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Donald H.J. Hermann

Rosalind D. Gagliano

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# AIDS, THERAPEUTIC CONFIDENTIALITY, AND WARNING THIRD PARTIES

DONALD H.J. HERMANN\*  
ROSALIND D. GAGLIANO\*\*

## I. INTRODUCTION: AIDS—MENTAL HEALTH AND PUBLIC HEALTH

Infection with the human immunodeficiency virus (HIV) has been linked to myriad psychiatric disorders including depression, paranoia, psychoses, dementia, and delirium.<sup>1</sup> Recent reports indicate that the psychiatric consequences of HIV infection may occur significantly earlier than overt physical signs of infection.<sup>2</sup> The result is that otherwise asymptomatic patients may exhibit psychiatric disorders.<sup>3</sup> Concomitant severe emotional disorders are likely to be present in persons who know they are infected, without any other psychiatric disorders being present. This clinical picture should not be surprising in light of the devastating course of HIV-caused acquired immune deficiency syndrome (AIDS), the likely terminal nature of the disease, and the stigma often associated with the illness' widely publicized risk factors.<sup>4</sup> Complicated cases of physical disease thus are fraught with sensitive issues affecting the treatment and counseling mental health care professionals provide.

The need to meet the psychiatric and counseling needs of HIV-

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\* Professor of Law and Philosophy, and Director, Health Law Institute, DePaul University. A.B., Stanford University, 1965; J.D., Columbia University, 1968; LL.M., Harvard University, 1974; M.A., Northwestern University, 1979; Ph.D., Northwestern University, 1981.

\*\* Consultant, Evangelical Health Systems, Oakbrook, Illinois, and LL.M. Candidate, DePaul University College of Law. B.S.N., University of Maryland, 1976; J.D., St. Mary's University, 1986.

1. Holland & Tross, *The Psychosocial and Neuropsychiatric Sequelae of the Acquired Immune Deficiency and Related Disorders*, 103 ANNALS INTERNAL MED. 760, 761-62 (1985); Navia, Jordan & Price, *The AIDS Dementia Complex: Clinical Features*, 19 ANNALS NEUROLOGY 517, 517-18, 522 (1986); Perry & Jacobsen, *Neuropsychiatric Manifestations of AIDS-Spectrum Disorders*, 37 HOSP. COMMUNITY PSYCHIATRY 135, 135-37 (1986).

2. Grant, Atkinson, Hesselink, Kennedy, Richman, Spector & McCutchan, *Evidence for Early Central Nervous System Involvement in the Acquired Immunodeficiency Syndrome (AIDS) and other Human Immunodeficiency Virus (HIV) Infections*, 107 ANNALS INTERNAL MED. 828, 835 (1987).

3. *Id.* ("[O]ur data suggests that persons with asymptomatic HIV infections may have incipient central nervous system impairment.").

4. See, e.g., Morin, Charles & Malyon, *The Psychological Impact of AIDS on Gay Men*, 39 AM. PSYCHOLOGIST 1288, 1289-90 (1984).

infected persons is reflected in recent federal legislation.<sup>5</sup> Title II of the Health Omnibus Programs Extension Act of 1988<sup>6</sup> provides in part for federal funding of demonstration projects to provide counseling and mental health treatment for HIV-infected AIDS patients experiencing serious psychological reactions caused by their disease.<sup>7</sup>

Immediate and continuous collection of accurate information on the medical condition of HIV-infected persons is vital to efforts aimed at determining the spread of the disease, finding a cure, updating treatment, and educating the public.<sup>8</sup> Superimposed on the urgent need for data acquisition is the need to protect the privacy of persons infected with HIV.<sup>9</sup> The Presidential Commission on the Human Immunodeficiency Virus Epidemic (the President's Commission) reported that throughout its investigation of the spread of HIV, it was confronted with discrimination against individuals who are seropositive or at a more advanced stage of HIV infection.<sup>10</sup> Individuals at risk for HIV infection are concerned that a positive test entry into their medical record or knowledge of their infectious status may negatively affect their insurability, their employability, and their ability to receive needed health care.<sup>11</sup> Current legislation in all states mandates reporting diagnosed cases of AIDS; many statutes, however, strictly limit disclosure to public health authorities.<sup>12</sup> Some states provide for contact tracing or partner notification, which would permit state public health personnel to inform the spouse or known past sexual partners of an AIDS-diagnosed patient.<sup>13</sup> Most states, however, do not require the reporting of test results of HIV-infected individuals who have not progressed to an AIDS diagnosis. There is thus no authority in most states for public

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5. S. 2889, 100th Cong., 2d Sess., 134 CONG. REC. S15,693 (daily ed. Oct. 13, 1988).

6. *Id.* at S15,697.

7. *Id.* at S15,705.

8. See PRESIDENTIAL COMM'N ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC, REPORT OF THE PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC 2-3 (June 1988) [hereinafter PRESIDENT'S COMM'N].

9. *Id.* at 126-28.

10. *Id.* at 119-21.

11. *Id.* at 119.

12. See INST. OF MED. NAT'L ACAD. OF SCI., CONFRONTING AIDS: DIRECTIONS FOR PUBLIC HEALTH, HEALTH CARE, AND RESEARCH 14 (1987).

13. See Massachusetts Medical Soc'y, *Partner Notification for Preventing Human Immunodeficiency Virus (HIV) Infection—Colorado, Idaho, South Carolina, Virginia*, 37 MORBIDITY & MORTALITY WEEKLY REP. 393 (1988). In addition, two states—Georgia and Nebraska—authorize state health department personnel to *notify* contacts of HIV-infected patients in special cases, e.g., rape or incest. *Id.* at 393-94.

health officials to contact the spouses or sexual partners of persons who are only HIV-positive. Likewise, health care personnel or counselors, including psychiatrists, psychologists, or psychiatric social workers, have no explicit authority to inform the spouse or known sexual partner of the HIV status of a patient or client.<sup>14</sup>

Because the likelihood of transmitting HIV presumably increases with the frequency of sexual encounters,<sup>15</sup> an uninformed current sexual partner is a likely candidate for infection if safe sex precautions, including barrier protections, are not utilized. Therefore, the issue arises whether health care personnel or therapists should have the discretionary authority to inform a spouse, known sexual partner, or intravenous (IV) needle-sharing partner of a patient's HIV status. The further question arises whether they should have a duty to warn the patient's partner under any circumstances.

The relationship between therapist and patient is protected by a rule of confidentiality which vests in the patient control over information about the patient's health condition.<sup>16</sup> An increasing body of case law and statutory provisions, however, have identified a therapist's duty "to warn" or "to protect" the patient's intended victims

14. PRESIDENT'S COMM'N, *supra* note 8, at 128.

15. Peterman & Curran, *Sexual Transmission of Human Immunodeficiency Virus*, 256 J. A.M.A. 2222, 2222 (1986) [hereinafter Peterman]. This presumption, as opposed to certainty, underscores the incomplete nature of our medical knowledge. As the authors note:

Though the risk groups for AIDS are well understood, little is known about the absolute risk of acquiring infection through sexual contact. This risk depends on two variables: the number of sexual contacts with an infected partner and the likelihood of transmission of infection during sexual contact with an infected partner. . . . If infection with the AIDS virus is like other sexually transmissible infections, . . . the probability that transmission will occur increases with the frequency of exposure.

*Id.* (footnotes omitted; emphasis added). The problem is that we are not yet certain that HIV infections *are* like other sexually transmissible infections.

16. See, e.g., *Horne v. Patton*, 291 Ala. 701, 709-11, 287 So. 2d 824, 830-32 (1973) (citing privacy and implied contract principles); *Vassiliades v. Garfinckel's, Brooks Bros.*, 492 A.2d 580, 592 (D.C. 1985) (holding that breach of obligation of confidentiality gives rise to a tort). See also *Hammonds v. Aetna Casualty & Surety Co.*, 243 F. Supp. 793, 801 (N.D. Ohio 1965) (finding a contract between a patient and his physician and that "[a]s an implied condition of that contract . . . the doctor warrants that any confidential information gained through the relationship will not be released without the patient's permission.")

The patient's control, which is reflected in the physician's general duty of confidentiality, is not necessarily absolute, however. See, e.g., *Horne*, 291 Ala. at 709, 287 So. 2d at 829 (physician's duty "is subject to exceptions prompted by the supervening interests of society, as well as the private interests of the patient himself." (Emphasis added)). See also *infra* text accompanying notes 32-46.

from harm.<sup>17</sup>

Many therapists who attempt to diminish the danger of further transmission through HIV therapy or counseling may try to obtain a patient's assurance that he or she will refrain from high-risk activities and will inform present or former sexual partners of the situation.<sup>18</sup> When a patient refuses to inform a spouse, sexual partner, or needle-sharing partner of his or her HIV infection, however, the patient's therapist may have an ethical or legal duty to warn those partners.<sup>19</sup> Such action may directly conflict with traditional ethical standards and statutes protecting confidentiality of the patient's medical records.

This article examines the evolution of this conflict. The article discusses state statutes<sup>20</sup> and proposed federal legislation<sup>21</sup> authorizing an exception to the rule of confidentiality. The article then focuses on potential effects of these laws upon the therapeutic relationship and therapists' authority to warn third parties. In addition, the article examines reasons not to impose such a duty. Alternative approaches are applied first to spouses, then to sexual partners or IV needle-sharing partners who are identifiable and limited in number. Finally, the article explores the desirability of providing therapists or counselors with discretionary authority to warn spouses or sexual partners, rather than fixing a mandatory duty to warn.

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17. For the seminal case holding such a duty exists under certain circumstances, see *Tarasoff v. Regents of the Univ. of Cal.*, 17 Cal. 3d 425, 439, 551 P.2d 334, 345, 131 Cal. Rptr. 14, 25 (1976), *aff'g in part*, 529 P.2d 553, 118 Cal. Rptr. 129 (1974). For an article illustrating *Tarasoff's* influence on, and unexpected benefits to, the treatment of a specific case, see Wulsin, Bursztajn & Gutheil, *Unexpected Clinical Features of the Tarasoff Decision: The Therapeutic Alliance and the "Duty to Warn"*, 140 AM. J. PSYCHIATRY 601 (1983) [hereinafter Wulsin].

18. See Council on Ethical & Judicial Affairs, *Ethical Issues Involved in the Growing AIDS Crisis*, 259 J. A.M.A. 1360, 1360 (1988).

19. *Id.* at 1360-61. For guidelines issued by the American Medical Association (AMA), see *infra* text accompanying note 104.

20. See, e.g., CAL. HEALTH & SAFETY CODE § 199.25 (West Supp. 1988) (permitting disclosure by a physician to a spouse if the physician reasonably believes that the patient will not make the disclosure).

21. H.R. 5142, 100th Cong., 2d Sess., 134 CONG. REC. H7969 (daily ed. Sept. 23, 1988). This bill passed the House on September 23, 1988, and went to Conference Committee, where all provisions about confidentiality of test records and authorization for spousal and other warnings were deleted. 134 CONG. REC. H10,251 (daily ed. Oct. 12, 1988). Senator Kennedy of Massachusetts has pledged to "make it a priority in the [next] Congress to pass legislation that include[s] a reasonable and rational confidentiality standard for HIV counseling and testing." *Id.* at S15,690.

## II. THE NEED FOR CONFIDENTIALITY

Obligatory confidentiality is a hallmark of the mental health care profession.<sup>22</sup> The American Psychiatric Association (APA) considers confidentiality paramount to appropriate and effective treatment due to the unique nature of mental health treatment.<sup>23</sup> A patient will not speak freely with a therapist or counselor if public disclosure is likely; effective treatment calls for true and complete communication by the patient of his or her ideas and intentions.<sup>24</sup> Maintaining privacy in this fashion also benefits society at large because it encourages individuals who need mental health treatment to seek help without fearing public disclosure, humiliation, and stigma.<sup>25</sup> Similarly, in the AIDS information-gathering context, where information about an individual's HIV status is important not only for personal treatment, but also for public health, including epidemiological studies, assured confidentiality is necessary to encourage voluntary participation of HIV-infected persons.<sup>26</sup>

The concept of confidentiality, which is based on the right to privacy, recognizes that the decision to share personal information rests with the patient.<sup>27</sup> A concomitant legal duty has arisen render-

22. See, e.g., AM. PSYCHOLOGICAL ASS'N, ETHICAL PRINCIPLES OF PSYCHOLOGISTS 5-6 (1981 rev.) [hereinafter ETHICAL PRINCIPLES OF PSYCHOLOGISTS]; NAT'L ASS'N OF SOCIAL WORKERS, PROFESSION OF SOCIAL WORK: CODE OF ETHICS (1980), reprinted in 2 ENCYCLOPEDIA OF SOCIAL WORK 951-56 (18th ed. 1987) [hereinafter SOCIAL WORKERS' CODE OF ETHICS].

23. An American Psychiatric Association (APA) ethical principle states: "Because of the sensitive and private nature of the information with which the psychiatrist deals, he must be circumspect in the information that he chooses to disclose to others about a patient." American Psychiatric Association, *The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry*, 130 AM. J. PSYCHIATRY 1058, 1063 (1973) [hereinafter *APA Principles of Medical Ethics*].

24. See Goldstein & Katz, *Psychiatrist-Patient Privilege: The GAP Proposal and the Connecticut Statute*, 118 AM. J. PSYCHIATRY 733, 734 (1962). As the authors note,

Even under optimum conditions of confidentiality, it is difficult for the patient to confide his thoughts and feelings to another person. If to that difficulty is added the possibility of disclosure at some future date, it can be expected that he will not speak freely and that his concern about the other implications of treatment will be reinforced.

*Id.*

25. See, e.g., Beigler, *Psychiatric Confidentiality and the American Legal System: An Ethical Conflict*, in PSYCHIATRIC ETHICS 224 (S. Block & P. Chodoff ed. 1981).

26. See, e.g., Comment, *Protecting Confidentiality in the Effort to Control AIDS*, 24 HARV. J. ON LEGIS. 315, 325-27 (1987); Note, *The Constitutional Rights of AIDS Carriers*, 99 HARV. L. REV. 1274, 1280 (1986).

27. A New York court stated this point absolutely: "Every patient, and particularly every patient undergoing psychoanalysis, has such a right to privacy." *Doe v. Roe*, 93 Misc. 2d 201, 213, 400 N.Y.S.2d 668, 676 (Sup. Ct. 1977). The Court further quoted the California Supreme Court, which noted that "a large segment of the psychiatric pro-

ing therapists liable in contract<sup>28</sup> or in tort<sup>29</sup> for breaches of patients' confidential communications made in the course of treatment. As with most rules of law, however, the duty of confidentiality is not absolute, and instances in which exceptions are warranted have been identified.

### III. THE DUTY TO WARN IN THE THERAPEUTIC RELATIONSHIP

Exceptions to the therapist's duty to maintain patient confidentiality are embodied in the principles of the APA:

A physician may not reveal the confidences entrusted to him in the course of medical attendance or the deficiencies he may observe in the character of the patient unless he is required to do so by law, or *unless it becomes necessary to protect the welfare of the individual or community.*<sup>30</sup>

Similar provisions occur in the professional codes of mental health care workers, including those governing psychologists, social workers, and psychiatric nurses.<sup>31</sup>

Court decisions from various jurisdictions have announced exceptions to the physician's duty of confidentiality.<sup>32</sup> Most cases have determined that a therapist's duty to control a dangerous patient or decrease the risk of harm to the patient or other persons outweighs the confidential nature of the relationship.<sup>33</sup> The landmark case authorizing a breach of confidentiality is the California Supreme Court's decision in *Tarasoff v. Regents of the University of California*.<sup>34</sup> In *Tarasoff* the patient informed his therapist of his intention to kill an unnamed person, readily identifiable as the girl with whom he

fession concurs . . . that an absolute privilege of confidentiality is essential to the practice of psychotherapy . . . ." *In re Lifschutz*, 2 Cal. 3d 415, 421, 467 P.2d 557, 560, 85 Cal. Rptr. 829, 832 (1970).

28. *See, e.g.*, *Hammonds v. Aetna Casualty & Surety Co.*, 243 F. Supp. 793, 801 (N.D. Ohio 1965).

29. *See, e.g.*, *Horne v. Patton*, 291 Ala. 701, 287 So. 2d 824 (1973).

30. *APA Principles of Medical Ethics*, *supra* note 23, at 1063.

31. *See, e.g.*, *ETHICAL PRINCIPLES OF PSYCHOLOGISTS*, *supra* note 22, at 5; *SOCIAL WORKERS' CODE OF ETHICS*, *supra* note 22, at 954.

32. *See, e.g.*, *Simonsen v. Swenson*, 104 Neb. 224, 228, 177 N.W. 831, 832 (1920) (physician held not liable for breach of confidentiality for warning patient's landlady of his contagious disease).

33. *See, e.g.*, *Naidu v. Laird*, 539 A.2d 1064, 1072 (Del. 1988) (a psychiatrist owes a broad duty to exercise reasonable care in the treatment and discharge of mentally ill patients to protect against reasonably foreseeable events).

34. 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976), *aff'g in part*, 529 P.2d 553, 118 Cal. Rptr. 129 (1974).

was infatuated.<sup>35</sup> Despite attempts by the therapist, his supervisors, and the campus police to detain the patient in order to thwart any act of violence, the patient murdered the young woman two months later.<sup>36</sup> The court analogized a therapist's duty to warn third parties to a health care provider's liability for failure to control dangerous patients.<sup>37</sup> The court then made a second analogy to a decision finding that a physician has an obligation to warn a patient if the patient's condition or medication renders certain conduct, such as driving, dangerous to others.<sup>38</sup> The court held that "[a] physician or a psychotherapist treating a mentally ill patient . . . bears a duty to use reasonable care to give threatened parties such warnings as are essential to avert foreseeable danger arising from his patient's condition or treatment."<sup>39</sup> The *Tarasoff* decision departed from earlier cases that found liability for failure to control a patient or to warn those who could control the patient.<sup>40</sup> Instead, the court in *Tarasoff* imposed upon the therapist a duty to warn the patient's intended victim.<sup>41</sup> On rehearing the California Supreme Court reformulated the obligation as one of a "duty of care" that could be fulfilled by informing appropriate authorities of any threat by the patient or by taking other measures to thwart an expressed act of violence against an intended victim.<sup>42</sup>

Courts increasingly are encountering the issue presented in the *Tarasoff* decision.<sup>43</sup> Judges are faced with the task of balancing the patient's confidentiality interest against society's interest in protecting the public from harm. When facing this dilemma and finding in

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35. *Id.* at 432, 551 P.2d at 341, 131 Cal. Rptr. at 21.

36. *Id.* at 432-33, 551 P.2d at 341, 131 Cal. Rptr. at 21. The parents of the murdered woman were the plaintiffs in the case. 17 Cal. 3d at 429, 551 P.2d at 339, 131 Cal. Rptr. at 19.

37. 529 P.2d at 558, 118 Cal. Rptr. at 134 (citing *Vistica v. Presbyterian Hosp.*, 67 Cal. 2d 465, 469, 432 P.2d 193, 196, 62 Cal. Rptr. 577, 580 (1967) (hospital has "reasonable care" duty to prevent harm when it "has notice or knowledge of facts from which it might reasonably be concluded that a patient would be likely to harm himself or others . . .")).

38. *Id.* (citing *Kaiser v. Suburban Transp. Sys.*, 65 Wash. 2d 461, 465, 398 P.2d 14, 16, *language amended per curiam*, 401 P.2d 350, 350 (1965)).

39. *Id.* at 559, 118 Cal. Rptr. at 135.

40. *See, e.g., Hicks v. United States*, 511 F.2d 407, 419 (D.C. Cir. 1975) (finding mental hospital negligent for not giving information to court deciding dangerous patient's competency for release).

41. *Tarasoff*, 529 P.2d at 559, 118 Cal. Rptr. at 135. *See generally* Greenberg, *The Evolution of Tarasoff: Recent Developments in the Psychiatrist's Duties to Warn Potential Victims, Protect the Public, and Predict Dangerousness*, 12 J. PSYCHIATRY & L. 315, 317 (1984).

42. *Tarasoff*, 17 Cal. 3d at 439, 551 P.2d at 345-46, 131 Cal. Rptr. at 25-26.

43. *See generally* Comment, *Psychotherapists' Duty to Warn: Ten Years After Tarasoff*, 15 GOLDEN GATE U.L. REV. 271 (1985).

favor of the societal interest,<sup>44</sup> courts generally limit what is included in the individual's interest in confidentiality. The scope of the duty to warn, however, varies among jurisdictions addressing the issue. Some courts narrowly define the duty and have interpreted *Tarasoff* as requiring a warning only when the intended victim is specifically identifiable.<sup>45</sup> Other courts recognize a duty to protect the general public even absent an identifiable victim when danger to others is foreseeable.<sup>46</sup>

Attempts to define the duty to warn have generated controversy about when the duty arises and how it is to be discharged.<sup>47</sup> *Tarasoff* represents the view that once a therapist actually determines, or reasonably should have determined under applicable professional standards, that a patient poses a serious danger of violence to another person, the therapist has a duty to exercise reasonable care to pro-

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44. See, e.g., *Bellah v. Greenson*, 141 Cal. Rptr. 92, 94-95 (1977), *aff'd on reh'g*, 81 Cal. App. 3d 614, 622, 146 Cal. Rptr. 535, 539-40 (1978) (refusing to extend *Tarasoff* liability to danger of self-inflicted harm or property damage). The court noted that *Tarasoff* required a therapist to disclose confidential information if "the strong interest in confidentiality [was] counterbalanced by an even stronger interest . . . [in] safety from violent assault." 81 Cal. App. 3d at 621, 146 Cal. Rptr. at 539. The court recognized that the therapeutic relationship would be compromised if therapists revealed a patient's manifest suicidal tendencies. *Id.* Further, the need for confidentiality was not outweighed by the risk of suicide or property damage. *Id.* at 622, 146 Cal. Rptr. at 540.

45. *Thompson v. County of Alameda*, 27 Cal. 3d 741, 754, 614 P.2d 728, 735, 167 Cal. Rptr. 70, 77 (1980) (duty to warn depends on and arises from existence of prior threat to specific identifiable victim); *Furr v. Spring Grove State Hosp.*, 53 Md. App. 474, 489, 454 A.2d 414, 421 (1983) (duty to warn and duty of reasonable care denied when there is no identifiable victim).

46. See, e.g., *Lipari v. Sears, Roebuck & Co.*, 497 F. Supp. 185, 194-95 (D. Neb. 1980) (applying Nebraska law and emphasizing the importance of foreseeability in defining the scope of the duty to exercise due care); *Petersen v. State*, 100 Wash. 2d 421, 428-29, 671 P.2d 230, 237 (1983) (following *Lipari* approach); *Estate of Mathes v. Ireland*, 419 N.E.2d 782, 784 (Ind. App. 1981) (emphasizing need for "a knowledge of the likelihood . . . [of] bodily harm before duty to warn exists). The duty to protect the general public also was expressed by the dissent in *Thompson v. County of Alameda*, 27 Cal. 3d at 759, 614 P.2d at 740, 167 Cal. Rptr. at 81 (Tobriner, J., dissenting). Justice Tobriner authored the majority opinion in *Tarasoff v. Regents of the Univ. of Cal.*, 17 Cal. 3d 425, 551 P.2d 934, 131 Cal. Rptr. 14 (1976), *aff'g in part*, 529 P.2d 553, 118 Cal. Rptr. 129 (1974). Justice Tobriner, in *Thompson*, explained:

The principles underlying the *Tarasoff* decision indicate . . . the existence of an identifiable victim is not essential to the cause of action. Our [majority] decision rested upon the basic tenet of tort law that a "defendant owes a duty of care to all persons who are *foreseeably* endangered by his conduct." 27 Cal. 3d at 760, 614 P.2d at 739, 167 Cal. Rptr. at 81 (citation omitted; emphasis in original). See generally Greenberg, *supra* note 41, at 324-30 (discussing and distinguishing post-*Tarasoff* interpretive case law).

47. See, e.g., Quinn, *The Impact of Tarasoff on Clinical Practice*, 2 BEHAVIORAL SCI. & L. 319, 322 (1984) ("Both the imposition of a mandated positive duty on clinicians and the specificity of that duty . . . caused an uproar in the professional community.").

tect the foreseeable victim from that danger.<sup>48</sup>

The California Supreme Court followed the *Tarasoff* reasoning in *Hedlund v. Superior Court of Orange County*,<sup>49</sup> extending the therapist's duty to protect third parties beyond the intended victim.<sup>50</sup> Evaluating foreseeability and determining whether a therapist knows or should know requires to some degree that the therapist be able to predict future behavior.<sup>51</sup> But such predictions cannot be made with mathematical precision. Weighing expert testimony and other evidence to determine whether the therapist knew or should have known of the patient's dangerous propensity is a matter for the finder of fact.

Establishing a professional standard of care for predicting future dangerous behavior gives rise to distinct problems. Traditionally, where schools of medical thought differ regarding reasonable practice within a specialty, courts defer to the doctrines of the particular school the physician follows, if it is followed by a respected segment of physicians in that specialty.<sup>52</sup> The APA, representing a significant segment of psychiatric practitioners, maintains that holding psychiatrists to a standard of care for predicting violent acts is not reasonable.<sup>53</sup> The APA contends that therapists do not possess the skills to predict dangerousness reliably.<sup>54</sup> Some commentators raise additional objections to imposing a duty to warn when treatment is conducted on an outpatient basis, arguing that eliminating

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48. *Tarasoff v. Regents of the Univ. of Cal.*, 17 Cal. 3d, 425, 438, 551 P.2d 334, 345, 131 Cal. Rptr. 14, 25 (1976), *aff'g in part*, 529 P.2d 553, 118 Cal. Rptr. 129 (1974). The court stated the therapist's conduct would be measured against the traditional reasonable care standard. *Id.*

49. 34 Cal. 3d 695, 669 P.2d 41, 194 Cal. Rptr. 805 (1983).

50. *Id.* at 705-07, 669 P.2d at 46-47, 194 Cal. Rptr. at 810-11. The court in *Hedlund* relied upon *Tarasoff*'s premise that the duty to warn arises when the therapist knew or should have known of the patient's dangerousness, and reasoned that liability also may exist for harm to others who would foreseeably be injured if the threats were to be carried out. *Id.*

51. *Tarasoff*, 17 Cal. 3d at 437-38, 551 P.2d at 344-45, 131 Cal. Rptr. at 24-25. The *Tarasoff* majority, relying upon a "reasonable care" standard, rejected the contention that "imposition of a duty to protect third parties was unworkable because therapists [could not] accurately predict whether or not a patient will resort to violence." *Id.*

52. W. PROSSER, D. DOBBS, R. KEETON & D. OWEN, PROSSER & KEETON ON THE LAW OF TORTS § 32, at 187 (5th ed. 1984).

53. See *Tarasoff*, 17 Cal. 3d at 437-38, 551 P.2d at 345, 131 Cal. Rptr. at 24-25 (amicus argument). See generally Diamond, *The Psychiatric Prediction of Dangerousness*, 123 U. PA. L. REV. 439 (1979) (discussing the difficulty of predicting violent behavior).

54. See *Tarasoff*, 17 Cal. 3d at 437-38, 551 P.2d at 344-45, 131 Cal. Rptr. at 24-25 (citing the APA's amicus argument stating that a therapist's ability to predict dangerousness is too unreliable to be valid).

the therapist's control obviates the duty requirement.<sup>55</sup> Other commentators state that the confusion surrounding the obligation and the attendant liability forces therapists to breach confidentiality by issuing warnings, even if the risk of harm is remote.<sup>56</sup>

A study conducted among California psychiatrists demonstrated in both private and public practice that cases requiring a *Tarasoff* warning often end in an alienated therapeutic alliance.<sup>57</sup> Most of the therapists surveyed, however, viewed the duty to warn as an ethical responsibility and stated that protecting life and preventing violence serve a greater ethical good than preserving confidentiality.<sup>58</sup>

In contrast, an earlier study concerning the clinical effects of the duty to warn demonstrated a potential for harmony between the warning required by *Tarasoff* and therapeutic confidentiality.<sup>59</sup> This case study suggested that successful alignment of the conflicting duties may actually enhance therapy by bringing the potential victim into the therapeutic process.<sup>60</sup> While recognizing the importance of evaluating the perceived risk according to individual case circumstances, this study advocated directly informing the patient of the intended breach of confidence.<sup>61</sup> The authors suggested reviewing the breach with the patient in an open, inclusive and straightforward manner similar to the process for obtaining informed consent.<sup>62</sup> Obtaining the patient's consent to the warning and exploring the rationale for it allows the therapist a measure of external control, emphasizing an intention to protect both victim and patient from

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55. Note, *Psychiatrists' Liability to Third Parties For Harmful Acts Committed By Dangerous Patients*, 64 N.C.L. REV. 1534, 1545 (1986).

56. See Roth & Meisel, *Dangerousness, Confidentiality, and the Duty to Warn*, 134 AM. J. PSYCHIATRY 508, 509 (1977).

57. Beck, *Violent Patients and the Tarasoff Duty in Private Psychiatric Practice*, 13 J. PSYCHIATRY & L. 361, 375 (1985).

58. *Id.* at 374. Less than 13% of the sample reported that they saw the duty as primarily or entirely one of legal responsibility rather than one of ethical responsibility. *Id.*

59. Wulsin, *supra* note 17, at 601-02.

60. *Id.* at 602. The authors cite other advantages:

[T]he patient can identify with the therapist's deliberate (verbal) approach to negotiating with the intended victim . . . [and] the approach . . . may permit use of a "less restrictive therapeutic setting," where the alliance functions in place of an elaborate panoply of constraints and warnings to promote the patient's ability to work therapeutically with people, including particularly the intended victim.

*Id.*

61. *Id.*

62. *Id.*

harm.<sup>63</sup> In one case the patient chose to issue the warning to the intended victim over the telephone, in the presence of the therapist.<sup>64</sup> As the authors stated:

The clinical context that gives rise to the issue of a *Tarasoff* duty contains an inherent paradox; the patient seems to act to thwart his own wishes. That is, the patient who intends harm informs the therapist, who has—in theory at least—some power to prevent that harm. The paradox of informing the therapist reflects the patient's fear of his own aggressive wishes and his ambivalence toward actually harming the victim. Continuing the process of informing the victim forces a graphic labeling of affects and moves them . . . back into the interpersonal context where they developed; more importantly, the patient talks to the intended victim instead of acting. If the warning is performed with explicit recognition of the patient's ambivalence about the intended harm, it allows the therapist to ally with the healthy part of the patient's ego that fears the assault.<sup>65</sup>

This analysis suggests that informing an identifiable victim of the threat of violence made by a patient may not only protect the patient and the potential victim, but also will contribute to a successful therapeutic outcome.

#### IV. INFORMING THIRD PARTIES IN THE AIDS CONTEXT

In all states, there are statutes requiring that physicians, hospitals, and laboratories report AIDS diagnoses to public health authorities.<sup>66</sup> The Centers for Disease Control and the National Institutes of Health define reporting requirements to include the subject's name and other personal information. One state, Colorado, also requires the reporting of HIV infection as well as personal information about the subject.<sup>67</sup> Others that require the reporting of HIV infections, like Illinois, do not require personal

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63. Wulsin, *supra* note 17, at 602.

64. *Id.*

65. *Id.*

66. *See, e.g.*, N.C. GEN. STAT. § 130A-135 (1987); OR. REV. STAT. § 433.004 (Supp. 1988); TEX. REV. CIV. STAT. ANN. art. 4419b-1 (Vernon Supp. 1988). *See generally* Centers for Disease Control, *Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome*, 36 MORBIDITY & MORTALITY WEEKLY REP. 3S (Supp. 15 Aug. 14, 1987) (discussing the recently broadened definition of AIDS for purposes of reporting AIDS cases to public health authorities).

67. COLO. REV. STAT. §§ 25-4-1401 to -1410 (1982 & Supp. 1987).

data.<sup>68</sup> Precedents for such reporting mandates are found in statutes that require the reporting of other contagious diseases, including sexually transmitted venereal diseases.<sup>69</sup> The AIDS reporting statutes that require disclosure to public health authorities generally do not address the issue of the reporting therapist's or counselor's duty to inform third parties that they have been exposed to HIV or that they may be in danger of exposure. Case law suggests, however, that physicians may have a duty to warn family members of danger posed to them by a family member diagnosed with a sexually transmitted disease<sup>70</sup> or with a contagious disease.<sup>71</sup> Interestingly, while all states have adopted legislation that requires reporting AIDS-diagnosed patients, only a few states have enacted legislation or adopted regulations providing for contact notification without the express consent of the diagnosed person.<sup>72</sup> A California statute specifically provides immunity from prosecution for a physician disclosing a patient's HIV status to a third party believed to be the patient's spouse.<sup>73</sup>

Illinois law provides for notification of both parties to an intended marriage in the event that either tests positive for HIV in a test administered pursuant to obtaining a marriage license.<sup>74</sup> On the other hand, the Illinois AIDS Confidentiality Act<sup>75</sup> appears to prohibit physicians from warning third parties without the patient's

68. ILL. ANN. STAT. ch. 111-1/2, para. 7404 (Smith-Hurd Supp. 1988).

69. *See, e.g.*, COLO. REV. STAT. § 25-4-402 (1982); N.J. STAT. ANN. § 26:1A-7 (West 1964 & Supp. 1988); N.Y. PUB. HEALTH LAW § 201 (McKinney 1971 & Supp. 1988). *See generally* F. GRAD, PUBLIC HEALTH LAW MANUAL 16-17 (1975).

70. *Simonsen v. Swenson*, 104 Neb. 224, 225, 177 N.W. 831, 832 (1920) (syphilis). The "family member" in this case was the patient's landlady, whom the doctor warned because the disease was in a stage where it could be spread by casual contact. *Id.*

71. *See, e.g.*, *Gammill v. United States*, 727 F.2d 950, 954 (10th Cir. 1984) (recognizing the duty but declining to apply it under the facts of this hepatitis case); *Davis v. Rodman*, 147 Ark. 385, 391, 227 S.W. 612, 614 (1921) (typhus); *State v. Wordin*, 56 Conn. 216, 229, 14 A. 801, 804 (1887) (diphtheria); *Hofmann v. Blackmon*, 241 So. 2d 752, 753 (Fla. Dist. Ct. App. 1970) (tuberculosis); *Shepard v. Redford Community Hosp.*, 151 Mich. App. 242, 246, 390 N.W.2d 239, 241 (1986) (meningitis); *Skillings v. Allen*, 143 Minn. 323, 326, 173 N.W. 663, 664 (1919) (scarlet fever); *Jones v. Stanko*, 118 Ohio St. 147, 147, 160 N.E. 456, 457 (1928) (smallpox).

72. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 199.25 (West Supp. 1988); TEX. REV. CIV. STAT. ANN. art. 4419b-1, § 9.03(b)(7) (Vernon Supp. 1988); 1988 S.C. ACTS 508; 1988 N.Y. LAWS 584. In addition, Maryland and Oregon have policies requiring physicians or state officials to notify persons known to be at risk, if the patient refuses to tell the persons voluntarily. INTERGOVERNMENTAL HEALTH POL. PROJECT, GEORGE WASHINGTON UNIV., 1 AIDS: A PUBLIC HEALTH CHALLENGE 4-17 (1987).

73. The provision is permissive and may be interpreted to apply solely to the attending or diagnosing physician. CAL. HEALTH & SAFETY CODE § 199.25 (West Supp. 1988).

74. ILL. ANN. STAT. ch. 40, para. 204(b) (Smith-Hurd Supp. 1988).

75. ILL. ANN. STAT. ch. 111-1/2, paras. 7301-7358 (Smith-Hurd Supp. 1988).

consent.<sup>76</sup> Other statutory provisions permit the Illinois Department of Public Health to engage in contact tracing of diagnosed AIDS patients, but do not require reporting the names of HIV-infected patients.<sup>77</sup> In addition, no provision is made for contacting past or present sexual or needle-sharing partners of persons who are HIV-infected if the seropositive individual has not actually received an AIDS diagnosis.

Texas authorizes disclosure to the spouse of a person who tests positive for HIV.<sup>78</sup> Confidentiality provisions were recently amended in Wisconsin to authorize disclosure to persons known to be needle-sharing contacts or sexual partners of a deceased individual who had been diagnosed with AIDS.<sup>79</sup> The New York legislature recently enacted a statute authorizing physicians to warn the sexual or needle-sharing partners of AIDS patients of potential exposure without consent, despite the patient's objections, where the physician reasonably believes the patient will not make the disclosures.<sup>80</sup>

While hardly establishing a trend, these enactments demonstrate legislative recognition of the dilemma physicians face and represent tentative steps toward its resolution. The United States Congress recognizes the problem as well. The House of Representatives addressed it in a bill entitled the AIDS Federal Policy Act of 1988.<sup>81</sup> This legislation included confidentiality provisions<sup>82</sup> and granted authority to inform spouses, as well as sexual and needle-sharing partners, of the status of HIV-infected persons.<sup>83</sup> Although the provisions of this bill were excluded from the AIDS legislation that the 100th Congress eventually passed,<sup>84</sup> the House bill provides a model approach to the problem of how to handle the potential risk to third parties. Included in the bill were provisions for a grant program and confidentiality protections for AIDS counseling

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76. *Id.* at para. 7357.

77. See Illinois Sexually Transmissible Disease Control Act, ILL. ANN. STAT. ch. 111-1/2, paras. 7401, 7405 (Smith-Hurd Supp. 1988).

78. TEX. REV. CIV. STAT. ANN. art. 4419b-1, § 9.03(b)(7) (Vernon Supp. 1988) (permissive authorization to disclose; no duty to disclose).

79. WIS. STAT. ANN. § 146.025(5)(a)(14) (West Supp. 1988).

80. Act of Sept. 1, 1988, ch. 584, § 2782(4)(A), 1988 N.Y. Laws (WESTLAW, NY-LEGIS database) (to be codified at N.Y. PUB. HEALTH LAW § 2782(4)(A)). This law, however, forbids the physician from disclosing the identity of the patient. *Id.*

81. H.R. 5142, 100th Cong., 2d Sess., 134 CONG. REC. H8076 (daily ed. Sept. 23, 1988).

82. *Id. passim.*

83. *Id.* at § 2329, 134 CONG. REC. at H8081.

84. 134 CONG. REC. S15,693 (daily ed. Oct. 13, 1988) (statement of Sen. Cranston).

and testing.<sup>85</sup> The bill conditioned receipt of federal funds on state compliance with specific requirements, including those for reporting and contact tracing.<sup>86</sup> The bill also provided that a physician or counselor could disclose identifying information about a person who tested positive for HIV if the disclosure were made to the tested person's spouse, sexual partner, or needle-sharing partner; if the physician or counselor were to reasonably believe that the tested person would not voluntarily inform those at risk; and if the disclosure were medically appropriate.<sup>87</sup>

Permissive statutes authorizing disclosure to a spouse or known sexual partners do not facially create a legal duty to warn. Physicians believing that the duty to warn in this context is ethical in origin may derive reassurance from such enactments. In the absence of clear legal authority allowing physicians to make such disclosures, the issue will remain one in which physicians who choose to make warnings do so at their own legal risk.

The case of the recalcitrant AIDS patient is not purely conjecture. One physician relates an experience in which an HIV-positive patient, consumed with anger over his diagnosis, announced his intention to have sexual relations with other people to infect as many as possible.<sup>88</sup> In another case a gynecologist became unexpectedly involved in an ethical situation that began when a patient informed him that her son was bisexual.<sup>89</sup> The physician knew the son was at risk for HIV infection and also knew that the young man was engaged to one of the physician's female patients.<sup>90</sup> The physician elected not to inform the other patient and later fell subject to the patient's rage and indignation for failure to disclose the danger to her.<sup>91</sup> In another case Rock Hudson's former sexual partner brought suit against two physicians involved in Hudson's care, alleging that they conspired to prevent him from discovering Hudson's disease and condition.<sup>92</sup>

Earlier cases involved a physician's duty to warn a patient's fam-

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85. H.R. 5142, § 2302, 100th Cong., 2d Sess., 134 CONG. REC. H8077 (daily ed. Sept. 23, 1988).

86. *Id.* at § 2308, 134 CONG. REC. at H8078.

87. *Id.* at § 2329, 134 CONG. REC. at H8081.

88. Howe, *Ethical Problems in Treating Military Patients with Human Immunodeficiency Virus Diseases*, 3 J. CONTEMP. HEALTH L. & POL'Y 111, 143 n.131 (1987) [hereinafter Howe].

89. Greenfield, *A Gynecological Dilemma Involving AIDS*, 2 CLINICAL PRAC. SEXUALITY 30 (1985); Howe, *supra* note 88, at 139 n.117.

90. Greenfield, *supra* note 89.

91. *Id.*

92. Gorney, *The New Laws of Love: The Courts, Sexually Contracted Diseases and a Partner's Right to Know*, Wash. Post, Nov. 14, 1985, at C-1, col. 2; Howe, *supra* note 88, at 139.

ily or member of the household of the danger presented by a patient's contagious disease.<sup>93</sup> These cases did not reach the question of a physician's responsibility to warn third parties at risk where a competent adult patient, after full counseling, had already agreed to make the disclosure.

Although physicians have been held liable for a breach of the duty to warn in the various contexts already identified, it is unclear whether the holdings in such cases extend to situations involving HIV infection. Duty to warn cases have generally involved psychiatrists who have failed to take steps to protect clearly identified third parties from a dangerous act of a patient.<sup>94</sup> In the infectious disease context, liability has been imposed when neither the patient nor the third party was advised of the risk that the patient's condition posed to the third party.<sup>95</sup> Existing case law would have to be extended to impose on a health care provider a duty of disclosure where a competent, fully informed patient, who had agreed after competent counseling to make his or her own disclosure, failed to do so. Imposing such a duty may deter therapists from making specific inquiries about the sexual and needle-sharing activities of a patient if doing so would create legal liability for failing to use information obtained to warn involved persons.

#### V. HYPOTHETICAL CASE OF THERAPIST FAILING TO INFORM SPOUSE OF HIV-INFECTED PATIENT

Whether a therapist has the responsibility to notify individuals at risk for HIV was recently the subject for debate between attorneys from two California law firms.<sup>96</sup> The debate was based upon a hypothetical fact situation involving a married, forty-one-year-old man whose lucrative, but stressful, professional life prompted him to

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93. See, e.g., *Hofmann v. Blackmon*, 241 So. 2d 752, 753 (Fla. Dist. Ct. App. 1970) (tuberculosis); *Simonsen v. Swenson*, 104 Neb. 224, 225, 177 N.W. 831, 832 (1920) (landlady informed that boarder was in infectious state of syphilis).

94. The landmark case is *Tarasoff v. Regents of the Univ. of Cal.*, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976), *aff'g in part*, 529 P.2d 553, 118 Cal. Rptr. 129 (1974), in which the victim was clearly identifiable. *But see also* *Thompson v. County of Alameda*, 27 Cal. 3d 741, 614 P.2d 728, 167 Cal. Rptr. 70 (1980) (Tobriner, J., dissenting), discussed *supra* note 46.

95. See, e.g., *Wojcik v. Aluminum Co. of America*, 18 Misc. 2d 740, 746-47, 183 N.Y.S.2d 351, 357-58 (Sup. Ct. 1950) (finding liability when employer failed to advise employee or employee's wife of employee's X-ray results showing presence of tuberculosis).

96. Girardi, Keese, Traver & Cooksey, *Featured Debate: Psychotherapist Responsibility in Notifying Individuals at Risk for Exposure to HIV*, 25 J. SEX RES. 1 (1988) [hereinafter Girardi].

enter psychotherapy. During the second year of therapy, the patient had a homosexual affair, which he disclosed to the therapist. The patient firmly refused to follow the therapist's repeated suggestion that he inform his wife of the affair. He persisted in his refusal even after testing positive to the HIV antibody, which he also refused to disclose to his wife. A few years later, the patient was diagnosed with AIDS, but still adamantly refused to disclose his illness to his wife. The wife finally received the information from an anonymous telephone caller. When she confronted her husband, he refused to discuss the matter with anyone other than the therapist. She then obtained an HIV test, which found her to be seropositive. She sued the therapist for negligence in failing to warn her of a "serious threat of danger" posed by her husband's disease.

The attorney-teams were assigned representative roles and asked to submit arguments and rebuttal appropriate to their respective roles, as if the case were being heard before a jury in a California court. Counsel for the plaintiff wife emphasized that the therapist's failure to disclose conflicted with the paramount duty to promote the general health of society. Upholding patient confidentiality in this context was tantamount to permitting the plaintiff "to walk blindly into an absolutely undetectable 'ambush.'"<sup>97</sup> The plaintiff's counsel contended that the danger posed by AIDS is equivalent to the threat of physical violence, long relied upon by courts as triggering the duty to warn.

Defense counsel argued that the patient's failure to inform his wife that he had AIDS was not the violent act contemplated in *Tarasoff*. Further, despite continued routine sexual intercourse between the plaintiff and her husband, the defendant contended that his wife was not "clearly" in danger of contracting AIDS. The defense dismissed the fact of the plaintiff's seropositivity as not providing clear evidence that the wife would develop AIDS. According to the defense, science has not shown that all seropositive individuals will develop AIDS.

The defense argument implied that the danger posed by the patient may be plotted in degrees, and that continuing sexual relations with a spouse who has no reason to believe he or she is at risk does not rise to the degree of dangerousness requiring a warning because it cannot be shown with medical certainty that he or she will develop AIDS and die. One study notes that "[s]ince infection is transmitted to only about 10% to 50% of steady heterosexual part-

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97. *Id.* at 8.

ners, the likelihood of transmission to a partner with a single exposure must be quite low, probably less than 1% per contact."<sup>98</sup>

Nevertheless, it is clear that repeated contacts increase the likelihood of infection. Moreover, the uninformed partner who does become infected also may become pregnant and deliver an infected infant. Or a surviving spouse may remarry following the spouse's death, the true nature of the death having been kept confidential. If the new spouse becomes HIV-positive following repeated exposure, he or she too may have a cause of action as a foreseeable victim of the physician's failure to take necessary protective action. Moreover, seropositive but asymptomatic children produced from the marriage may "carry" the virus into the next generation. It can be argued that even the remote risk of such situations mandates warning an unsuspecting spouse, and is consistent with protecting and promoting the general welfare of society. Thus, merely the potential for development of full-blown AIDS following transmission of the virus should be the principal criterion for determining whether a duty to warn should be imposed upon a physician.

Defense counsel in the debate distinguished *Tarasoff*, where the danger posed was based on the patient's mental condition, from the hypothetical case involving the patient's physical condition. Counsel for the plaintiff, however, argued that the patient's persistent refusal to inform the spouse, despite the patient's knowledge of the consequences of HIV infection, should be regarded as sufficient to demonstrate to a therapist that the patient's mental or emotional condition posed a definite danger to the spouse. The argument is not without support. One commentator, for example, has suggested that "from a psychiatric perspective, the assertion that a patient with HIV who wants to infect others has an underlying mental illness is credible."<sup>99</sup>

## VI. RESERVATIONS ABOUT IMPOSING A DUTY TO WARN

Hesitancy about imposing a duty to warn has been multifaceted. There is concern that patients may be less forthcoming if they do not retain control over who is informed about their HIV status. In addition, there is concern that therapists may be reluctant to explore the possible danger to third parties with the patient if such an

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98. See generally Peterman, *supra* note 15, at 2224 (discussing the likelihood of transmission through repeated exposure, and consequences of heterosexual promiscuity); see also Howe, *supra* note 88, at 137 & n.101.

99. Howe, *supra* note 88, at 146 & n.144 (discussing involuntary hospitalization of promiscuous individuals with HIV as a means of protecting others).

exploration may lead to therapists' legal liability for failure to warn the third party. This hesitancy has led to the suggestion that merely threatening to warn the spouse or known sexual partners may stimulate the patient into appropriate action while helping him or her overcome the denial often associated with HIV-related diagnoses.<sup>100</sup> A therapist's threat to inform the third party would leave control in the patient to the extent that he or she could choose to inform the third party. At least such an approach would eliminate patient fear that others were being informed of the patient's HIV status without the patient's knowledge.

Others who are reluctant to impose a duty to warn have been inclined to recognize an authority to warn in the appropriate circumstances. This approach would permit a physician or public health official limited disclosures to a patient's spouse or known sexual partner, especially where spouses or heterosexual partners are involved since they are unsuspecting and therefore unlikely to assume the precautions taken by members of high risk groups.<sup>101</sup> Giving physicians this authority without exposing them to legal liability would eliminate physician reluctance to explore with the patient any danger of transmission to third parties.

Some who favor a duty to warn would place that obligation on public health authorities, who have general authority for contact tracing in sexually transmissible and communicable diseases, some of whom have been given explicit authority to perform contact tracing in the HIV context.<sup>102</sup> The rationale of the latter, least-intrusive approach is that it would afford protection to the greatest number of individuals without affecting therapist-patient confidentiality.

The American Medical Association (AMA) has endorsed reliance on the physician as a last-resort source of warning to endangered third parties.<sup>103</sup> In its most recent report, the AMA Council on Ethical and Judicial Affairs adopted the following guidelines to aid physicians encountering the duty to warn dilemma:

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100. *Id.* at 141 & n.123 (citing Perry & Markowitz, *Psychiatric Interventions for AIDS-Spectrum Disorders*, 37 *HOSP. & COMMUNITY PSYCHIATRY* 1001, 1005 (1986)).

101. Echenberg, *A New Strategy To Prevent the Spread of AIDS Among Heterosexuals*, 254 *J. A.M.A.* 2129, 2129 (1985); Mills, Wofsy & Mills, *Special Report: The Acquired Immunodeficiency Syndrome*, 314 *NEW ENG. J. MED.* 931, 932 (1986) [hereinafter Mills]. Research into the statistics of the heterosexual AIDS epidemic indicate that by 1991, the percentage of women who suffer from AIDS will rise to at least 9% of the total AIDS population. Discounting the number of women drug abusers, the predicted rise in percentage is attributed to sexual partnership with an infected person. Osborn, *AIDS: Politics and Science*, 318 *NEW ENG. J. MED.* 444, 446 (1988).

102. Mills, *supra* note 101, at 933.

103. Council on Ethical & Judicial Affairs, *supra* note 18, at 1361.

Where there is no statute that mandates or prohibits the reporting of seropositive individuals to public health authorities and a physician knows that a seropositive individual is endangering a third party, the physician should (1) attempt to persuade the infected patient to cease endangering the third party; (2) if persuasion fails, notify authorities; and (3) if the authorities take no action, notify the endangered third party.<sup>104</sup>

## VII. DUTY TO WARN VERSUS AUTHORITY TO WARN

During debate of one proposed piece of AIDS legislation, the AIDS Federal Policy Act of 1988,<sup>105</sup> the House of Representatives considered the alternatives of a mandatory *duty* to warn as opposed to a permissive *authority* to warn. An amendment to the House bill was offered<sup>106</sup> which would have required states receiving federal funds under the proposed act to compel physicians diagnosing an HIV-infected patient to "make reasonable efforts" to disclose the fact of infection to the patient's spouse.<sup>107</sup> Further, a counselor or therapist learning that a client is HIV-infected would be required to "make reasonable efforts" to disclose that fact to the patient's spouse.<sup>108</sup> The physician would be required first to permit the patient to make the initial disclosure to the spouse;<sup>109</sup> then, notwithstanding such disclosure, the physician or counselor would also be required to disclose the information.<sup>110</sup> The amendment required implementation of a *state* enforcement mechanism, but provided that "[no] physician or counselor may be sued or held liable by any *private* person for the failure to make an effort to notify any individual."<sup>111</sup>

Opponents of this legislation cited the opposition of the AMA and the National Governors' Association.<sup>112</sup> The opposition's

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104. *Id.*

105. H.R. 5142, 100th Cong., 2d Sess., 134 CONG. REC. H7969 (daily ed. Sept. 23, 1988). The bill passed the House, see *supra* note 21, but was not included in the comprehensive federal health legislation enacted into law in November 1988. See Health Omnibus Programs Extension of 1988, Pub. L. No. 100-607, 102 Stat. 3048 (1988). See also 134 CONG. REC. S15,690 (daily ed. Oct. 13, 1988) (statement of Sen. Kennedy).

106. 134 CONG. REC. H8073-74 (daily ed. Sept. 23, 1988) (amendment proposed by Rep. McCollum).

107. *Id.* at H8073.

108. *Id.*

109. *Id.*

110. 134 CONG. REC. at H8073-74.

111. *Id.* at H8074 (emphasis added).

112. *Id.* (statement of Rep. Waxman).

thrust was that decisions about medical practice should be left to the discretion of medical practitioners, and decisions about regulating medical practice should be best left to the states.<sup>113</sup>

Other opponents stressed the necessary vagueness and imprecision of any duty to warn statute and objected on two bases: first, the difficulty in specifying the nature of a reasonable effort to identify a spouse and to inform; and second, the inability to establish a uniform and appropriate penalty for noncompliance.<sup>114</sup> The vote against this proposal was 279 to 105, with 47 not voting.<sup>115</sup>

The House bill as originally proposed and adopted included a provision for nonconsensual, discretionary disclosure to third parties.<sup>116</sup> It allowed a therapist, counselor, or physician under specified conditions to disclose information about a patient's HIV status to the patient's spouse or to an individual the patient had identified as a sexual or needle-sharing partner.<sup>117</sup> The specified conditions were that the patient had been counseled about making medically appropriate disclosures of appropriate information to the respective third parties, that the counselor or physician believed that the patient would not inform the third parties, and that the disclosure and its extent was medically appropriate.<sup>118</sup> The Senate bill to amend the Public Health Service Act<sup>119</sup> with the House bill as an amendment passed the House 367 to 13, with 51 not voting.<sup>120</sup> It was not, however, incorporated into the omnibus public health bill that Congress eventually passed.

Granting physicians the authority to inform third parties under the conditions specified by the House bill would provide a means for disclosing to third parties medically relevant information in appropriate circumstances. Providing such authority without imposing a duty to warn avoids the counter-productive impact of a duty to warn, which would result in liability for physicians and therapists who fail to comply with the law. Such potential liability may influence a therapist or physician to avoid inquiring into possible dangers to third parties.

The compromise to patient confidentiality, however, is not fully

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113. *Id.*

114. 134 CONG. REC. at H8074 (statement of Rep. Madigan).

115. *Id.* at H8075.

116. H.R. 5142, 100th Cong., 2d Sess., 134 CONG. REC. H8076, H8081 (daily ed. Sept. 23, 1988).

117. *Id.*

118. *Id.*

119. 134 CONG. REC. H8076 (daily ed. Sept. 23, 1988).

120. *See supra* note 105.

addressed by this type of legislation. This defect can best be corrected by physicians and therapists informing patients at the outset of treatment that one area of inquiry will be the possible danger of HIV transmission. At that time, the patient should be told it may be necessary for the patient to inform his or her spouse, sexual partners, or needle-sharing partners to prevent infection, and that if the patient fails to inform such persons, it is the obligation of the physician or therapist to do so. Such informed consent protects patient autonomy and provides continuing support for the physician-patient relationship should the issue of third-party protection arise.

### VIII. CONCLUSION

Establishing in a vacuum a duty to warn third parties of the potential of HIV infection will not resolve the dilemma posed by the need for confidentiality and the need to protect third parties in the context of HIV infection. The problem of when and under what circumstances a warning should be given poses great difficulty, both in terms of specifying the circumstances under which the duty arises and in fixing an appropriate remedy or penalty for failure to comply. For instance, will a therapist whose patient admits to continued high-risk behavior, but refuses to submit to an HIV antibody test, be required to notify the patient's spouse or known sexual partner that the patient or client *may* have been exposed to HIV? Will the duty unreasonably burden the therapist with obligations to become a sub-specialist in acquired immunodeficiency disorders?<sup>121</sup> For the mental health therapist, the disruptive influence the breach may have upon the therapist-patient therapeutic relationship also must factor into the decision. In the absence of explicit statutory authorization for disclosures, physicians must balance the interests affected in such situations against the very real possibility of legal liability for breaches of confidentiality.

In the mental health context, shifting the burden of notification to public health authorities to resolve the dilemma of duty to third parties presents several problems. At present most public health authorities having notification authority have such authority only in cases of actual AIDS diagnoses. Such authority does not extend to those patients who are still in the earlier, HIV infection stage of the syndrome. By its official nature, state contact tracing is likely to intensify the emotional distress of the person who is informed of pos-

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121. See generally Girardi, *supra* note 96, at 26-27 (demonstrating the onerousness of imposing a general duty to warn in this context).

sible HIV exposure. Including the patient or client in the discussion with the spouse or with the sexual or needle-sharing partner provides a therapeutic forum better suited to dealing effectively with the gravity of the situation, especially if there will be continuing contact between the patient and the spouse or the sexual or needle-sharing partner. Therapists are better suited than public officials to intervene, counsel, and facilitate toward positive behavior in such crises.

Additional problems of follow-up and patient confidentiality compound the issue. It is doubtful that the ethical therapist will deem his or her duty fulfilled by merely notifying public health authorities. The physician or therapist may be motivated by conscience to seek some mechanism to determine whether or not the individual who may have been infected has indeed been notified by the patient or by the public health authority. Therapists also will require reassurance that the names of potentially infected persons reported to authorities receive the protection necessary to maintain the degree of confidentiality to which the persons potentially exposed, as well as patients, are equally entitled.

Until legislation addressing these vital issues is promulgated, therapists facing the dilemma must depend on their ethical consciences to determine which course of action to follow. In many instances the therapist may be forced to choose between a potential rupture of the therapeutic alliance with the patient and the possible prevention of disease transmission to other persons, which might not only help the third party but also contribute in a small way to halting the epidemic. In the absence of a workable, implemented authority to warn third parties in danger of HIV infection, spouses and other sexual or needle-sharing partners of infected persons who refuse to confirm their disease or conform their behavior remain unwittingly at the mercy of therapists and physicians. These health care providers, who after all are only human and fallible, may or may not choose to risk legal liability to further their ethical sense of obligation to protect third parties.