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ARTICLE

Handling Cases of Willful Exposure Through HIV Partner Counseling and Referral Services¹

James G. Hodge, Jr., J.D., LL.M.* and Lawrence O. Gostin, J.D., LL.D. (Hon.)**

I. INTRODUCTION

In December, 1998, the Centers for Disease Control and Prevention (CDC) issued comprehensive guidelines on partner counseling and referral services (PCRS) for individuals living with HIV/AIDS.² Though the terminology has changed, PCRS is based on partner notification,³ the traditional public health practice of assisting individuals infected with a communicable disease in notifying their sexual and/or needle-sharing partners of the real or potential exposure to disease.⁴ As part of a comprehensive public health strategy (including testing

services, screening of sub-populations, reporting of cases of infectious disease, and medical interventions for those infected),⁵ PCRS offers significant public health benefits for individuals living with HIV/AIDS, their partners, and the community.⁶ Persons who may be unaware of their risk are informed of their potential exposure to HIV.⁷ Notified partners are advised to test for HIV and counseled about practicing safer behaviors to avoid future exposure.⁸ Those who choose to test and are found to be infected can pursue early medical treatment

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2. DIVS. OF HIV/AIDS PREVENTION, U.S. DEP'T OF HEALTH & HUMAN SERVS., HIV PARTNER COUNSELING AND REFERRAL SERVICES - GUIDANCE (Dec. 30, 1998) [hereinafter DHHS & CDC].

3. Lawrence O. Gostin & James G. Hodge, Jr., *Piercing the Veil of Secrecy in HIV/AIDS and Other Sexually Transmitted Diseases: Theories of Privacy and Disclosure in Partner Notification*, 5 DUKE J. GENDER L. & POL'Y 9, 12-13 (1998).

4. *Id.*

5. DHHS & CDC, *supra* note 2, at ii.

6. *Id.* at § 1.4.

7. *Id.* at § 1.2.

8. *Id.*

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(which may substantially prolong their lives),⁹ practice preventive behaviors, and reduce their own risk of becoming infected with other sexually-transmitted diseases.¹⁰ At the community level, PCRS (in coordination with other public health programs) can improve disease surveillance, identify high risk social sexual networks, and contribute to the development of comprehensive public health programs to lower HIV transmission rates.¹¹

PCRS begins when individuals seek HIV counseling or testing through private care providers or publicly funded programs.¹² These individuals (or "clients") are offered professional counseling services to assess and reduce their risks of acquiring or transmitting HIV.¹³ Clients are encouraged to volunteer specific information about their sex and needle-sharing partners, and to plan how and when partners are informed of their risk of exposure.¹⁴ Either the client or the PCRS provider informs each located partner of his or her possible exposure to HIV.¹⁵ Newly-informed partners are referred to counseling, testing, and necessary social and medical services, thus completing the PCRS cycle.¹⁶

PCRS typically follows instances of infection resulting from unknowing or unintended exposure to disease. However, partner counselors or public health authorities may discover

that a client or other person poses some danger of exposing others to HIV and is not willing to avert that risk. For example, a PCRS counselor may be aware that a person who knows he is infected with HIV has engaged or is presently engaging in unsafe sexual or needle-sharing activity with partners who are unaware of the risk.¹⁷ This information may be apparent from: (1) counseling sessions with clients engaging in such unsafe practices; (2) interviews with clients who are partners of persons engaging in such unsafe behaviors; or (3) information provided by health care workers, mental health workers, or law enforcement authorities.¹⁸

In its PCRS Guidelines, CDC does not fully address these cases of "*willful exposure*" of HIV. For the purposes of this article, we define "*willful exposure*" as the intentional act of a competent¹⁹ individual infected with HIV to expose others to HIV through unsafe sexual or needle-sharing practices.²⁰ Our definition is intentionally narrow and meant to apply only to individuals with HIV who knowingly engage in certain risky or high risk behaviors. Thus, willful exposure does not necessarily involve HIV-infected individuals who (1) are *unaware* of their infection and thus unknowingly expose others to HIV; (2) *unintentionally* expose others to HIV (e.g. due to a faulty condom); (3) lack *understanding* of the consequences of their

9. See A. Mark Isley, *Health Law Survey*, 71 DENV. U. L. REV. 981, 997 (1994) (noting that HIV-infected individuals can "live and function longer with the disease") (citing Arthur S. Leonard, *Ethical Challenges of HIV Infection in the Workplace*, 5 NOTRE DAME J.L. ETHICS & PUB. POL'Y 53, 63 (1990)). See also Mike Cooper, *AIDS Deaths Drop for 1st Time, U.S. Attributes 12% Decline in First Half of 1996 to Better Treatment, Slowing of Epidemic*, S.F. EXAM'R, Feb. 27, 1997, at A1 (stating that experts also attribute the decline to broadened access to effective treatment and care).

10. As the CDC suggests in its report, PCRS serves two primary goals: (1) providing services to HIV-infected persons and their sex and needle-sharing partners so they can avoid infection or, if already infected, can prevent transmission to others; and (2) helping partners gain earlier access to individualized counseling, HIV testing, medical evaluation, treatment, and other prevention services. DHHS & CDC, *supra* note 2, at § 1.2.

11. *Id.* at § 1.4.

12. *Id.* at § 1.5.

13. *Id.*

14. Ideally, partners are prioritized (i.e. current spouses and other sexual partners are notified before previous sexual partners) and (1) informed of possible exposure to HIV; (2) provided accurate information about HIV transmission and prevention; (3) informed of the benefits of knowing one's serostatus; (4) assisted in accessing counseling, testing, and

other support services; and (5) cautioned about revealing their own or others' serostatus. *Id.* at § 3.3.

15. *Id.* at § 3.2.

16. *Id.*

17. *Id.* at § 3.4.2.

18. *Id.*

19. Whether an individual (e.g. a minor, a person with a mental disability or substance abuse problem), is competent for the purposes of the definition of willful exposure is a separate determination in accordance with state laws.

20. The willful exposure of others to HIV may occur in many different ways. Individuals with knowledge of their HIV infection may donate contaminated blood or other bodily fluids. The national screening of blood donations for HIV has largely eliminated the risk of willful exposure through blood donations. Individuals may also attempt to infect others through biting, spitting, or splattering of blood. Although criminal charges have been brought against individuals with HIV who engage in these behaviors, factual and epidemiologic evidence have regularly demonstrated the low risks involved in these contexts. Individuals with knowledge of their HIV infection may also willfully expose others to infection through unsafe sexual or needle-sharing practices. These are cases which PCRS counselors and public health departments are likely to face and thus, our definition of willful exposure focuses almost exclusively on these instances.

risky actions (e.g. those with a substantial mental disabilities); (4) expose competent partners who *assume the risks* (i.e. partners are aware of the HIV status of the individual and the potential risks associated with exposure); or (5) may knowingly expose others to HIV, but are not morally responsible for such exposures (e.g. victims of domestic abuse, rape, or incest, or minors engaged in commercial sex work).²¹ Thus, cases of willful exposure (as we define them) involve knowledgeable, competent, infected individuals who intentionally try to infect unknowing partners.

Often these unsuspecting partners may be heterosexual women.²² A well-publicized case of willful exposure in Chautauqua and surrounding counties in New York in 1998 involved an individual who allegedly had unsafe sex with multiple female partners (most of whom were minors) despite knowing he had HIV and that HIV was transmissible to others

through unsafe sexual practices.²³ After public health and law enforcement authorities conducted their own investigations, a suspect was detained in New York City and later pleaded guilty to criminal charges of reckless endangerment (among others).²⁴ At least a dozen women in Chautauqua County alone were infected with HIV through this single individual.²⁵ Similar cases have been documented in Tennessee,²⁶ Missouri,²⁷ and other states.²⁸

Countless other documented and undocumented cases of willful exposure exist. Numerous studies suggest that some individuals infected with HIV who know they are infected continue unsafe sexual or needle-sharing behaviors.²⁹ While these studies vary in the percentages of unprotected and undisclosed exposures found among individuals in differing populations, they cumulatively reveal a significant pattern of risk behaviors.³⁰ The impact of this pattern may be accentuated among heterosexual

21. While these examples do not fit within the definition of willful exposure set forth in this report, specific guidance concerning public health responses to such examples should be consulted. See NEW YORK STATE DEPARTMENT OF HEALTH, GUIDELINES FOR LOCAL AND STATE DEPARTMENT OF HEALTH STAFF, RESPONDING TO CONTINUED SEXUAL RISK AND NEEDLE-SHARING RISK BEHAVIOR ON THE PART OF PERSONS KNOWN OR SUSPECTED TO BE AWARE OF BEING INFECTED WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) (Draft as of March 21, 1999).

22. See DHHS & CDC, *supra* note 2, at § 3.3.

23. Brian A. Brown, *The Charge Is Murder, The Weapon AIDS*, WALL ST. J., Nov. 3, 1997, at A23; Shannon Brownlee et al., *AIDS Comes to Small-town America*, U.S. NEWS & WORLD REP., Nov. 10, 1997, at 52; Jennifer Frey, *Nushawn's Girls*, WASH. POST, June 1, 1999, at C1. For an epidemiologic review of this case, see *Cluster of HIV-Positive Young Women—New York, 1997-1998*, 48 MORBIDITY AND MORTALITY WKLY. REP. (May 28, 1999), at 413.

24. These charges included (1) *attempted assault in the second degree* (on the theory that he intended to cause serious physical injury to others by engaging in unprotected sex despite knowing such behavior could infect others); and (2) *reckless endangerment in the first degree* (on the theory that he acted with depraved indifference to human life by having unprotected sex).

25. Frey, *supra* note 23, at C1.

26. See *HIV-infected Woman Slept with 50 Men*, WASH. TIMES, July 31, 1998, at A13.

27. See Kristina Sauerwein, *Man's Deadly Legacy Triggers Frantic Race*, ST. LOUIS POST-DISPATCH, Apr. 11, 1997, at A1.

28. See Phillip Morris, *An Unlikely Bearer of HIV and Words of Warning*, THE PLAIN DEALER, July 11, 2000, at 9B. See also Kevin Mayhood, *Boy, 15, Faces Felony Charge After Spitting in Officer's Pop*, COLUMBUS DISPATCH, May 3, 2001, at 0A1.

29. See, e.g., *Continued Sexual Risk Behavior Among HIV-Seropositive, Drug-Using Men Atlanta; Washington, D.C.; and*

San Juan, Puerto Rico, 1993, 45 MORBIDITY AND MORTALITY WKLY. REP. 151, 151 (1996) (study of 116 HIV-seropositive and illicit drug users revealed that 28% reported having vaginal or anal sex without a condom in past 30 days, 32% had not disclosed their serostatus to all partners, and 63% had partners of unknown or negative serostatus); William W. Darrow et al., *Impact of HIV Counseling and Testing on HIV-Infected Men Who Have Sex with Men: The South Beach Health Survey*, 2 AIDS AND BEHAV. 115 (1998) (29% of HIV-seropositive men had engaged in unprotected insertive anal intercourse in past year with partners with HIV negative or unknown HIV status); Christine J. De Rosa & Gary Marks, *Preventive Counseling of HIV-Positive Men and Self-Disclosure of Serostatus to Sex Partners: New Opportunities for Prevention*, 17 HEALTH PSYCHOL. 224 (1998) (77% of HIV-seropositive men with HIV-unknown status partners failed to disclose their infection prior to sexual practices); Jeffrey D. Fisher et al., *Dynamics of Sexual Risk Behavior in HIV-Infected Men Who Have Sex with Men*, 2 AIDS AND BEHAV. 101, 106 (1998) (research findings based on surveys and interviews suggest that risky behaviors occur with some frequency); Carol F. Kwiatkowski & Robert E. Booth, *HIV-Seropositive Drug Users and Unprotected Sex*, 2 AIDS AND BEHAV. 151, 156 (1998) (47% of HIV-positive, sexually-active injection drug users (IDUs) reported having unprotected sex in past 6 months); Lisa R. Metsch et al., *Continuing Risk Behaviors Among HIV-Seropositive Chronic Drug Users in Miami, Florida*, 2 AIDS AND BEHAV. 161, 167 (1998) (approximately one-third of HIV-positive injectors and one-half of HIV-positive non-injectors continue to have unprotected sex and approximately one-third of HIV-positive injectors are continuing to engage in risky injecting practices).

30. Furthermore, many of these studies are based on self-reported actions of individuals with HIV. Actual rates of unsafe behaviors may be higher. Although it is critical from the public health perspective to know the serostatus of partners with individuals with HIV, this information is often unknown. Some studies have begun focusing on HIV-seropositive individuals' actual behaviors and knowledge of partner

women³¹ (especially minorities)³² where rates of HIV infection have escalated despite lowering rates of infection among other groups in the past decade.³³ HIV/AIDS remains among the leading causes of death among women between the ages of 25-44,³⁴ many of whom are infected through partners for which they are unaware of their HIV status.³⁵

Cases of willful exposure reveal the existing and future risks to the public health (especially women) which may be presented by individuals who willfully expose others to HIV through unsafe sexual or needle-sharing behaviors. In response to a documented case of willful exposure, a PCRS counselor or other public health official may, in his or her professional judgment, decide to act to avert a legitimate public health threat to known or unknown persons in the community. Yet handling such cases raises difficult issues in law, ethics, and public health practice.

Public health authorities may be unable or ill-equipped to successfully control risks of this type for several reasons: (1) they may lack sufficient resources to properly investigate these cases;³⁶ (2) they may lack knowledge or jurisdiction over the individual who willfully exposes others to HIV once his behaviors extend into

other communities;³⁷ and (3) they are bound to maintain the confidentiality of sensitive information they obtain from PCRS.³⁸ How do health care workers and public health departments balance the duty to maintain the privacy of public health information related to PCRS against their obligation to fulfill a partner's right to know of their exposure to infection? What are the legal powers and duties of public health departments to protect the health and safety of individuals as part of their mission to protect the public health? What is the role of the criminal law concerning persons who may intentionally or knowingly attempt to infect others with HIV or other communicable diseases?

This article addresses these legal and ethical questions which PCRS counselors and public health departments must assess in responding to these encounters. In PART II, we examine issues underlying the tension between the right to privacy of sensitive health data and the right to know about risks of which an individual is unaware. PCRS attempts to resolve this tension by disclosing exposure-related information to partners to the extent possible without infringement of the infected individual's autonomy and privacy. Legal and ethical

serostatus. Additional epidemiological work in this area, however, remains to be done.

31. See Center for Disease Control National Center for HIV, STD and TB Prevention – Divs. of HIV/AIDS Prevention, 12 Surveillance Rep. *Estimated female adult/ adolescent AIDS incidence, by exposure category and year of diagnosis, 1997, 1998 and 1999, U.S.*, available at <http://www.cdc.gov/hiv/stats/hasr1201/fig10.htm> (last modified Dec. 6, 2000).

32. See Center for Disease Control National Center for HIV, STD and TB Prevention – Divs. of HIV/AIDS Prevention, 12 Surveillance Rep. *Estimated female adult/ adolescent AIDS incidence, by exposure category and race/ethnicity, diagnosed in 1999, and cumulative totals through 1999, U.S.*, Surveillance Rep. 12, available at http://www.cdc.gov/hiv/stats/hasr1201/table_21.htm (last modified Dec. 6, 2000).

33. See CDC, *HIV/AIDS Among US Women: Minority and Young Women at Continuing Risk* [available at <http://www.cdc.gov/hiv/pubs/facts/women.htm>] (last modified Jan 31, 2001) [hereinafter, *HIV/AIDS Among US Women*]:

HIV infection among U.S. women has increased significantly over the last decade, especially in communities of color. . . . [I]n the United States, between 120,000 and 160,000 adult and adolescent females are living with HIV infection, including those with AIDS. [From 1992-1998] . . . a growing proportion of women were living with AIDS, reflecting the ongoing shift in populations affected by the epidemic. In 1992, women accounted for 14% of persons living with AIDS—by 1999, the proportion had grown to 20%. In just over a decade, the pro-

portion of all AIDS cases reported among adult and adolescent women more than tripled, from 7% in 1985 to 23% in 1998. The epidemic has increased most dramatically among women of color. African American and Hispanic women together represent less than one-fourth of all U.S. women, yet they account for more than three-fourths (77%) of AIDS cases reported to date among women in our country. In 1999 alone . . . , women of color represented an even higher proportion of cases. While AIDS-related deaths among women were decreasing as of 1998, largely as a result of recent advances in HIV treatment, HIV/AIDS remains among the leading causes of death for U.S. women aged 25-44.

Id.; See also Pascale M. Wortley & Patricia L. Fleming, *AIDS in Women in the United States: Recent Trends*, 278 JAMA 911 (Sept. 17, 1997).

34. *HIV/AIDS Among US Women*, *supra* note 33. HIV is ranked as the 5th for women age 25-44 in 48 National Vital Statistics Report (July 24 2000) available at http://www.cdc.gov/nchs/fstats/deaths.htm/pdf/nvs48_11_8.pdf.

35. See DHHS & CDC, *supra* note 2 (While AIDS-related deaths among women are now decreasing, largely as a result of recent advances in HIV treatment, HIV/AIDS remains among the leading causes of death for U.S. women aged 25-44.).

36. *Id.* § 1.3.

37. *Id.* § 2.2.

38. *Id.* § 4.3.

duties also suggest that PCRS counselors may be obliged to disclose individually-identifiable information to satisfy statutory duties or privileges to warn or to accomplish legitimate public health purposes.

PART III briefly examines the responsibilities of governmental agencies to protect the public health regarding cases of willful exposure, as well as the circumstances in which an individual can be criminally prosecuted. The intentional exposure of another to a communicable disease is deemed a crime in most jurisdictions, whether under (1) general criminal law (including charges of murder, voluntary manslaughter, involuntary or reckless manslaughter, assault and battery, reckless endangerment, or attempts of each of these crimes); (2) STD-specific offenses; or (3) HIV-specific offenses. Although the use of criminal law in the interests of preventing the spread of any disease is generally considered contrary to public health practice, which emphasizes the ethic of voluntarism, and should only be a final resort, cases may arise where criminal sanctions are appropriate, even essential.

In PART IV, we present our recommendations for the procedures and options PCRS counselors and public health departments should consider before, during, and after taking any action concerning cases of willful exposure. These include: (1) developing a public health plan to clarify public health duties and responsibilities; (2) creating strong protections for privacy and security of public health information related to investigations; (3) determining through sound investigation the existence of a health threat; (4) seeking legal assistance the moment a case of willful exposure is detected; (5) pre-examining the public health impact before any action is taken; (6) advising the suspected individual before public action is taken; (7) choosing the least restrictive alternative

needed to avert a risk to the public health; and (8) disclosing information about a willful exposure in accordance with one of three options. These options include disclosing information to persons potentially at risk, criminal justice or law enforcement authorities, or, in extremely rare circumstances, the media. A brief conclusion follows.

II. LEGAL AND ETHICAL THEORIES UNDERLYING PRIVACY AND THE RIGHT TO KNOW

In its PCRS Guidelines, CDC specifically notes the importance of maintaining the confidentiality of all persons involved in PCRS.³⁹ CDC recommends that (1) attempts to contact sex or needle-sharing partners should be confidential to the highest degree possible;⁴⁰ (2) partners should be informed of their exposure to HIV privately;⁴¹ (3) partners should be provided only that amount of information which is justified, which is never to include the client's gender, name, or physical description, or time, type, or frequency of exposure;⁴² and (4) PCRS counselors must not reveal any confidential information about partners to clients.⁴³ Preserving the security of personal information is as important as protecting privacy. Previously, CDC has issued guidelines concerning the security of HIV and other public health information held by public health departments,⁴⁴ including protecting such data through physical and technological means,⁴⁵ restricting access to those public health authorities which need the information, and prohibiting unnecessary handling or transportation of the information.⁴⁶

Protecting individual privacy and security,⁴⁷ especially concerning sensitive health data like HIV status, is synergistic with accomplishing public health goals.⁴⁸ Respecting privacy interests allows individuals to feel secure in volunteering sensitive health or other information

39. *Id.*

40. *Id.*

41. *Id.*

42. *Id.*

43. *Id.*

44. See MODEL STATE PUBLIC HEALTH PRIVACY ACT (1999) available at www.critpath.org/msphpa/modellaw5.htm [hereinafter MSPHPA]. The project was sponsored by the Centers for Disease Control and Prevention (CDC), the Council of State and Territorial Epidemiologists (CSTE), the Association of State and Territorial Health Officers (AS-

THO), and the National Conference of State Legislatures (NCSL).

45. *Id.* § 5-101.

46. *Id.* art. V, § 5-101[b].

47. For definitions of privacy, confidentiality, and security, see LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 127-28 (2000).

48. Lawrence O. Gostin & James G. Hodge, Jr., *The "Names Debate": The Case for national HIV Reporting in the United States*, 61 ALB. L. REV. 679, 683 (1998).

about themselves or others.⁴⁹ Failure to protect personal privacy may lead to unwarranted discrimination or stigmatization against individuals, thus discouraging their participation in public health efforts.⁵⁰

Individual privacy, however, may not extend so far as to protect individuals who place others at risks of which they are unaware. Legal duties to disclose and warn of exposure to infectious diseases,⁵¹ as well as ethical principles of beneficence (the duty to do good)⁵² and non-maleficence (the duty to not harm),⁵³ support a person's right to know of his exposure to HIV. A resulting dilemma arises from the inherent tension between HIV-infected individuals' rights to privacy and their partners' rights to know.

These observations are perhaps no more relevant in public health practice than as applied in PCRS. PCRS encourages the disclosure of exposure-related information to partners,⁵⁴ provided such disclosure is made without infringing on an infected individual's autonomy and privacy to the extent possible.⁵⁵ Thus, PCRS recognizes the value of providing information to further the right to know (of partners) while protecting privacy (of individuals with HIV) by only disclosing non-identifiable data.

Yet, at times, PCRS cannot satisfy either goal. Individual privacy may be compromised where a partner notified of exposure deduces the actual source. Consider, for example, a monogamous, married woman who is notified by a county public health department of her exposure to HIV. She has not had any sexual partners beside her husband for over 20 years. She does not inject illicit drugs. She has had "unsafe" sex with her husband, and may affirmatively conclude that he must have exposed her

to HIV, thus breaching his entitlement to individual privacy. Although it is highly contestable whether the husband's privacy right has any moral priority over her right to know, the end result of PCRS is that his privacy interest (in avoiding the disclosure of his HIV status) is revealed through PCRS.⁵⁶

Coextensively with a patient's right to privacy, an individual's right to know may be squandered where notification of exposure to HIV is replete of the source of the exposure. Think about a woman who is notified of her exposure to HIV but not the source. She injects heroin with friends, and concludes that one of her needle-sharing partners must have HIV. She refuses to share needles in the future, but is oblivious to the actual source of her exposure, her boyfriend of two years. Although she will have been advised to practice safe behaviors (including safe sexual behaviors), she may continue to place herself at risk of exposure through unsafe sexual behavior due to her incorrect assumption that her drug behaviors must have placed her at risk. In these scenarios, rights to privacy and to know are compromised through PCRS.

In the following sections we explain laws supporting the privacy rights of individuals and the rights to know of their partners in the context of partner notification in order to demonstrate the fundamental tension at stake when PCRS counselors or public health departments are faced with a case of willful exposure.

A. Legal Rights to Privacy

Though protecting health information privacy is increasingly important within a modern public health information infrastructure which

49. *See id.*

50. *See* Ferdinand Schoeman, AIDS and Privacy, in AIDS & ETHICS 240, 241 (Frederic G. Reamer ed., 1992). People infected with HIV have much to fear besides the disease. Because of the association of AIDS with promiscuity, primarily homosexual but also heterosexual, or the self-abandonment connected with intravenous (IV) drug usage, any adult with AIDS is suspected of degeneracy. . . . The level of public ignorance about the disease, the deficiency of scientific understanding surrounding aspects of its transmission, and the general hysteria about AIDS mean that people diagnosed as HIV positive must face social, economic, and medical hurdles no one with such dire medical prospects should have to confront. . . . A diagnosis of HIV infection, or even suspicion of

this, is sufficient in some cases to deprive people of housing, employment, life and health insurance, social tolerance, routine and even emergency medical treatment like mouth-to-mouth resuscitation, schooling, social contacts, friendships, the right to travel in and out of countries—a social identity.

51. *See, e.g.,* B.N. v. K.K., 538 A.2d 1175, 1179 (Md. App. 1988).

52. TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 259-325 (4th ed. 1994).

53. *Id.* at 189.

54. DHHS & CDC, *supra* note 2, at § 1.5.

55. *Id.* at §§ 3.1.1, 4.3.

56. *See id.* at § 1.5.

features regular exchanges of health data,⁵⁷ individual privacy is not necessarily paramount to communal interests justifying such exchanges and individual interests justifying some disclosures. A primary communal interest underlying the use and disclosure of individual health data is the protection of public health, which, many suggest, cannot be thwarted through restrictive privacy provisions.⁵⁸ Ideally, a balance between individual privacy and communal interests can be attained through rigorous legal safeguards of health information,⁵⁹ expressed through federal or state constitutional protections⁶⁰ of health information, privacy legislation, or case law.⁶¹ As discussed in this section, however, existing legal safeguards are inadequate, fragmented, and inconsistent.

1. Constitutional Right to Privacy

Scholars have debated the existence and extent of a constitutional right to informational privacy independent of the Fourth Amendment prohibition on unreasonable searches and seizures.⁶² To some, judicial recognition of a constitutional right to informational privacy is particularly important since the government is a

primary collector and disseminator of health information.⁶³ As a result, individuals need protection from the government itself without resort to federal or state legislation. An effective constitutional remedy is the surest method to shield them from unauthorized government acquisition or disclosure of personal information.

Unfortunately, a right to informational privacy is not specifically provided for in the Constitution.⁶⁴ The Supreme Court, however, has judicially recognized a limited right to informational privacy as a liberty interest within the Fifth and Fourteenth Amendments to the Constitution.⁶⁵

A flexible test has been utilized by courts balancing government invasion of privacy against the strength of the government interest.⁶⁶ Courts have chosen not to interfere with traditional governmental information collection, provided the government articulates a valid societal purpose and employs reasonable security measures.⁶⁷ Unquestionably, the government could enunciate a valid societal purpose in collection and disclosure of health information, including enhancing public health and law enforcement.⁶⁸

57. See Seth F. Kreimer, *Sunlight, Secrets, and Scarlet Letters: The Tension Between Privacy and Disclosure in Constitutional Law*, 140 U. PA. L. REV. 1, 4-5 (1991).

58. See, e.g., Lawrence O. Gostin and James G. Hodge, Jr., *Genetic Privacy and the Law: An End to Genetics Exceptionalism*, 40 JURIMETRICS J. 21, 36-39 (1999).

59. See *id.* at 41. The law is merely one tool to improve individual privacy protections. Internal privacy policies of health care providers, data processors, and other private sector entities which acquire, use, and disclose identifiable health data can greatly impact individual expectations of the privacy of their health information. The same can be said for voluntarily-executed policies of governmental holders of data, including public health agencies, researchers, universities and academic centers, and other commissions or agencies. Adherence to ethical principles and human rights documents in support of the privacy of individual health data may also lead to greater privacy protections. Ultimately, however, where government and the private sector fail to administer sufficient privacy protections, the law may guide, if not require, such protections.

60. See, e.g., Richard C. Turkington, *Legacy of the Warren and Brandeis Article: The Emerging Unencumbered Constitutional Right to Informational Privacy*, 10 N. ILL. U. L. REV. 479, 508-09 (1990).

61. See, e.g., *Whalen v. Roe*, 429 U.S. 589, 598-602 (1977); *Nixon v. Administrator of General Services*, 433 U.S. 425, 457-65 (1977).

62. See, e.g., Kreimer, *supra* note 57; Turkington, *supra* note 60; Francis S. Chlapowski, Note, *The Constitutional Protection of Informational Privacy*, 71 B.U. L. REV. 133 (1991).

63. See, e.g., Kreimer, *supra* note 57, at 4-6.

64. See Lawrence O. Gostin, *Health Information Privacy*, 80 CORNELL L. REV. 451, 495-98 (1995); see also Gostin, *supra* note 58, at 42.

65. *Whalen*, 429 U.S. at 606; see also *Nixon*, 433 U.S. 425. In *Whalen*, the Court considered "whether the constitutional right to privacy encompasses the collection, storage, and dissemination" of public health information by the government. See Gostin, *supra* note 58, at 42; see also *Whalen* 429 U.S. at 591. The Court recognized "the threat to privacy implicit in the accumulation of vast amounts of personal information in computerized data banks or other massive government files." See *Whalen*, 429 U.S. at 605. No violation was found in *Whalen* because the Court determined that the state had sufficient "standards and procedures for protecting the privacy of sensitive medical information." *Id.*; see also Gostin, *supra* note 58, at 42.

66. See, e.g., *United States v. Westinghouse Electric Corp.*, 638 F.2d 570, 578 (3d Cir. 1980). The Third Circuit held that the National Institute of Occupational Safety and Health was entitled to receive the medical records of private employees exposed to toxic substance, subject to their informed consent. The court enunciated five factors to be balanced in determining the scope of the constitutional right to informational privacy: (1) the type of record and the information it contains, (2) the potential for harm in any unauthorized disclosure, (3) the injury from disclosure to the relationship in which the record was generated, (4) the adequacy of safeguards to prevent non-consensual disclosure, and (5) the degree of need for access (i.e., a recognizable public interest).

67. *Id.*

68. See generally Gostin, *supra* note 58, at 42.

The right to privacy under the federal and state constitutions is, of course, limited to state action. As long as the federal or state government itself collects information or requires other entities to collect it, state action will not be a central obstacle. Even so, the constitutional right to privacy, in the context of public health, has proven to be nominal, especially in instances where, as with PCRS, government policies protect individual privacy to the degree possible and individuals are not compelled to comply.

2. *Legislative and Administrative Protections*

Statutory law at the federal, state, and local levels protects health information privacy in various settings where information concerning willful exposure cases may arise, namely among health care workers, PCRS counselors, or STD or other publicly operated or funded health clinics. The existing level of privacy protections depends on the type and holder of information.

A growing number of statutes and regulations protecting privacy have been considered or enacted by state and federal legislatures.⁶⁹ Several statutes and regulations protecting privacy of health information have been enacted by the federal government. The Privacy Act of 1974 requires federal agencies to utilize "fair information practices with regard to the collection, use, or dissemination of systematized records," including health data.⁷⁰ The Freedom of Information Act (FOIA) of 1966 requires the federal government to disseminate "various information"⁷¹ but exempts from disclosure several categories of records which include personally-identifiable health information.⁷² Other fed-

eral regulations require privacy protections in relation to the treatment of persons for drug or alcohol dependency in federally-funded facilities⁷³ and the administration of human subject research.⁷⁴

Most states have passed privacy statutes that mimic the federal Privacy Act⁷⁵ and FOIA,⁷⁶ and, thus, apply only to state collections of data. A few states have enacted comprehensive medical information privacy acts.⁷⁷ These laws provide broad protections of health information acquired, collected, used, or disclosed within the state.⁷⁸ States have also passed disease-specific privacy laws which set forth stringent privacy and security protections for certain types of information, including medical information concerning one's HIV status⁷⁹ or other sexually-transmitted disease,⁸⁰ genetic information,⁸¹ information utilized in medical research (such as state cancer registries), or public health information.⁸²

Though existing federal and state privacy statutes and regulations are meaningful and serve valuable ends, they collectively represent a patchwork effort to address privacy and security concerns of individuals in their health information. These statutes do not comprehensively protect health information regardless of its subject or holder. Some kinds of data are treated as super-confidential, while other data are virtually unprotected. Many state health information privacy laws struggle to balance competing interests underlying the acquisition, use, and disclosure of identifiable health information between individual privacy and warranted, communal uses of health information.⁸³ Our model state privacy proposal, the *Model State Public*

69. See Gostin, *supra* note 64, at 499-508; See also Gostin, *supra* note 58, at 43.

70. 5 U.S.C. § 552(b)(1)-(3), (6) (1994); See Gostin, *supra* note 58, at 44.

71. 5 U.S.C. § 552 (1994).

72. *Id.* at § 552 (b)(6); Gostin, *supra* note 58, at 44.

73. 42 U.S.C. § 290dd-2 (1994).

74. 45 C.F.R. §§ 46.101-404 (2000).

75. See, e.g., N.Y. PUB. OFF. LAW §§ 91-99 (McKinney 1988 & Supp. 2001) (mimics Privacy Act).

76. See, e.g., MISS. CODE §§ 25-61-1 to 25-61-17 (1999) (mimics FOIA).

77. See, e.g., CAL. CIV. CODE §§ 56 - 56.37 (West 1982 & Supp. 2001); WASH. REV. CODE ANN. §§ 70.02.005 - 70.02.904 (West 1992 & Supp. 2001).

78. See *id.*

79. See Harold Edgar & Hazel Sandomire, *Medical Privacy Issues in the Age of AIDS: Legislative Options*, 16 AM. J.L. & MED. 155 (1990) (examining state legislation dealing with HIV related problems in medical privacy laws).

80. See Lawrence O. Gostin, *The Future of Public Health Law*, 12 AM. J. L. & MED. 461, 463-65 (1986).

81. See, e.g., Gostin, *supra* note 58.

82. See Lawrence O. Gostin et al., *The Public Health Information Infrastructure*, 275 JAMA 1921 (1996).

83. See, e.g., ALA. CODE § 22-11A-2 (2001) (requiring health and social workers to report notifiable diseases, but prohibiting the use of that information for any but public health purposes); WASH. REV. CODE § 48.43.505 (West Supp. 2001) (requiring consideration of the effects of privacy standards within health insurance on care and disease management programs).

*Health Privacy Act (MSPHPA)*⁸⁴ (which specifically concerns public health information), attempts to reach this balance by recognizing individual and communal interests in identifiable public health data. The MSPHPA empowers people to access, inspect, and amend their health information;⁸⁵ learn the ways in which it is used and disclosed;⁸⁶ request a record of disclosures;⁸⁷ and seek criminal or civil sanctions for actions inconsistent with the Act.⁸⁸ Coextensively, the Act allows public health agencies to acquire, collect, and use identifiable health information so long as such information is needed to accomplish legitimate public health purposes.⁸⁹ Disclosures of identifiable data outside of public health may be made for any purpose with advance, written informed consent,⁹⁰ but for only a few, narrow purposes without informed consent.⁹¹ Though states have failed to uniformly implement modern privacy protections as suggested in the MSPHPA, many support comprehensive national health information privacy legislation or administrative regulations.

Future federal health information privacy legislation or regulations mandated by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA)⁹² may provide a floor for protections. HIPAA seeks to reduce

the administrative and financial burdens of health care by standardizing the electronic transmission of health-related data.⁹³ In addition to security provisions concerning electronic health information, HIPAA requires Congress to pass legislation setting uniform standards for the transmission of health insurance information.⁹⁴ While several health information privacy bills have been considered by Congress,⁹⁵ no action to date has been taken.

In the absence of Congressional action, HIPAA requires that the Department of Health and Human Services (DHHS) draft and implement administrative regulations.⁹⁶ While DHHS would prefer that Congress pass privacy legislation,⁹⁷ the agency has issued regulations that may reflect the eventual national regulatory framework for protecting health information privacy.⁹⁸ DHHS' regulations focus on five key principles: (1) BOUNDARIES - health care information should be disclosed for health purposes only (e.g., treatment, payment, or other health care operations), with limited exceptions;⁹⁹ (2) SECURITY - health information should not be distributed unless the patient authorizes it or there is a clear legal basis for doing so, subject to the authorized need for information.¹⁰⁰ Those who receive such information must safeguard it;¹⁰¹ (3) CONSUMER CONTROL -

84. See MSPHPA, *supra* note 44.

85. *Id.* §§ 6-101 - 104.

86. *Id.* §§ 2-101 - 102, 4-108 - 109, 6-101.

87. *Id.* § 4-109.

88. *Id.* §§ 7-101 - 105.

89. A 'legitimate public health purpose' means a population-based activity or individual effort primarily aimed at the prevention of injury, disease, or premature mortality, or the promotion of health in the community, including (a) assessing the health needs and status of the community through public health surveillance and epidemiological research, (b) developing public health policy, and (c) responding to public health needs and emergencies.

Id. § 1-103(9).

90. *Id.* § 4-103.

91. Disclosures without informed consent by public health agencies or secondary recipients may only be made: (1) "directly to the individual;" (2) "to appropriate federal agencies or authorities;" (3) "to health care personnel in a medical emergency when necessary to protect the health or life of the person who is the subject of the information;" (4) pursuant to a court order sought exclusively by public health agencies in light of a clear danger to an individual or public health; (5) to appropriate agencies performing health oversight functions; or (6) to identify a deceased individual, determine the manner of death, or provide information where the deceased is a prospective organ donor. *Id.* at §§ 4-104 - 107.

92. Pub. L. No. 104-191, 110 Stat. 1936.

93. *See id.*

94. *Id.* § 264; see also Jane Harman, *Topics for Our Times: New Health Care Data - New Horizons for Public Health*, 88 AM. J. OF PUB. HEALTH 1019, 1021 (July 1998).

95. See, e.g., Health Care Personal Information Nondisclosure Act of 1999, S. 578, 106th Cong. (1999); Medical Information Protection Act of 1998, S. 2609, 105th Cong. (1998); Health Care Personal Information Nondisclosure Act of 1998, S. 1921, 105th Cong. (1998); Medical Information Privacy and Security Act, S. 1368, 105th Cong. (1998); Consumer Health and Research Technology (CHART) Protection Act, H.R. 3900, 105th Cong. (1998); Medical Privacy in the Age of New Technologies Act of 1997, H.R. 1815, 105th Cong. (1998); Fair Information Practices Act of 1997, H.R. 52, 105th Cong. (1998).

96. Pub. L. No. 104-191, 110 Stat. 1936.

97. NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS, HEALTH PRIVACY AND CONFIDENTIALITY RECOMMENDATIONS (1997) available at <http://www.ncvhs.hhs.gov/privrecs.htm>.

98. *Id.*

99. *Id.* at § 164.502

100. *See id.*

101. *See id.*

persons are entitled to know of the existence and purposes in which their health information is being used.¹⁰² They are also entitled to correct misinformation in their health records,¹⁰³ (4) ACCOUNTABILITY - those who improperly hold, distribute, or use health information should be criminally punished, especially when such actions are for monetary gain. Individuals affected by such actions should have civil recourse; and (5) PUBLIC RESPONSIBILITY - privacy interests of individuals must not override national priorities of public health, medical research, health services research, quality assurance, health care fraud and abuse, and law enforcement in general. These regulations, when implemented in April 2003, will not preempt all state health information privacy laws.¹⁰⁴ Rather, only those state laws which conflict with or are less protective of federal privacy rights would be preempted. State laws which are more protective of privacy, such as some disease-specific laws, would survive.

3. Common Law Protections

Modern privacy law and proposals hinge on a fundamental principle that identifiable health data be disclosed only with informed consent. This principle owes its inception to the common law duty of confidentiality of certain health care professionals (generally physicians) not to disclose health information concerning patients. CDC's PCRS Guidelines specifically adopt a duty of confidentiality between counselors and clients.¹⁰⁵ Unwarranted disclosures may subject responsible parties to civil liability under several legal theories,¹⁰⁶ including "breach of confidentiality,"¹⁰⁷ "invasion of pri-

vacuity,"¹⁰⁸ "breach of implied term of contract,"¹⁰⁹ and "breach of fiduciary relationship."¹¹⁰ These duties, however, are not absolute. Disclosures without individual consent may lawfully be made to protect third parties from identifiable harm,¹¹¹ to report information for public health purposes as required by state law,¹¹² or sometimes to address medical emergencies.¹¹³ Thus, the utility of duties of confidentiality in the context of PCRS is limited.

B. A Partner's Right to Know

While constitutional, statutory, and common law rules concerning health information privacy support an individual's autonomous right to control the disclosure of personal information,¹¹⁴ these provisions, as we suggest above, are not absolute.¹¹⁵ Individual privacy may justifiably be limited where other persons have a legitimate right to know the information. Partner notification furthers the right to know despite the inevitable infringement, whether slight or substantial, of individual privacy. Though often associated with the notification of persons who are at risk of becoming infected with a communicable disease,¹¹⁶ "partner notification has at least three distinct, if at times overlapping, meanings: (1) contact tracing (e.g. PCRS); (2) the duty of infected persons to *disclose* their infection to a sexual partner; and (3) the duty of health care providers to *warn* of sexual and other risks to the partners of their infected patients."¹¹⁷

The second meaning of partner notification (*the duty to disclose*) recognizes an individual's ethical and legal obligation to disclose his HIV

102. *See id.* § 164.520.

103. *See id.* § 164.526.

104. Lise Rybowksi, *Protecting the Confidentiality of Health Information*, NAT'L HEALTH POL'Y. F. 1, 16-17 (July 1998), available at <http://www.nhpf.org>.

105. *See supra* text accompanying note 20.

106. *See, e.g.*, McCormick v. England, 494 S.E.2d 431, 436 (S.C. Ct. App. 1997); Gostin, *supra* note 64, at 508-11; Gostin & Hodge, *supra* note 3, at 42-43.

107. Alan B. Vickery, Note, *Breach of Confidence: An Emerging Tort*, 82 COLUM. L. REV. 1426 (1982).

108. McCormick, 494 S.E.2d at 436.

109. *Hammonds v. Aetna Cas. & Sur. Co.*, 243 F. Supp. 793, 801 (N.D. Ohio 1965); *Doe v. Roe*, 400 N.Y.S.2d 668, 674 (N.Y. Sup. Ct. 1977).

110. *Ritter v. Rush-Presbyterian-St. Luke's Med. Ctr.*, 532 N.E.2d 327, 331 (Ill. App. Ct. 1988); *Alexander v. Knight*, 177 A.2d 142, 146 (Pa. Super. Ct. 1962).

111. *See, e.g.*, *Tarasoff v. Regents of the Univ. of California*, 551 P.2d 334, 346 (Cal. 1976).

112. *See, e.g.*, ALASKA STAT. § 18.15.136 (Mitchie 2000) (allowing disclosure of information concerning persons with Tuberculosis).

113. *See, e.g.*, TEX. HEALTH & SAFETY CODE ANN. § 81.046(c) (Vernon 2001) (allowing the release of "[m]edical or epidemiological information . . . to the extent necessary in a medical emergency to protect the health or life of the person identified in the information"). *Id.*

114. *See supra* II.

115. *See supra* II.B.

116. *See* DHHS & CDC, *supra* note 2.

117. Gostin & Hodge, *supra* note 3, at 14.

infection to a sexual or needle-sharing partner or to reasonably protect the partner from avoidable health risks. Stated alternatively, if it is foreseeable that a person's behavior will cause harm to another, that person has a duty to take reasonable steps (or due care) to avoid such behavior. In this context, due care requires at a minimum the obligation to disclose one's condition to others at risk of exposure, including sexual or needle-sharing partners.¹¹⁸ If an individual fails to fulfill the duty to disclose, sexual and needle-sharing partners can recover tort damages through civil actions brought on theories of "assault or battery, fraud or misrepresentation, infliction of emotional distress, seduction, and negligence."¹¹⁹ When an individual informs his sexual or needle-sharing partners of his HIV infection and the partner engages in risky behaviors with the infected individual, the partner essentially assumes the risk (and consequences) of such behaviors.

The third meaning of partner notification derives from the common law doctrine known as a "power or duty to warn" (more accurately termed the "power or duty to protect").¹²⁰ Through conversations with the infected patient, a physician or other health care worker (HCW) may conclude that certain persons are at risk of contracting HIV. Under the duty to warn, the HCW may have the power (*i.e.* permission) or duty to inform a foreseeable third party of her exposure to infection if an infected individual refuses to inform his partner, regardless of whether the patient consents to such no-

tification.¹²¹ Even where a HCW is unaware of the existence of such partners, a HCW's failure to advise infected patients of the potential to infect others is actionable negligence when brought by a third party infected by the patient.¹²² In the case of HIV infections, duty to warn statutes (depending on the state) typically require sex or needle-sharing partners to be notified only if (1) there is a significant risk of transmission, (2) the patient cannot or will not contact the partner, and (3) the HCW has notified the patient of his or her intent to notify specified partners.¹²³

Where the HCW exercises a power or duty to warn, a breach of the duty of patient confidentiality likely will occur. Significant legal and ethical dilemmas arise from this conflict. To what extent should patient confidentiality be sacrificed in the performance of the duty to warn? Many states have attempted to resolve this question by statutorily recognizing a privilege (versus a duty) to warn others of a patient's infectious condition. "Privilege to warn" statutes¹²⁴ differ from state to state in three key components: (1) the voluntariness of disclosure; (2) the scope of disclosure; and (3) the legal duties imposed. Some statutes give HCWs the discretion to decide whether to notify a patient's contacts.

For example, laws passed in California and New York provide that a physician may notify a contact if the physician reasonably believes a

118. A crucial issue is whether it is reasonably foreseeable that sexual contact or needle sharing might harm one's partner. In general, reasonable persons who know or should know that they have HIV must communicate this fact to a partner prior to sexual relations. An individual's knowledge of infection can be actual (an individual has specific knowledge of his HIV status based on, for example, a positive test result) or constructive (an individual knew or should have known of his HIV infection due to his risky behaviors, early clinical symptoms, or other knowledge which a reasonable person would equate with having HIV infection). While courts agree that a duty to disclose follows an individual's actual knowledge of his infection, imposing such a duty is difficult where a person is specifically unaware of his HIV status, but may be imputed to have constructive knowledge of infection. Most courts have resisted imposing a duty to disclose unless the person actually knows of his infected status since an individual with HIV may be asymptomatic for months or years given HIV's long latency period.

119. See Gostin and Hodge, *supra* note 3, at 38-39.

120. Christine E. Stenger, Note, *Taking Tarasoff Where No One Has Gone Before: Looking at "Duty to Warn" Under the AIDS Crisis*, 15 ST. LOUIS U. PUB. L. REV. 471, 494 (1996).

121. Ronald Bayer, PhD. & Kathleen E. Toomey, MD, MPH., *HIV Prevention and the Two Faces of Partner Notification*, 82 AM. J. PUB. HEALTH 1158 (1992).

122. *Reisner v. Regents of the Univ. of Cal.*, 37 Cal. Rptr. 2d 518, 523 (Cal. Ct. App. 1995).

123. See Gostin & Hodge, *supra* note 3, at 44.

124. In addition to modifying preexisting confidentiality statutes, states enacted statutes which specifically guarantee the confidentiality of STD or HIV status. CAL. CIV. CODE § 56.10 (West 1982 & Supp. 2001) (protecting physician-patient confidentiality); CAL. HEALTH & SAFETY CODE § 120705 (West 1996) (protecting STD information); CAL. HEALTH & SAFETY CODE § 120820 (West 1996) (protecting HIV information); see also HAW. REV. STAT. § 325-101 (Mitchie 2000); 410 ILL. COMP. STAT. 50/3 (West 1997); TEX. HEALTH & SAFETY CODE ANN. § 81.103 (Vernon 2001).

significant risk of transmission exists,¹²⁵ believes the patient will not warn the partner,¹²⁶ and notifies the patient of the physician's intent to warn the person at risk.¹²⁷ Most statutes allow notification of spouses, sexual partners, or needle-sharing partners.¹²⁸ Some statutes limit warnings to an individual's spouse or cohabitating sexual partner of over one year.¹²⁹ Most states provide immunity for HCWs who decide not to disclose,¹³⁰ others provide no protection from potential liability,¹³¹ essentially failing to resolve the conflict between the duty to warn and the duty of confidentiality.

Even if the legal and ethical duties of HCWs to protect individual privacy are defined in some states, the role of PCRS counselors in cases of willful exposure is different from that of HCWs. Unlike HCWs who need information for clinical purposes and are often the first to determine HIV status, PCRS counselors acquire such information voluntarily from individuals to accomplish public health purposes.¹³² While HCWs may often be private sector employees, PCRS counselors are likely state or local government employees and thus, must uphold constitutional privacy and other protections. HCWs share a distinct relationship with patients from which the law and ethics have traditionally recognized affirmative duties. PCRS counselors do not "owe" clients these duties under the same legal theories (although they may assume these duties as part of their public health practice).

Like HCWs, however, PCRS counselors may often find themselves at the center of the conflict between protecting privacy and furthering the right to know.¹³³ PCRS counselors are required to maintain the privacy and security of client identity under federal and state constitutional, statutory, and regulatory laws.¹³⁴ Yet, a

central objective of PCRS is the notification of unsuspecting persons at risk of exposure to HIV.¹³⁵ In cases of willful exposure, disclosing identifiable information about individuals may be needed to stop practices which are injurious to the public health for several reasons: (1) there may be insufficient information to allow PCRS counselors to directly notify partners of such individuals engaging in unsafe sexual or needle-sharing behaviors; (2) knowledge of the individual's identity may be critical to enabling unsuspecting individuals to protect themselves; and (3) the individual's behavior may be criminal in nature. This need to disclose identifiable information by PCRS counselors, however, must be weighed against legal and ethical duties to not disclose identifiable patient information as well as other legal interests, including the potential to resort to criminal enforcement, which we discuss below.

III. THE MISSION OF PUBLIC HEALTH AND CRIMINAL LAW

Assessing the role of PCRS counselors in abating cases of willful exposure to HIV infection necessitates an examination of the degree to which such efforts are consistent with the mission of public health. Public health has always been primarily about the health of populations,¹³⁶ as well as the health of individuals.¹³⁷ Public health has as its broadest mission the assurance of the conditions for people to be healthy.¹³⁸ Principal among the many duties encompassed under this directive is the control of threats to the health of the public,¹³⁹ including HIV/AIDS.¹⁴⁰ Though the federal government and private sectors serve critical functions, accomplishing these duties is quintessentially the responsibility of state governments pursuant to their police powers.¹⁴¹ These expansive powers,

125. CAL. HEALTH & SAFETY CODE § 121015(a) (West 1996); N.Y. PUB. HEALTH LAW § 2782(4)(a)(2) (McKinney 1993 & Supp. 2001).

126. CAL. HEALTH & SAFETY CODE § 121015(b); § 2782(4)(a)(3).

127. *Id.* § 121015(b); § 2782(4)(a)(4).

128. *See, e.g., id.* § 121015(a); §§ 2780(10), 2782(4)(a)(1); CONN. GEN. STAT. § 19a-584(a) (West & Supp. 2001); FLA. STAT. ch. 456.061(1) (West 2001); GA. CODE ANN. § 24-9-47(g) (2001).

129. *See, e.g.,* KY. REV. STAT. ANN. § 311.282(1)(a) (Michie 1995 & Supp. 2000).

130. *See, e.g.,* FLA. STAT. ch. 456.061(2) (West 2001); IDAHO CODE § 39-610(5) (Michie 1993).

131. PA. STAT. ANN. tit. 35, § 7609(c) (West 1993); VA. CODE ANN. § 32.1-36.1(A)(11) (Michie 1997).

132. DHHS & CDC, *supra* note 2, at § 1.5.

133. *See infra* II.

134. *See infra* II.A.

135. *See infra* II.

136. Gostin, *supra* note 48, at 688.

137. *Id.*

138. INSTITUTE OF MEDICINE, THE FUTURE OF PUBLIC HEALTH 35, 37-40 (1988).

139. *See id.*

140. *See id.*

141. Gostin, *supra* note 48, at 48.

reserved exclusively to the states through the Tenth Amendment of the federal Constitution,¹⁴² may be defined as the power of states to regulate in the interests of the health, safety, morals, and general welfare of the public.¹⁴³ In the field of public health, state police powers constitute the original source of governmental authority.¹⁴⁴ Public health regulation is at the core of the police power.¹⁴⁵

As an important part of a comprehensive public health strategy to control the spread of HIV, PCRS is consistent with the mission of public health and thus, authorized via state police powers. Presumably, the mission of public health requires the notification of persons who are unknowingly at risk of infection due to the *willful* conduct of others the same as it would justify notification of persons at risk due to unintentional behaviors. Yet, what if notification of at risk individuals is not possible? For example, PCRS counselors may become aware of an individual engaging in risky behaviors intending to infect others, but the counselors may not know the identity of these persons. Furthermore, even if notification occurs (because those at risk can be identified), what should PCRS counselors do if they know an individual is continuing to place others at risk? Should they identify the individual to law enforcement authorities?

Although criminal charges against competent individuals with HIV who intentionally or recklessly engage in unsafe sexual or needle-sharing behaviors with unknowing partners are authorized pursuant to state police powers, criminal prosecution in such cases is considered inconsistent with the public health ethic of voluntarism.¹⁴⁶ Intermeshing criminal sanctions in areas of public health regulation undermines the trust that individuals ideally should have in public health services.

Without suggesting that these criminal measures represent an appropriate or fair response to this or other public health issues, it is important that PCRS counselors and public health officials understand the nature of these potential criminal sanctions. Realistically, criminal charges have previously been and will continue to be brought against individuals who willfully expose others to HIV and other communicable diseases under general criminal theory and STD- and HIV-specific offenses. The following sections review criminal charges potentially applicable to cases of willful exposure not for the purposes of condoning such sanctions, but rather to explain them and the problems in applying criminal law to cases of willful exposure.

A. Criminal Offenses Generally

Individuals with HIV who have unsafe sex or share drug injection equipment without informing their partners are committing a criminal act in most states. The theory of criminal activity varies by state and depends on the severity of the individual's actions and the underlying facts.¹⁴⁷ Individuals who knowingly and intentionally engage in conduct risking transmission of HIV may be charged with a variety of serious crimes, including murder, voluntary manslaughter, involuntary or reckless manslaughter, assault¹⁴⁸ and battery,¹⁴⁹ reckless endangerment,¹⁵⁰ or attempts at each of these crimes (where infection does not arise or has not yet resulted in the death of another).¹⁵¹

Many of these prosecutions, however, have been brought against persons with HIV who engage in violent behaviors, such as biting or spitting on another, or who intentionally donate infected blood.¹⁵² Few persons with HIV who merely engage in unprotected sex with another or share contaminated needles are charged with

142. See James G. Hodge, Jr., *Implementing Modern Public Health Goals Through Government: An Examination of New Federalism and Public Health Law*, 14 J. CONTEMP. HEALTH L. & POL'Y 93, 95 (1997).

143. See James G. Hodge, Jr., *The Role of New Federalism and Public Health Law*, 12 J. L. & HEALTH 309 (1998).

144. *Id.* at 319.

145. *Id.* at 323-24.

146. See Lawrence O. Gostin, *The Politics of AIDS: Compulsory State Powers, Public Health, and Civil Liberties*, 49 OHIO ST. L. J. 1017, 1041 (1989).

147. See, e.g., Gostin, *supra* note 48.

148. Peter Slevin, *Judge Sends a Message In Assault with HIV*, WASH. POST, Oct. 16, 1999, at B7.

149. See, e.g., *Doe v. Johnson*, 817 F. Supp. 1382, 1396 (W.D. Mich. 1993).

150. See, e.g., *Hancock v. Commonwealth*, 998 S.W.2d 496, 499 (Ky. Ct. App. 1998).

151. *Smallwood v. State*, 680 A.2d 512, 513 (Md. 1996) (charging defendant who knew he was HIV positive and raped three women, with assault with intent to murder, reckless endangerment, and attempted murder).

152. Gostin, *supra* note 146, at 1045-48.

substantial offenses such as attempted murder or other intentional crimes (for many of the reasons discussed below). These criminal offenses, however, may be brought against egregious individuals who willfully expose others to HIV.¹⁵³

A "crime" may be defined as any intentional or reckless act done in violation of duties which an individual owes to the community.¹⁵⁴ Consequently, any criminal charge requires a culpable mental state. In cases of willful exposure to HIV, this mental state may be of two types: (1) intentional or knowing transmission; or (2) reckless or negligent transmission.¹⁵⁵ Persons "*intentionally*" transmit HIV infection (or attempt to transmit if infection does not result) if they have the conscious objective of causing a harmful result, such as infection or death.¹⁵⁶ For example, an individual may intentionally engage in unsafe sexual or needle-sharing acts with another in order to kill the person by infecting the person with HIV.¹⁵⁷ Assuming the facts support this level of criminal intent (which is exceedingly difficult to show),¹⁵⁸ criminal charges based on the intentional nature of the individual's actions may be brought.¹⁵⁹ Persons act "*knowingly*" if they have knowledge of their infection and the modes of transmission or if they reasonably should have known. Individuals with HIV act knowingly when they are practically certain that their conduct (unsafe sexual or needle-sharing activity with another) will risk harm (HIV infection) or death to another.¹⁶⁰

Proving that an individual knew he was infected at the time of the alleged criminal behavior may be difficult. Individuals may be anonymously tested for HIV.¹⁶¹ Even when individuals are not tested anonymously, privacy and confidentiality protections of health care and public health information in some states

may prohibit the release of test results for criminal prosecutions.¹⁶² Proving that an individual knew his actions would transmit the virus is also problematic. Epidemiological studies have demonstrated the low probabilities of HIV transmission through single instances of unsafe sexual or needle-sharing practices.¹⁶³ HIV-positive individuals may assume, at times incorrectly, that their partners are also HIV-positive, thus avoiding the risk of subsequent transmission. Even when actions occur over multiple occasions with identifiable partners, individuals may lack specific knowledge of the likely modes of transmission. For these reasons, criminal charges based on intentional or knowing exposure to HIV through unsafe sexual or needle-sharing behavior are often unsuccessful.¹⁶⁴

Persons act "*recklessly*" when they consciously disregard a substantial and unjustifiable risk (like the risk of transmitting HIV). Persons act "*negligently*" when they should be aware of a substantial and unjustifiable risk, but are not and act inconsistently with that risk. Under criminal law theories, individuals who disregard risks to others through their unsafe sexual or needle-sharing behaviors deviate from the standard of conduct that reasonable, law-abiding persons would adhere to in a similar situation. This deviation from an accepted standard of conduct may be classified as criminally *reckless* or *negligent*, with resulting criminal charges brought. Criminal charges for reckless or negligent exposure to HIV may technically be framed against individuals who know that they have HIV (or are simply at high risk of HIV infection) and who engage in sexual or needle-sharing activities with others (who may or may not be aware of the individual's infection) for reasons other than intentionally or knowingly attempting to cause harm to another.¹⁶⁵

153. See *Smallwood*, 680 A.2d at 513.

154. BLACK'S LAW DICTIONARY 334 (5th ed. 1979).

155. Gostin, *supra* note 146, at 1042-52.

156. *Id.* at 1042.

157. *Id.*

158. *Id.* at 1043.

159. *Id.* at 1042.

160. See *Burk v. State*, 478 S.E.2d 416, 417 (Ga. Ct. App. 1996).

161. Center for Disease Control and Prevention (CDC) & CDC National Prevention Information Network, *Understanding the HIV Counseling and Testing Process*, at <http://www.hivtest.org/consumer/index/htm> (last visited May 28, 2001).

162. D.C. CODE ANN. § 24-492 (1999); ME. REV. STAT. ANN. tit. 5, § 19203-D(2) (West 1964).

163. The estimated risk of HIV transmission for each instance of intravenous needle or syringe exposure is 0.67%. CDC, *Management of Possible Sexual, Injecting-Drug-Use, or Other Nonoccupational Exposure to HIV, Including Considerations Related to Antiretroviral Therapy Public Health Service Statement*, 47 MMWR 1 (Sept. 25, 1998), available at <http://www.cdc.gov/hiv/pubs/mmwr1998.html>.

164. Gostin, *supra* note 146, at 1041, 1043.

165. See, e.g., MO. ANN. STAT. § 191.677(2) (West Supp. 2001).

As with intentional and knowing offenses, numerous problems relate to prosecuting individuals with HIV under these theories of criminal culpability. First, it is difficult to suggest that sexual activity represents a significant deviation from the reasonable person's standard of conduct. Sexual activity is a common behavioral trait. While CDC recommends sexual abstinence or cessation of drug use for those with HIV,¹⁶⁶ its PCRS Guidelines acknowledge a full range of client-centered counseling alternatives,¹⁶⁷ including the need to provide counseling in methods that reduce or eliminate the risk of transmission during sexual intercourse.¹⁶⁸ Provided such practices are used, individuals with HIV may engage in sexual activities with little to no risk to others.¹⁶⁹

Second, utilizing a reckless or negligent standard for criminal culpability widens the pool of individuals who may be prosecuted. Under such theories, it is not necessary to show an individual knew he was infected with HIV before charging the individual with criminal conduct.¹⁷⁰

Third, imposing a reckless or negligent standard fails to target individuals whose conduct is truly blameworthy. The breadth of such theories could criminalize, for example, the activities of an individual with HIV who is engaged in a long-term, consensual sexual relationship with another individual. Punishing individuals who lack evil or antisocial intentions while engaging in activities with others who are aware of the risks is antithetical to public health and criminal practice.

Fourth, the broad use of criminal law to deter individual conduct may deleteriously effect public health, specifically where it discourages at risk individuals from being tested and participating with PCRS.

B. STD- and HIV-specific Offenses

Many states have passed disease-specific laws for sexually-transmitted diseases (STDs) or communicable diseases in general (including STDs).¹⁷¹ These varied laws make criminal the knowing exposure of another to a STD (e.g. syphilis or gonorrhea), where the following elements are shown: (1) individual knowledge of infection with a STD; (2) engagement in sexual behavior; and (3) the failure to disclose the infection to the sexual partner.¹⁷² These statutes typically designate such crimes as misdemeanors.¹⁷³ Criminal sentences for violations include monetary fines or short periods of imprisonment.¹⁷⁴ Though the motivation for STD-specific statutes historically relates to controlling the spread of these diseases, these statutes are rarely enforced in the modern era for STDs besides HIV.

STD-specific offenses, however, may be charged to individuals with HIV who engage in unsafe sexual or needle-sharing activity in states where HIV is classified as a STD.¹⁷⁵ Some states did not originally view HIV/AIDS as a STD in the traditional sense, thus presenting a gap in coverage for criminalizing such behaviors among persons with the disease. In response to this gap, some states created a new category of HIV-specific offenses.

Dozens of states make it a crime to transmit or expose others to HIV.¹⁷⁶ While HIV-specific statutes, like their STD counterparts, differ in scope and application across states, all of these laws make it a criminal offense for individuals to knowingly engage in some type of behavior which poses a risk of transmission of HIV.¹⁷⁷ These behaviors may include sexual intercourse, needle-sharing, or otherwise attempting to transfer any "bodily fluid" to another.¹⁷⁸ As well, HIV-specific offenses do not generally require a showing of individual intent.¹⁷⁹ The state need only show that an individual (1) knew he was infected with HIV,¹⁸⁰ (2) engaged

166. CDC, HIV COUNSELING, TESTING AND REFERRAL STANDARDS AND GUIDELINES (1994).

167. DHHS & CDC, *supra* note 2.

168. *Id.* § 1.2.

169. *See id.*

170. *See, e.g.*, MO. ANN. STAT. § 191.677 (West Supp. 2001).

171. IDAHO CODE § 39-607 (Michie 1949); OKLA. STAT. ANN. tit. 21, § 1192 (West Supp. 2001); VA. CODE ANN. § 18.2-67.4:1 (Michie Supp. 2001).

172. *See, e.g.*, IDAHO CODE § 39-607 (Michie 1949).

173. *See id.*

174. *Id.*

175. FLA. STAT. ANN. § 384.24(2) (West 1998).

176. CATHERINE HANSENS, STATE CRIMINAL STATUTES ON HIV TRANSMISSION (1998).

177. *Id.*

178. *See generally* Gostin, *supra* note 146, at 1041.

179. *Id.*

180. *Id.*

in well-defined, risky behavior (like unsafe sex or needle-sharing);¹⁸¹ and (3) failed to inform his partner of the risk.¹⁸²

HIV-specific offense may carry significantly greater penalties than STD-specific offenses. Violations may constitute a felony, allowing for hefty monetary fines and lengthy prison sentences.¹⁸³ In 1998, the Arkansas Supreme Court, for example, upheld the conviction and sentencing of a twenty-four year old man to thirty years in prison for knowingly transmitting HIV to a woman through unprotected sex.¹⁸⁴

IV. GUIDELINES CONCERNING WILLFUL EXPOSURE

As we have discussed, cases of willful exposure to HIV infection through unsafe sexual or needle-sharing behaviors may arise under several contexts and implicate issues related to individual privacy, partner's right to know, public health duties, and criminal sanctions.¹⁸⁵ Not all instances of willful exposure require affirmative public health action beyond traditional counseling and education services. PCRS counselors may not need to act further when these measures abate a public health threat related to an isolated case of willful exposure, either through a change in the behavior of the individual who exposed others or through the adoption of safe practices by the partner of such individual. Persistent, systematic behaviors of some individuals who may intend to infect others may, however, place PCRS counselors in a precarious position between respecting individual rights and protecting public health. Many of these cases will inevitably involve some difficult trade-offs on a per case basis. Some basic legal, ethical, and practical recommendations that public health departments and PCRS counselors should consider in handling cases of willful exposure, however, are summarized below.

1. *Develop a Public Health Plan.* Public health departments in conjunction with local PCRS counselors should develop a set of standards and procedures applicable to most cases of willful exposure. This plan may help clarify public health duties and responsibilities and re-

duce the opportunity for ill-advised responses. Law enforcement, mental health, and other relevant authorities at the state and federal levels should be consulted during the development of this plan to facilitate the assignment of responsibilities.

2. *Determine Through Investigation the Existence of a Health Threat.* Public health action related to cases of willful exposure should not be based on mere conjecture or unsubstantiated statements. Public health departments and their agents must be prepared to show the existence of a health threat resulting allegedly from an individual's behavior by objective scientific evidence from well-executed and organized epidemiologic investigations. The methods for conducting these investigations without significantly infringing on individual privacy should constitute a portion of the public health plan (above) and be consistent with further recommendations.

3. *Create Strong Protections for Privacy and Security of Public Health Information Related to Investigations of Cases of Willful Exposure.* Information acquired or used as part of formal and informal public health investigations of cases of willful exposure is highly sensitive. Public health departments must not disclose this information to anyone from outside the department (or the circle of governmental authorities engaged in the investigation) unless those persons have a compelling need for the information. Unwarranted disclosures, even if made in the auspices of protecting public health, may still violate federal and state privacy and antidiscrimination laws.

4. *Seek Legal Assistance.* The moment an actual case of willful exposure is detected by PCRS counselors or public health departments, legal counsel should be consulted to determine appropriate courses of action. State laws concerning the privacy of health information and the duties of HCWs and others to warn persons at risk of infection vary significantly. Counsel, who are familiar with each state's laws and regulations, should assist the department in considering options for action, if necessary, without violating individual constitutional rights or

181. *Id.*

182. *Id.*

183. IDAHO CODE § 39-608 (Michie 1949).

184. Lynda Richardson, *Wave of Laws Aimed at People with H.I.V.*, N. Y. TIMES, Sept. 25, 1998, at A1.

185. *See infra* Parts II - III.

subjecting the department or its officials to civil or criminal liability.

5. *Pre-examine the Public Health Impact of Actions Taken.* After consulting with legal counsel and before taking any action to avert such a risk to the public health, an expert assessment should be made of the likely public health impact such action may have in the community based in part on the results of similar actions in other cases. Immediate risks to identifiable members of the community resulting from a case of willful exposure must be balanced against potential future risks to the public health resulting from improper, excessive, or unintended actions. Individuals with prior knowledge in handling cases of willful exposure should be consulted.

6. *Advise the Individual Before Public Actions Are Taken.* To the extent possible, an individual who is allegedly engaging in the willful exposure of others to HIV should be notified of the public health department's planned course of action. Such individuals are entitled to know of the actions taken in order to exercise their legal and ethical rights and potentially protect themselves against potential retribution by aggrieved individuals.

7. *Choose the Least Restrictive Alternative.* These standard procedures and options must be exercised in accordance with a graded series of less restrictive alternatives.¹⁸⁶ The public health plan should require PCRS counselors to choose the least restrictive alternative to accomplish the public health goal. Increasingly serious interventions should be deployed only when less restrictive alternatives have failed to avert an identifiable risk to the public health.

8. *Be Cautious About Disclosing Information.* When action is deemed necessary, however, there are three general options which a public health department or PCRS counselor may take in response to a demonstrated case of willful exposure of others to HIV. They may disclose information about the exposure(s) to (1) persons potentially at risk; (2) criminal justice, law enforcement, or other state or local authorities; or (3) the media.

Any known partners of an individual who willfully exposes others to HIV should be specifically notified and counseled to practice safe sexual and needle-sharing practices as soon as possible provided the identity and other information concerning the individual allegedly responsible for the exposure is kept confidential. If the identities of the sexual and needle-sharing partners of such individuals are not easily verified or obtainable at all, a public health department may have to consider other options.

A more difficult decision arises when a case of willful exposure reveals that designated persons may be exposed to infection in the future without their knowledge. For example, a public health investigation may conclude that an individual with HIV targets single women at a local college. Deciding whether to notify the community of persons at risk is highly complex. Public health departments must weigh the benefits to the group, less restrictive alternatives, and the impact on public health efforts. In other cases, the class of individuals, however, may be too diverse or large to reach through specific notices (e.g., an individual targets married women in a large metropolitan area). Other options may need to be considered in these cases, including providing specific notice to the affected population of the general threat of the spread of communicable disease through unsafe sexual activity.

To avert the risks to a population or identifiable individuals, PCRS counselors and public health departments may need to alert criminal justice, law enforcement, or other state or local authorities (e.g. substance abuse counselors, mental health practitioners, or state health care workers) of an individual's criminal behavior. This option should be pursued only with compelling evidence of a significant and imminent danger to the public health or identifiable persons and if there are no less intrusive ways to avert the harm. Such notices should only be made after (a) confirming the identity of the individual allegedly willfully exposing others; (b) confirming the individual's intention to further expose others to HIV (whether by direct evidence or compelling circumstantial evidence

186. The first of these alternatives may likely be to contact the individual allegedly exposing others to infection, attempt to counsel the individual on the need to practice safe sexual

and needle-sharing behaviors, and obtain the identity of his partners for purposes of notification.

such as a demonstrated pattern of exposures); (c) consulting legal counsel to examine whether state privacy or public health law allows the release of identifiable public health information to such entities by public health departments; and (d) examining the public health impact of such disclosure.

While public health departments may initially assist a criminal investigation with such information, they should not provide any additional assistance or become inter-meshed or associated with the criminal investigation. Public health authorities must avoid at all costs an image in the community as actively assisting in the criminal investigation of persons.¹⁸⁷

There may even be instances where disclosure of individually-identifiable information to local media may be warranted, *but these are extremely rare*. Such disclosures of individual information are the most offensive to principles of individual privacy and are usually more extensive than needed. Broadcast and print media may help to serve the public health objective of warning diverse groups or larger populations of known risks resulting from individuals who willfully expose others to HIV, or assisting with the collection of information about such cases. However, disclosures of sensitive information to the media, such as a person's HIV status and name, identity, or picture, may present more opportunity for harm than public health good. Media sources may unfairly depict individual behavior, improperly report the circumstances of a given case, initiate their own investigations of individual conduct, arouse needless fear among populations, and otherwise

deplete public health resources by manufacturing ill-advised public health responses (such as mass HIV testing) among populations to an otherwise legitimate though limited public health threat.

V. CONCLUSION

PCRS counselors and local public health departments may uncover cases of willful exposure of HIV as part of their broader roles in protecting the public health. Each incident presents counselors with a difficult series of choices. Should the privacy rights of an individual who intentionally tries to infect others be respected through PCRS, or should the right to know of unsuspecting partners predominate? Does the mission of public health suggest a role for these public health authorities to abate willful exposures of HIV? Criminal remedies may be available—should these be pursued and by whom? When should disclosures of sensitive public health information be made? Without dictating the actions of PCRS counselors concerning these cases, we have attempted to guide their responses through information and process-oriented recommendations. Ultimately, each case of willful exposure may need to be addressed on a case by case basis. Like the disease itself, however, exposure of unknowing persons to HIV through the intentional risky behaviors of infected individuals is a largely preventable public health problem which requires an educated, informed, and guided public health response.

187. Occasionally, law enforcement authorities may approach public health departments with requests for information related to separate investigations of cases of willful exposure. While the circumstances underlying such requests vary and the degree to which such information may be pro-

vided depends greatly on state laws, public health departments generally should resist providing authorities any identifiable information in the absence of a compelling public health purpose.