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NOTES

THE NEW AIDS "LOOK BACK" STATUTE: CONTACT TRACING IN THE HEALTH CARE SETTING—A STEP IN THE WRONG DIRECTION

INTRODUCTION

Since the first reported case of acquired immunodeficiency syndrome ("AIDS") on June 5, 1981, this fatal and presently incurable disease has reached epidemic proportions and currently threatens the health and welfare of forty million people worldwide.1 Only a decade since the Centers for Disease Control ("CDC") identified AIDS, it has become one of the leading causes of death in men and women twenty-five to forty-four years of age in the United States.2 The CDC predicts that, in this country alone, approximately 400,000 cases of AIDS will be reported by the year 1993.3 In the same period, the CDC predicts that AIDS will result in approximately 300,000 deaths.4 As a result of this growing crisis, the American public has become increasingly concerned about how AIDS is contracted and in what settings transmission is most likely.5

One area of concern involves the possibility of transmission in

1. Centers for Disease Control, The HIV/AIDS Epidemic: The First 10 Years, 265 JAMA 3228, 3228 (1991). According to the World Health Organization, approximately eight to ten million adults and one million children worldwide are infected with HIV, the virus which causes AIDS. Id. The World Health Organization predicts that 40 million persons may be infected with the disease by the year 2000. Id.

2. Id. See also Gary R. Noble, How the Response to the Epidemic of HIV Infection Has Strengthened the Public Health Care System, 106 PUB. HEALTH REP. 608, 608-610 (1991) (discussing the number of AIDS cases and projections in the United States).

3. Centers for Disease Control, HIV Prevalence Estimates and AIDS Case Projections for the United States: Report Based upon a Workshop, 39 MORBIDITY & MORTALITY WKLY. REP. 1, 12 (1990) [hereinafter HIV and AIDS Case Projections]. The CDC predicts that there will be 390,000-480,000 reported cases of AIDS, resulting in 285,000-340,000 deaths, through the year 1993. Id.

4. Id.

the health care setting.\textsuperscript{6} Until recently, the primary focus of transmission risk in the health care setting concerned the transmission from infected patient to health care provider ("HCP").\textsuperscript{7} However, last year the well-publicized case of Kimberly Bergalis, a Florida woman who contracted the human immunodeficiency virus ("HIV") during dental treatment,\textsuperscript{8} sparked enormous public concern regarding the transmission of HIV, the virus which causes AIDS.\textsuperscript{9} Since this incident, public attention has increasingly shifted to focus on the potential risk of transmission from an HIV-infected HCP to a patient.\textsuperscript{10}

In response to the increased public concern, many states are attempting to enact legislation in an effort to reduce the risk of HIV transmission in the health care setting.\textsuperscript{11} On October 4, 1991, the governor of Illinois signed into law an important amendment to the existing Illinois AIDS/HIV law.\textsuperscript{12} The new "Look Back" statute focuses primarily on HIV-infected HCPs.\textsuperscript{13} Under the statute, if the Illinois Department of Public Health ("Health Department") determines that an HIV-infected HCP exposed a patient to HIV during


\textsuperscript{8} On June 14, 1991, the CDC strongly suggested that an infected Florida dentist transmitted the virus to five of his patients during dental treatment. See Centers for Disease Control, Update: Transmission of HIV Infection During Invasive Procedures - Florida, 40 MORBIDITY & MORTALITY WkLY. REP. 377 (1991) [hereinafter Transmission of HIV Infection During Invasive Procedures].

\textsuperscript{9} See, e.g., Mike Clary, AIDS Victim Infected By Dentist Dies, L.A. TIMES, Dec. 9, 1991, at A4 (discussing Kimberly Bergalis, one of five patients who contracted HIV during dental treatment, and her appeal to Congress for mandatory testing). See also Victoria Slind-Flor, HIV-Infected Physicians Face Limits, NAT'L L. J., Aug. 5, 1991, at 3, 24 (discussing efforts of the courts, medical organizations, and agencies to respond to the risk of HIV transmission from HCP to patient). See also Lawrence K. Altman, An AIDS Puzzle: What Went Wrong In Dentist's Office?, N.Y. TIMES, July 30, 1991, at C3 (stating that the documented transmissions of HIV to five patients in Florida has had an enormous impact on public health policy).

\textsuperscript{10} HIV IN THE HEALTH CARE WORKPLACE, supra note 7, at 3.

\textsuperscript{11} Health Care Providers with HIV Infection (Aids Policy Center, Intergovernmental Health Policy Project, George Washington University, Washington, D.C.), Feb. 1992, at 1 [hereinafter Intergovernmental Health Policy Project]. Currently, 19 states have introduced bills related to HCPs who are HIV-infected. Id. Furthermore, seven states have enacted laws related to HCPs who are HIV-infected. Id.


\textsuperscript{13} Id.
treatment, the Health Department may conduct "contact tracing." Contact tracing involves notifying past patients of the HCP's HIV status. Furthermore, the statute authorizes the Health Department to have complete access to the HCP's patient records in order to notify patients whom the HCP has exposed to HIV.

Illinois is the first state to enact a statute which allows a public health department to conduct contact tracing and retrospective patient notification regarding an HIV-infected HCP. In addition, Illinois is the first state to authorize a public health department to have complete access to an HIV-infected HCP's patient records. Clearly the Illinois General Assembly realized the importance of its vote on October 4, 1991, when one representative warned, "I'd like for everyone in the [legislative] body to realize that the whole country is watching Illinois this morning and watching this vote... we are being watched." Although Illinois has taken a large step to control the spread of AIDS/HIV in the health care setting, the "Look Back" statute is ineffective, potentially counterproductive and should be amended.

This Note addresses Illinois' recent legislative attempt to control the spread of HIV in the health care setting. Part I of this Note examines HIV and the potential risks of HIV transmission from HCP to patient. Part II sets forth the history and events that prompted the Illinois legislature to enact the "Look Back" statute. Part III examines the "Look Back" statute, and discusses the legislature's intent. Part IV analyzes the "Look Back" statute, determining that although the statute is constitutional, it is an inappropriate way to address the risk of HIV transmission in the health care setting. Finally, Part V proposes amendments to the "Look Back" statute to make it more effective.


15. Id.


17. Intergovernmental Health Policy Project, supra note 11. Currently seven states (California, Florida, Hawaii, Illinois, Louisiana, Maryland, and Texas) have laws regarding HIV-infected HCPs. Id.

18. See infra notes 118-119 and accompanying text for a discussion of states that have attempted to pass legislation aimed at the HIV-infected HCP.

I. HIV AND THE RISK OF TRANSMISSION FROM HEALTH CARE PROVIDERS

A. Acquired Immunodeficiency Syndrome

In 1981, the CDC documented the first cases of a disease now known as AIDS. The disease assails the human immune system causing severe immune system deficiencies. These deficiencies render the immune system unable to fight off certain infections which would not ordinarily affect people whose immune systems are working normally. Although treatment of some symptoms is available for persons afflicted with AIDS, presently no known cure for AIDS exists. The disease is always fatal.

A retrovirus called HIV causes AIDS. This virus attacks a person's white blood cells. Once infected, the cells cease to func-


22. See AIDS: Testing Democracy, supra note 5, at 850. The types of infections which afflict persons diagnosed with AIDS are commonly referred to as "opportunistic infections." Id. at 850 n.54. The clinical definition of AIDS is usually characterized by the onslaught of one or more "opportunistic infections" or the occurrence of particular malignant tumors. Id. at 850.

23. Michael L. Closen et al., AIDS: Cases and Materials 112 (1989) [hereinafter AIDS: Cases and Materials]. An individual who is diagnosed as having AIDS is unable to fight off such illnesses as pneumonia, oral disorders, and even the common cold. Pederson, supra note 21, at 657.


25. Id. at 292.

26. See id. at 292.

27. AIDS: Cases and Materials, supra note 23, at 112. Retroviruses have been defined as "unique RNA viruses reproduced by a viral DNA intermediate integrated within the host cell's DNA." Id.

28. See Human Immunodeficiency Virus, 232 Science 697 (1986); see also The Merck Manual, supra note 20, at 288. Although the virus that causes AIDS is now commonly referred to as the human immunodeficiency virus (HIV), the retrovirus has previously been referred to as T-lymphotrophic virus Type III (HTLV-III), lymphadenopathy-associated virus (LAV), and the AIDS-associated-retrovirus (ARV) by different laboratories. Id. See also AIDS: Testing Democracy, supra note 5, at 855-61 (discussing how HIV causes AIDS).

29. HIV attacks certain white blood cells known as T-cells. AIDS: Cases and Materials, supra note 23, at 122. These white blood cells are composed primarily of lymphocytes and macrophages. Id. They function as a critical part of the immune system. Id. Some of their functions include producing antibo-
tion normally. As a result, the immune system is weakened and unable to fight off common everyday illnesses.

After an individual becomes infected with HIV, there is a delay prior to the appearance of antibodies. Therefore, despite infection, the HIV-infected individual will initially test negative for HIV. This period during which the individual is infected but antibodies are not detectable is commonly referred to as the "window period." The "window period" generally lasts from three weeks to six months. A person who is tested while in the "window period" will not test positive for HIV although he or she is infected and capable of transmitting the disease to others.

HIV transmission can occur in a number of ways. All of these modes require some exchange of specific bodily fluids. The most common modes of transmission include engaging in sexual intercourse, sharing previously used syringes, and receiving blood, body parts or bodily fluids. Because exchange of bodily fluids transmits HIV, the public has become concerned about the possibility of HIV transmission in the health care setting.

dies and working to destroy foreign materials. Id. After invading the cell, the virus replicates and destroys host cells. See also ROBERT M. JARVIS ET AL., AIDS LAW IN A NUTSHELL 6-7 (1990) (discussing HIV's effect on the human immune system).

33. Currently, there are two recognized tests for the presence of antibodies produced in response to HIV. Id. at 17-18. The first test is a preliminary test which detects the presence of antibodies produced by the immune system in response to HIV. Id. This test is called the enzyme-linked immunosorbent assay (ELISA). Id. The second test is a confirmation type test for a positive result to the ELISA. Id. This test is called the Western blot test. JARVIS ET AL., supra note 29, at 18.
34. AIDS: CASES AND MATERIALS, supra note 23, at 131.
35. Id.
36. JARVIS ET AL., supra note 29, at 14. Some authorities have determined that the window period may last as long as several years. Id.
37. Id. at 18.
38. Id. at 7.
39. Id. HIV has been found to exist in blood, semen, vaginal secretions, saliva, tears, breast milk, urine, and amniotic fluid. Centers for Disease Control, Recommendations for Prevention of HIV Transmission in Health-Care Settings, 36 MORBIDITY & MORTALITY WKL. REP. 3s (1987) [hereinafter Recommendations for Prevention of HIV Transmission in Health-Care Settings].
40. JARVIS ET AL., supra note 29, at 7-8.
B. The Threat of Transmission in the Health Care Setting

Undoubtedly, the opportunity for HIV transmission and direct exposure to HIV occurs frequently in the health care setting. Authorities have documented HIV transmission from an infected patient to an HCP. HCPs repeatedly come into contact with bodily fluids and/or body parts. In addition, many HCPs perform “exposure-prone invasive procedures” on patients. Consequently, an HIV-infected HCP who performs invasive procedures provides an opportunity for possible HIV transmission to a patient.

Although authorities now know that an HIV-infected HCP is capable of transmitting the virus to a patient, the exact number of HCPs who are HIV-infected or who have AIDS is not known.

42. AIDS: CASES AND MATERIALS supra note 23, at 120.
43. See Centers for Disease Control, Estimates of the Risk of Endemic Transmission of Hepatitis B Virus and Human Immunodeficiency Virus to Patients by the Percutaneous Route During Invasive Surgical and Dental Procedures 4 (Jan. 30, 1991) (unpublished manuscript on file with the author) [hereinafter Estimates of the Risk of Endemic Transmission of HIV to Patients] (discussing transmission of HIV in the health care setting). Currently, the exact number of HCPs who have contracted HIV through occupational exposure is not known. Julie L. Gerberding, Managing HIV Exposure in Health Care Settings, 5 FOCUS: A GUIDE TO AIDS RESEARCH AND COUNSELING, (The AIDS Health Project, San Francisco, Ca), July 1990, at 1. However, the CDC reports that over 25 HCPs have seroconverted after exposure at work. Id. Furthermore, additional undocumented or unreported cases of occupational exposure of HIV to HCPs are thought to exist. Id.
44. AIDS: CASES AND MATERIALS, supra note 23, at 120.
45. The CDC described “exposure-prone” procedures as the following: digital palpation of a needle tip in a body cavity or the simultaneous presence of the HCW's fingers and a needle or other sharp instrument or object in a poorly visualized or highly confined anatomic site. Performance of exposure-prone procedures presents a recognized risk of percutaneous injury to the HCW, and — if such injury occurs — the HCW’s blood is likely to contact the patient’s body cavity, subcutaneous tissues, and/or mucous membranes.
Centers for Disease Control, Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures, 40 MORBIDITY & MORTALITY WkLY. REP. 1, 4 (1991) [hereinafter Recommendations for Preventing HIV and HBV].

The CDC defined “invasive procedure” as “surgical entry into tissues, cavities, or organs or repair of major traumatic injuries” which may be associated with the following:

(1) an operating or delivery room, emergency department, or outpatient setting, including both physician’s and dentist’s offices; 2) cardiac catheterization and angiographic procedures; 3) a vaginal or cesarean delivery or other invasive obstetric procedure during which bleeding may occur; or, 4) the manipulation, cutting, or removal of any oral or perioral tissues, including tooth structure, during which bleeding occurs or the potential for bleeding exists.

Recommendations for Prevention of HIV Transmission in Health-Care Settings, supra note 39, at 6s-7s.
46. Keyes, supra note 6, at 603.
However, the CDC reports that in the United States there are over 5,400 reported cases of HCPs infected with AIDS. The CDC estimates that of the reported HCPs with AIDS, approximately 1,200 are dentists and approximately 330 are surgeons. Furthermore, an unidentified number of HCPs in the United States have HIV, but have not yet been diagnosed with clinical AIDS. One estimate based on CDC statistics predicts that there are between 50,000 and 75,000 HIV-infected HCPs in the United States. Thus, although the precise number of HIV-infected HCPs is not yet available, the existing estimates demonstrate that a significant number of HCPs may be HIV-infected.

Once an HCP has become HIV-infected, the risk that he or she will transmit the virus to a patient depends primarily on two factors. First, a "portal of entry" for the virus must exist. Second, the transfer of blood or bodily fluid from the infected HCP to the patient must occur. Because one or both of these factors are often present during exposure-prone invasive procedures, an HIV-infected HCP who performs these procedures creates a risk that transfer of blood or bodily fluid to a patient may occur.

Transfer of blood or bodily fluid from an HIV-infected HCP can occur in a number of ways. First, transmission can occur through the use of a sharp instrument contaminated with the blood of the infected HCP or another infected patient. Second, an HCP may be cut by a sharp bone fragment or other material which is inside a patient's body. Third, transmission can occur if an HCP bleeds

48. Mary E. Chamberland et al., Health Care Workers With AIDS; National Surveillance Update, 266 JAMA 3459, 3450 (1991). As of June 30, 1990, there have been 5,425 reported cases of health care workers with AIDS in the United States. Id. at 3450. See also Estimates of the Risk of Endemic Transmission of HIV to Patients, supra note 43, at 4 (which estimates that 5,815 persons working in the health care setting have AIDS).

49. Id. at 5. The CDC estimates that 1,248 dental workers and 336 surgeons have been diagnosed with AIDS. Id.


52. Keyes, supra note 6, at 600.

53. Id. at 602.

54. HIV IN THE HEALTH CARE WORKPLACE, supra note 7, at 7.


56. Id. at 1.

57. Id. at 1-2. An example of this type of situation might include a patient who has sustained traumatic injury due to glass or metal fragments.
into a patient's open wound or "body cavity." 58 Fourth, if an infected HCP is afflicted with an open lesion, secretions from the lesion in contact with a patient's open wound can transmit the disease. 59

Although transfer of bodily fluids must take place for HIV to be transmitted, transfer of such fluids in itself will not guarantee that transmission occurs. 60 Various factors determine whether HIV transmission actually occurs. 61 One factor is the level of HIV concentration in the HCP's blood. 62 Another factor is the HCP's general health and level of immunity. 63 A third factor is the specific techniques and procedures practiced by the HCP. 64 The type of infection control precautions exercised can also be a factor in whether transmission will occur. 65

Assuming that HCPs follow recommended sterilization and infection prevention precautions, most transmissions of HIV in the health care setting will result when a HCP sustains an injury during patient treatment. 66 Clearly, even strict adherence to infection control practices cannot prevent accidents or injuries during inva-

58. Id. at 2. An example of this type of situation might include an HCP who sustains a cut or injury during an exposure-prone invasive procedure such as surgery.
59. Id.
60. Keyes, supra note 6, at 600.
61. See HIV IN THE HEALTH CARE WORKPLACE, supra note 7, at 8. Other factors which may determine whether HIV transmission occurs include the severity of the injury and type of injury sustained by the HCP, the presence or absence of infection control procedures practiced by the HCP, and the stage of the person's HIV infection. Id.
62. See Centers for Disease Control, Update: Transmission of HIV Infection During Invasive Dental Procedures, 40 MORBIDITY & MORTALITY Wkly. Rep. 377-81 (1991) [cited in HIV IN THE HEALTH CARE WORKPLACE, supra note 7, at 4]. This factor includes the "titer" or concentration of the virus in the health care professional's blood. HIV IN THE HEALTH CARE WORKPLACE, supra note 7, at 4. Concentrations of HIV in the blood are high after initial exposure to the virus. Id. However, once the body's immune system responds to the introduction of the virus, the concentration of HIV in the blood drops. Id. Later, as the disease begins to overwhelm the immune system, that level again increases signifying the appearance of clinical AIDS. Id. at 4-5.
63. Keyes, supra note 6, at 600.
64. See HIV IN THE HEALTH CARE WORKPLACE, supra note 7, at 7.
65. Id. Studies show that many health care professionals who are routinely exposed to blood do not regularly conform to universal infection control guidelines and "sustain high rates of parenteral and mucous membrane exposures to blood." Larry Gostin, CDC Guidelines on HIV- or HBV-Positive Health Care Professionals Performing Exposure-Prone Invasive Procedures, 19 L. MED. & HEALTH CARE 140, 141 (1991) [hereinafter CDC Guidelines on HIV- or HBV-Positive Health Care Professionals]. For a recent example of such a study, see e.g. Kenneth R. Courington et al., Universal Precautions Are Not Universally Followed, 126 ARCHIVES OF SURG. 93-96 (1991).
sive procedures.67 HCPs may sustain a cut or puncture wound to their hands while using sharp instruments or through contact with bone or tooth fragments.68 Thus, the frequency with which a HCP sustains a percutaneous (through the skin) injury during an invasive procedure is crucial to determining the potential risk of HIV transmission.69

Presently, it is difficult to precisely determine the rate of percutaneous injury sustained by HCPs.70 However, studies reveal that glove punctures occur approximately twenty-five percent of the time.71 In addition, actual skin penetration is estimated to occur during ten percent of all glove punctures.72 Thus, a significant injury to the skin during an invasive procedure is estimated to occur in one out of forty cases.73 Moreover, other studies indicate that the rate of injury sustained by an HCP in the course of an invasive procedure may actually be higher.74

As a result of the inaccuracy of these estimates, the CDC has been unable to determine the exact risk of transmission from an infected HCP to a patient during an invasive procedure.75 How-

69. Keyes, supra note 6, at 601.
70. See HIV IN THE HEALTH CARE WORKPLACE, supra note 7, at 5-7.
72. Id.
73. Id.
74. See HIV IN THE HEALTH CARE WORKPLACE, supra note 7, at 6-7. According to the Office of Technology Assessment, the CDC recently conducted an unpublished study of percutaneous (through the skin) injuries sustained by health care workers in four hospitals. Id. at 6. A total of 1,382 surgical invasive procedures were observed. Id. The study found that 99 percutaneous injuries to the health care worker occurred in 95 of the 1,382 procedures performed. Id.
Furthermore, in a voluntary retrospective study of dental care providers in the New York metropolitan area, 94% of the participants reported accidental percutaneous injuries during dental procedures. Id. at 6-7.
75. Recommendations for Preventing HIV and HBV, supra note 45, at 1. Researchers have conducted at least five retrospective studies in an effort to determine whether sporadic transmission of HIV has taken place from HCP to patient. See, e.g., Richard N. Danila et al., supra note 50; Centers for Disease Control, Update: Transmission of HIV Infection During an Invasive Dental Procedure - Florida, 40 MORBIDITY & MORTALITY WKLY. REP. 21 (1991); Ban Mishu et al., A Surgeon With AIDS: Lack of Evidence of Transmission to Patients, 264 JAMA 467 (1990); John D. Porter et al., Management of Patients Treated by Surgeon With HIV Infection, 335 LANCET 113 (1990); Frances P. Armstrong et al., Investigation of a Health Care Worker with Symptomatic
ever, the CDC has estimated the risk of HIV transmission for certain types of HCPs. The CDC estimates that the sporadic risk of transmission from an HIV-positive surgeon to a patient during an invasive procedure is between approximately one in 42,000 and one in 420,000. Although this estimate seems low, the cumulative risk of transmission over the course of an HIV-infected HCP’s career may actually be quite notable. Thus, although the risk that a patient will contract the disease from an infected HCP is small, the aggregate risk of transmission from an infected HCP is significant enough to justify health policy precautions.

Although the CDC has been unable to determine a precise estimate of the risk of transmission from HCP to patient, existing evidence indicates that HIV transmission from an infected HCP to a patient is possible and has in fact occurred. According to CDC

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*Human Immunodeficiency Virus Infection: An Epidemiologic Approach, 152 MILITARY MED. 414 (1987). Other than the documented dental transmissions in Florida, these studies show little if any evidence of transmission. However, retrospective studies fail to accurately assess the potential risk of transmission. Recommendations for Preventing Transmission of HIV and HBV, supra note 45, at 4. The CDC reported the following:

[T]he limited number of participants and the differences in procedures associated with these five investigations limit the ability to generalize from them and to define precisely the risk of HIV transmission from HIV-infected HCWs to patients. A precise estimate of the risk of HIV transmission from infected HCWs to patients can be determined only after careful evaluation of a substantially larger number of patients whose exposure-prone procedures have been performed by HIV-infected HCWs.

Id.


77. Id. The CDC estimated the risk of sporadic HIV transmission from an infected HCP to patient by using a “risk assessment model.” Id. Results show that the probability of transmission from an HIV-infected surgeon to patient was between one in 41,667 and one in 416,667. Id. at 7. Furthermore, the model estimates that the risk of HIV transmission for a patient during invasive dental procedures is between one in 263,158 and one in 2,631,579. Id. at 8.

78. See Estimates of the Risk of Endemic Transmission of HIV to Patients, supra note 43, at Table 1 (examining the cumulative probability that an HIV-positive surgeon will transmit the virus).

79. CDC Guidelines on HIV or HBV-Positive Health Care Professionals, supra note 65, at 141. The cumulative risk of HIV transmission over the course of a HCP’s entire career may be significant. Id. Gostin makes this assertion by assuming first that the patient’s risk of transmission is at the lower end of the CDC’s estimate (1/400,000). Id. The risk that an HIV-positive health care worker will transmit the virus to a patient increases with the number of invasive procedures performed. Id. For example, assuming 500 seriously invasive procedures, the risk of transmission is 1 in 800. Id. Assuming 1,000 operations, the risk is 1 in 400. Id. Furthermore, assuming that the higher range of risk is accurate (1/40,000), the risk that a patient will contract HIV becomes 1 in 40 assuming 1000 seriously invasive procedures. Id.

80. Larry Gostin, The HIV-Infected Health Care Professional; Public Policy, Discrimination, and Patient Safety, supra note 68, at 664.

81. Transmission of HIV Infection During Invasive Procedures, supra note 8, at 380. The CDC reports that five patients became infected with the AIDS
director Dr. William Roper, while the risk of transmission of HIV from infected HCPs to patients is small, it is "nonetheless a real risk" that "cannot be wished away."\textsuperscript{82} The CDC reports that five documented cases of HIV transmission occurred in patients receiving treatment from an HIV-infected dentist.\textsuperscript{83} Furthermore, the CDC estimates that up to 128 patients may have been infected with HIV during medical procedures over the last ten years.\textsuperscript{84} Therefore, although the risk of HIV transmission from an infected HCP to a patient may be low, evidence demonstrates that the risk is real.\textsuperscript{85}

In summary, HIV-infected HCPs who perform invasive procedures pose some risk of transmission to their patients.\textsuperscript{86} Although this risk may be small, the consequences of transmission are fatal.\textsuperscript{87} In a recent decision regarding an HIV-infected HCP, the Superior Court of Pennsylvania commented that, "it is no consolation to the one or two individuals who become [HIV] infected after innocently consenting to medical care by an unhealthy doctor that they were part of a rare statistic."\textsuperscript{88} Therefore, measures need to be taken to protect patients from the risk of HIV transmission from an infected virus after receiving treatment from their HIV-positive dentist. \textit{Id.} at 380. All of the patients were infected with "HIV strains that were closely related to each other and to the strain infecting the dentist but distinct from viruses obtained from control patients living in the same geographic area as the dental practice." \textit{Id.} In each case, the infected dentist performed invasive procedures on the patients. \textit{Id.} Furthermore, none of the patients had confirmed prior exposure to HIV. \textit{Id.} Although the exact route of transmission remains unknown, the report strongly suggests that the HIV transmission occurred during dental treatment. \textit{Id.}


\textsuperscript{83} Transmission of HIV Infection During Invasive Procedures, supra note 8, at 377-81.

\textsuperscript{84} Estimates of the Risk of Endemic Transmission of HIV to Patients, supra note 43, at Table 2. Actual CDC estimates of the number of patients infected during dental and surgical procedures over the last ten years range from 13-128. \textit{Id.}

\textsuperscript{85} See generally Transmission of HIV Infection During Invasive Procedures, note 8, at 377-81 (discussing the transmissions from infected HCPs to patients in Florida).

\textsuperscript{86} See generally Estimates of the Risk of Endemic Transmission of HIV to Patients, supra note 43, at 6-11 (discussing the probability of transmission from HCP to patient).

\textsuperscript{87} Leckelt v. Board of Comm'rs, 714 F. Supp. 1377, 1392 (E.D. La. 1989). The Leckelt court stated:

The health status of an employee who is in constant daily contact with debilitated and pre- and post-surgical patients, as well as, patients undergoing invasive procedures and patients with open routes to their blood systems, is of primary importance in light of the knowledge that AIDS is a terminal disease. \textit{Id.}

Various states have responded by enacting legislation aimed at the HIV-infected HCP. Specifically, Illinois has responded with "Look Back" statute.

II. THE HISTORY BEHIND THE ILLINOIS "LOOK BACK" STATUTE

On June 14, 1991, the CDC reported that a Florida dentist who was HIV-infected transmitted the virus to five of his patients during dental treatment. This report confirmed fears that an HIV-infected HCP may be capable of transmitting HIV to a patient. Since that time, widespread public attention has focused on the risk of HIV transmission from infected HCPs to patients.

The growing public concern regarding the documented transmission of HIV from HCP to patient prompted a number of leading medical associations to publish recommendations for HIV-infected HCPs. Consequently, on July 12, 1991, the CDC published a re...

89. See Michael L. Closen, A Call for Mandatory HIV Testing and Restriction of Certain Health Care Professionals, 9 St. Louis U. Pub. L. Rev. 421, 422 (1990) (recommending that HCPs who engage in patient contact involving a risk of transmission of blood should be required to undergo HIV testing). See also Scott H. Isaacman, The Other Side of the Coin: HIV-Infected Health Care Workers, 9 St. Louis U. Pub. L. Rev. 439, 493-94 (1990) (recommending that routine testing of HCPs should only be required if a definite risk of HIV transmission exists or if the HCP is occupationally exposed to HIV).

90. See infra notes 118-19 and accompanying text (discussing those states that have attempted to pass legislation aimed at the HIV-infected HCP).


92. See generally Transmission of HIV Infection During Invasive Procedures, supra note 8, at 377-81.

93. Public Policy, Discrimination, and Patient Safety, supra note 68, at 663.

94. See, e.g., Hospitals, Health Care Professionals, and AIDS, supra note 40, at 12; see also Public Policy, Discrimination, and Patient Safety, supra note 68, at 663-665. (discussing whether HIV-infected HCPs should be required to disclose their HIV status, whether HCPs should be subject to routine testing, and whether HIV-infected HCPs should be required to limit their practice).

95. See, e.g., AMERICAN MEDICAL ASSOCIATION, CODE OF MEDICAL ETHICS: CURRENT OPINIONS 48 (1992) (on file with the author). The AMA recommends: [a] physician who knows that he or she has an infectious disease, which, if contracted by the patient would pose a significant risk to the patient, should not engage in any activity that creates a risk of transmission of that disease to the patient. The precautions taken to prevent transmission . . . should be appropriate to the seriousness of the disease and must be particularly stringent in the case of a disease that is potentially fatal . . . . A physician who knows that he or she is seropositive should not engage in any activity that creates a risk of transmission of the disease to others.


Additionally, the American Dental Association states that HIV-infected dentists should either refrain from performing invasive procedures on patients or disclose their HIV status. STATEMENT OF THE AMERICAN DENTAL ASSOCIATION ON HIV-INFECTED DENTISTS (Jan. 16, 1991) (on file with the author).

The American Academy of Orthopedic Surgeons also believes that an HIV-infected orthopedic surgeon should not perform invasive procedures except in...
port recommending that all HCPs who perform invasive procedures should know their HIV status.96 Furthermore, the CDC report suggests that HCPs who are HIV-infected should refrain from performing exposure-prone procedures unless they receive approval from an “expert review panel.”97

Although the CDC and others have published recommendations to address this problem, many states have taken a different route in proposing their own guidelines for HIV-infected HCPs. Consequently, various state medical and public health organizations have also responded to the documented dental transmissions. Some organizations recommend that an HIV-infected HCP should refrain from performing exposure-prone invasive procedures.98 However, others recommend that HIV-infected HCPs may continue to perform all medical procedures for which they are qualified.99

In response to this public confusion, last year the CDC attempted to prepare a list of specific medical procedures to be deemed exposure-prone invasive procedures.100 In attempting to formulate this proposed list, the CDC requested the aid of several leading medical organizations, including the American Medical Association, the American Dental Association, and others.101 However, after receiving almost unanimous opposition to their efforts, the CDC decided not to complete their proposed list of exposure-prone invasive procedures.102 The CDC has stated that their proposed list will be completed at an unspecified date.103

In addition to this widespread public attention regarding HIV transmission from HIV-infected HCPs to patients, a recent incident

96. Recommendations for Preventing HIV and HBV, supra note 45, at 5.
97. Id.
100. See CDC Apparently Will Drop Proposal to List HIV Exposure-Prone Procedures, Daily Report for Executives (BNA), Dec. 5, 1991, at A-16 (discussing the CDC’s decision to delay its list of exposure-prone invasive procedures) [hereinafter CDC Apparently Will Drop Proposal].
102. See Warren E. Leary, AMA Backs Off on an AIDS Risk List, N.Y. Times, Dec. 15, 1991, at 38L (discussing medical and health groups who oppose the CDC’s proposed list); see also Medical Groups Oppose Plan to List Exposure-Prone Invasive Procedures, 29 Gov’t Empl. Rel. Rep. (BNA) 1490 (1991) (discussing the lack of cooperation from medical and health groups in supporting the CDC’s proposed list).
103. CDC Apparently Will Drop Proposal, supra note 100, at A-16.
in Nokomis, Illinois prompted Illinois to introduce the strongest AIDS notification statute in the country.\textsuperscript{104} In Nokomis, a dentist contracted HIV and eventually died of an AIDS-related illness.\textsuperscript{105} Following this incident, the county informed previous patients that their dentist had contracted HIV and subsequently died.\textsuperscript{106} As a result, hundreds of patients sought HIV testing.\textsuperscript{107} This incident and the widely publicized Kimberly Bergalis case provided the impetus for the enactment of Illinois "Look Back" statute.\textsuperscript{108}

### III. Illinois' Legislative Response: A "Look Back" Statute

Illinois initially responded to the AIDS epidemic by enacting two statutes: the AIDS Confidentiality Act\textsuperscript{109} and later the Sexually Transmissible Disease Control Act ("STD Act").\textsuperscript{110} The AIDS Confidentiality Act and the STD Act place a premium on confidentiality in the diagnosis and treatment of HIV-infected persons.\textsuperscript{111}

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\textsuperscript{106} Because the county conducted this disclosure and patient notification before the Illinois "Look Back" statute was enacted, the county proceeded with the express consent of the dentist's widow. Elise S. Aron, \textit{Health Care Workers With AIDS - The Legislative Response}, 24 VIEWPOINT (Illinois Public Health Ass'n, Springfield, Ill.), Dec. 1991, at 6, 7 (on file with author).

\textsuperscript{107} Weisberg, \textit{supra} note 105, at 1. In Nokomis, approximately 4,500 former patients were notified. \textit{Id}. Out of those, 1,200 voluntarily submitted to HIV testing and counseling from the state; this number constituted roughly 30 percent of the HCP's practice. \textit{Id}. None of the patients who sought testing discovered that they were HIV-infected. Telephone Interview with Chet Kelly, Administrator for the AIDS Activity Section, Illinois Department of Public Health (Feb. 7, 1992).

\textsuperscript{108} Papajohn & Ellin, \textit{supra} note 104, at 8.

\textsuperscript{109} ILL. REV. STAT. ch. 111 1/2, para. 7301-7316 (1991). The AIDS Confidentiality Act became effective September 21, 1987. \textit{Id}. at para. 7301. The Act seeks to encourage confidentiality of those persons who submit to HIV testing. \textit{Id}. at para. 7302. The act restricts the Health Department in disclosing the identity of persons who undergo HIV testing except under certain circumstances and to certain individuals. \textit{Id}. at para. 7309. Moreover, the act prohibits disclosure unless the person requesting disclosure demonstrates a "compelling need" for such information. \textit{Id}.

\textsuperscript{110} ILL. REV. STAT. ch. 111 1/2, para. 7401-7410 (1991). The STD Act became effective in Illinois on January 1, 1988. \textit{Id}. at para. 7401. The act establishes guidelines for the reporting of persons with a sexually transmissible disease to the Public Health Department, conducting contact investigation, and maintaining confidentiality of sensitive medical information regarding infection. \textit{Id}. at para. 7404-7408. Illinois has been aggressive in its legislative attempts to respond to the AIDS epidemic. For example, Illinois was one of the first states to enact a statute to criminalize the transmission of HIV. \textit{See} ILL. REV. STAT. ch. 38, para. 12-15.2 (1991); \textit{see generally} Michael L. Closen & Jeffrey S. Deutchman, \textit{A Proposal to Repeal the Illinois HIV Transmission Statute}, ILL. BAR J. 592-600 (1990) (discussing the criminalization statute).

\textsuperscript{111} \textit{See} ILL. REV. STAT. ch. 111 1/2, para. 7309 (1991) (prohibiting disclosure of the identity of persons who have been tested for HIV except to certain per-
Both acts seek to control the spread of AIDS/HIV and to assure that test results and medical information will be kept private.\textsuperscript{112} Thus, the statutes encourage an individual who suspects he or she may be infected with HIV to seek testing with the assurance that the Health Department will keep test results and subsequent medical records confidential.\textsuperscript{113} Furthermore, both acts authorize the Health Department to release information regarding HIV-infected individuals only under certain circumstances.\textsuperscript{114}

However, on October 4, 1991, Illinois Governor Jim Edgar signed into law an important amendment to the STD Act, the Illinois "Look Back" statute.\textsuperscript{115} This "landmark legislation"\textsuperscript{116} is currently the only AIDS statute in the country authorizing a public health department to reveal the identity of an HIV-infected HCP and to allow review of confidential patient files.\textsuperscript{117} In addition, this statute is the first to mandate contact tracing and ret-

\textsuperscript{112} The AIDS Confidentiality Act encourages voluntary testing by assuring that test results will remain confidential. \textit{See also} ILL REV. STAT. ch. 111 1/2, para. 7302 (1991). The STD act seeks to assure individuals that medical information concerning their infection will be kept confidential. \textit{See also} ILL REV. STAT. ch. 111 1/2, para. 7402 (1991).

\textsuperscript{113} \textit{See} Ill. Rev. Stat. ch. 111 1/4, para. 7302 (1991); ILL. REV. STAT. ch. 112 1/2, para. 7402 (1991)(stating the legislature's intent of providing confidentiality in both statutes).


\textsuperscript{117} The Health Department released Emergency Amendments on October 28, 1991. ILL. ADMIN. CODE tit. 77, § 623 (1991). The Emergency Amendments implement Public Act 87-763, the Illinois "Look Back" statute. \textit{Id.} These amendments are effective for a 150 day period which began October 28, 1991. \textit{Id.} In the event that an HCP or patient declines to inform contacts of HIV exposure, the Emergency Amendments allow for the Health Department to disclose this information. \textit{Id.} § 693.40(b)(3)(7)(viii). The Health Department is authorized to disclose the type of health care provider who exposed his patient to HIV, without disclosing his or her name. \textit{Id.} § 693.45(a)(1). However, this will almost always reveal the HCP's identity.

In addition, the Health Department recently released officially Adopted Amendments which became effective March 30, 1992. 16 Ill. Reg. 5291. How-
rospective notification of patients. Consequently, the “Look Back” statute authorizes a major change in previous provisions regarding contact tracing and confidentiality of HIV-infected persons.

The “Look Back” statute authorizes the Health Department to investigate patient files of any HCP who is HIV-infected. Under the statute, when the Health Department receives a report of HIV or AIDS in the health care setting, the Department may, “when medically appropriate, investigate the subject of the report and his or her person’s contacts... to assess the potential risks of transmission.” The statute defines “contacts” who are subject to investigation as “individuals who have undergone invasive procedures performed by an HIV infected health care provider...” As a result, the “Look Back” statute gives the Health Department broad discretion in determining when it can investigate the patient files of an HCP who is HIV-infected.

ever, the Adopted Amendments are substantially the same as the Emergency Amendments with regard to notification of health care contacts. Id. While no states except Illinois have proposed or passed laws that authorize a public health department to reveal that information to patients, currently four states have proposed bills that require HCPs who are HIV-infected to report their status to a public health department or licensing board. These states include Maryland, H.B. 1156 (1991), Michigan, S.B. 633 (1992), New York, A.B. 4835 (1991), and Ohio, H.B. 419 (1991). Furthermore, no states other than Illinois have proposed or passed laws that authorize a public health department to have access to an HIV-infected HCP’s patient files. See generally Intergovernmental Health Policy Project, supra note 11 (summarizing pending bills and existing laws from various states regarding HIV-infected HCPs).


Id. at para. 7405.5(a). The statute defines contacts as “individuals who have undergone invasive procedures from an HIV-infected health care provider.” The statute also includes as contacts “health care providers who have performed invasive procedures for persons infected with HIV...” Id. However, this Note will focus specifically on the statute as it applies to HIV-infected HCPs.

See id. at para. 7405.5(a) (discussing the Health Department’s authority to investigate contacts when it deems it “medically appropriate” to do so).
Following investigation of patient files, if the Health Department determines that an infected HCP may have exposed a patient to HIV, the statute provides two alternatives. First, the statute gives the infected HCP an opportunity to notify all past and current patients whom the HCP may have exposed to the virus. However, if the HCP fails to adequately inform his patients of the potential risk of HIV transmission in a "timely fashion," the statute then authorizes the Health Department to have access to the HIV-infected HCP's patient files. Additionally, the statute then authorizes the Health Department to notify the contacts and to offer testing and counseling.

The legislature's intent in authorizing the Health Department to review files and notify contacts is twofold. First, the statute seeks to guarantee that the Health Department will notify patients of HIV exposure so that they can be tested, counseled, and

125. See id. at para. 7405.5(b). The statute additionally provides for the HCP to submit information or comments, regarding action the Health Department intends to take. Id.

126. Id.

127. Id. at para 7405.5(a). The Emergency Amendments issued by the Health Department allow the HIV-infected HCP 45 days to notify his patients. ILL. ADMIN. CODE tit. 77, § 693 (1991).

128. Act of Oct. 4, 1991, Pub. A. 87-763, 1991 Ill. Legis. Serv. 3672, 3673 (West) (codified as amended at ILL. REV. CODE ch. 111 1/4, para. 7405.5(c) (1991)). However, the statute states that "the subject's records shall not be copied or seized by the Department." Id. Furthermore, the statute requires the following:

All information and records held by the Department and local health authorities pertaining to activities conducted pursuant to this Section shall be strictly confidential and exempt from copying and inspection under the Freedom of Information Act. Such information and records shall not be released or made public by the Department or local health authorities, and shall not be admissible as evidence, nor discoverable in any action of any kind in any court or before any tribunal, board, agency or person and shall be treated in the same manner as the information and those records subject to the provisions of Part 21 of the Code of Civil Procedure except under the following circumstances:

(1) When made with the written consent of all persons to whom this information pertains;

(2) When authorized under Section 8 to be released under court order or subpoena pursuant to Section 12-16.2 of the Criminal Code of 1961; or

When made by the Department for the purpose of seeking a warrant authorized by Sections 6 and 7 of this Act. Such disclosure shall conform to the requirements of subsection (a) of Section 8 of this Act. Id. at para. 7405.5(d).

129. Id. at para. 7405(c). Although photocopying of patient records is expressly forbidden, the statute allows the Public Health Department to scrutinize all patient records and make notes by hand.

130. Id. at para. 7405(b).

131. See House Transcript, supra note 19, at 7 (statement of Representative Munizzi). Representative Munizzi stated, "The initial intent of this Bill is to disseminate the information that someone may or may not be affected, to allow them to receive advice of counsel of the actual disease, and to, also, control it, to stop it from spreading." Id.
treated. The legislature assumes that patients who have been treated by an HIV-positive HCP are at risk of becoming infected with the virus. Further, the legislature assumes that patients have a right to know of that risk so that they may be tested. Testing may reveal HIV infection before symptoms occur; thus, the patient will have an opportunity to benefit from early treatment and intervention.

Second, the legislature believes that retrospective notification of patients exposed to HIV will help control the general spread of AIDS. Thus, the legislature assumes that persons who are notified that their HCP has exposed them to HIV can take necessary steps to avoid transmitting the virus to others.

By enacting the "Look Back" statute, the Illinois General Assembly has taken an unprecedented step in an attempt to respond to HIV transmission in the health care setting. This statute is the first to mandate contact tracing whenever an HIV-infected HCP exposes one of his or her patients to HIV through an invasive procedure. However, despite the admirable intentions of the Illinois legislature, the "Look Back" statute has several inherent flaws which will impede its effectiveness and thwart its purpose.

IV. ANALYSIS OF THE "LOOK BACK" STATUTE

The Illinois General Assembly intended the "Look Back" statute to constitute a positive step toward preventing HIV transmission in the health care setting. However, since its enactment, many individuals and professional organizations have attacked the statute on constitutional grounds. These critics assert that the statute violates privacy rights of HCPs and patients. Despite these criticisms, the statute does not constitute a violation of either the

132. House Transcript, supra note 19, at 11 (statement of Representative Pullen).
133. Id.
134. Id.
135. Id.
136. House Transcript, supra note 19, at 7-8 (statement of Representative Munizzi).
137. Id. at 8 (statement of Representative Munizzi).
138. House Transcript, supra note 19, at 11-12.
139. See supra notes 118-19 and accompanying text for a discussion of various state's attempts to enact legislation aimed at the HIV-infected HCP.
140. STATE OF ILLINOIS, 87th Gen. Assem., House of Representatives Transcript at 7 (statement of Representative Munizzi).
141. See infra notes 149-50 and accompanying text listing organizations that have attacked the "Look Back" statute on constitutional grounds.
patient's or the HCP's constitutional right to privacy.\textsuperscript{142} However, merely passing minimal constitutional requirements does not make the statute effective or good public policy.\textsuperscript{143} The statute contains several inherent flaws which frustrate its purpose and thwart its effectiveness as a response to HIV transmission in the health care setting.\textsuperscript{144} Therefore, the statute must be amended so that it is more effective in addressing this urgent problem.

The “Look Back” statute contains deficiencies which render it ineffective.\textsuperscript{145} First, the statute is filled with overbroad language which makes the statute, at best, difficult to implement.\textsuperscript{146} Second, the statute contains several provisions which impede its objective.\textsuperscript{147} As a result, if the Illinois General Assembly fails to amend the statute, the statue will not adequately control the spread of HIV in the health care setting.\textsuperscript{148}

\textbf{A. Right to Privacy}

The Illinois “Look Back” statute has generated a wide variety of criticism throughout the state from various individuals and professional organizations.\textsuperscript{149} Many criticize the statute for its break

\begin{footnotesize}
\begin{enumerate}
\item See infra notes 153-60 and 180-87 and accompanying text for a discussion of why the “Look Back” statute does not violate privacy rights of HCPs or patients.
\item See Michael L. Closen, Mandatory Disclosure of HIV Blood Test Results to the Individuals Tested: A Matter of Personal Choice Neglected, 22 Loy. U. Chi. L.J. 445, 478 (1991) (stating that the important question to consider regarding AIDS/HIV legislation is not whether the statutes meet minimal constitutional standards, but whether the statutes amount to good public policy).
\item See Letter from John Hammell, Project Director, AIDS and Civil Liberties Project, Roger Baldwin Foundation, American Civil Liberties Union of Illinois, to Jeff W. Johnson, Division of Governmental Affairs, Illinois Department of Public Health 1 (Oct. 23, 1991) (on file with the Roger Baldwin Foundation) [hereinafter Letter from John Hammell to Health Department] (responding to the Health Department’s request for comments regarding the Draft Emergency Rules).
\item Id.
\item See infra notes 208-30 and accompanying text for a discussion of overbroad language in the “Look Back” statute.
\item See infra notes 231-60 and accompanying text for a discussion of the statute’s shortcomings.
\item See Letter from Karen Fishman, Executive Director, AIDS Foundation of Chicago, to Jeff W. Johnson, Division of Government Affairs, Illinois Department of Public Health 1 (Oct. 22, 1991) (on file with the AIDS Foundation of Chicago) [hereinafter Letter from Karen Fishman to Health Department] (responding to the Health Department’s request for comments regarding the Draft Emergency Rules).
\item See Letter from Mathew S. Nosanchuk, Staff Counsel, AIDS and Civil Liberties Project, Roger Baldwin Foundation, American Civil Liberties Union of Chicago, to Anthony Decker, member of Governor’s Task Force on HIV in Health Care (Jan. 27, 1992) (on file with the Roger Baldwin Foundation) (stating that the Illinois “Look Back” statute is “medically unjustified and legally defective”); see also Letter from John Hammell to Health Department, supra note 144, at 1 (stating that there are “inherent problems with Senate Bill 999
\end{enumerate}
\end{footnotesize}
from previously followed procedures protecting the identity of HIV-infected persons.\(^{150}\) Opponents of the statute assert that it constitutes a violation of the HIV-infected HCP's fundamental right to privacy.\(^{151}\) Still others have voiced concerns about the potential violation of the patient's right to privacy and intrusion into the doctor-patient relationship.\(^{152}\) However, this Note will show that the "Look Back" statute does not constitute a violation of either the HCP's right to privacy or the patient's right to privacy.

1. The "Look Back" Statute Does Not Violate the HCP's Right to Privacy

Opponents of the "Look Back" statute argue that it violates the

\[\text{[the Illinois "Look Back" statute] that frustrate achievement of that goal, no matter what regulations the Department adopts to implement the law\]}\); see also Letter from Karen Fishman to Health Department, supra note 148, at 1 (stating that the "Look Back" statute is poor public policy, will fail to prevent the spread of HIV, and will drain existing money allocated to AIDS prevention and education); see also Letter from Karen Fishman, Executive Director, AIDS Foundation of Chicago, to Jim Edgar, Governor of Illinois (Aug. 5, 1991) (on file with the AIDS Foundation of Chicago) [hereinafter Letter from Karen Fishman to Governor Edgar] (urging Governor Edgar to veto Senate Bill 999); see also Letter from Dan Bigg, President, HIV Coalition for North Suburban Cook County, to Jim Edgar, Governor of Illinois (Aug. 2, 1991) (on file with the HIV Coalition for North Suburban Cook County) [hereinafter Letter from Dan Bigg to Governor Edgar] (urging Governor Edgar to veto Senate Bill 999).

Additionally, in December of 1991, a coalition was formed called the Coalition to Repeal the Illinois AIDS Notification Law. Letter from Mark Ishaug, Public Affairs Officer, AIDS Foundation of Chicago, to Members of the Service Providers Council (Dec. 18, 1991) (on file with the AIDS Foundation of Chicago). The Coalition is currently backed by more than twenty organizations including AIDS service providers, community groups, and health facilities. Memorandum from the Coalition to Repeal the Illinois AIDS Notification Law 4 (Jan. 10, 1991) (on file with the AIDS Foundation of Chicago) [hereinafter Memorandum from the Coalition to Repeal the Illinois AIDS Notification Law].

150. Letter from John Hammell, Project Director, AIDS and Civil Liberties Project, Roger Baldwin Foundation, American Civil Liberties Union of Illinois, to Jim Edgar, Governor of Illinois 4 (Aug. 20, 1991) (on file with the Roger Baldwin Foundation) [hereinafter Letter from John Hammell to Governor Edgar]; see also Behringer Est. v. Medical Ctr. at Princeton, 592 A.2d 1251, 1269 (N.J. Super. Ct. Law Div. 1991) (stating that all individuals who are HIV-infected, whether HCPs or patients, have an interest in maintaining confidentiality about their condition).

Despite public knowledge and education regarding the transmission of HIV, people diagnosed with HIV/AIDS are often subject to great prejudice and discrimination. Id. Many of those who are HIV-infected are members of groups who have traditionally been disfavored by society including homosexuals and intravenous drug users. Id. Thus, being labelled as HIV-infected often carries with it an adverse social stigma. Id.

151. Letter from John Hammell to Governor Edgar, supra note 150, at 6.

152. Letter from John Hammell to Governor Edgar, supra note 150, at 6; House Transcript, supra note 19, at 3-4 (statement of Representative Lang).
HCP's right to privacy.153 This argument is based on the fact that the statute allows the Health Department to reveal the identity of an HIV-infected HCP to any patient who the HCP has exposed to the virus through treatment.154 Opponents of the statute assert that this disclosure of personal information violates the Fourth155 and Fourteenth Amendments156 to the United States Constitution and article I, section 6 of the Illinois Constitution.157

Concededly, courts have held that every person should be guaranteed a "zone of privacy" in which information or behavior of a highly personal nature should not be disclosed.158 Moreover, courts regard information concerning one's body or state of health as extremely sensitive in nature, and therefore, courts afford this information a high degree of protection.159 However, a person's privacy interest in keeping personal medical information confidential is not an absolute privilege.160

To determine whether there is a constitutional violation, courts look to see if the statute in question infringes on a constitutional right and whether a "compelling state interest" exists.161 Courts have held that protecting the public health is a "compelling state

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153. See Letter from John Hammell to Governor Edgar, supra note 150, at 6 (stating that the ACLU believes that the HCP's privacy right is protected by the United States Constitution and Article I, § 6 of the Illinois Constitution).


155. U.S. CONST. amend. IV.

156. U.S. CONST. amend XIV, § 2.

157. ILL. CONST. art. I, § 6; see Letter from John Hammell to Governor Edgar, supra note 150, at 6 (stating that the "Look Back" statute violates constitutional rights of both HCPs and patients).

158. See Whalen v. Roe, 429 U.S. 589, 599 (1977). The Whalen court stated that the protection of privacy usually involves two different interests. Id. One interest is the "individual interest in avoiding disclosure of personal matters." Id. The second interest is "the interest in independence in making certain kinds of important decisions." Id. See also Small v. Kusper, 513 N.E.2d 1108, 1111 (Ill. App. Ct. 1987).

159. See, e.g., Doe v. Borough of Barrington, 729 F. Supp. 376, 384 (D.N.J. 1990). The district court stated that the privacy interest concerning whether one has been infected with HIV is information of the most sensitive nature. Id. Thus, because of the social stigma often attached to persons who are HIV-infected, the privacy interest in the knowledge that one is infected with HIV is given a higher degree of protection than ordinary medical records. Id. See also Doe v. Attorney Gen. of the United States, 941 F.2d 780, 796 (9th Cir. 1991).

160. See Borough of Barrington, 729 F. Supp. at 385; see also United States v. Westinghouse Elec. Co., 638 F.2d 570, 577-78 (3d Cir. 1980) (requiring that certain medical information be reported to state health representatives does not automatically amount to an invasion of privacy); see also Doe v. Attorney Gen., 941 F.2d at 796 (stating that the privacy protection give to medical records is a "conditional right" which may be encroached upon if the government has a "proper governmental purpose").

As a result, courts have upheld the disclosure of personal information when that disclosure is necessary to protect the public health. Thus, courts have found a proper governmental interest to exist when reporting such information as venereal disease, child abuse, and certification of fetal death. In addition, to determine whether a compelling state interest exists, courts balance the competing interests of society and the interests of the individual. Thus, the disclosure of medical records will be upheld when the societal interest in disclosure outweighs the individual's privacy interest.

In *Whalen v. Roe*, doctors and patients challenged a statute which required that the identity of persons who were prescribed "potentially harmful drugs" be reported to the state health department. The *Whalen* court held that reporting this information served the vital state interest of controlling the distribution of dangerous drugs. The court reasoned that the reporting requirement was a reasonable exercise of the state's police power. The court determined that disclosure of private medical information to a public health agency is an essential part of modern medicine, and therefore, does not automatically amount to an invasion of

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163. *Id.* at 577. Disclosure of private medical records to public health agencies and others is essential to modern medicine despite the fact that the records may be highly sensitive in nature. *Whalen v. Roe*, 429 U.S. 589, 602 (1977).
164. *Whalen*, 429 U.S. at 602. Requiring the reporting of sensitive information to the state in order to protect the general health and welfare of the community does not automatically amount to an invasion of privacy. *Id.*
166. *Westinghouse Elec. Corp.*, 638 F.2d at 578. In *Westinghouse*, the court named the following factors which should be considered in balancing the competing interests of the individual and society: the type of file requested; the information the file may contain; the potential for harm resulting from disclosure; potential injury to the relationship in which the record was procured; regarding whether sufficient safeguards subsequent disclosure are present; the need for the information; and whether there is a statute or recognized public interest warranting disclosure. *Id.*
167. *Doe v. Borough of Barrington*, 729 F. Supp. 376, 385 (D.N.J. 1990). There, the court found a police officer violated privacy rights when he disclosed a citizen's HIV-status to another person. *Id.* The court found that the government's interest in disclosure did not outweigh the individual's right to privacy because there was no risk that the informed person may have been infected with HIV. *Id.*
169. *Id.* at 598.
170. *Id.* at 602.
privacy.\footnote{171}

In \textit{In re Hershey Medical Center},\footnote{172} the Superior Court of Pennsylvania followed the \textit{Whalen} Court's reasoning in permitting two hospitals to disclose the identity of an HIV-infected staff physician to certain patients and colleagues.\footnote{173} The court determined that disclosure of the HIV-infected HCP's health status served the "compelling state interest"\footnote{174} of protecting patients from the risk of a fatal disease and preventing transmission of AIDS/HIV.\footnote{175} The court acknowledged that the risk that "Dr. Doe" transmitted HIV to one of his patients was minimal.\footnote{176} However, in balancing the competing interest, the court found that the public's interest in disclosure far outweighed the HCP's interest in keeping his HIV-infected status confidential.\footnote{177} In strong language, the court noted that "Dr. Doe's medical problem was not merely his. It became a public concern the moment he picked up a surgical instrument and became a part of a team involved in invasive procedures."\footnote{178}

Similarly, the disclosure requirements of the "Look Back" statute do not constitute a violation of the HCP's right to privacy.\footnote{179} The statute's purpose\footnote{180} serves the compelling state interest of protecting patients who may be at risk of HIV transmission and of controlling the spread of a deadly disease.\footnote{181} Furthermore, in balancing the competing interests, the scales undoubtedly tip in

\footnotesize{\begin{itemize}
    
    \item \footnote{171}{\textit{Id.}}
    \item \footnote{172}{\textit{In re Hershey Med. Ctr.}, 595 A.2d 1290 (Pa. Super. Ct. 1991).}
    \item \footnote{173}{\textit{Id.} at 1291. The two hospitals notified a total of 447 patients who might have been exposed to the HIV-infected physician. \textit{Id.} at 1292. This list contained only the names of those patients who had undergone an invasive procedure performed by the physician. \textit{Id.} at 1293. The court found that it was the duty of the hospital to inform persons who were placed at some degree of risk of infection due to the nature of their contacts with the physician. \textit{Id.} Moreover, the name of the physician was not actually revealed to the patient. \textit{Id.} at 1298. However, the physician's name was revealed to certain other medical professionals in order to help others. \textit{Id.} at 1298.}
    \item \footnote{174}{\textit{Id.} at 1297. The lower court ordered that the HCP's identity be disclosed pursuant to the Confidentiality of HIV-Related Information Act. \textit{Id.} This act is similar to the Illinois AIDS Confidentiality Act. ILL. REV. STAT. ch. 111 1/2 para. 7301-7316 (1991).}
    \item \footnote{175}{\textit{In re Hershey Med. Ctr.}, 595 A.2d at 1295-96. The court described a compelling need as a "concrete medical need" necessary to make an important decision rather than just a desire to know. \textit{Id.} at 1295.}
    \item \footnote{176}{\textit{Id.} at 1297.}
    \item \footnote{177}{\textit{Id.}}
    \item \footnote{178}{\textit{Id.} at 1298.}
    \item \footnote{179}{\textit{In re Hershey Med. Ctr.}, 595 A.2d at 1302.}
    \item \footnote{180}{See House Transcript \textit{supra} note 19, at 7-8 (statement of Representative Munizzi) (stating that the purpose of the "Look Back" statute is to control the spread of AIDS/HIV and to provide information to patients concerning potential risk of transmission so that appropriate steps can be taken).}
    \item \footnote{181}{See Doe v. Borough of Barrington, 729 F. Supp 376, 385 (D.N.J. 1990) (stating that the prevention of a fatal disease is a valid state objective).}
\end{itemize}}
favor of the general public.\textsuperscript{182}

Although the risk that an HIV-infected HCP will transmit the virus to a patient is small, the consequences of transmission are fatal.\textsuperscript{183} As noted above, it would hardly be consoling to an innocent patient who discovers he or she has contracted HIV from an HCP to learn that he or she was part of a rare statistic.\textsuperscript{184} As a result, the right of patients to know whether they have been placed at risk of contracting HIV far outweighs the HCP's privacy right in keeping his or her HIV status confidential.\textsuperscript{185} Therefore, the “Look Back” statute does not constitute a violation of the HCP's right to privacy.\textsuperscript{186}

2. The “Look Back” Statute Does Not Violate the Patient's Right to Privacy

Opponents of the “Look Back” statute also argue that it violates the patient's right to privacy and the doctor-patient relationship.\textsuperscript{187} This argument is based on language in the statute which

\begin{itemize}
\item \textsuperscript{182} \textit{In re} Hershey Med. Ctr., 595 A.2d at 1297. The court concluded that despite the small risk of transmission, Dr. Doe did create a health risk to his patients. \textit{Id.} at 1298.
\item \textsuperscript{183} \textit{The MERCK MANUAL, supra} note 20, at 292.
\item \textsuperscript{184} \textit{In re Hershey Med. Ctr.}, 595 A.2d at 1296.
\item \textsuperscript{185} \textit{Id.} at 1298. The court does not deny that generally one's own health concerns are a private matter. \textit{Id.} However, the “public's right to be informed in this sort of potential health catastrophe is compelling and far outweighs a practicing surgeon's right to keep information regarding his disease confidential.” \textit{Id.} at 1302.
\item \textsuperscript{186} \textit{See} Doe v. Attorney Gen. of the United States, 941 F.2d 780, 795 (9th Cir. 1991) (no violation of an HCP's right to privacy occurred when the HCP was required to reveal to government officials that he was HIV-infected). \textit{See also} \textit{In re} Hershey Med. Ctr., 595 A.2d at 1290 (no violation of an HCP's right to privacy occurred when the identity of an HIV-infected HCP was revealed to certain colleagues and patients); \textit{see also} United States v. Westinghouse Elec. Corp., 638 F.2d 570, 577-78 (3rd Cir. 1980) (reporting requirements regarding sensitive medical information upheld where the government demonstrated a need to control the public health).
\item \textsuperscript{187} \textit{See} Letter from John Hammell to Health Department, \textit{supra} note 144, at 2. The American Civil Liberties Union of Chicago expressly objects to disclosure of private information regarding a patient's prior medical history. \textit{Id.} Specifically, the letter states, “[s]uch information may be very private, especially if the person has undergone an abortion, a vasectomy, a hysterectomy or other invasive procedures which clearly involve highly personal matters.” \textit{Id.} \textit{See also} House Transcript, \textit{supra} note 19, at 3-4 (statement of Representative Lang). Opposing the “Look Back” statute, Representative Lang stated that the statute's disregard for patient confidentiality prohibited him from supporting the bill. \textit{Id.} at 3. According to Representative Lang, a physician's patient files should be held sacred and should not be available to anyone without that patient's permission. \textit{Id.} Interestingly, Lang proposed a solution to the issue of patient confidentiality that was not adopted by the drafters of the statute. \textit{Id.} at 4. Lang suggested that each HCP offer a consent form to the patient. \textit{Id.} Through this form, the patients could authorize their files to be turned over to the Health Department in the event of an emergency. \textit{Id.}
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authorizes the Health Department to scrutinize confidential patient records of an HIV-infected HCP and to scrutinize medical records of an HIV-infected patient. Critics argue that the statute needlessly allows the Health Department to investigate every single invasive procedure performed on HIV-infected persons, thereby delving into many patient's confidential medical records. Furthermore, opponents assert that the statute allows the Health Department to investigate these files absent a medically justified risk that the HCP has transmitted HIV to a patient.

Courts have acknowledged that a patient's confidential medical files and the doctor-patient relationship do amount to a privacy right. Understandably, many patients would object to the state having access to private medical information in their patient files. However, after balancing the competing interests, the "Look Back" statute does not violate the patient's right to privacy or the doctor-patient relationship.

188. Act of Oct. 4, 1991, Pub. A. 87-763, 1991 Ill. Legis. Serv. 3672, 3673 (West) (codified as amended at ILL. REV. STAT. ch. 111 1/2, para. 7405.5(c) (1991)). The statute states that "the Department shall have access to the subject’s records to review for the identity of contacts." Id. "Contacts" include not only patients who have undergone an invasive procedure performed by an HIV-infected HCP, but also HCPs who have performed an invasive procedure on HIV-infected patients. Id. Therefore, the statute authorizes the health Department to have access to a patient file if an HIV-infected HCP has performed an invasive procedure on that patient. Id. Additionally, the statute allows the Health Department to examine patient files of any HIV-infected individual to determine if any HCP has been put at risk through performing invasive procedures on that individual. Id.

189. Letter from John Hammell to Health Department, supra note 144, at 3.

190. Id.

191. See Whalen v. Roe, 429 U.S. 589, 596 (1977) (noting that the doctor-patient relationship "is one of the zones of privacy accorded constitutional protection"). See also United States v. Westinghouse Elec. Corp., 838 F.2d 570, 578 (3d Cir. 1980) (personal medical records are within the sphere of materials afforded privacy protection). See also Estate of Behringer v. Medical Ctr., 592 A.2d 1251, 1268 (N.J. Super. Ct. 1991). The physician-patient privilege is recognized as a privacy right and afforded constitutional protection. This obligation of confidentiality imposes a duty on the physician not to disclose patient communications, patient records, or other patient information. Id.

However, exceptions to this privacy right do exist. Id. Those exceptions include disclosure of such information as is necessary to protect the community or the individual. Id. Furthermore, another exception to this privacy right is the duty to statutorily report certain contagious medical conditions to a public health department. Id. at 1296.

192. House Transcript, supra note 19, at 4 (statement of Representative Lang).

193. WHALEN, 429 U.S. at 597. The court found that state legislation which infringes on privacy rights will not be found unconstitutional merely because it may be unnecessary in whole or in part. Id. Rather, the court stated that "states have broad latitude in experimenting with possible solutions to problems of vital local concern." Id. Furthermore, the court noted that denying states the right to experiment might impose grave consequences on the en-
Courts must apply the “compelling state interest” test to determine whether the statute violates the patient’s right to privacy and the doctor-patien relationship. Therefore, courts must balance the competing interests of society against the interests of the individual. The state has a “compelling state interest” to protect the individual and control the spread of a fatal disease. When balancing the public's interest in disclosure against the patient's interest in privacy, the scales tip in favor of the public. The public's need to know whether persons have been placed at risk of contracting a fatal disease outweighs the patient's right to keep his or her medical files private.

In McBarnette v. Feldman, a New York court upheld the release of confidential patient files to the state health department following a report that the patients' dentist had contracted AIDS and subsequently died. The court held that although the doctor-patient privilege served an "important social function," that privilege is not absolute. Moreover, the court stated that the privilege must yield in certain situations, "especially where the legislature has abrogated the privilege to effectuate an overriding public policy.

Similarly, the “Look Back” statute does not violate the patient’s right to privacy or the doctor-patient privilege. Clearly doctor-patient privilege must give way when necessary to protect persons potentially exposed to a fatal disease. Furthermore, the

tire nation. Id. The court noted, “a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.” Id.

196. See Doe v. Attorney Gen. of the United States, 941 F.2d 780, 796 (9th Cir. 1991); In re Hershey Med. Ctr., 595 A.2d 1290, 1295-96 (Pa. Super. 1991); Westinghouse, 638 F.2d at 580 (recognizing the privacy interest in medical information, yet holding that the need for disclosure was compelling).
200. Id.
201. Id. at 904.
202. Id.
203. See McBarnette, 582 N.Y.S.2d at 904. In McBarnette, the court stated that “the practice of medicine is subject to regulation by the state under its broad police powers and that authorization could be found to obtain patient records for purposes of investigation of a physician or dentist, notwithstanding the confidential physician-patient privilege.” Id.
204. Id.
argument of doctor-patient privilege is without merit in light of the knowledge that AIDS constitutes a serious public health hazard and can be transmitted during invasive procedures.\textsuperscript{205} Therefore, the statute constitutes a valid exercise of the state's police power and does not violate the patient's right to privacy or the doctor-patient relationship.\textsuperscript{206}

B. Overbroad Language Renders the Statute Ineffective

Although the statute does not violate the HCP's or patient's fundamental privacy rights, it is filled with broad, overinclusive language which frustrates its effectiveness.\textsuperscript{207} The statute authorizes the Health Department to investigate whenever it receives a report that an HCP "may present or may have presented a possible risk of HIV transmission."\textsuperscript{208} The statute then authorizes the Health Department to investigate the subject of that report and that subject's contacts when it is "medically appropriate."\textsuperscript{209}

Consequently, the statute allows the Health Department broad discretion to examine all patient files of an HCP who "may present a possible risk of HIV transmission."\textsuperscript{210} This broad grant of discretion is both costly and impractical for a number of reasons.\textsuperscript{211} First, the Health Department will be burdened with the task of scrutinizing literally thousands of medical files\textsuperscript{212} in an effort to determine

\textsuperscript{205.} See \textit{id.}

\textsuperscript{206.} \textit{Whalen}, 429 U.S. at 601. Disclosure of private medical information to a department of public health is important to modern medicine and the health of the community. \textit{Id.} Thus, a court order requiring such disclosure does not automatically violate privacy rights even when the information disclosed adversely affects other's views about the character of the individual. \textit{Id.} See also Doe v. Puget Sound Blood Ctr., 819 P.2d 370, 385 (Wash. 1991) (Dore, Chief Justice, dissenting). The court stated that individual privacy rights must frequently "give way" to a state's actions in promoting the health, safety and welfare of the community. \textit{Id.} Further, "the public has a right to be informed of those who have the human immunodeficiency virus, and those who don't, in order to protect themselves. The alternative is that a great number of citizens will innocently contract HIV and be condemned to a painful death." \textit{Id.}

\textsuperscript{207.} See Letter from John Hammell to Governor Edgar, \textit{supra} note 150, at 5-6 (claiming that the statute is "unconstitutionally vague"); see also Letter from Karen Fishman to Governor Edgar, \textit{supra} note 148, at 1 (stating that the statute uses certain words "so vague they are meaningless"); see also Letter from Dan Bigg to Governor Edgar, \textit{supra} note 149, at 1 (stating that the statute is "vague and misleading").


\textsuperscript{209.} \textit{Id.}

\textsuperscript{210.} \textit{Id.}

\textsuperscript{211.} Letter from John Hammell to Governor Edgar, \textit{supra} note 150, at 2.

\textsuperscript{212.} The Health Department reports that as of September 30, 1991, there are 7,037 individuals infected with HIV and 5,814 individuals infected with AIDS in Illinois. \textit{See} Memorandum from Judy Jondahl, Nursing Coordinator, Warren Staley, Medical Coordinator, Michael Vold, Dental Coordinator, Illinois Department and Professional Regulation, to Thomas Chiola, General Counsel 1-2
whether any invasive procedures have been performed or whether a possible risk of HIV transmission exists.\textsuperscript{213} Second, absent statutory guidelines, the Health Department must then make thousands of discretionary decisions regarding whether they should notify patients who have been exposed to HIV.\textsuperscript{214} Therefore, the Health Department will be spending an enormous amount of existing AIDS funding and resources to examine files in search of possible risks of HIV transmission while making many unguided discretionary decisions.\textsuperscript{215}

In addition, the language of the statute is both overbroad and ineffective because many HCPs do not regularly maintain files of patients they treat. For example, paramedics, emergency medical technicians, blood technicians, surgical assistants, and various other HCPs have no system of keeping patient records or files. Therefore, when the Health Department receives a report of HIV infection in one of these HCPs, the Health Department has no practical or efficient way of discovering whether these HCPs have exposed a person to HIV. As a result, the Health Department will have to spend an enormous amount of time and resources in an attempt to discover patients who have been placed at risk, and often this will result in a futile search.

Furthermore, the statute is overbroad because it currently relies on the CDC's 1987 definition of invasive procedures.\textsuperscript{216} The statute defines invasive procedures as "those procedures termed invasive by the Centers for Disease Control in current guidelines or recommendations for the prevention of HIV transmission in health

\textsuperscript{(Dec. 11, 1991) (on file with the Illinois Department of Professional Regulation) (regarding HIV in the health care setting Task Force projection). Furthermore, 216 HCPs have been diagnosed with AIDS in Illinois. \textit{Id} at 2. Moreover, according to CDC estimates, there are 513 HCPs potentially infected with HIV in this state. \textit{Id}.}

\textsuperscript{213. \textit{See Letter from John Hammell to Health Department, supra note 144, at 3.}}

\textsuperscript{214. Letter from John Hammell to Governor Edgar, supra note 150, at 2; Letter from John Hammell to Health Department, supra note 144, at 3.}

\textsuperscript{In November 1991, the Governor of Illinois organized a "Task Force" to address the statute's problems and ambiguous language. Telephone Interview with Tom Schafer, Chief of Communications, Illinois Department of Public Health, Springfield Office (Mar. 24, 1991). The Task Force's duties include making recommendations to the Health Department regarding how to implement the "Look Back" statute. \textit{Id}}}

\textsuperscript{\textit{Pursuant to an April 1, 1992 deadline, the Task Force did make formal recommendations concerning the implementation of the statute. Telephone interview with Chet Kelly, Administrator for the AIDS Act:ivity Section, Illinois Department of Public Health (June 1, 1992). One of the Task Force's primary concerns was implementing the statutory language which authorizes the Health Department to notify patients who have been treated by an infected HCP. \textit{Id}.}}

\textsuperscript{215. Letter from John Hammell to Governor Edgar, supra note 150, at 2.}

Before the “Look Back” statute became effective, the CDC attempted to create a list of procedures deemed risk-prone invasive procedures. However, due to intense opposition from medical organizations and lobbies, in November of 1991 the CDC abandoned its attempt to list invasive procedures. Hence, as the statute now stands, it will utilize the CDC’s 1987 definition of invasive procedures rather than relying on the CDC’s proposed list. However, the CDC published their 1987 definition long before the medical community recognized HIV transmission from an infected HCP to patient as a potential problem in the health care setting. Consequently, Illinois now has a law on the books that does not have a medically current definition of “invasive procedures.”

The CDC’s 1987 definition is overbroad, ambiguous, and fails to give adequate guidance regarding which specific types of procedures pose a significant risk of HIV transmission for the purposes of this statute. Certain invasive procedures pose a higher risk of HIV transmission than others. Examples of these types of procedures include the presence of a sharp instrument and an HCP’s fingers in a poorly visualized site within the body. The 1987 definition provides little guidance concerning what procedures are to be regarded as “invasive procedures” for the purposes of the notification requirements of the “Look Back” statute.

Finally, the statute’s definition of “health care provider” is overinclusive. The statute defines “health care provider” as “any physician, dentist, podiatrist, nurse, or other person providing health care services of any kind.” Consequently, the statute in-
cludes many HCPs who do not perform invasive procedures and therefore pose little or no risk of HIV transmission to their patients. As a result, the statute unnecessarily authorizes the Health Department to search and review many patient files without justification. Because the Health Department must unnecessarily review many files, the statute requires the additional expense of investigating and reviewing patient files when potentially no risk of HIV transmission exists. Therefore, the statute's definition of "health care provider" is overbroad and the legislature must amend and limit it.

C. **The Statute Fails to Further its Objective**

In addition, the “Look Back” statute is an ineffective response to the problem of HIV transmission from an HIV-infected HCP to patient because it fails to adequately further its objective. It is unlikely that the statute will do much to advance its fundamental goal of stopping the spread of HIV in the health care setting.

The statute is ineffective for several reasons. First, the statute deters HCPs from seeking HIV tests. Under the “Look Back” statute, any HCP who tests positive for HIV must report his or her condition to the Health Department and allow for the notification of patients. Understandably, many patients would not know-

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228. See Letter from John Hammell to Governor Edgar, supra note 150, at 6 (stating that the statute authorizes the Health Department to have access to all of an HCP’s files in order to determine which patients may be HIV-infected).

229. See id. at 3.

230. See Letter from Karen Fishman to Health Department, supra note 148, at 1 (stating that the “Look Back” statute “will do virtually nothing to prevent HIV transmission and is likely to drain resources from existing education, prevention and care programs as well”); see also Letter from Dan Bigg to Governor Edgar, supra note 149, at 1 (stating that the “Look Back” statute will fail to prevent the spread of HIV).

231. See Jean Latz Griffin, Dental Student Has HIV, Patients Told, CHI. TRIB., July 24, 1991, § 2, at 1. The Northwestern University Dental School recently informed approximately 125 patients that a student who performed dental services for them tested positive for HIV. Id. At the time of the notification, the “Look Back” statute had not become law. Id. However, even if it had been effective, it would not have led to notification of the former patients if the student had not come forward. Id.

232. See Letter from John Hammell to Governor Edgar, supra note 150, at 5. The “Look Back” statute will reveal identities of those persons who are infected with HIV before they have been diagnosed with full-blown AIDS. Letter from John Hammell to Health Department, supra note 144, at 2. This requirement is contrary to previous Health Department guidelines and Illinois legislation which provided for reporting of HIV status only after a person had been diagnosed with AIDS. Id. The American Civil Liberties Union believes that this requirement will deter voluntary testing for HIV and therefore ultimately harm the public health. Id.

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AIDS patients fear the very real possibility of losing their doctor. Therefore, under the statute, an HIV-infected HCP must face the very real possibility of losing his or her practice and livelihood. As a result, many HCPs who suspect they are HIV-infected will have strong motivations for refusing testing. Consequently, many HIV-infected HCPs will continue to practice and perform invasive procedures on unsuspecting patients despite posing risk of HIV transmission.

Second, the "Look Back" statute is ineffective because it provides both the HCP and the patient with a false sense of security concerning HIV infection. If an HCP believes he or she has been exposed to HIV and therefore voluntarily submits to HIV testing, a negative result may give the HCP a false sense of assurance that he or she is HIV-negative. A person having HIV may test negative during the "window period" even though the individual is capable of transmitting the virus. As a result, any single negative test for HIV may cause an HCP to believe that he or she is free from HIV infection, when in fact the HCP is infected and is capable of transmitting the disease. Consequently, absent routine testing of HCPs, a false sense of security regarding HIV infection may cause the HCP to practice less stringent infection control precautions while treating patients. Thus, it is likely that unless further legislation is enacted, the statute may actually increase the incidence

234. See Patricia A. Marshall et al., Patient's Fear of Contracting the Acquired Immunodeficiency Syndrome From Physicians, 150 ARCHIVES OF INTERNAL MED. 1501, 1501 (1990) (reporting on a study conducted to assess patients' fear of contracting HIV from their doctor). The study found that many individuals are fearful of contracting AIDS during medical treatment. Id. at 1501.

235. See generally Eileen Hansen & Tom Steel, Examining the Doctor: The HIV Testing Debate, TX. LAw., Oct. 28, 1991, at 18. Many HIV-infected HCPs are subject to discrimination. Id. The American Association of Physicians for Human Rights has documented 30 cases of discrimination against an HIV-infected HCP. Id. Disclosure of the HIV-infected HCP's health status threatens to seriously disrupt his or her private life and to destroy his or her practice. Id.

236. See Elizabeth Rosenthal, Study Sees Moves on HIV Infection Backfiring, N.Y. TIMES, Sept. 10, 1991, at C5 (reporting on a study conducted by the Medical Expertise Retention Program in San Francisco). The survey polled 196 HCPs. Id. Of those surveyed, 67% stated that they would refuse HIV testing even if they suspected they might be HIV-infected. Id. The reason that the HCPs would refuse testing was because they feared that a positive result would cause them to suffer discrimination or to lose their practice. Id.

237. See id.; Letter from John Hammell to Governor Edgar, supra note 150, at 5.

238. Letter from John Hammell to Health Department, supra note 144, at 3.

239. See Culloton, supra note 116, at 14. Moreover, patients that are not contacted by the Department of Public Health may consequently believe they are safe from HIV exposure and that their HCP is HIV-negative. Id.

240. See supra notes 32-37 and accompanying text for a discussion of the "window period."

241. JARVIS ET AL., supra note 29, at 18.

242. Letter from John Hammell to Health Department, supra note 144, at 3.
of HIV.\textsuperscript{243}

A third reason that the "Look Back" statute is ineffective is that it is inconsistent with previous Illinois AIDS/HIV legislation.\textsuperscript{244} The AIDS Confidentiality Act and STD Act are both based on the premise that maintaining confidentiality of those persons who are HIV-infected will encourage voluntary testing.\textsuperscript{245} However, by disclosing the HIV status of any HCP who tests positive for HIV, the "Look Back" statute destroys confidentiality of HCPs who are HIV-infected. As a result, the statute will actually discourage HCPs from seeking voluntary testing.\textsuperscript{246} Therefore, many HCPs who suspect they may be HIV-infected will refuse to be tested, thereby obstructing the underlying goal of previous Illinois AIDS/HIV legislation.\textsuperscript{247}

Finally, the statute is ineffective because it will cost taxpayers millions of dollars and will subsequently deplete necessary funds for AIDS research and education.\textsuperscript{248} The Health Department estimates that implementing the "Look Back" statute will cost taxpayers approximately $400,000 per year.\textsuperscript{249} However, public officials have estimated that the statute will actually cost closer to ten million dollars annually to implement.\textsuperscript{250} This estimate is not unreasonable given that one recent "Look Back" investigation involving a single HCP was conducted in Minnesota at a cost of $130,000.\textsuperscript{251}

Moreover, as of December 1991, over 260 HCPs have been diag-

\textsuperscript{243} See Letter from John Hammell to Governor Edgar, \textit{supra} note 150, at 5.

\textsuperscript{244} Id.

\textsuperscript{245} See ILL. REV. STAT. ch. 111 1/2, para. 7302 (1991) (the AIDS Confidentiality Act states that "the public health will be served by facilitating informed, voluntary, and confidential use of tests designed to reveal HIV infection"). \textit{See also} ILL. REV. STAT. ch. 111 1/2, para. 7402 (1991) (the STD Act states that "sexually transmissible diseases, by their nature involve sensitive issues of privacy, and it is the intent of the General Assembly that all programs designed to deal with these issues afford patients privacy, confidentiality, and dignity").

\textsuperscript{246} See \textit{Doctors with AIDS: Fear vs. Facts}, CHI. TRIB., Oct. 28, 1991, \S 1, at 12. HCPs who are forced to disclose their HIV status risk losing "their jobs, chances for a career, income, and reputation." \textit{Id.} As a result, many HCPs are fearful and reluctant to submit to voluntary HIV testing. \textit{Id.} \textit{See also} Benjamin Schatz, \textit{supra} note 51.

\textsuperscript{247} Letter from John Hammell to Governor Edgar, \textit{supra} note 150, at 5.


\textsuperscript{249} Aron, \textit{supra} note 106, at 7.

\textsuperscript{250} \textit{Highlights of the Illinois Look-Back Statute, supra} note 248, at 31.

\textsuperscript{251} Richard N. Danila et al., \textit{A Look-Back Investigation of Patients of an HIV-Infected Physician: Public Health Implications}, 325 JAMA 1406 (1991). This study concluded that "Look Back" investigations were not warranted unless there exists a "clearly identifiable risk of transmission of the infection, substantially higher than the risk requiring limitation of an HIV-infected health care worker's practice prospectively." \textit{Id.} at 1406.
nosed with AIDS in Illinois.252 Given this number, and assuming a cost of only $50,000 per investigation, the potential cost of implementing the “Look Back” statute is staggering. Yet, the statute not only authorizes the Health Department to conduct “Look Back” investigations, it mandates that they be conducted.253 Clearly, a system of monitoring or licensing HIV-infected HCPs would be less costly and far more practical.254

In summary, the Illinois “Look Back” statute is an inappropriate way to attack the problem of HIV transmission in the health care setting.255 Although the statute has a valid state objective and is constitutional, it will be ineffective in furthering the legislature’s intent. In fact, the statute may actually increase the spread of HIV.256 As it stands, the statute is overinclusive, costly, and will be wholly ineffective in reducing the incidence of HIV transmission.257 The statute falls short because it seeks only to notify persons of possible HIV transmission rather than proposing a solution for preventing HIV infection.258 Consequently, the statute constitutes poor public health policy and sets a dangerous precedent for other states.259 The Illinois legislature must aspire to create AIDS legislation that addresses current and future public concerns without losing sight of potentially harmful effects and costs. Therefore, the Illinois legislature should amend the “Look Back” statute so that it can more appropriately address HIV transmission in the health care setting.

V. PROPOSAL

Illinois must amend and clarify the “Look Back” statute or the incidence of AIDS/HIV may actually increase.260 Currently, the statute provides to any HCP who suspects that he or she may have been exposed to HIV numerous reasons why he or she should re-

252. See Memorandum from Judy Jondahl, Nursing Coordinator, Warren Staley, Medical Coordinator, Michael Vold, Dental Coordinator, Illinois Department of Professional Regulation, to Thomas Chiola, General Counsel at 2 (Dec. 11, 1991) (on file with the Illinois Department of Professional Regulation).
254. Id.
255. Letter from John Hammell to Governor Edgar, supra note 150, at 1.
256. See Culloton, supra note 116, at 14. Robert Shofield, lobbyist for the American Civil Liberties Union, states, “I really, honestly believe that more people will die as a result of this bill.” Id.
257. Letter from John Hammell to Governor Edgar, supra note 150, at 1.
258. See Culloton, supra note 116, at 14. The “Look Back” statute fails to address transmission of HIV, and instead focuses solely on notification. Id. Furthermore, HCPs who suspect they may be HIV-infected can evade ramifications of the statute by having HIV testing performed out of state. Id.
259. Letter from Karen Fishman to Governor Edgar, supra note 148, at 1.
260. Letter from John Hammell to Governor Edgar, supra note 150, at 1.
fuse testing.\textsuperscript{261} Furthermore, the statute is filled with overbroad language which makes it confusing and ineffective.\textsuperscript{262} Thus, the statute will be, at best, difficult to implement and, at worst, counterproductive.\textsuperscript{263}

Consequently, the legislature should amend the "Look Back" statute so that it will more appropriately address the problem of HIV transmission in the health care setting. Part A of this section recommends that the legislature amend the statute to require routine mandatory testing for HCPs who perform invasive procedures. Part B recommends that the legislature limit the disclosure requirements of the "Look Back" statute in order to make it more effective. Part C of this section recommends that the legislature define the types of invasive procedures that the drafters designed the statute to address. Finally, part D recommends that the legislature more appropriately define "health care provider" for the purposes of the statute.

\textbf{A. Routine Mandatory Testing of HCPs Who Perform Invasive Procedures}

The "Look Back" statute does not require mandatory testing of HCPs who perform invasive procedures.\textsuperscript{264} Therefore, HCPs who perform invasive procedures can easily circumvent the statute simply by refusing HIV testing.\textsuperscript{265} In addition, any HCP who suspects he or she may be HIV-infected can easily evade the statute by seeking HIV testing in another state.\textsuperscript{266} This result stems from a compromise between the advocates of the "Look Back" statute and the medical lobby.

Those who oppose mandatory testing of HCPs who perform invasive procedures argue that it is inappropriate for several reasons. First, opponents argue that the risk of HIV transmission from an infected HCP to a patient is extremely low.\textsuperscript{267} This argument is unpersuasive. Although the risk of HIV transmission from an infected HCP to a patient is low, the risk is real and cannot be elimi-

\textsuperscript{261} See supra notes 234-237 and accompanying text for a discussion of how the "Look Back" statute deters voluntary testing.

\textsuperscript{262} Letter from John Hammell to Governor Edgar, supra note 150, at 1.

\textsuperscript{263} Id.


\textsuperscript{265} Letter from John Hammell to Governor Edgar, supra note 150, at 5.

\textsuperscript{266} Culloton, supra note 116, at 14.

nated. Clearly it is little consolation to a person who contracts HIV from an HCP that he or she is one in a thousand.

Second, opponents argue that most HCPs who discover they are HIV-infected would voluntarily refrain from conducting any procedures which might put patients at risk of HIV exposure. These opponents argue that the duty of the HCP to adhere to professional and ethical norms would cause him or her to refrain from performing these procedures. However, this argument is inadequate and is far outweighed by the danger of transmission to patients. Studies reveal that many HCPs do not follow universal infection control precautions. Therefore, the fact that some HCPs practice infection control does not completely eliminate the risk of HIV transmission. HCPs should not be left to police themselves when the consequences of a failure to do so might mean death to an individual.

Third, opponents object to mandatory testing of HCPs because it would be costly. Although routine testing of HCPs who perform invasive procedures would potentially be very costly to the state's already limited funding for AIDS/HIV, there is an alternative to requiring the state to provide funds. The HCP could pay for his or her own testing. In addition, the HCP should be responsible for supplying the Health Department with the test results. The HCP can then pass this cost on to patients who will be the ultimate beneficiaries of mandatory testing.

270. HIV-Infected Surgeons, supra note 267, at 1137.
271. Id.
272. See Albert R. Jonsen, Is Individual Responsibility a Sufficient Basis for Public Confidence?, 151 ARCHIVES OF INTERNAL MED. 660, 661-662 (1991) (for a discussion of whether the individual responsibility exercised by an HIV-infected HCP is a sufficient basis on which to monitor).

273. See, e.g., Kenneth Courington et al., Universal Precautions Are Not Universally Followed, 126 ARCHIVES OF SURG. 93, 93-96 (1991) (concluding that noncompliance with infection control precautions occurs frequently in the health care setting). In operating room procedures, the authors found that failure to comply with infection control precautions occurred 75% of the time. Id.
274. Id.
275. Jonsen, supra note 272, at 662.
277. Id.
279. Id.
280. Id.
The Illinois General Assembly must amend the “Look Back” statute to require routine mandatory testing of HCPs who perform invasive procedures for the statute to be effective. Furthermore, the Health Department should restrict those HCPs who test positive for HIV from performing invasive procedures absent approval from the patient. Without this necessary amendment, the Illinois “Look Back” statute will be completely ineffective and impossible to implement.

B. The Statute Should Limit Disclosure of HCP’s HIV Status to Patients

The “Look Back” statute gives the Health Department broad authority to investigate HIV-infected HCPs who have performed invasive procedures on patients. Although the statute is constitutional, the Illinois legislature should amend the “Look Back” statute so that it limits the Health Department’s authority to investigate an HCP who “may present a possible risk of HIV transmission.” Specifically, the legislature should amend the statute to provide the Health Department with the authority to investigate and to contact individuals who have had a “significant” or “material” risk of contracting HIV. The legislature should also attempt to describe which risks they consider to be “significant” or “material.”

Courts have held that a risk is significant if it would influence the patient’s decision of whether or not to consent to treatment. Given that AIDS is a deadly and incurable disease, the risk becomes “significant” at a relatively low risk of transmission. Therefore, a risk is significant if it presents an opportunity for blood or bodily fluid transfer to a patient during a procedure where the patient’s body cavity or other “portal of entry” is exposed. These types of procedures include, but should not be limited to, surgical, obstetric, and dental procedures.

281. See supra notes 207-229 and accompanying text for a discussion regarding why the “Look Back” statute is ineffective.
283. Letter from John Hammel to Governor Edgar, supra note 150, at 3.
284. Id. Specifically, the American Civil Liberties Union suggests that the statute should adopt the standard generally used by the courts to determine if a patients should be informed about risks. Id. This standard would allow patients to be informed when there is a “significant” or “material” risk. See id., construed in, Miceikis v. Field, 347 N.E.2d 320, 324 (Ill. App. Ct. 1976).
286. See HIV-Infected Surgeons, supra note 267, at 1135 (if the CDC’s estimate of HIV transmission of one in 40,000 surgeries is accurate, then procedures with the greatest risk of HIV transmission could have a risk of one in 10,000. Few would not consider this a “significant” risk).
Amending the statute to apply to "significant" or "material" risks would be appropriate for several reasons. First, it is costly and inappropriate to scrutinize thousands of patient medical records in an effort to notify subjects of "a possible risk of HIV transmission."287 The state's cost to implement the "Look Back" statute is estimated to reach $400,000 the first year.288 Thus, the state will incur unnecessary costs in an effort to investigate and inform thousands of patients of HCPs who "may present or may have presented a possible risk of HIV transmission."289

Second, amending the statute to investigate contacts who have had a "significant" risk of contracting HIV will amount to better public policy.290 Notifying every patient who an HIV-infected HCP has examined or treated will do little to stop the spread of HIV.291 It will only provide a patient with alarming information that he or she might have been exposed to a fatal disease.292 Investigating those contacts who have had a "significant" risk of HIV transmission would be a better use of funds and would better respect the HIV-infected HCP's privacy concerns.293

C. The Legislature Should Clarify the Definition of Invasive Procedures

The "Look Back" statute does not adequately define "invasive procedures." Instead, the statute relies upon the CDC's 1987 definition of what constitutes such procedures.294 After the "Look Back" statute was passed, however, the CDC abandoned its attempts to create an updated list of invasive procedures as a result of intense opposition from the medical lobby.295 Therefore, the legislature, together with the medical community, must develop a list or current definition of such procedures.

By creating a list of invasive procedures, the Illinois legislature would clarify the statute and make it more effective. Many invasive procedures are prone to a higher risk of HIV exposure than others.296 These types of procedures should be expressly defined as

287. Memorandum from the Coalition to Repeal the Illinois AIDS Notification Law, supra note 149, at 1-2.
289. Memorandum from the Coalition to Repeal the Illinois AIDS Notification Law, supra note 149, at 1-2.
290. Letter from John Hammell to Governor Edgar, supra note 150, at 1, 3.
291. Id. at 4.
292. Id.
293. Id.
295. CDC Apparently Will Drop Proposal, supra note 100, at A-16.
296. Recommendations for Preventing HIV and HBV, supra note 45, at 4.
the types of procedures where patient notification is appropriate. If the legislature amended the statute in this way, the Health Department would have guidelines to follow rather than having to make judgmental decisions about which types of procedures warrant patient notification. This type of amendment would facilitate implementing the statute and offer direction concerning when patient notification is appropriate. Therefore, the statute should be amended so that it sets forth these procedures.

D. The Legislature Should Limit the Definition of “Health Care Provider”

The “Look Back” statute does not adequately define “health care provider.” The statutory definition includes any person “providing health care services of any kind.” This definition is overinclusive because it includes many HCPs who may not perform invasive procedures in the purview of the statute. The Illinois General Assembly should clarify this language by including only those types of HCPs who perform exposure-prone invasive procedures. Therefore, the statute should limit its definition to surgeons, dentists, and any other HCP who engages in invasive procedures that include the presence of a sharp instrument and an HCP’s hands in a poorly visualized site within the body. Clarifying this definition would save the state the cost of combing through files of HCPs who pose little or no risk of HIV transmission to their patients.

CONCLUSION

AIDS has grown from a disease that was once thought to affect only certain groups to a worldwide problem that leaves no one in our society untouched. The AIDS epidemic has now raised serious questions regarding HIV-infected health care providers and the risk they pose when performing invasive procedures. Because HIV transmission from an HIV-infected dentist to at least five of his patients has already occurred, the medical community can no

298. Letter from John Hammell to Governor Edgar, supra note 150, at 1-2.
299. See Recommendations for Preventing HIV and HBV, supra note 45, at 4 for the CDC’s description of what kinds of procedures constitute “exposure-prone.”
300. Id.
301. HIV-Infected Surgeons, supra note 267, at 1135.
303. Transmission of HIV Infection During Invasive Procedures, supra note 8, at 377-381.
longer stand mute and wait for more concrete evidence regarding risk of transmission.\textsuperscript{304} According to Nancy Dickey from the American Medical Association, "it is simply unacceptable for the medical profession to stand by, wait, and watch for possible cases of health care workers infecting patients with HIV in order to bring more scientific confidence to our recommendations."\textsuperscript{305}

As a result of the lack of guidance from federal organizations, states must propose legislative solutions to solve this urgent problem. The Illinois legislature should be recognized for its efforts to control HIV transmission in the health care setting. However, contact tracing pursuant to the Illinois "Look Back" statute is an ineffective response to the problem of HIV-infected health care providers. The "Look Back" statute merely proposes a short-term remedy to a problem that warrants a long-term solution. Ultimately, if not amended, the statute will be counterproductive and may actually increase the incidence of AIDS/HIV.\textsuperscript{306}

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\textsuperscript{305} Id.

\textsuperscript{306} During the publication process of this article, the Health Department released amendments to the “Look Back” statute. Adopted at 12 Ill. Reg. 10097, effective May 27, 1988; amended at 15 Ill. Reg. 11686, effective Aug. 15, 1991; emergency amendment at 15 Ill. Reg. 16462, effective Oct. 28, 1991, for a maximum of 150 days; amended at 16 Ill. Reg. 5921, effective March 30, 1992. The Amendments define both "invasive procedure" and "exposure-prone invasive procedure." \textit{Id.} § 693.10. The statute's definition, however, does not differ significantly from the CDC's 1987 definition originally relied upon by the statute.

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