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DOCTORS, AIDS, AND CONFIDENTIALITY IN THE 1990s

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The 1980s witnessed the rapid progression of AIDS from a mysterious new illness to a world-wide pandemic. Research into the cause and treatment of AIDS, underfunded in the early 1980's, gathered momentum in the latter part of the decade. Scientists learned much about HIV, the virus that causes AIDS, and many improvements were made in the care of persons with AIDS and HIV-infection. Unfortunately, there has been little progress toward the development of either an effective vaccine or a cure for the disease.

Because AIDS made its first appearance mainly among male homosexuals and intravenous drug abusers, and because the disease was rapidly and uniformly fatal, persons with AIDS encountered widespread discrimination in housing, education, employment, medical treatment, insurance, and other areas. The exponential growth of the number of cases of HIV-infection was paralleled by an exponential growth in litigation relating to AIDS, as those who were discriminated against because of their illness, or suspected illness, sought redress in the courts. After hearing expert testimony that HIV-infection was not transmissible by casual social contacts, courts generally responded to discriminatory practices based on fear of contagion by prohibiting discriminatory practices.

State legislatures also responded to the discriminatory treatment of the HIV-positive, and to the demands of AIDS activists, by enacting AIDS-specific legislation on an unprecedented scale. Legislatures passed laws prohibiting discrimination against those known to be HIV-positive, requiring informed consent for testing for HIV-infection, and preserving the confidentiality of HIV test results. Public health officials as well as AIDS activists viewed confidentiality as essential for encouraging people to come forward and be tested, counseled, and treated. At the federal level, the 1990 Americans with Disabilities Act, which prohibits discrimination against the disabled in a broad range of circumstances, extended protection to those infected with HIV. At the same time, however, a number of states made it a criminal offense to knowingly engage in conduct likely to transmit HIV to another person.

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The AIDS-confidentiality statutes merely reinforced the physician's existing duty to maintain the confidentiality of all information obtained in the course of the physician-patient relationship. First articulated in the ancient Hippocratic Oath, that duty can today be found in the Code of Ethics of the American Medical Association, state medical licensure laws, state privilege statutes, the Constitutional right of privacy, and the common law. The duty to maintain confidentiality is not absolute, however, and has often been subordinated to other important societal concerns, such as the protection of innocent third parties who may be at risk.

The AIDS-confidentiality statutes generally provide that physicians may only reveal HIV test results to designated individuals without the subject's consent. The typical statute lists numerous exceptions, however, where HIV test results may be disclosed to additional parties if good cause is shown. Exceptions may include disclosure to a health care worker who has been significantly exposed to a patient's blood or other bodily secretions, or to a rape victim. Some statutes provide immunity from liability for persons disclosing HIV test results in good faith, but others provide heavy penalties (a substantial fine or imprisonment) for unauthorized disclosure. Due to the great variability among the statutes, and the severe penalties that may attend their violation, physicians should familiarize themselves with the AIDS-confidentiality statutes in the states in which they practice. Physicians should also seek legal advice before taking action if the statute is ambiguous.

The lawsuits brought against physicians for breach of confidentiality of AIDS-related information are largely governed by traditional tort theories of liability. Actions have been based on invasion of privacy and breach of the physician's ethical duty to maintain confidentiality. A few of the more recent cases also cite to the local AIDS-confidentiality statute. The 1990s will unquestionably see more litigation brought under the AIDS-confidentiality statutes, including Constitutional challenges to the many exceptions to confidentiality allowed in various statutes. Future litigation will establish whether courts will interpret the statutes broadly or narrowly, and litigation will determine how the courts will resolve the many ambiguities in the statutes.

In *Anderson v. Strong Memorial Hospital*,¹ an HIV-positive hospital patient brought suit against his physician, hospital, and a local newspaper. The patient had agreed to be photographed by the newspaper after his physician assured him that he would not be recognizable in the published photograph.² He was in fact recog-

1. 531 N.Y.S.2d 735 (N.Y. Sup. Ct. 1988), *aff'd*, 542 N.Y.S.2d 96 (N.Y. App. Div. 1989).

2. *Id.* at 737.

nized in the photograph.³ The trial court found that the patient's right to confidentiality encompassed his identity,⁴ and the patient ultimately obtained damages of \$35,000 from the physician and hospital for breach of confidentiality.⁵

In *Doe v. Shady Grove Adventist Hospital*,⁶ doctors diagnosed the plaintiff as having AIDS after he was hospitalized for pneumonia. The patient sued the hospital for breach of confidentiality of his medical records and invasion of privacy.⁷ He alleged that a respiratory therapist had shared his medical records with a colleague who knew the patient, and that the colleague had in turn shared the information with the patient's family and friends.⁸ The court stated that the allegations in the complaint, if true, made out a patent violation of the patient's right to privacy.⁹

Two cases involving HIV-positive workers' compensation claimants raise troubling issues of a possible conflict between the physician's duty to maintain the confidentiality of HIV-related information and his obligation to supply complete and truthful information about a patient to third parties who are legally entitled to such information. In *Estate of Urbaniak v. Newton*,¹⁰ the claimant informed a nurse that he was HIV-positive so that she might take precautions to avoid becoming infected from instruments that were contaminated by his blood.¹¹ The patient had also told the nurse he did not want his HIV status revealed to others or placed in his file.¹² She nevertheless told the insurance company physician who was examining the claimant that he was HIV-positive.¹³ The physician included this fact in his report to the California Workers' Compensation Appeals Board because he considered it relevant to the claimant's diagnosis and treatment. The California Court of Appeals, reversing summary judgment for the defendant, held that the allegations stated a valid claim for invasion of privacy under the California Constitution, but dismissed the plaintiff's other claims.¹⁴

In *Doe v. Roe*,¹⁵ a flight attendant sought treatment from a

3. *Id.* at 737-38.

4. *Id.* at 738-39.

5. *Anderson v. Strong Memorial Hosp.*, 573 N.Y.S.2d 828, 829 (N.Y. Sup. Ct. 1991).

6. 598 A.2d 507 (Md. Ct. Spec. App. 1991).

7. *Id.* at 508-09.

8. *Id.* at 509.

9. *Id.* at 516.

10. 277 Cal. Rptr. 354 (Cal. Ct. App. 1991).

11. *Id.* at 356.

12. *Id.*

13. *Id.*

14. *Id.* at 362-63.

15. 599 N.Y.S.2d 350 (N.Y. App. Div. 1993).

New York physician for ear and sinus problems.¹⁶ He told the physician that he was HIV-positive, but asked her to keep the information confidential.¹⁷ The plaintiff subsequently filed a claim for workers' compensation in Pennsylvania, alleging that his ear and sinus problems were work-related.¹⁸ The Pennsylvania court subpoenaed the New York physician and directed her to appear at a hearing in Pittsburgh with all her medical records pertaining to the plaintiff.¹⁹ The subpoena was accompanied by medical reports concerning the plaintiff which contained authorizations, signed by him, for the release of his medical records.²⁰ Rather than attend the hearing in Pittsburgh, defendant elected to forward her chart on the plaintiff to his employer's attorney.²¹ As the chart contained the information that the plaintiff was HIV-positive, he sued the physician for breach of confidentiality, invasion of privacy, and several other causes of action.²² On cross-motions for summary judgment, the New York Appellate Court held the physician potentially liable for both compensatory and punitive damages, despite her claim that she had acted in good faith.²³

In applying New York law, because the alleged breach of confidentiality occurred in New York, the court discerned a strong public policy favoring the confidentiality rights of the HIV-positive in New York's AIDS-confidentiality statute.²⁴ The court read a private right of action into the statute, although none was explicitly granted.²⁵ The court also concluded that the authorizations furnished to the defendant were not sufficient to allow her to release AIDS-related information, as they did not comply with the requirements of New York's AIDS-confidentiality law.²⁶ The court further noted that the defendant was not obligated to obey a Pennsylvania subpoena.²⁷

This case demonstrates a broad interpretation of an AIDS-confidentiality statute, and one which seems unduly harsh toward a physician who may very well have believed, albeit erroneously, that she was required, or at least permitted, to release the information. It is also questionable whether the drafters of the New York AIDS-confidentiality law contemplated that it would be used to withhold medical information that might be relevant to the proper adjudica-

16. *Id.* at 351.

17. *Id.*

18. *Id.* at 351-52.

19. *Id.* at 352.

20. *Doe*, 599 N.Y.S.2d at 352.

21. *Id.*

22. *Id.* at 351-52.

23. *Id.* at 357-58.

24. *Id.* at 353, 357.

25. *Doe*, 599 N.Y.S.2d at 352-53.

26. *Id.* at 355.

27. *Id.* at 357.

tion of a workers' compensation claim. The plaintiff's medical problem, a sinus condition, has in fact been reported to be seen with increased frequency and severity in patients with HIV-infection.²⁸

In other cases, courts have held that patients waived their confidentiality rights with respect to their HIV status by placing their medical condition at issue in litigation. In *Lee v. Calhoun*,²⁹ for example, a patient amended his malpractice complaint to include counts for defamation, invasion of privacy, and breach of doctor-patient confidentiality after the surgeon told a newspaper reporter that the patient was infected with the AIDS virus.³⁰ Responding to the reporter's questions about the malpractice lawsuit, the surgeon explained that the plaintiff's medical condition, a perforated bowel that required emergency surgery, was a consequence of his having AIDS.³¹ The Court of Appeals for the Tenth Circuit upheld the dismissal of plaintiff's claims for defamation, invasion of privacy, and breach of confidentiality.³² The court held that the plaintiff became a public figure when he filed the \$38 million malpractice suit, and that the surgeon's statement that the patient had AIDS was conditionally privileged, as it was true and pertained to the surgeon's defense of the lawsuit.³³

Similarly, in *Dwight B. v. Board of Education of Newburgh*,³⁴ a New York court ruled that a physician who was a defendant in a medical malpractice suit could introduce evidence of the plaintiff's positive HIV test on the issue of whether the plaintiff had been harmed by the physician's allegedly negligent diagnosis and treatment of his head injury.³⁵ The court held that by bringing the action the plaintiff had placed his medical condition at issue.³⁶ The court apparently agreed with the physician's argument that the plaintiff's HIV status affected the plaintiff's life expectancy and, hence, would be relevant to the amount of damages, and that suppressing this information would violate the defendant's right to a fair trial.³⁷

Physicians may be faced with real or apparent conflicts between their ethical or statutory duty to the patient and their obligations under hospital regulations. In *Weston v. Carolina Medicorp*,

28. See Abigail Zuger, *A Recalcitrant Case of Sinusitis*, AIDS CLINICAL CARE, Oct. 1993, at 81.

29. 948 F.2d 1162 (10th Cir. 1991), cert. denied, Lee v. Baptist Medical Ctr., 112 S. Ct. 2940 (1992).

30. *Id.* at 1163-64.

31. *Id.* at 1164.

32. *Id.* at 1168.

33. *Id.* at 1165-66.

34. 600 N.Y.S.2d 414 (N.Y. Sup. Ct. 1993).

35. *Id.* at 415-16.

36. *Id.* at 416.

37. *Id.* at 415-16.

Inc.,³⁸ an obstetrician-gynecologist sued the owner of the hospital that had revoked his staff privileges.³⁹ The physician had admitted a patient whom he knew to be HIV-positive, but, contrary to the hospital's policy, did not place her on blood and body fluid isolation or inform any other hospital personnel that the patient was HIV-positive.⁴⁰ He argued that he was entitled to withhold information about the patient's HIV status because a state statute mandated strict confidentiality of AIDS-related information.⁴¹ The Court of Appeals of North Carolina disagreed, however, finding that the hospital's policy was consistent with the statute. The statute contained an exception for the release of information to health care personnel providing medical care to a patient, and the court held that the physician was, therefore, required to abide by the hospital's policy.⁴² Physicians who find that they are subject to apparently conflicting rules and regulations relating to the confidentiality of AIDS-related information should seek the advice of counsel. At a minimum, physicians should document their reasons for any actions that they take.

A number of courts have held that even prisoners have a right to confidentiality of HIV-related information, and prison doctors may find themselves liable for breach of confidentiality for revealing such information directly or indirectly. In *Nolley v. County of Erie*,⁴³ a federal district court in New York held that prison officials had violated an HIV-positive prisoner's privacy rights under New York's AIDS-confidentiality law and the Constitution by its policy of placing red stickers on the records and possessions of prisoners infected with contagious diseases.⁴⁴ The plaintiff ultimately recovered \$68,401 in damages, despite being unable to prove actual damages.⁴⁵

In *Hillman v. Columbia County*,⁴⁶ the Wisconsin Court of Appeals found that a prison inmate could maintain an action against the county and jail employees for invasion of privacy based upon their unauthorized disclosure of his HIV test results.⁴⁷ In *Harris v. Thigpen*,⁴⁸ however, the Court of Appeals for the Eleventh Circuit held that state prisoners' constitutionally protected privacy interest in preventing nonconsensual disclosure of their HIV-positive status

38. 402 S.E.2d 653 (N.C. Ct. App. 1991).

39. *Id.* at 656.

40. *Id.* at 655-56.

41. *Id.* at 659.

42. *Id.*

43. 776 F. Supp. 715 (W.D.N.Y. 1991).

44. *Id.* at 725-26.

45. *Nolley v. County of Erie*, 802 F. Supp. 898 (W.D.N.Y. 1992).

46. 474 N.W.2d 913 (Wis. Ct. App. 1991).

47. *Id.* at 924-25.

48. 941 F.2d 1495 (11th Cir. 1991).

may be outweighed by legitimate penological interests in segregating HIV-positive prisoners.⁴⁹ A federal court in New York dismissed a similar lawsuit for breach of medical confidentiality where the physician's disclosure of a prisoner's HIV status was authorized by statute.⁵⁰ The confidentiality rights of state prisoners, at least with respect to information about their HIV status, will depend on a court's interpretation of any relevant AIDS-confidentiality statute, the penological interests advanced by the state, and the court's balancing of the state's interests against the prisoner's privacy rights. The privacy rights of federal prisoners, on the other hand, will be governed by regulations adopted by the Federal Bureau of Prisons in 1990⁵¹ which provide that HIV test results are confidential and only those with a need to know should have access to the information.⁵²

There are other considerations when the HIV-positive patient is a physician. In two cases, a physician-patient's right to confidentiality was subordinated to concerns for the possible safety of his own patients. In *Estate of Behringer v. Medical Center at Princeton*,⁵³ a surgeon, who was diagnosed with AIDS at the hospital in which he had surgical privileges, sued the hospital and several of its employees for breach of confidentiality of his HIV test results and for discrimination when the hospital revoked his surgical privileges.⁵⁴ The Superior Court of New Jersey ruled that the hospital had failed to take reasonable steps to maintain the confidentiality of the surgeon-patient's medical records, but stated that the potential risk to patients of an HIV-infected surgeon warranted the restriction of his privileges.⁵⁵

In *In re Application of the Milton S. Hershey Medical Center*,⁵⁶ a Pennsylvania Superior Court upheld a trial court order that permitted two hospitals to disclose the identity and HIV-positive status of a resident physician. The hospitals were permitted to reveal the status to some of the physicians' colleagues, and to disclose to some of his patients that a physician who had been involved in their care was HIV-positive.⁵⁷ After weighing the physician's privacy interest against the hospital's interest in protecting the health of the public, the court concluded that the trial court had not abused its

49. *Id.* at 1516-22.

50. *Selby v. Rapping*, 91 Civ. 2607, 1992 WL 400739 (S.D.N.Y. Dec. 28, 1992).

51. Control, Custody, Care, Treatment and Instruction of Inmates; Human Immunodeficiency Virus (HIV) Programs, 55 Fed. Reg. 52,824 (1990) (to be codified at 28 C.F.R. § 549).

52. *Id.*

53. 592 A.2d 1251 (N.J. Super. Ct. Law Div. 1991).

54. *Id.* at 1254.

55. *Id.* at 1276-83.

56. 595 A.2d 1290 (Pa. Super. Ct. 1991).

57. *Id.* at 1293-96.

discretion or violated the state's AIDS-confidentiality law.⁵⁸ The Pennsylvania Supreme Court agreed, holding that the trial court's decision reasonably balanced the interests of Dr. Doe, the public, and the hospital.⁵⁹ The court observed that "Confidentiality was not the purpose of the Act, but rather was the means chosen by the legislature to further the Act's goal of limiting the spread of HIV and AIDS."⁶⁰

The last two cases raise complex issues which are discussed in greater depth elsewhere in this symposium. Evidence may continue to accumulate reflecting that the HIV-positive physician or surgeon poses a negligible risk of transmitting HIV to his patients. If so, physician-patients may eventually be afforded the same right to confidentiality regarding their HIV status as any other patient.

Both legal and medical literature discuss a possible duty on the part of the physician to warn third parties at risk of contracting HIV from a patient.⁶¹ A case often cited for the existence of such a duty is the well-known *Tarasoff v. Regents of the University of California*.⁶² In *Tarasoff*, the California Supreme Court held that a psychiatrist who knows, or reasonably should know, that his patient poses a threat of violence to another person has a duty, arising out of the psychiatrist-patient relationship, to warn or otherwise protect that other person.⁶³ Many jurisdictions now recognize a similar duty, although some have limited it in various ways by statute or judicial decision. Interestingly, the *Tarasoff* court rationalized its holding in part by citing earlier decisions holding physicians liable for failing to warn third parties who contracted contagious diseases from their patients.⁶⁴

The duty to warn clearly conflicts with the duty to maintain the confidentiality of communications imparted in the course of the physician-patient relationship. However, *Tarasoff* and its progeny have balanced the patient's interest in confidentiality against the public's right to be protected from foreseeable harm, and have generally favored the latter. When the question arose of a possible duty to warn those at risk of acquiring HIV, various governmental and professional groups issued statements which were meant to provide guidance to physicians, but which left many areas of ambiguity. The President's Commission on AIDS, for example, advo-

58. PA. STAT. ANN. tit. 35, § 7608(a)(2)(1990).

59. *In re Application of Milton S. Hershey Medical Ctr.*, 634 A.2d 159 (Pa. Super. Ct. 1993).

60. *Id.* at 163.

61. *See, e.g.*, Michael L. Perlin, *Tarasoff and the Dilemma of the Dangerous Patient: New Directions for the 1990's*, 16 L. AND PSYCHOL. REV. 29 n.91-94 (1992).

62. 551 P.2d 334, 347 (Cal. 1976).

63. *Id.*

64. *Id.* at 354.

cated "rigorous maintenance of confidentiality,"⁶⁵ yet would allow disclosure of an individual's HIV-infection "to a spouse or sexual partner when the individual will not inform such party. . . ."⁶⁶ Similarly, the American Medical Association's Council on Judicial and Ethical Affairs would allow notification of third parties at risk as a last resort, when the physician's attempts to persuade the patient to inform the third party have failed and when public health authorities have declined to act.⁶⁷ Neither guideline addresses the question of how the physician is supposed to determine whether or not the patient has informed the third party of his HIV status, or how long he may wait before taking action. The increasing numbers of women and teen-age girls who are acquiring HIV-infection from heterosexual relations with infected males may result in more pressure being exerted on physicians to notify known sexual partners of their HIV-positive patients.

There are few reported decisions involving AIDS and the duty to warn, but several cases involving other contagious diseases may provide clues as to how courts may rule in future AIDS cases. In a case involving a patient with hepatitis—a disease which is less deadly than HIV-infection but which is transmitted in similar ways—the Supreme Court of Pennsylvania held that a physician could be liable to a third party who had sexual relations with the patient and contracted hepatitis where the physician had erroneously counseled the patient that she could safely engage in sexual relations if she remained symptom-free for six weeks following her exposure to the disease.⁶⁸ While confidentiality was not at issue in this case, the case does stand for the proposition that a physician who treats a patient for a sexually transmissible disease may be held liable to a third party who contracts the disease from the patient because of the physician's negligence.

In *Bradshaw v. Daniel*,⁶⁹ the Supreme Court of Tennessee ruled that a physician has a legal duty to warn a non-patient of the risk of exposure to the source of his patient's non-contagious disease, in this case, Rocky Mountain Spotted Fever (RMSF). A week after the patient died of the disease, his wife was stricken with it, and she died several days later.⁷⁰ Her son sued the physician for failing to warn the wife of her risk of exposure.⁷¹ Plaintiff's expert testified that because of the "clustering effect" of RMSF, the stan-

65. REPORT OF THE PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC, 126 (1988).

66. *Id.* at 127.

67. Council on Ethical and Judicial Affairs, Am. Med. Ass'n, *Ethical Issues Involved in the Growing AIDS Crisis*, 259 JAMA 1360, 1361 (1988).

68. *DiMarco v. Lynch Homes-Chester County, Inc.*, 583 A.2d 422 (Pa. 1990).

69. 854 S.W.2d 865 (Tenn. 1993).

70. *Id.* at 867.

71. *Id.*

dard of care required that a physician treating a patient with it advise the patient's family of the symptoms of the disease, the incubation period, and the need for immediate medical attention should symptoms appear.⁷² RMSF has a high mortality rate if not treated promptly, but it has a low mortality rate if treated immediately. Although RMSF differs from AIDS in that RMSF is not directly communicated from person to person, those in close proximity to the RMSF patient are at a significantly increased risk of catching the disease.⁷³ Most persons in close physical proximity to persons with AIDS are not at risk of contracting the disease, but a duty to warn might be extended to those known by the physician to be engaging in behaviors with the patient that make the transmission of HIV likely to occur.

The *Bradshaw* opinion referred to numerous other cases holding a physician liable to a third party. In those cases the third party contracted a contagious disease from the patient either because the physician failed to diagnose the disease or because, having diagnosed it, he nevertheless omitted to warn others of the risk of infection.⁷⁴ It may be only a matter of time until more physicians are sued for failing to warn persons who acquired HIV from their HIV-positive patients.

The few cases in which physicians who treated HIV-positive patients were sued for failing to warn at-risk third parties have had different outcomes, due to differences in both the factual settings and the law of the jurisdiction. The federal district court in Puerto Rico held that a physician had no duty, under Puerto Rican law, to inform the patient's family that the patient was HIV-positive.⁷⁵ In that case, there was no evidence that the patient had spread HIV to any family member, although the wife claimed to live in fear of contracting AIDS.⁷⁶ A mortician and his wife who sued a hospital and physician for failing to inform the mortician that a corpse he embalmed was infected with HIV had their claims dismissed, and the dismissal was upheld on appeal, where the mortician repeatedly tested negative for the virus and there was no evidence of actual exposure to the virus.⁷⁷

When, however, a police officer who was bitten by an HIV-positive patient, whom he was attempting to subdue in a hospital emergency room, sued the hospital for failing to warn him that the

72. *Id.*

73. *Id.*

74. *Bradshaw*, 854 S.W.2d at 871.

75. *Reyes v. United States*, 770 F. Supp. 58, 63 (D. P.R. 1991), *aff'd*, 971 F.2d 744 (1st Cir. 1992).

76. *Id.* at 59.

77. *Funeral Serv. by Gregory, Inc., v. Bluefield Community Hosp.*, 413 S.E.2d 79, 84 (W. Va. 1991), *overruled by Courtney v. Courtney*, 437 S.E.2d 436 (W. Va. 1993).

patient was HIV-positive, he obtained a \$1.9 million verdict against the hospital.⁷⁸ This verdict was upheld on appeal, despite the fact that he tested negative for HIV.⁷⁹ In support of the verdict, there was evidence that the hospital had failed to follow its own regulation that required it to warn of patients carrying contagious diseases, that the officer had suffered an injury which exposed him to AIDS-infected blood, and that he might have taken additional precautions had he known he was dealing with an HIV-positive patient.⁸⁰

When the physician is a psychiatrist, the duty to warn a third party at risk of contracting HIV from his patient may be more compelling because the patient's mental condition may render him less willing or able to curb the behaviors likely to spread HIV.⁸¹ HIV-positive patients in institutions for the mentally ill are a special concern to those charged with their care, because patients in mental institutions not infrequently engage in sexual relations with each other.⁸² Some commentators have proposed an exception to the AIDS-confidentiality laws for psychiatric patients whose mental disorders impair their ability to follow AIDS-related safety precautions,⁸³ but such patients may already be covered under some of the exceptions provided in existing AIDS-confidentiality statutes.

The predictability of violence is relatively poor compared with the predictability that HIV will be spread by certain kinds of behavior. Therefore, it seems likely that courts that charge psychiatrists with the duty to warn third parties at risk of violence from their patients would also charge physicians with the duty to warn third parties at risk of contracting HIV-infection from their patients. A crucial distinction, of course, is that one may be the victim of a violent attack without having done anything to provoke it, whereas a person who contracts HIV has (usually) engaged in behaviors which he knows or reasonably should know carry the risk of transmitting the virus, and could have taken measures to prevent himself from acquiring the virus (e.g., by engaging in only "safe" sex, or using only new or sterilized needles for injecting intravenous drugs) without knowing whether or not his partner was HIV-positive.

Statutes which specifically address a physician's duty to warn in the context of HIV-infection will, of course, take precedence over

78. *Johnson v. W. Va. Univ. Hosps., Inc.*, 413 S.E.2d 889, 897 (W. Va. 1991).

79. *Id.*

80. *Id.* at 893.

81. See J. Arturo Silva et al., *An HIV-infected Psychiatric Patient: Some Clinicolegal Dilemmas*, 17 BULL. AM. ACAD. PSYCHIATRY & L. 33-43 (1989).

82. *Id.*

83. See Timothy E. Botello et al., *A Proposed Exception to the AIDS Confidentiality Laws for Psychiatric Patients*, 35 J. FORENSIC SCI. 653-60 (1990).

common law principles. A number of states enacted such statutes in the 1980s.⁸⁴ They typically permit, but do not require, a physician to notify a third party at risk of exposure to HIV from the test subject, and often immunize the physician from liability for whichever course he chooses to follow.⁸⁵ Some permit the physician to notify a third party but prohibit him from disclosing the patient's identity. Some place the duty of informing third parties at risk on the state health department, and provide that a physician who reports positive HIV test results to the state health department has fulfilled any duty he might owe to a third party. The statutes vary greatly as to the circumstances that justify the issuance of a warning, and to whom a warning may be issued. Physicians must therefore familiarize themselves with the statutes in their jurisdiction when considering whether to issue a warning to a third party.

The legal developments of the 1980s with respect to HIV-infection were a reflection of the epidemiological and scientific developments occurring at the time. Should any dramatic changes take place in the 1990s in the nature of the virus, the course of the epidemic, the availability of an effective vaccine or treatment, or otherwise, legal rules developed in the 1980s, including rules protecting the confidentiality of one's HIV status, would very likely be changed to reflect the new medical realities.

At the close of 1993, newspaper articles were predicting that the AIDS epidemic would continue to worsen throughout the world. In the absence of a vaccine or a cure for AIDS, the only strategy for containing the epidemic is to prevent the transmission of HIV. This requires that people abstain from behaviors likely to transmit the virus, yet behavioral changes have proven extraordinarily difficult to effect. Furthermore, the epidemic has been with us for so long that a certain amount of complacency, or fatalism, has set in, which makes behavioral change even less likely to occur. People might be more prone to abstain from high-risk behaviors if they knew for certain that their partners were HIV-positive, a factor which tends to favor the issuance of warnings to third parties.

The relatively liberal response to HIV-infection, (exemplified by the AIDS-specific statutes discussed above) compared with the response to other epidemics in the past, may be attributed to the low infectivity of HIV and the inability of the virus to be transmitted by normal social contact.⁸⁶ Should HIV, which is known to be highly mutable, assume a more virulent form, confidentiality con-

84. See Scott Burris, *Testing, Disclosure, and the Right to Privacy*, in AIDS LAW TODAY: A NEW GUIDE FOR THE PUBLIC 115-149 (Scott Burris et al. eds., 1992).

85. *Id.*

86. See John Harris & Soren Holm, *If Only AIDS Were Different!*, HASTINGS CENTER REPORT, Nov.-Dec. 1993, at 6-12.

cerns might give way to concerns over preventing the further spread of infection, and the legal response might change. Two cases reported at the end of 1993 indicated for the first time that HIV may, rarely, be spread by relatively casual contact.⁸⁷ These reports did not engender any immediate panic, but if additional cases should turn up, the situation might well change.

The 1990s are likely to see many changes both in the way health care is delivered and in the way medical information is communicated. These changes are bound to affect the confidentiality of AIDS-related information. President Clinton has proposed a sweeping reform of the nation's health care delivery systems⁸⁸ which, if enacted, would have profound effects on the confidentiality of patient information. Under this proposal, a National Health Board would be responsible for the collection and dissemination of a broad range of information, as well as for safeguarding its confidentiality. President Clinton's Health Security Act allows two years from the date of its passage for the promulgation of standards for the protection of the privacy of patient information, and three years for the submission of a comprehensive proposal for federal privacy protection for health information, which many have complained is too long. The Clinton plan, and other health care reforms that have been proposed on both the state and national levels, rely on computer technology to lower the cost of medical record-keeping. The use of computerized medical records makes possible the invasion of patient privacy and breach of medical confidentiality on a massive scale, and current legislation (both state and federal) is inadequate to deal with this potential problem. Many, including some members of the United States Congress, have called for federal medical privacy legislation that would provide heavy penalties for the unauthorized accessing or misuse of information contained in medical records.⁸⁹ It is unclear what effect a federal statute aimed at protecting the privacy of medical information would have on the AIDS-confidentiality statutes already enacted in more than thirty states; a uniform federal statute might preempt existing state privacy statutes, or it might leave in effect state laws that are more strict than the federal law.

As the AIDS epidemic continues to grow, there will be many pressures to reduce AIDS confidentiality in the 1990s. Identifica-

87. Dennis Hevesi, *AIDS Report Leads to Worry of Panic*, N.Y. TIMES, Dec. 5, 1993, at A33.

88. Pres. Clinton's Health Care Reform Proposal and Health Security Act, (as presented to the 103d Congress, 1st. Sess. on Oct. 27, 1993) (CCH Rep. No. 773, Nov. 1, 1993).

89. See Sheri Alpert, *Smart Cards, Smarter Policy: Medical Records, Privacy, and Health Care Reform*, HASTINGS CENTER REP., Nov.-Dec., 1993, at 13-23; *New Technologies Require Laws to Protect Individual Privacy*, 43 HEALTH L. REP. (BNA) 1486 (1993).

tion of HIV-positive newborns is a controversial subject, and is likely to become more so as more babies are born to HIV-positive mothers and more effective methods of treating HIV-positive babies are developed. Many state health departments now test newborns for HIV anonymously to track the path of the AIDS epidemic.⁹⁰ Informing the mothers whose babies test positive for HIV is controversial because identification of the mothers is tantamount to testing the mothers for HIV without their consent (since the babies could only have received the virus from their mothers), which is forbidden by statute in a number of states. Many pediatricians support informing the mothers so that the children can get treated prophylactically, or at least be carefully monitored. Since not all newborns with positive HIV-antibody tests actually harbor the virus (some having inherited only the antibody to the virus and not the virus from their mothers), informing the mothers could also prevent the future infection through breast-feeding of those babies who are not truly HIV-positive.

The reemergence of tuberculosis (TB) in the late 1980s, after it seemed on the verge of extinction, also threatens the confidentiality of HIV-related information. The prevalence of HIV-infection is believed to be responsible for the resurgence of tuberculosis, as HIV-positive individuals exposed to TB have a high rate of progression to active TB after a relatively short time.⁹¹ Tuberculosis is potentially a greater threat than AIDS because it is spread much more easily from person to person; being in the same room with an infected individual may suffice. The failure of some TB patients to complete their medical treatment has resulted in the development of drug-resistant strains of tuberculosis that have proven very difficult to treat.⁹² Since identification of those co-infected with HIV and TB is essential for the initiation of treatment to curtail the development and spreading of tuberculosis, there may be growing pressure to place limits on the privacy of HIV-related information in order to curb the spread of TB.⁹³ In 1991, Connecticut became the first state to require physicians to report the names of people infected with both tuberculosis and HIV, after seeing the number of people in the state infected with tuberculosis rise 22% in the first

90. Mireya Navarro, *Testing Newborns for AIDS Virus Raises Issue of Mothers' Privacy*, N.Y. TIMES, Aug. 8, 1993, at A1.

91. Charles L. Daley et al., *An Outbreak of Tuberculosis With Accelerated Progression Among Persons Infected with the Human Immunodeficiency Virus*, 326 NEW ENG. J. MED. 231, 231-35 (1992).

92. Josh Barbanel, *Rise in Tuberculosis Forces Review of Dated Methods*, N.Y. TIMES, July 10, 1991, at B1.

93. *Hill v. Evans*, No. CIV.A.91-A-626-N, 1993 WL 439966, at *11 (M.D. Ala. Oct. 7, 1993).

six months of the year.⁹⁴ Prior to this time, physicians were required to report only those with full-blown AIDS, not HIV-infection. Although Connecticut has a higher percentage than other states of HIV-positive individuals who are also infected with TB, other states may decide to follow Connecticut's lead in requiring doctors to report the names of those who are doubly infected.

As HIV-infection becomes more prevalent, there may be increasing pressures to reveal the HIV status of potential organ donors, since HIV-transmission has been shown to occur in organ transplants of various kinds. In numerous lawsuits brought by persons who contracted HIV from blood transfusions or blood products, plaintiffs have attempted to learn the identity of those who donated the HIV-infected blood. They met with varying responses from the courts, which were torn between facilitating compensation of the plaintiffs and protecting the supply of blood by guaranteeing donor confidentiality. A full discussion of this issue is beyond the scope of this article, and the subject has been treated in depth elsewhere.⁹⁵ Routine testing of blood and blood products for HIV-antibody since March, 1985, has reduced the risk of HIV-infection from blood transfusions to a negligible amount,⁹⁶ but other organs are more difficult to test for HIV. Testing of would-be donors and identification of those who are HIV-positive may be seen as necessary to prevent HIV-transmission by this route. The physician who discloses that a potential organ donor is HIV-positive may therefore escape liability for breach of confidentiality.

Persons infected with HIV have shown a marked variability in the course of their illness, with some developing full-blown AIDS within a year or two of first testing positive, and others remaining symptom-free for over ten years. Some individuals with heavy exposure to HIV (such as prostitutes, or women married to HIV-positive men who practiced unprotected sex for years) have failed to contract the virus. This leads to speculation that some individuals may harbor a natural immunity to HIV. Research on the human genome is proceeding with great rapidity, and it is possible that a genetic factor responsible for resistance to HIV, if one exists, will be identified. If an effective vaccine for HIV-infection should be developed, it would be important to identify those with a natural resistance to the disease in order to avoid vaccinating them unnecessarily, which would be wasteful of scarce resources. The

94. See Laura Johannes, *AIDS-TB Cases Must Be Listed*, NEW HAVEN REG., July 19, 1991, at 1.

95. See, e.g., Ross D. Eckert, *The AIDS Blood-Transfusion Cases: A Legal and Economic Analysis of Liability*, 29 SAN DIEGO L. REV. 203 (1992); Joseph Kelly, *The Liability of Blood Banks and Manufacturers of Clotting Products to Recipients of HIV-Infected Blood*, 27 J. MARSHALL L. REV. 465, (1994).

96. HEALTH LAWYERS' NEWS REPORT, Nov. 1993, at 7. "The CDC estimates the risk of infection from a single pint of blood at one-in-225,000." *Id.*

HIV-resistant cannot be identified without simultaneously identifying the HIV-susceptible, however, and that could result in discrimination against the latter, similar to the discrimination against those who are already HIV-positive.

Eventually the need to maintain the confidentiality of AIDS-related information should diminish, for the following reasons:

(1) As AIDS becomes more and more prevalent, and ceases to be identified as a disease affecting mainly homosexuals and intravenous drug-abusers, some of the disease's stigma will come to be viewed as just another one of the many terrible diseases that afflict mankind.

(2) Confidentiality is less an end in itself than a means of protecting the HIV-positive from discrimination. There are now many more tools available to fight the discrimination against persons with AIDS than existed in the 1980's, including the Americans with Disabilities Act and the many AIDS-specific state anti-discrimination statutes.

(3) The passage of a comprehensive health care reform bill, with guaranteed universal access to care regardless of pre-existing conditions, would eliminate one of the major concerns behind the opposition to the release of HIV-related information, that of losing one's health insurance coverage.

(4) As the knowledge of AIDS' low infectivity gradually becomes absorbed into the public's consciousness, another reason for the stigma surrounding the disease, the fear of contagion, will have been eliminated.

(5) As new treatments or vaccines are developed which may be effective in the early stages of HIV-infection, there will be compelling reasons to identify the HIV-positive so that treatment can begin as early as possible.

CONCLUSION

It will be years before developments which diminish the need for confidentiality are fully realized. Therefore, the persistence of widespread discrimination against persons with AIDS or HIV-infection means that we will have a need to preserve the confidentiality of AIDS-related information for years to come.