. Privacy is not context free. If people submit to personality testing, credit card information searches, the intrusion of government agents into their homes in exchange for social-service assistance, we must not necessarily accept the submission as proof that the experience was regarded as noninvasive. We must seek to differentiate voluntary from coerced revelations and the circumstances under which such action occurs.

189. Zerubavel, *supra* note 160, at 105.

190. *Id.*

to prevent disclosure.¹⁹¹ It is a passive strategy which consists of refraining from discussing certain private matters or avoiding practices such as listing one's name in the telephone book.¹⁹²

Concealment is a much more active strategy used to prevent disclosure.¹⁹³ Concealment involves the establishment of some actual informational barriers between others and oneself.¹⁹⁴ A person may completely conceal knowledge of certain information from others or may ask a select few to keep the information secret.¹⁹⁵

Finally, an individual may protect his or her information reserve by deliberately attempting to provide others with false information.¹⁹⁶

An awareness of the masquerades and deceptions that are part of good role performance is necessary to recall ourselves to our *own* selfhood and to our opposition to that of others. We must indeed deceive others to be true to ourselves. In this particular sense, privacy prevents the ego from identifying itself too closely with or losing itself in (public) roles. Daily life is therefore sparked by a constant tension between sincerity and guile, between self-release and self-containment, between the impulse to embrace that which is public and the drive to escape the discomfort of group demands. Accordingly, our identities are maintained by our ability to hold back as well as to affiliate. . . .

“Our sense of being a person can come from being

191. *Id.*

192. *Id.*

193. *Id.*

194. *Id.* Consider the social significance of clothes, veils, window shades, envelopes, and doors which, from a strictly sociological standpoint, act as informational barriers. *Id.*

195. The sexual revolution made it possible for people to express their sexuality openly. However, with the threat of mandatory AIDS testing, many have suggested that homosexuality will simply move underground. See CONFRONTING AIDS, *supra* note 71, at 120-26. See also Schwartz, *The Social Psychology of Privacy*, 73 AM. J. SOC. 741 (1977):

As some activities emerge from secrecy others go underground. Thus, the person who nowadays finds pleasure in the Bible will most likely partake of it in private rather than in a public place or conveyance. These new proprieties are perhaps specific instances of a general rule . . . that “what is originally open becomes secret, and what was originally concealed throws off its mystery. Thus we might arrive at the paradoxical idea that, under otherwise like circumstances, human associations require a definite ratio of secrecy which merely changes its objects; letting go of one it seizes another, and in the course of this exchange it keeps its quantum unvaried.”

Id. at 745 (quoting Simmel, *The Secret and the Secret Society*, in THE SOCIOLOGY OF GEORG SIMMEL, at 334 (1964)).

196. Zerubavel, *supra* note 160, at 106.

drawn into a wider social unit; our sense of selfhood can arise through the little ways in which we resist the pull. . . . [P]rivacy is one of the little ways in which we resist the pull of group commitments and reinforce our selfhood."¹⁹⁷

Fabrication, or lying, can be seen in innocent ways such as dying one's hair or removing a wedding ring under certain circumstances,¹⁹⁸ but there are some individuals who may lie and conceal their sexual status or intravenous drug use from their partners, and thus, place their partners at risk of becoming infected with the AIDS virus.¹⁹⁹ When an individual lies, others are at a disadvantage because they are barred from having access to genuine information. Others are prevented then from making an informed decision about whether to have any contact with the deceiver.²⁰⁰

The vulnerability of an AIDS information base may be shown by an individual's need to employ any of the above-mentioned defensive measures. Therefore, it is essential that others help to maintain the individual's sense of privacy in the face of disclosure.²⁰¹ This may be accomplished by keeping information once obtained confidential. Guarantees of confidentiality, whether implicit or explicit, neutralize the transfer of power that would otherwise accompany the bestowal of private information.²⁰² Both the status of the information seeker and the assurance of confidentiality legitimize the "need to know" and the intrusions necessary.²⁰³

C. CONSTITUTIONAL PROTECTIONS OF PRIVACY

AIDS testing implicates the potential invasion of personal privacy. Privacy issues exist concerning the collection of the information regarding seropositivity, as well as the storage of that information. In addition, confidentiality and the potential for disclosure to third parties is a serious problem. The Supreme Court and lower courts have addressed similar issues, but have not

197. Schwartz, *supra* note 195, at 752 (citation omitted).

198. Zerubavel, *supra* note 160, at 106.

199. See G. ANTONIO, *supra* note 26, at 27.

200. Baker, *supra* note 156, at 475.

201. See Comment, *supra* note 67, at 315; Gostin & Curran, *AIDS Screening, Confidentiality, and Duty to Warn*, 77 AM. J. PUBLIC HEALTH 361 (1987); Lacombe, *AIDS, Confidentiality, and Lab Requisitions*, 52 R.N. 78 (1989).

202. Schwartz, *supra* note 195, at 743.

203. *Id.*

always decided in favor of protecting an individual's right of privacy.

1. *Data Collection*

The Supreme Court has not always protected the amount of information that an individual discloses.²⁰⁴ For example, the Supreme Court allowed the state to perform a blood test on a defendant suspected of drunk driving to determine his blood alcohol content. In *Schmerber v. California*,²⁰⁵ the defendant had been arrested at a hospital while receiving treatment for injuries suffered in an accident involving the automobile that he had apparently been driving.²⁰⁶ In *Schmerber*, a police officer ordered a physician to draw a sample of the defendant's blood.²⁰⁷ Chemical analysis of the blood sample revealed that the blood alcohol level was high enough to constitute legal intoxication.²⁰⁸ The results of the test were admitted at trial against the defendant's assertions that his fourth and fifth amendment rights had been violated.²⁰⁹ On appeal, the Supreme Court did not find that the blood test constituted an unreasonable search and seizure under the fourth and fourteenth amendments.²¹⁰ The Court was satisfied that the test was reasonable stating:

Extraction of blood samples for testing is a highly

204. See, e.g., *California v. Greenwood*, 486 U.S. 35 (1988), in which the Court upheld a warrantless search and seizure of garbage left outside a home. *Id.* The Court held that there is not Fourth Amendment protection for garbage left at the side of a public street. *Id.* at 40. In a strong dissent, Brennan and Marshall stated:

[Greenwood] deserve[s] no less protection just because Greenwood used the bags to discard rather than to transport his personal effects. Their contents are no inherently any less private, and [the appellant's] decision to discard them, at least in the manner in which he did, does not diminish his expectation of privacy.

A trash bag, like any of the above-mentioned containers, "is a common repository for one's personal effects" and, even more than many of them, is "therefore . . . inevitably associated with the expectation of privacy. . . ." A single bag of trash testifies eloquently to the eating, reading, and recreational habits of the person who produced it. A search of trash, like a search of the bedroom, can relate intimate details about sexual practices, health, and personal hygiene. Like rifling through desk drawers or intercepting phone calls, rummaging through trash can divulge the target's financial and professional status, political affiliations and inclinations, private thoughts, personal relationships, and romantic interests. It cannot be doubted that a sealed trash bag harbors telling evidence of the "intimate activity associated with the 'sanctity of a man's home and the privacies of life'". . . .

Id. at 49-50 (footnotes and citations omitted).

205. 384 U.S. 757 (1966).

206. *Schmerber v. California*, 384 U.S. 757 (1966).

207. *Id.* at 759-760.

208. *Id.*

209. *Id.*

210. *Id.* at 770-71.

effective means of determining the degree to which a person is under the influence of alcohol. Such tests are a commonplace in these days of periodic physical examinations and experience with them teaches that the quantity of blood extracted is minimal, and that for most people the procedure involves virtually no risk, trauma, or pain.²¹¹

In addition, the majority did not find that the blood constituted "testimony" so that the defendant's fifth amendment rights against self-incrimination had not been violated.²¹² However, in a strong dissent, Justice Black recognized the communicative nature of blood.²¹³ He discussed the information being disclosed through the blood sample rather than focusing on the physical invasion of the needle-stick, stating:

The sole purpose of this project which proved to be successful was to obtain "testimony" from some person to prove that petitioner had alcohol in his blood at the time he was arrested. And the purpose of the project was certainly "communicative" in that the analysis of the blood was to supply information to enable a witness to communicate to the court and jury that petitioner was more or less drunk. . . . [T]he Fifth Amendment bars a State from compelling a person to produce papers he has that might tend to incriminate him. It is a strange hierarchy of values that allows the State to extract a human being's blood to convict him of a crime because of the blood's content but proscribes compelled production of his lifeless papers. Certainly there could be few papers that would have any more "testimonial" value to convict a man of drunken driving than would an analysis of the alcoholic content of a human being's blood introduced in evidence at a trial for driving while under the influence of alcohol.²¹⁴

In *Schmerber*, the Court declined to protect the information contained in the blood sample, holding that there was no expectation of privacy in the contents of the blood.²¹⁵ Rather than focusing on the psychological intrusion into the individual's information base, the Court concentrated on the simplicity of the procedure to

211. *Schmerber*, 384 U.S. at 771 (citations omitted).

212. *Id.*

213. *Id.* at 774.

214. *Schmerber*, 384 U.S. at 774-75.

215. *Id.*

remove blood.²¹⁶ Information about whether an individual is seropositive for HTLV-III would also be possible with just a needle-prick. Although the *Schmerber* standard is a test to determine whether there is probable cause to effect a fourth amendment search and seizure, it is unlikely that the Court would distinguish the invasiveness of the blood-alcohol level test and the AIDS test, as they are both simply blood tests that involve only minimal physical intrusions.²¹⁷

2. Data Storage

Privacy issues concerning data storage have been considered by the Supreme Court. One of the first cases dealing with the storage of personal information was *California Bankers Association v. Schultz*.²¹⁸ In *Schultz*, the Court upheld a federal statute requiring banks to maintain records of customers that included identifying information and the amount of large transactions against a fourth amendment attack.²¹⁹ The majority recognized that some limitation should be placed upon governmental intrusions where legitimate expectations of privacy exist.²²⁰ However, the Court has not often recognized any such legitimate privacy expectations.

*Whalen v. Roe*²²¹ challenged a New York statute requiring patients receiving certain drugs to have their names and addresses placed on a patient-identifying registry with the New York State Department of Health.²²² The plaintiffs argued that the statute threatened to impair their interest in the nondisclosure of private information.²²³ Although the Court recognized that the existence

216. *Id.* at 771-72.

217. In two recent cases decided by the Supreme Court, the Court upheld the drug testing programs of two federal employers. See *National Treasury Employees v. Von Raab*, 109 S. Ct. 1384 (1989); *Skinner v. Railway Labor Executives Ass'n*, 109 S. Ct. 1402 (1989). *Skinner* focused more on the privacy issues, recognizing that urinalysis "implicates . . . concerns about bodily integrity." *Id.* at 1412. In addition, "chemical analysis of urine . . . can reveal a host of private medical facts about an employee, including whether she is epileptic, pregnant, or diabetic." *Id.* at 1413. Even when commenting on the inherent intrusiveness of observing (visually or aurally) the act of urination, the Court found that these were indeed private concerns. *Id.* Yet, the Court found that the government's interests in maintaining safety outweighed the employees' privacy interests. *Id.* at 1414.

For a discussion of AIDS testing by employers, see Epstein, *AIDS Testing and the Workplace*, 33 U. CHIC. LEGIS. F. 33 (1988). See also *Glover v. Eastern Neb. Community Office of Retardation*, 867 F.2d 461 (8th Cir. 1989) (employer not permitted to test employees for AIDS because the risk of disease transmission to clients with mental retardation did not justify intrusion; unreasonable fourth amendment search and seizure).

218. 416 U.S. 21 (1974).

219. *California Bankers Ass'n v. Schultz*, 416 U.S. 21, 69 (1974).

220. See *id.* at 79.

221. 429 U.S. 589 (1977).

222. *Whalen v. Roe*, 429 U.S. 589 (1977).

223. *Id.* at 600.

in a readily available form of the information created a genuine concern that the information would become public knowledge and could possibly affect someone's reputation, it upheld the statute.²²⁴ The Court scrutinized the regulation's confidentiality safeguards and found that the patients had suffered no negative effects or serious invasions of privacy.²²⁵ The Court held that any possibility of negligent or intentional disclosure by public health officials or the judicially compelled disclosure of confidential information was "remote."²²⁶

The patients in *Whalen* were concerned primarily with their reputations, fearing that disclosure would lead to stigmatization as drug addicts.²²⁷ Such interests would be essentially the same as those of an AIDS carrier, who also would fear being ostracized by society if his/her identity was made public. However, so long as disclosure is limited to health officials with a legitimate need for the information and adequate procedures to ensure confidentiality are present, the individuals' privacy interests probably will not be impermissibly invaded. Thus, mandatory testing and reporting of positive AIDS test results might be found constitutional under the *Whalen* standard.

3. *Disclosure to Third Persons*

Although the data may be collectable and permissibly stored in a well-protected computer system, the few state courts to address the issue of the possible disclosure of names of people testing positive for the exposure to the AIDS virus have stressed the importance of preserving the privacy of medical records. For example, in *Rasmussen v. South Florida Blood Service, Inc.*,²²⁸ the Florida Supreme Court upheld the Court of Appeal's decision to squash a discovery order requiring a blood bank to disclose the names and addresses of fifty-one volunteer blood donors.²²⁹ The discovery request was for a tort suit for personal injuries sustained in a car accident.²³⁰ While hospitalized for injuries received in a car accident, the plaintiff received over fifty units of blood.²³¹ The

224. *Id.* at 602.

225. *Whalen*, 429 U.S. at 603-04.

226. *Id.* at 601. In a concurring opinion, Justice Brennan recognized that "limited reporting requirements in the medical field are familiar and are not generally regarded as an invasion of privacy." *Id.* at 606 (citation omitted).

227. *Id.* at 600. In *Paul v. Davis*, 424 U.S. 693 (1976), the Court declined to provide constitutional protection for a person's reputation. *Id.*

228. 500 So. 2d 533 (1987).

229. *Rasmussen v. South Florida Blood Service, Inc.*, 500 So. 2d 533 (1987).

230. *Id.* at 534.

231. *Id.*

plaintiff subsequently developed AIDS, and in the opinion of his physician, contracted the virus from the transfusions.²³² The plaintiff sought to discover the names and addresses of each blood donor.²³³ However, the Florida Supreme Court refused the discovery request, recognizing two zones of privacy.²³⁴ First, the court recognized the decision-making or autonomy zone of privacy interests; and second, the court recognized the confidentiality interest in avoiding disclosure of personal matters.²³⁵ The court characterized the plaintiff's request as one which would invade the donors' interests in avoiding disclosure of personal matters.²³⁶ The court stated:

The threat posed by the disclosure of the donors' identities goes far beyond the immediate discomfort occasioned by a third party probing into sensitive areas of the donors' lives. Disclosure of donor identities in any context involving AIDS could be extremely disruptive and even devastating to the individual donor. . . . AIDS, or suspicion of AIDS, can lead to discrimination in employment, education, housing and even medical treatment.²³⁷

Other cases have recognized similar concerns for the protection of other types of medical records collected by the government. In *Farnsworth v. Proctor & Gamble Company*,²³⁸ a products liability action had been filed against Proctor & Gamble for injuries suffered from toxic shock syndrome associated with the company's tampons.²³⁹ The Center for Disease Control had been served with a subpoena by Proctor & Gamble, seeking to discover the names and addresses of women who participated in research on toxic shock syndrome.²⁴⁰ The Eleventh Circuit Court of Appeals considered the privacy needs of the research participants.²⁴¹ The court was concerned that confidentiality problems would threaten medical research and public health control measures.²⁴² The Court of Appeals reasoned that adverse conse-

232. *Rasmussen*, 500 So. 2d at 534.

233. *Id.*

234. *Id.* at 537-38.

235. *Id.* The Florida Supreme Court held that disclosure of donor identities is disclosure in a damaging context, violating constitutionally protected privacy rights. *Id.* at 537.

236. *Rasmussen*, 500 So.2d at 537.

237. *Id.* (citations omitted).

238. 758 F.2d 1545 (11th Cir. 1985).

239. *Farnsworth v. Proctor & Gamble Company*, 758 F. 2d 1545 (11th Cir. 1985).

240. *Id.* at 1546.

241. *Id.* at 1547.

242. *Farnsworth*, 758 F.2d at 1547.

quences might flow from public disclosure; people might not be as willing to participate in the research if they feared that their records might somehow become public information.²⁴³ In upholding the district court judge's decision to issue a protective order preventing the company from discovering the names and addresses of the participants, the court stated:

Central to [the] purpose [of protecting health] is the ability to conduct probing scientific and social research supported by a population willing to submit to in-depth questioning. Undisputed testimony in the record indicates that disclosure of the names and addresses of these research participants could seriously damage this voluntary reporting. Even without an express guarantee of confidentiality there is still an expectation, not unjustified, that when highly personal and potentially embarrassing information is given for the sake of medical research, it will remain private.²⁴⁴

Further, in *Peninsula Counseling Center v. Rahm*,²⁴⁵ a Washington State Department of Social and Health Services regulation was upheld that required that mental health service providers provide the state with the names and diagnoses of all patients whose treatment was subsidized by state or federal funds.²⁴⁶ The court recognized a strong state interest involved in assuring that the government was not being defrauded by psychotherapists who might be prescribing unnecessary medication. The court found the measure permissible because of the confidentiality built into the system to protect the patients' medical records.²⁴⁷ While the dissent believed that the constitution should protect against compelled disclosure regardless of whether that information may, in fact, be disseminated to others because 'even if totally effective safeguards are devised against abuses of information . . . many people will still feel their privacy is violated by any sort of probing of their inner lives,'²⁴⁸ the majority in *Peninsula Counseling* and in most such privacy cases have failed to agree.²⁴⁹

As long as the government's purposes are permissible, and there are adequate safeguards to protect the information once col-

243. *Id.*

244. *Id.*

245. 719 P.2d 926 (Wash. 1986).

246. *Peninsula Counseling Center v. Rahm*, 719 P.2d 926 (Wash. 1986).

247. *Id.* at 929.

248. *Id.* at 933 (quoting Bazelon, *Probing Privacy*, 12 CONZ. L. REV. 587, 593 (1977)).

249. *Id.* at 930.

lected,²⁵⁰ there would appear to be no obstacles to what type of information the government could collect. If the government could collect information about an individual's drug consumption and psychiatric history, what is to stop the government from being able to obtain information about an individual's antibody status?²⁵¹

At first glance, it appears that personal privacy interests may not be enough to prevent the government from instituting mandatory testing to compile a data base on the population's seropositivity rate. However, if the Court were to recognize that less intrusive means were available to achieve the state's purpose in preventing the spread of AIDS, privacy rights might be protected after all. Less intrusive alternatives, such as education and voluntary testing with sufficient reporting procedures might obviate any need to drastically encroach upon personal privacy interests if such means could reasonably be expected to be as effective as a mandatory testing program.

D. LESS INTRUSIVE MEANS

When a fundamental right such as privacy is implicated, the Court generally applies a strict scrutiny analysis, forcing the state to justify its measures by first proving a compelling interest, and second, by proving that the measure adopted was the least intrusive means of achieving that interest.²⁵² Mandatory AIDS testing coupled with education and counseling may be seen as a less intrusive option than quarantining, but two additional measures may be even less intrusive than mandatory testing: education and voluntary testing.

1. Education

Because there is no vaccination or treatment program currently available to eliminate AIDS, the most effective measure for significantly reducing the spread of HTLV-III infection is education to induce changes in behavior.²⁵³ Education conveys knowl-

250. See, e.g., *Anonymity in AIDS Testing Assured by Computerized System of Random Numbers*, 102 PUB. HEALTH REP. 568 (1987).

251. There might be additional concern if the federal government were collecting this data because, pursuant to the Privacy Act of 1974, it is possible that the information could be turned over to persons who authorities believe to be in danger. See generally Federal Privacy Protection Act of 1974, 5 U.S.C. 552(a).

252. See *supra* notes 138-139 and accompanying text. In *Bowers v. Hardwick*, 478 U.S. 186 (1985), the Court did not characterize the interest as a right of privacy, but as a right to homosexual sodomy. *Id.* at 191. Such a right was not found to be a fundamental right, and that rational basis test was applied instead of a strict scrutiny analysis. *Id.* at 196.

253. See generally *CONFRONTING AIDS*, *supra* note 71. However, it is questionable whether education really is enough considering that we cannot even cure illiteracy in our

edge about how AIDS is spread and would motivate people to avoid transmission of the AIDS virus.²⁵⁴ However, in matters of sexual activity, obstacles exist to the elimination of risky behavior, including poorly understood individual attitudes and preferences that may have arisen early in life.²⁵⁵ Although during the past several years, members of the homosexual community have filled their publications with articles detailing means of reducing the spread of AIDS, these repeated attempts at enlightenment have proven only marginally successful. One study of AIDS and sexual behavior reported by a cross section of homosexuals in San Francisco revealed grim prospects:

A full 92-96% asserted they were still not taking the most basic prophylactic measures to reduce transmission and exposure to AIDS infection. The majority also felt that they had taken all precautions necessary to protect themselves.

35% of those who agreed that reducing their number of partners would reduce their risk of AIDS had sex with more than five partners the month prior to the sampling.

69% of the men having three or more sexual partners

country, much less a disease that we know very little about. For an example of a specific educational program, see Schulte, *Educational Program to Prevent HIV Transmission Among Teens*, 102 PUB. HEALTH REP. 551 (1987).

254. Considerable debate exists among public health officials as to what constitutes safe sex and how best to convey such information about the relative risk of various behaviors. See Goedert, *What is Safe Sex? Suggested Standards Linked to Testing For Human Immunodeficiency Virus*, 316 NEW ENG. J. MED. 1339 (1987); Handsfield, *AIDS & Sexual Behavior in Gay Men*, 75 AM. J. PUB. HEALTH 1449 (1985); Fleming, Cochi, Steece & Hull, *Acquired Immunodeficiency Syndrome in Low-Incidence Areas: How Safe is Unsafe Sex?*, 258 J. AM. MED. A. 785 (1987); 'Safe Sex' Stops the Spread of the Virus, 117 NEW SCI. 36 (1988). It may be more accurate to speak in terms of safer sex, because only total abstinence can guarantee that the virus will not be transmitted. See Goodman, *The Joy of Chastity*, 116 NEW SCI. 62 (1987). Nevertheless, there is some consensus of what is high risk behavior. See, e.g., Edwards, *High-Risk Sex Studied in Women, Men*, 132 SCI. NEWS 116 (1987).

Condoms have been shown to be effective at inhibiting the transmission of the AIDS virus. See *Confirmation for Condoms*, 114 NEW SCI. 29 (1987); Feldblum & Fortney, *Condoms, Spermicides, and the Transmission of Human Immunodeficiency Virus: A Review of the Literature*, 78 AM. J. PUB. HEALTH 52 (1988); Freifeld, *Condom Sense*, 19 HEALTH 92 (1987); Goldsmith, *Sex in the Age of AIDS Calls for Common Sense and 'Condom Sense'*, 257 J. AM. MED. A. 2261 (1987); Nightingale, *AIDS and Condoms: FDA Perspective*, AM. FAM. PHYSICIAN, Dec. 1987, at 235; Reitmeijer, Krebs, Feorino & Judson, *Condoms as Physical and Chemical Barriers Against Human Immunodeficiency Virus*, 259 J. AM. MED. A. 1851 (1988). However, more research needs to be done to see if condoms are effective in reducing transmission when anal intercourse is practiced. See *CONFRONTING AIDS*, *supra* note 71, at 97-98.

The Surgeon General has attempted to inform the public about AIDS by sending out brochures to all households. PUBLIC HEALTH SERVICE, *UNDERSTANDING AIDS: A MESSAGE FROM THE SURGEON GENERAL* (1988). The Public Health Service has investigated the public's response to such educational attempts. See Gergert & Maguire, *Public Acceptance of the Surgeon General's Brochure on AIDS*, 104 PUB. HEALTH REP. 130 (1989).

255. See, *CONFRONTING AIDS*, *supra* note 71, at 100.

the previous month agreed with the statement, "It is hard to change my sexual behavior because being gay means doing what I want sexually."²⁵⁶

In addition, IV drug users are unlikely to stop using IV drugs simply because of any educational campaign.²⁵⁷ Even the laws making the possession of drugs illegal are not enough to deter some individuals from their use. However, if drug consumption cannot be eliminated, the goal of education should be to explain the use of personal and sterile injection equipment as the only way to avoid transmitting the virus when using intravenous drugs.²⁵⁸

Although it would seem as if the incentive to avoid risk of infection should be strong enough to motivate addicts from engaging in the risky behavior of sharing needles, many IV drug users are so driven by their habit that they have no regard for the health consequences of using dirty needles.²⁵⁹ Research on IV drug users in New York City, shows that concern about dying from AIDS has

256. McKusick, Hortsman & Coates, *AIDS & Sexual Behavior Reported by Gay Men in San Francisco*, 75 AM. J. PUB. HEALTH 493-96 (1985), quoted in G. ANTONIO, *supra* note 26, at 62. Although sexual behavior is changed after education, it is not completely eliminated. For a review of the literature in this area, see Becker & Joseph, *AIDS and Behavior Change to Reduce Risk: A Review*, 78 AM. J. PUB. HEALTH 394 (1988). See also Centers for Disease Control, *Self-Reported Changes in Sexual Behaviors Among Homosexual and Bisexual Men From San Francisco City Clinic Cohort*, in 36 MORBIDITY & MORTALITY WEEKLY REP. 187 (1987); Coates, Morin & McKusick, *Behavioral Consequences of AIDS Antibody Testing Among Gay Men*, 258 J. AM. MED. A. 1889 (1987); *Fear of AIDS Alters Sex Behaviour*, 115 NEW SCI. 26 (1987); Martin, *The Impact of AIDS on Gay Male Sexual Behavior Patterns in New York City*, 77 AM. J. PUB. HEALTH 578 (1987); McCusker, Stoddard, Mayer, Zapka, Morrison & Saltzman, *Effects of HIV Test Knowledge on Subsequent Sexual Behaviors in a Cohort of Homosexually Active Men*, 78 AM. J. PUB. HEALTH 462 (1988); Winkelstein, Samuel, Padian, Wiley, Lang, Anderson & Levy, *The San Francisco Men's Health Study: Reduction in Human Immunodeficiency Virus Transmission Among Homosexual/Bisexual Men: 1982-1986*, 77 AM. J. PUB. HEALTH 685 (1987). For an even more current study with similar conclusions, see Martin, Garcia & Beatrice, *Sexual Behavior Changes and HIV Antibody in a Cohort of New York City Gay Men*, 79 AM. J. PUB. HEALTH 501 (1989).

More research is needed to determine the extent of risk reduction over time. Allen & Curran, *Prevention of AIDS and HIV Infection: Needs and Priorities for Epidemiologic Research*, 78 AM. J. PUB. HEALTH 381 (1988). See also EVALUATING AIDS PREVENTION: CONTRIBUTIONS OF MULTIPLE DISCIPLINES, (L. Leviton, A. Hegudus & A. Kubrin eds. 1990).

257. See Magura, Grossman, Lipton, Amann, Koger & Gehan, *Correlates of Participation in AIDS Education and HIV Antibody Testing by Methadone Patients*, 104 PUB. HEALTH REP. 231 (1989). It is important to prevent the spread of AIDS among the sexual partners of IV drug users, but sexual partners of IV drug users who do not themselves use drugs may be harder to reach, because they will not necessarily come in contact with treatment centers or with the criminal justice system. See CONFRONTING AIDS, *supra* note 71, at 106.

258. CONFRONTING AIDS, *supra* note 71, at 100. See also Jarlais & Friedman, *The Psychology of Preventing AIDS Among Intravenous Drug Users: A Social Learning Conceptualization*, 43 AM. PSYCHOLOGIST 865 (1988).

259. Interview with Richard Duncan, Professor of Law, University of Nebraska College of Law, Lincoln, Nebraska (November 1988). See also CONFRONTING AIDS, *supra* note 71, at 107-08.

changed the behavior of only a small number of drug users.²⁶⁰ One study of patients undergoing methadone treatment found that more than ninety percent knew that AIDS was transmitted through sharing injection equipment, but of these patients, only fifty-nine percent reported changing their behavior to reduce their risk of contracting AIDS.²⁶¹

Yet the success of current educational programs cannot be assessed without acknowledging that the effects will not be immediately reflected in declines in the incidence of full-blown AIDS cases, since the rate of full-blown cases reflects exposure years prior to the onset of the disease.²⁶² If there were reliable data on seropositivity in representative samples of target populations, these data could provide an indication of the effectiveness of such programs.²⁶³ However, such data are unavailable because positive test results are not reported in most states, and even where such results are reported, they bear no connection to particular educational programs.²⁶⁴ Thus, it may not be possible to determine whether this potentially less intrusive alternative is effective. Without hard data, the effectiveness of a program is impossible to measure.²⁶⁵

2. Voluntary Testing

At present, voluntary serological testing is a self-selecting process which under-represents the total infected population.²⁶⁶ Fur-

260. *Id.* at 108.

261. *Id.*

262. *Id.* at 104.

263. CONFRONTING AIDS, *supra* note 71, at 104.

264. *Id.* Further, the likelihood of infection for an individual can change with the prevalence of infection in the population. Even though an individual may reduce his or her number of sexual partners as a result of exposure to an education program, if the prevalence of the infection increases in the population, he or she may still get the disease. *Id.* This has been the case in San Francisco, where changes in sexual practices among homosexual men have been undermined by increasing seropositivity rates. *Centers for Disease Control, Self-Reported Behavioral Change Among Gay & Bisexual Men — San Francisco*, 34 MORBIDITY & MORALITY WEEKLY REP. 613-15 (1985).

265. See Barinaga, *New Effort Starts Up to Evaluate AIDS Education in United States*, 330 NATURE 99 (1987); *AIDS: Education & Testing Continued*, 132 SCI. NEWS 236 (1987). In order to evaluate the effectiveness of such programs, relevant longitudinal data must be gathered from participants in the programs and from control groups. Longitudinal data are necessary because only long-term changes in behavior patterns will be effective in controlling the spread of the epidemic. See CONFRONTING AIDS, *supra* note 71, at 104-05. See also *AIDS Educators: Prove You're Being Effective*, 52 R.N. 13 (1989); Booth, *Another Muzzle for AIDS Education?*, 238 SCI. 1036 (1987); Bloom & Carliner, *The Economic Impact of AIDS in the United States*, 239 SCI. 604 (1988); *Health Ministers Committed to Education*, 117 NEW SCI. 32 (1988).

266. It is undetermined how many people have been tested. However, voluntary testing is of some use because those who are informed of their seropositivity will be less likely to engage in risky behavior. See Coates, Stall, Kegeles, Lo, Morin & McKusick, *supra* note 143, at 860; *Legislation Calls for Voluntary AIDS Testing*, AM. FAM. PHYSICIAN, Sept.

ther, not everyone at risk will be tested voluntarily, and some suggest that those at the highest risk would avoid being tested because they would not want to know their test results.²⁶⁷

When compared to mandatory testing, voluntary testing is, in fact, more stigmatizing to the individuals tested. Going into a clinic by choice identifies the individual as a possible member of a high risk group. If all persons in the population were going in for testing, an individual at a high risk of infection would be less likely to be stigmatized even if he or she did test positive because he or she would be just another face in the crowd.

Purely anonymous voluntary testing does not advance the efforts of health officials to ameliorate the epidemic. Anonymous testing and the failure to maintain registries and keep track of patients represents lost opportunities for counseling and research.

While it is possible that reporting positive test results from voluntary testing would provide health authorities with some relevant data,²⁶⁸ research could be accomplished more effectively through mandatory testing.²⁶⁹ By tracking people over a period of time, the state could determine the patterns and characteristics of AIDS in the population, as well as determine the effects of the educational programs associated with the testing to see if education really is "enough."

1987, at 17. However, who is being tested voluntarily? Are those at risk being tested? Are homosexuals who engage in high risk behavior and IV drug users risking identification as homosexuals or drug addicts by voluntary testing? Only selected data exists on this because there are no reporting requirements for simply testing seropositive in most states.

267. See Krasinski, Borkowski, Bebenroth & Moore, *Failure of Voluntary Testing for Human Immunodeficiency Virus to Identify Infected Parturient Women in a High-Risk Population*, 318 NEW ENG. J. MED. 185 (1988).

268. Some argue that such reporting regulations may hinder accurate monitoring of the AIDS virus more than it helps. Comment, *supra* note 133, at 1132-33. Since health officials invariably have to ask people intimate questions that may embarrass them in order to understand the epidemiology of the virus, test subjects may be less likely to give accurate information when they know it may be disclosed. Marwick, *'Confidentiality' Issues May Cloud Epidemiologic Studies of AIDS*, 250 J. AM. MED. A. 1945-46 (1983). In addition, some have argued that those at risk may leave the state after being tested or fail to be tested altogether. *Id.* at 1946. After the legislation was proposed in Colorado, seventy-five percent of the gay men polled said they would not seek the test if results were reportable, thereby undermining the state's objectives. Comment, *supra* note 133, at 1133. See also Keegles, Coates, Lo & Katania, *Mandatory Reporting of HIV Testing Would Deter Men From Being Tested*, 261 J. AM. MED. A. 1275 (1989).

269. See generally *AIDS Antibody Testing*, *supra* note 143, at 859. In order to make a mandatory testing program work, citizens need to be assured of confidentiality so that they will feel comfortable about telling the truth about such personal subjects as their sexual history and past intravenous drug use. Further, if citizens understand that they are contributing to an important health goal, they may be more inclined to cooperate with health efforts. *Id.*

VII. CONCLUSION

During this century, the Supreme Court has only been faced with one important decision regarding public health law. In *Jacobsen v. Massachusetts*, the Supreme Court upheld the state's authority to require its citizens to be inoculated against smallpox. However, AIDS is neither preventable by vaccination nor curable at the present time. While it is transmissible, it is primarily transmissible through means of intimate sexual contact or intravenous drug use, topics that the American public is often reluctant to think about or systematically discuss. Unlike other contagious diseases, AIDS is transmitted only during a direct exchange of bodily fluids. "You have to go out and get AIDS. It won't come to you."²⁷⁰

The state's interest in controlling AIDS is certainly compelling. The most effective way to fight the disease is to limit its spread. However, it is not clear that mandatory AIDS testing and its encroachment upon individual freedom will reduce or eliminate the threat to public health. Further, some have questioned the worth of forcing people to take the antibody test. Moreover, some "people try to commit suicide when they [find] out they [are] seropositive,"²⁷¹ primarily because of the potential for discrimination and possible ostracization from their families.²⁷² Unless the testing is anonymous, there is always the threat of discrimination, but such anonymous testing will not be of much use to the state in its effort to track the spread and patterns of the disease.

Although the state has broad power to act in the interest of public health, the exercise of that power must be reasonable. Whatever method the government adopts to control the spread of AIDS must be tailored to bear upon the real dangers presented.

Mandatory screening would require the administration and interpretation of the ELISA, as well as the Western Blot for those who get a positive result with the ELISA. Significant expense would be incurred for the costs of the administration of laboratories, test equipment, and personnel.²⁷³ Such costs may be dispro-

270. Benjamin Schatz, lawyer directing the AIDS Civil Rights Project of National Gay Rights Advocates in San Francisco, quoted in Reidinger, *A Question of Balance: Policing the AIDS Epidemic*, A. B. A. J., June 1, 1987, at 69.

271. Reidinger, *supra* note 270, at 72.

272. See Hereck & Glunt, *An Epidemic of Stigma: Public Reactions to AIDS*, 43 AM. PSYCHOLOGIST 886 (1988).

273. For example, AIDS testing in North Dakota is free. Interview with Delbert Strietz, epidemiologist for State Department of Health at Grand Forks, N.D. (Dec. 10, 1989). The cost of processing the test is estimated at fifteen dollars. *Id.* Thus, if every

portionate to the costs of obtaining behavior shifts through education and counseling. Further, such costs may be disproportionate to the costs needed for research and development of a cure for those already infected and for the development of a vaccine.

If the real objective of the campaign against AIDS is to encourage more people to engage in non-risky behavior, perhaps the majority of the money available for AIDS should be placed in education or in establishing clinics where individuals can go in for voluntary testing. However, if these less intrusive means are not sufficient to reduce the spread of the disease, the medical costs for treating all those who will eventually develop full-blown AIDS may bankrupt this nation. Each case of full-blown AIDS will cost the government thousands of dollars in health care expenditures.²⁷⁴ No matter what course of action is taken there will be economic costs, and in the absence of certainty that such less intrusive alternatives are effective, it might be more appropriate to spend the money for universal testing, in hopes of preventing the spread of AIDS, rather than to allow the death toll to mount needlessly.²⁷⁵

The debate over mandatory AIDS testing is not likely to end until a vaccine or cure is found. However, a decision cannot be postponed much longer. Although "[m]ass mandatory testing is relatively unlikely among the population now" . . . but if the number of cases continues to rise, so will the pressure to do something. It's a classic police-power question. Testing is an effort by the state to control the disease's spread by notice and disclosure.'²⁷⁶

person in North Dakota were tested (approximately 600,000), the cost of the test alone would be nine million dollars. *Id.*

274. Health-care costs could well be \$250-600 billion per year, as costs per patient come close to \$150,000. R. LEE, *supra* note 9, at 48. See also AIDS: *Myths and Money*, 122 NEW SCI. 20 (1989); Arno, *The Economic Impact of AIDS*, 258 J. AM. MED. A. 1376 (1987); Bloom & Carliner, *The Economic Impact of AIDS in the United States*, 239 SCI. 604 (1988); Rogers, *Federal Spending on AIDS: How Much is Enough?*, 320 NEW ENG. J. MED. 1623 (1989); Winkenwerder, *Federal Spending for Illness Caused by the Human Immunodeficiency Virus*, 320 NEW ENG. J. MED. 1598 (1989).

275. Interview with Richard Duncan, Professor of Law, University of Nebraska College of Law, Lincoln, Nebraska (November 1988). Another factor which must be considered in any consideration of universal screening is the lag time from infection to seroconversion, that is, to a positive AIDS test. Most individuals are infected with the AIDS virus within 1-3 months of infection. See MERCK MANUAL, *supra* note 1, at 290. Thus, it is the opinion of the author that an individual should be tested every three months, if he or she has had a negative test and has not engaged in any high risk behavior, to be certain the individual is not infected. Moreover, the author opines that an individual who tests negative may engage in high risk behavior after the test and become infected. Thus, retesting will have to be done at least annually. Therefore, the cost of a mandatory testing program will continue.

276. Richard Epstein, *quoted in* Reidinger, *supra* note 270, at 72.

Public health officials have the authority to impose public health measures, and the courts are likely to defer to such judgments.²⁷⁷ Therefore, if one disagrees with the policy of mandatory testing, disagreement should be voiced to law-makers who will be making these important policy decisions.

277. For a similar conclusion, see Gray, *The Parameters of Mandatory Public Health Measures and the AIDS Epidemic*, 20 SUFFOLK U. L. REV. 505, 521-22 (1986).