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Hey Doc, Can You Keep a Secret - An Ohio Physician's Right to Warn Third Parties That They May Be at Risk of Contracting HIV

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HEY DOC, CAN YOU KEEP A SECRET? AN OHIO PHYSICIAN'S RIGHT TO WARN THIRD PARTIES THAT THEY MAY BE AT RISK OF CONTRACTING HIV

MARK WISEMAN

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Mr. X, who has feared for some time that he may have AIDS, submits to an AIDS test.¹ Unfortunately, the result is positive and his worst fears are confirmed. His doctor explains that even though he feels fine at the moment, symptoms can appear at any time. Distraught, Mr. X informs the physician not to tell anybody, including his wife. Mr. X will tell her, in due time. Although the doctor does not know Mrs. X personally, her name is in Mr. X's file and he could contact her easily. Mrs. X may already be infected, but the Doctor still feels compelled to notify her on the chance that she may avoid infection. Mr. X may eventually tell his wife, but the Doctor has no way of knowing. On the other hand, the doctor feels bound to abide by Mr. X's request and is bound to keep information obtained while treating him confidential. However, he knows that by telling Mrs. X he may save her life. What should he do?

¹ See *infra* notes 30-44 and accompanying text.

If Mr. X's doctor is located in Ohio, he only has to look to the Ohio Revised Code to obtain an answer. Section 3701.243 allows a physician to disclose the results of an HIV test to the patient's spouse or sexual partner.²

Because of § 3701.243, the doctor has the right to inform Mr. X's wife of the test results. The doctor may also notify any person he *thinks* is a sexual partner of Mr. X.³ Thus, the release of information as sensitive as a positive HIV test is left to the subjective determination by a doctor of who the patient's sexual partner is. But should an Ohio physician possess such a right? By enacting § 3701.243, the Ohio Legislature answered that question in the affirmative.

This note will seek to determine if granting a physician the right to warn third parties at risk is the appropriate solution to the above scenario and others like it. Part I will supply a background on the virus that causes AIDS. Part II will review possible legal justifications for this breach of the confidential doctor/patient relationship. Part III discusses why there is a need to maintain strict confidentiality of AIDS-related information. Finally, Part IV will discuss alternatives to granting physicians the right to warn.

I. WHAT IS AIDS?⁴

Acquired Immunodeficiency Syndrome (AIDS) was first discovered in the United States in 1981.⁵ Although there is evidence that it may have

² Section 3701.243 states:

(A) No person or agency of state or local government that acquires the information while providing any health care service or while in the employ of a health care facility or health care provider shall disclose . . . the following:

(1) The identity of any individual on whom an HIV test is performed;
(2) The results of an HIV test in a form that identifies the individual tested;
(3) The identity of any individual diagnosed as having AIDS or an AIDS-related condition.

(B)(1) Except . . . the results of an HIV test may be disclosed only to the following:

(a) The individual who was tested or the individuals' legal guardian, and his spouse or *any sexual partner*. (emphasis added)

OHIO REV. CODE ANN. § 3701.243 (Anderson 1989). Section 3701.243 was adopted by the Ohio Legislature on June 30, 1989 as part of Amended Substitute Senate Bill Number 2, which became known as "The AIDS Bill." The AIDS Bill amended 14 sections of the Ohio Revised Code and enacted 26 more sections.

³ It is interesting to note that, in its original form and as it was adopted by the Senate, The AIDS Bill did not provide for the permission to release test results to "any sexual partner." That language was added at the request of the Ohio State Medical Association. Conversation with Carolyn Towner of Ohio Capital Policy Consultants, Inc., Lobbyists for the OSMA, 1/9/91.

⁴ This overview of AIDS is not meant to be comprehensive. It is only meant to supply the reader with knowledge of the disease sufficient to the understanding of this paper. For a more comprehensive understanding of HIV/AIDS see JOHN LANGONE, AIDS: THE FACTS; Revised and updated (1991). (hereinafter AIDS: THE FACTS), and THE AIDS READER (edited by Nancy F. McKenzie) (hereinafter THE AIDS READER).

⁵ AIDS: THE FACTS, *supra* note 4 at 38.

existed before that time,⁶ developed countries have been dealing with AIDS for only ten years. Only 16 cases were documented in the United States between January and June of 1981.⁷ By June 1991, however, more than 113,000 people in the United States had died of AIDS.⁸ The World Health Organization expects this number to reach as many as 500,000 by the end of the century.⁹

Estimates of the total number of reported AIDS cases range from 170,000¹⁰ to 200,000¹¹ in the U.S. to an approximate 1.5 million worldwide.¹² As staggering as these figures are, both the incidence of AIDS and the actual case fatality rate are strongly believed to be higher because of incomplete reporting.¹³

AIDS itself is not one disease. Rather, "(i)t is a syndrome; a group of symptoms and diseases, opportunistic infections" that kill because a virus has rendered the body's immune system ineffective.¹⁴ That virus is HTLV-III (Human T-lymphotropic Virus Type III),¹⁵ which has become known as the Human Immunodeficiency Virus (HIV).¹⁶

AIDS is merely the final stage of infection.¹⁷ Thus far it appears that infection with HIV can result in any one of three scenarios: 1) some of those infected will develop full-blown AIDS; 2) others will develop AIDS-related complex (ARC) (or Pre-AIDS)¹⁸ and 3) others may remain entirely asymptomatic.¹⁹

⁶ *Id.*

⁷ *Id.* at 67.

⁸ Robert Steinbrook, *Speaking of: AIDS*, LOS ANGELES TIMES, June 25, 1991, p.8, col. 1 (hereinafter *Speaking of AIDS*).

⁹ Steven Findlay, *AIDS; the Second Decade*, U.S. NEWS & WORLD REPORT, June 17, 1991, p.20 (hereinafter *AIDS The Second Decade*). "The World Health Organization predicts the total number of global AIDS cases to be 1.5 million."

¹⁰ *Id.*

¹¹ Philip Elmer-Dewitt, *How Safe is Sex?*, TIME, November 25, 1991.

¹² *Speaking of AIDS*, *supra* note 8. "according to World Health Organization estimates, there is no global record of AIDS deaths."

¹³ 38 MORBIDITY AND MORTALITY WEEKLY REPORT 229-36, *Report on HIV/AIDS*, Jan.-Dec. 1989 at 20; see also PUBLIC AND PROFESSIONAL ATTITUDES TOWARD AIDS PATIENTS, A NATIONAL DILEMMA (Edited by David Rogers and Eli Ginzberg) at 105. "An additional 10-20% are believed to have been missed by the case surveillance system".

¹⁴ AIDS: THE FACTS, *supra* note 4, at 69.

¹⁵ Madeleine Weldon-Linne et al., *AIDS-Virus Antibody testing: Issues of Informed Consent and Patient Confidentiality*, 75 ILL. B.J. 204, (1986) (hereinafter *AIDS Testing*).

¹⁶ Patricia Fultz, *The Biology of Human Immunodeficiency Viruses* in THE EPIDEMIOLOGY OF AIDS 3 (R. Kaslow & D. Francis, eds. 1989) (hereinafter EPI-DEMOLOGY). Virtually every authority agrees with the proposition that HIV is the causative agent for AIDS; but see Peter Duesberg, *Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome: Correlation but not Causation* in THE AIDS READER, *supra* note 4, at 42.

¹⁷ AIDS: THE FACTS, *supra* note 4, at 8.

¹⁸ "The ARC category is ill-defined (in fact, there is no nationally accepted definition of it) and somewhat controversial, since many of its ever-growing range of symptoms and illnesses are also found in patients who meet the technical definition of AIDS itself; often the difference may well be semantic." AIDS: THE FACTS, *supra* note 4, at 11.

¹⁹ Sheldon Landesman et al., *Special Report: The AIDS Epidemic*, 312 NEW ENGLAND J. MED. 521-25 (No. 8, 1985) (hereinafter *Special Report*).

Current research indicates that only about 15-46% of those individuals who are HIV-positive will develop AIDS within seven years of infection.²⁰ However, this figure may be deceiving because of the relatively short amount of time that HIV has been identified and researched. Thus, it may be the case that the amount of HIV victims who develop AIDS will eventually approach 100 percent.²¹

There is no way of determining who of those infected with HIV will eventually contract AIDS²² or how long the process may take, as the time between exposure and the onset of symptoms can range anywhere from 6 months to 7 - 10 years.²³

There is no known cure for AIDS.²⁴ In fact, once someone is diagnosed as having AIDS, he (or she) will most likely die within two years.²⁵ It cost this country approximately \$3.3 billion to treat and care for AIDS victims in 1989, and the cost is expected to more than double to \$7.8 billion by 1993.²⁶

Not only are there approximately 170,000 people who have been diagnosed as having AIDS, but there are also the individuals who are HIV positive (seropositive) and not yet aware of their affliction. Official estimates differ, but most range from 1 to 2 million in the United States²⁷ and 8 - 10 million worldwide.²⁸

Understanding that there are millions of individuals who are HIV positive and capable of developing AIDS or infecting others at any time, while unaware of their condition, is crucial to the consideration of any dilemma involving this disease. In 1988, The President's Commission on HIV/AIDS (Hereinafter "President's Commission") recognized the need to consider the epidemic in broader terms, "the term 'AIDS' is obsolete, 'HIV infection' more correctly defines the problem . . . Continual focus on AIDS rather than the entire spectrum of HIV disease has left our nation unable to deal adequately with the epidemic."²⁹

Exactly how many people are infected with HIV is still a mystery. Because it is possible that someone like Mr. X contracted the virus up to 10 years ago, until an individual develops symptoms, the only way to find out is to get tested.

²⁰ Margaret Hamburg & Anthony Fauci, *Aids: The Challenge to Biomedical Research*, in *LIVING WITH AIDS* (Stephen Graubard ed.) at 48; see also *AIDS: THE FACTS*, *supra* note 4, at 8-9.

²¹ *LIVING WITH AIDS*, *supra* note 20, at 48.

²² *AIDS: THE FACTS*, *supra* note 4, at 70.

²³ American Public Health Association, Special Initiative on AIDS, *CONTACT TRACING AND PARTNER NOTIFICATION*, Nov. 1988 at 1. (hereinafter *CONTACT TRACING*).

²⁴ "The best guess of most scientists is that neither a cure nor a vaccine will be found by the end of the century." *AIDS: The Second Decade*, *supra* note 9.

²⁵ *LIVING WITH AIDS*, *supra* note 20, at xx.

²⁶ *AIDS: The Second Decade*, *supra* note 9.

²⁷ *Id.* (As of June 1991 the Centers for Disease Control estimated that there were 1 to 1.5 million Americans infected with HIV.) See also, *THE AIDS READER*, *supra* note 4, at 25. (Between 1 and 2 million believed to be infected in 1988.)

²⁸ *Speaking of AIDS*, *supra* note 8.

²⁹ *REPORT OF THE PRESIDENT'S COMMISSION ON HIV/AIDS* at XVIII (1988) (hereinafter *THE PRESIDENT'S COMMISSION*).

A. What Is An AIDS Test?

The term "AIDS test" is a misnomer as there is no actual test for AIDS.³⁰ There is a test, however, that was adopted in 1985 by The Food & Drug Administration (the ELISA³¹ test) to determine if blood donated for transfusions had been exposed to HIV.³² The test does not detect the presence of HIV in a person's blood. Rather, it measures the presence of HIV antibodies, the body's natural response to infection.³³ Once a person tests positive, there is no way of determining when exposure took place or when (or even if) that person will go on to develop ARC or AIDS.³⁴

The ELISA, though widely used, is not highly accurate.³⁵ Because it was designed to be sensitive, there are a large number of false positive results (individuals who are not actually infected, yet test positive).³⁶ In fact, $\frac{1}{2}$ to $\frac{2}{3}$ of the positive results in any given sample will be false positives.³⁷ False positive results can usually be verified, however, as a second ELISA on an uninfected individual will likely yield a negative result.³⁸

There are other confirmatory tests, such as the Western Blot.³⁹ However, these confirmatory tests, which are more costly and time-consuming than the ELISA,⁴⁰ are not practical as widespread screening tests.

Usually, after consecutive positive results using ELISA, the HIV-positive diagnosis is confirmed with a Western Blot.⁴¹ If that person is infected, he is then capable of transmitting the virus to someone else.

Just as certain individuals who are not infected test positive, there are individuals who, though infected with HIV, will test negative. This can be contributed to the unknown latency period between the initial infection and the development of antibodies (seroconversion).⁴² During this period, when the HIV is capable of "hiding" in only 1 out of every 500,000 white

³⁰ AIDS: THE FACTS, *supra* note 4, at 215.

³¹ ELISA stands for "Enzyme Linked Immunosorbent Assay".

³² AIDS: THE FACTS, *supra* note 4, at 215.

³³ AIDS Testing, *supra* note 15, at 207.

³⁴ *Id.*

³⁵ AIDS: THE FACTS, *supra* note 4, at 217.

³⁶ *Id.*; AIDS Testing, *supra* note 15, at 207.

³⁷ AIDS: THE FACTS, *supra* note 4, at 217. Generally false positive readings are "just over the line of the test for positivity" whereas 'true positive' results are several times above the positivity threshold.

³⁸ *Id.*

³⁹ AIDS: THE LEGAL ISSUES, DISCUSSION DRAFT OF THE AMERICAN BAR ASSOCIATION AIDS COORDINATING COMMITTEE (1988) at 83 (hereinafter AIDS: THE LEGAL ISSUES); see also, AIDS: THE FACTS, *supra* note 4 at 218. The Western Blot can sometimes suggest whether the infection is a new or an old one.

⁴⁰ AIDS: THE LEGAL ISSUES, *supra* note 39, at 83.

⁴¹ David P.T. Price, *Between Scylla & Charybdis: Charting a Course to Reconcile the Duty of Confidentiality and the Duty to Warn in the AIDS Context*, 94 DICKINSON L. REV. 435, 443 (Winter 1990) (hereinafter *Charting a Course*).

⁴² See generally, AIDS: THE FACTS, *supra* note 4, at 223.

blood cells, the ELISA test is unable to detect infection.⁴³ Negative test results have even been documented on individuals known to have AIDS or AIDS-related conditions.⁴⁴

All HIV positive individuals can transmit the disease to an unsuspecting partner. Those who have been informed of their infection through testing, however, can be made aware of the need to change their behavior so as to stop the transmission or minimize the risk.

B. Transmission

Thus far, all of the evidence overwhelmingly points to the conclusion that HIV can be transmitted in only a few ways, all of which involve intimate physical contact with an infected individual or his blood.

Transmission can result from: 1) sharing a needle with an infected individual (as is the case mostly with IV-drug users),⁴⁵ 2) exposing one's own blood to the blood from an infected individual (as can happen to a health care worker while operating or performing emergency medical services; or during a blood transfusion),⁴⁶ 3) prenatally (from mother to child during pregnancy),⁴⁷ and 4) intimate sexual contact (including receptive anal or vaginal intercourse).⁴⁸ The most efficient mode of transmission is through a blood transfusion, while infection through sexual intercourse is believed to be one of the least efficient.⁴⁹

⁴³ *Id.* at 220.

⁴⁴ *Id.* at 219. In one study, 82% of 88 AIDS patients tested positive, 16% were borderline and 2% tested negative; but see THE AIDS READER, *supra* note 4, at 46. "Antibody to HIV is confirmed in only about forty percent of the U.S. cases and in only 7 percent of the AIDS cases from New York and San Francisco."

⁴⁵ Ronald Valdiserri, PREVENTING AIDS (1989) at 4-5 (hereinafter PREVENTING AIDS).

⁴⁶ THE AIDS READER, *supra* note 4, at 79. There have been a total of over 1,500 reported cases of contamination through blood transfusions. However, since testing introduced in 1985 for all donated blood, HIV transmission by this route has practically disappeared. *Id.* at 75; see also AIDS: THE FACTS, *supra* note 4, at 222. The risk of contracting HIV through contaminated blood during a transfusion is estimated to be 1 in 100,000, while the risk of death from the complications of general anesthesia is ten times greater at 1 in 10,000.

⁴⁷ THE AIDS READER, *supra* note 4, at 79; Richard Kaslow & Donald Francis, *Epidemiology: General Considerations*, in EPIDEMIOLOGY, *supra* note 16, at 99 (hereinafter *General Considerations*). "There have been few but relatively convincing cases of transmission from mother to infant by breast feeding."

⁴⁸ *Id.* at 98. Studies have shown the risk of transmission during oro-genital contact to be "uncertain, but quite low," leaving receptive anal and vaginal intercourse to be considered the most important routes of sexual spread.

⁴⁹ Likelihood of transmitting HIV virus in a single exposure:

Type of Exposure	Efficiency of Transmission
Blood transfusion	greater than 90%
Infected mother to child	30%
Sexual intercourse	0.1 - 1.0%
Injecting drug use	0.5 - 1.0%
Health care, needle sticks, etc.	less than 0.5%

Speaking of AIDS, *supra* note 8.

It is highly doubtful that HIV can be transmitted through non-intimate social contact. A person is not at risk of contracting HIV by breathing the same air or by using the same furniture as an infected individual.⁵⁰ Nor have there been any documented cases of HIV transmission through saliva.⁵¹ Thus, "there is ample evidence that HIV can not be transmitted casually and that fear of infection from routine or social contact with an infected individual is unfounded."⁵²

C. Prevention and Treatment

Presently there is no known cure for HIV.⁵³ Different drugs have been introduced as treatments, but they are all still in the experimental stage.⁵⁴ The United States Public Health Service has noted that no vaccine for widespread use will likely be introduced before the year 2000.⁵⁵

Because of the nature of the HIV virus, infection with HIV is lifelong.⁵⁶ Once a person has a virus such as HIV, treatments are limited to alleviating symptoms.⁵⁷ At present, two drugs have been granted FDA approval to be used for the treatment of the virus itself, AZT (Azidothymidine)⁵⁸ and DDL.⁵⁹ These are limited, however, to merely slowing its replication, not its cure.⁶⁰ Other drugs and therapies that are available for widespread use today are aimed at fighting the infections to which HIV victims are more susceptible.⁶¹

⁵⁰ Alfred Saah, *HIV - 1 Infection in Low - Risk Populations*, in EPIDEMIOLOGY, *supra* note 16, at 242-43.

⁵¹ "There is indirect, but strong and consistent epidemiologic evidence against transmission by saliva through kissing or contact with other oral epithelial surfaces," *General Considerations*, *supra* note 47, at 99; but see, "AIDS through Kissing? Unlikely, but Possible says U.S. Expert," Report from the 7th International Conference of AIDS, June 21, 1991, Agence France Presse.

⁵² Alfred Saah, *HIV-1 Infection in Low Risk Populations*, in EPIDEMIOLOGY, *supra* note 15, at 242.

⁵³ ACTION ON AIDS 9 (Barbara Misztal & David Moss ed. 1990).

⁵⁴ AIDS: THE FACTS, *supra* note 4, at 152-88, listing and explaining the many treatments and drugs that have been proposed for use to slow the growth of HIV.

⁵⁵ *Id.* at 150.

⁵⁶ LIVING WITH AIDS, *supra* note 20, at 32.

⁵⁷ AIDS: THE FACTS, *supra* note 4, at 150.

⁵⁸ AZT, in 1987, was the first anti-AIDS drug to receive FDA approval. It is considered standard therapy for HIV infection. Jerry Adler & Mary Hager et al., *Living with the virus; when - and how - HIV Turns to AIDS*, *Newsweek*, Nov. 18, 1991, at 63-64 (hereinafter *When HIV turns*).

⁵⁹ DDL, in 1991, was the second drug to receive FDA approval. It was developed for patients who cannot develop a tolerance for AZT. *Id.*

⁶⁰ *Id.*

⁶¹ *Id.* With respect to diseases most common to AIDS victims - "about 85% of the AIDS patients studied have had one or both of two relatively rare diseases: (1) *Pneumocystis Carinii* Pneumonia (PCP), a parasitic infection of the lungs; and (2) a type of cancer known as Kaposi's sarcoma (KS)." In the United States, prior to 1980, KS primarily affected elderly men and was very seldom fatal. PCP was seen primarily in patients with severe underlying illnesses, such as leukemia, or in patients receiving therapy with drugs known to suppress the immune system. OHIO DEPARTMENT OF HEALTH, QUESTIONS AND ANSWERS ABOUT AIDS at 3-4.

The fact that treatments for the disease are aimed at blocking its advancement, instead of curing it, has highlighted the need to ascertain its presence at the earliest possible stage of infection. It is generally agreed that "early treatment of asymptomatic HIV infection is beneficial in preventing or delaying the onset of illness."⁶²

Clinical intervention at early stages of infection is not the only means of fighting HIV. Behavior modification is also an important tool to use against the spread of this disease. This includes education of the general public, specifically high-risk groups, as to safe sex and safe drug-use techniques.⁶³

II. POSSIBLE LEGAL JUSTIFICATION FOR THE RIGHT TO WARN

Generally, patients can expect that the information obtained by their physicians while treating them will be kept confidential. In Ohio, this is reflected in both case law⁶⁴ and by statute.⁶⁵ Through the trust and more open communication brought about by guaranteed confidentiality, it is expected that more effective treatment will result.⁶⁶ Patients receiving psychological treatment can also expect their physicians to keep information confidential.⁶⁷

Although this is an important right, it is not absolute. There are situations in which the patient's right to have that information kept secret is outweighed by public policy considerations. Such situations include: where the physician knows or suspects that a minor was abused,⁶⁸ where he knows or believes the injury was the result of a crime,⁶⁹ or - as in the situation most applicable to the conflict between Mr. X and his doctor - where the breach is necessary to protect a third person.⁷⁰

⁶² THE AIDS READER, *supra* note 4, at 347. Earlier discovery of infection can offer individuals "(a) inhibition of viral replication or improvement of immunological status (b) better management of symptoms or prevention of the onset of opportunistic infections [and] (c) better general health care." *Id.* at 349.

⁶³ See, generally, *The President's Commission*, *supra* note 29, at 83-91 (Chapter on Education); see also *Needle Exchange Apparently Helps*, S.F. CHRON., June 21, 1991, at A15 (describing a San Francisco program where sterile needles are exchanged for those of IV - drug users and its apparently positive effect).

⁶⁴ See e.g., *Hammonds v. Aetna Casualty & Surety Company*, 243 F. Supp. 793 (N.D. Ohio, 1965) (any unauthorized disclosure by a physician of privileged information is against public policy and the offending physician may be held in damages).

⁶⁵ See e.g., OHIO REV. CODE ANN. § 2317.02 (Anderson 1986) (a physician shall not testify concerning a communication made to him by his patient).

⁶⁶ "To foster the best interest of the patient and to insure a climate most favorable to a complete recovery, men of medicine have urged that patients be totally frank in their discussions with their physicians." *Hammonds supra* note 64, at 797; "The general rationale for requiring confidentiality is the public interest in encouraging patients to furnish the information needed by their health-care providers to diagnose and care for them." AIDS: THE LEGAL ISSUES, *supra* note 39, at 105; "It is trust which enables the patient to tell the physician those private things which are necessary for a proper diagnosis". Martin Gunderson et al., AIDS: TESTING AND PRIVACY 134 (1989) (hereinafter TESTING AND PRIVACY).

⁶⁷ OHIO REV. CODE ANN. § 4732.19 (Anderson 1977).

⁶⁸ OHIO REV. CODE ANN. § 2151.421(A)(1) (Anderson 1989).

⁶⁹ OHIO REV. CODE ANN. § 2921.22 (Anderson 1989).

⁷⁰ See *infra* notes 74-76 and 106-20 and accompanying text.

Even before the HIV crisis, the code of ethics of The American Medical Association reflected a permissible breach to help a third person in danger: "A physician may not reveal the confidence entrusted to him in the course of medical attendance . . . unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or the community."⁷¹

While there is strong moral justification for allowing a physician to breach this confidentiality and inform a third party of his/her spouse's HIV status, what is the legal basis for this breach? As of May, 1992, 18 states other than Ohio had provisions granting physicians the right to warn spouses or contacts of an HIV-positive individual.⁷² In an attempt to justify this right, commentators have looked to the reasoning behind two lines of cases for support.⁷³ Those cases have involved patients with contagious diseases and the mentally ill.

A. Contagious Disease Cases

Several early cases have served to establish the proposition that a physician has the privilege (or duty) to disclose information about a patient with a contagious disease in order to protect the public welfare.

In 1928, the Ohio Supreme Court recognized a duty to warn third persons in *Jones v. Stanko*.⁷⁴ The physician in *Jones*, believing there to be no disease and thus no risk, informed the neighbor of a smallpox victim

⁷¹ The Principles of Medical Ethics of the American Medical Association (1957), Section 9, as quoted in *Tarasoff v. Regents of the University of California*, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Reporter 14 (1976).

⁷² See, ALA. CODE § 22-11A-38(d)(1988); CAL. HEALTH & SAFETY CODE § 199.25(a) (West 1988); GA. CODE ANN. 24-9-47(g) (1990); ILL. REV. STAT. ch. 111 § 12, para. 7309 (1991); IND. CODE ANN. § 16-1-10.5 - 11.5(b)(2) (West 1991); KAN. STAT. ANN. § 65-6004(b) (1990); LA. REV. STAT. ANN. § 40-1300.14(E)(1) (West 1991); MD. GENERAL HEALTH CODE ANN. § 18-337(b) (1989); MICH. COMP. LAWS ANN. § 333.5131(5)(b) (West 1989); MO. REV. STAT. § 191.656(2)(d) (1988); N.Y. PUBLIC HEALTH LAW § 2782(4)(a) (1991); OKLA. STAT. ANN. tit. 63, § 1-502.2(A)(4) (West 1988); PA. STAT. ANN. tit. 35, § 7609(a)(Purdon, 1990); R.I. GEN. LAWS § 23-6-17(b)(V) (1990); S.C. CODE ANN. § 44-29-146 (Law. Co-op 1988); TEX. HEALTH & SAFETY CODE ANN. § 81.103(b)(7) (1991); VA. CODE ANN. § 32.1-36.1(A)(1) (1990); WASH. REV. CODE § 70.24.105 (1988). Four other states provide for the Health Department to notify a spouse or contact once information is received from the physician: ARIZ. REV. STAT. ANN. § 32-1457(A)(1990); COLO. REV. STAT. §§ 25-4-1402(1) and 1406(2) (1988); CONN. GEN. STAT. ANN. § 19a-584(a)-(b) (West 1989); W. VA. CODE § 16-3C-3(d) (1988).

⁷³ See e.g., Joseph D. Piorowski, Jr., Note, *Between a Rock and a Hard Place: AIDS and the Conflicting Physician's Duties of Preventing Disease Transmission and Safeguarding Confidentiality*, 76 GEO. L.J. 169 (1987); Frederick R. Fahner, Comment, *The Physician's Duty to Warn Nonpatients: AIDS Enters the Equation*, 5 COOLEY L. REV. 353 (1988); Jill Suzanne Talbot, *The Conflict Between a Doctor's Duty to Warn a Patient's Sexual Partner that the Patient Has AIDS and a Doctor's Duty to Maintain Patient Confidentiality*, 45 WASH. & LEE L. REV. 355 (Wint. 1988).

⁷⁴ 118 Ohio St. 147, 160 NE 456 (1928).

that there was no danger of contracting the disease. The neighbor, relying on the doctor's assurances, assisted in tending to the victim, contracted the disease and died.⁷⁵

In finding the physician negligent, the court explicitly recognized a physician's duty to breach doctor/patient confidentiality and warn third parties of the risk of a contagious disease, "It is the duty of a physician who is treating a patient afflicted with small pox to exercise ordinary care in giving notice of the existence of such contagious disease to other persons who are known by the physician to be in dangerous proximity to such patient."⁷⁶

In *Davis v. Rodman*,⁷⁷ a 1921 case from the Supreme Court of Arkansas, physicians were declared to have a duty to warn third parties at risk. The attending physician in *Davis* was accused of negligently placing typhoid patients among their families without warning the families of the nature of the disease or how to guard against its spread.⁷⁸ The court held that in addition to being liable for any negligent act that would help spread the disease, a doctor owed a duty to those ignorant of the disease (and likely to be in contact with the patient) to instruct and advise them as to the character of the disease.⁷⁹ The imposition of this duty has been upheld in modern cases as well.⁸⁰

A privilege to warn, rather than a strict duty, was created by the Supreme Court of Nebraska in 1920 in *Simonsen v. Swenson*.⁸¹ *Simonsen* held that a physician should be privileged, if no other means of protection is possible, to make the necessary disclosure to prevent those likely to come in contact with the carrier of a contagious disease from being exposed.⁸²

In that case, a hotel guest diagnosed as having syphilis, was told by his physician to leave the hotel in order to protect the other guests and the owner. Upon learning of the patient's failure to leave the premises, the doctor warned the hotel owner that the patient may have had a "contagious disease" and instructed her to disinfect his room so as to prevent its spread.⁸³ The disclosure was viewed, not as the betrayal of a professional confidence, but as a risk that any patient with a contagious disease faces, "No patient can expect that if his malady is found to be of a dangerously contagious nature he can still require it to be kept secret from those to whom, if there was no disclosure, such disease would be transmitted."⁸⁴

⁷⁵ *Id.*

⁷⁶ *Id.*

⁷⁷ 147 Ark. 385; 227 S.W. 612 (1921); see also *Skillings v. Allen* 143 Minn. 323, 173 N.W. 663 (1919).

⁷⁸ *Davis v. Rodman*, 147 Ark. at 386, 227 S.W. at 613.

⁷⁹ *Id.* at 614.

⁸⁰ See, e.g., *Hofmann v. Blackmon*, 241 So. 2d 752 (Fla. Dist. Ct. App. 1970), cert. denied, 245 So. 2d 257 (Fla. 1971); *Wojcik v. Aluminum Company of America*, 18 Misc. 2d 740, 183 N.Y.S.2d 351 (N.Y. Super. Ct. 1959).

⁸¹ 104 Neb 224, 177 NW 831 (1920).

⁸² *Id.* at 832.

⁸³ *Id.* at 831.

⁸⁴ *Id.* at 832.

The reasonable expectation of disclosure that was present in these cases, does not exist in the HIV situation. A common thread running through the contagious disease cases which created that reasonable expectation was the presence of the legislative implication of a physician's duty to warn. This implication arose in the form of a statute that clearly codified every physicians' duties with respect to known cases of the disease. In the case of HIV, there are no statutes dictating measures to be taken by physicians which necessitate public disclosure of the diagnosis.

1. Implication of Duty Drawn From Statutory Scheme

The diseases that arose in the contagious disease cases (smallpox, typhoid, syphilis and scarlet fever) were all communicable through casual contact. The states in which they were decided had statutes requiring physicians to report any case of an infectious disease to the health department so precautions could be undertaken.

The Ohio Supreme Court in *Jones* noted the presence of just such a statute:

the General Code . . . requires a practicing physician, when treating a disease dangerous to the public health or required by the board of health to be reported, to report to the health officer, within whose jurisdiction the person is so found, the name, age, color and sex of the patient, and the house and place in which such person may be found.⁸⁵

The decisions in *Davis*⁸⁶ and *Simonsen*⁸⁷ were influenced by similar statutes. The Nebraska Supreme Court in *Simonsen* noted the effect such a statute had on this type of decision: "[r]ecognition of [the doctor's duty to warn third persons] is given by statutes in this state . . . [that] require reports of, and provide quarantines for, diseases which are contagious and dangerous."⁸⁸

In other words, to allow (or require) a doctor to warn family members and parties who may come in contact with an infected individual is a logical extension of a law that requires the physician to warn local health officials so that they may take measures aimed at protecting the general public from the disease.

2. Ohio's Statutory Scheme: No Implication

In Ohio, no such logical extension to create a privilege to warn in the HIV situation exists. The Ohio Revised Code does require a physician to

⁸⁵ OHIO GENERAL CODE § 4427.(1928).

⁸⁶ 227 S.W. at 614.

⁸⁷ 177 N.W. at 832.

⁸⁸ *Id.*

report various contagious diseases (Asiatic flu, Cholera, etc.) to the Health Department.⁸⁹ However, reporting of HIV-positive tests is covered in a different subsection which requires any information that identifies an individual to be kept confidential.⁹⁰

There are exceptions to the confidentiality requirements of HIV-related information in Ohio. A physician can release the result of an HIV test to the subject's guardian,⁹¹ to anyone who has a medical need to know (those who have been exposed to the subject's blood or those who may, in the course of treatment, become exposed)⁹² or to law enforcement authorities in connection with a criminal investigation.⁹³

It could be argued that the presence of these privileges to disclose the results of a positive HIV test is evidence of a statutory purpose that justifies granting physicians the privilege to warn spouses. However, the statutory scheme in Ohio does not create such a clear implication. This is because the Legislature has also created anonymous testing centers⁹⁴ and a confidential partner notification system.⁹⁵

Anonymous testing centers allow individuals to receive HIV tests by means of a system that does not link them to the test results.⁹⁶ These anonymous subjects then have the choice of whether to receive counseling

⁸⁹ OHIO REV. CODE ANN. § 3701.24 (B) (Anderson 1989).

⁹⁰ "Persons [administering HIV tests] . . . shall report promptly every case of AIDS, every AIDS related condition, and every confirmed positive HIV test to the department of Health . . . Information reported under this division that identifies an individual is confidential." OHIO REV. CODE ANN. § 3701.24(C) (Anderson 1989).

⁹¹ OHIO REV. CODE ANN. § 3701.243 (B)(1)(a) (Anderson 1989).

⁹² (B)(1) The results of an HIV test . . . may be disclosed only to the following: (g) a health care provider, emergency medical services worker, or peace officer who sustained a significant exposure to the body fluids of another individual, if that individual was tested pursuant to division (E)(6) of section 3701.242 of the Revised Code.

OHIO REV. CODE ANN. § 3701.243 (B)(1)(g) (Anderson, 1989).

(2) The results of an HIV test . . . may be disclosed to a health care provider or an authorized agent or employee of a health care facility or health care provider. If the provider, agent or employee has a medical need to know the information and is participating in the diagnosis, care, treatment of the individual on whom the test was performed.

OHIO REV. CODE ANN. § 3701.243 (B)(2) (Anderson 1989).

⁹³ (h) to law enforcement authorities pursuant to a search warrant or a subpoena issued by or at the request of a grand jury, a prosecuting attorney, city director of law or similar chief legal officer of a municipal corporation or village solicitor, in connection with a criminal investigation or prosecution.

OHIO REV. CODE ANN. § 3701.243 (B)(1)(h) (Anderson 1989).

⁹⁴ OHIO REV. CODE ANN. § 3701.241 (B)(2) (Anderson 1989).

⁹⁵ OHIO REV. CODE ANN. § 3701.241 (A)(3) (Anderson 1989).

⁹⁶ (9) "Anonymous Test" means an HIV test administered so that the individual to be tested can give informed consent to the test and receive the results by means of a code system that does not link his identity to the request for the test or the test results.

OHIO REV. CODE ANN. § 3701.24 (A)(9) (Anderson 1989).

and, if they are HIV positive, to participate in a confidential partner notification program or to leave, not having made anyone aware of their HIV positive status.⁹⁷

This statutory scheme falls short of those schemes which implied a duty to warn spouses and sexual partners in the contagious disease cases. By creating anonymous testing,⁹⁸ Ohio has determined that gathering information about HIV and notifying those who are infected of their status are important interests. More important, in fact, than the spouses' right to know of possible HIV infection. Therefore, without a clear legislative implication that favors a warning, the contagious disease cases are not an applicable precedent to the situation involving Mr. X.

The other area in which the breach of the doctor/patient confidentiality could be analogous to the HIV context is that involving the mentally ill.

B. Cases Involving The Mentally Ill

A duty to warn potential victims of violent patients was first created by the California Supreme Court in 1976 in *Tarasoff v. Regents of University of California*.⁹⁹ According to *Tarasoff*, "When a therapist determines, or . . . should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim from such danger."¹⁰⁰ This duty was found after a psychologist failed to inform a young woman, or her family, that his patient had expressed an intention to kill her.¹⁰¹

Tarasoff adopted the 'special relation' exception to the rule that there is no duty to prevent one person from physically harming another. This exception calls for a duty to warn if there is a special relation between the person possessing the information (the doctor) and the person it concerns (the patient), or between the doctor and the person that could be harmed (the third person).¹⁰² The court balanced the possible damage to the psychotherapist/patient relationship and the infringement of the patient's privacy against the potential harm that was to be averted by a warning.¹⁰³

⁹⁷ See generally, OHIO'S HIV (AIDS) TESTING PROGRAM, Ohio Department of Health, Jan. 31, 1991 at 3 (hereinafter *Ohio's Testing Program*); see also, CONTACT TRACING, *supra* note 23, at 2.

⁹⁸ Note, "Ohio is one of 41 states to offer anonymous and confidential testing during 1990", OHIO'S TESTING PROGRAM, *supra* note 97, at 2; see e.g., KAN. STAT. ANN. § 65-6007 (1989); MICH. COMP. LAWS § 333.5133 (9)(1991); MO. REV. STAT. § 191.686 (1)(1990); N.J. REV. STAT. § 26:5c-6 (1990).

⁹⁹ 17 Cal. 3d 425, 551 P. 2d 334, 131 Cal. Reporter 14 (1976).

¹⁰⁰ *Id.*

¹⁰¹ *Id.*

¹⁰² There is no duty to control the conduct of another person so as to prevent him from causing physical harm to another unless there exists "(a) a special relation . . . between the actor and the third person which imposes a duty upon the actor to control the third person's conduct, or (b) a special relation . . . between the actor and the other which gives to the other a right of protection." *Tarasoff*, 551 P.2d at 343, quoting RESTATEMENT (SECOND) OF TORTS § 315.

¹⁰³ *Id.* at 346-347.

Most jurisdictions have adopted a duty to warn in psychotherapist cases.¹⁰⁴ Indeed, "[i]t is an exceptional decision when a state court refuses to adopt and apply the doctrine."¹⁰⁵ The Ohio Supreme Court first recognized this duty in the 1988 decision - *Littleton v. Good Samaritan Hospital & Health Center*.¹⁰⁶

Littleton held that a psychiatrist had a duty to take reasonable precautions to protect an infant from her mother's violent propensities.¹⁰⁷ The mother, Theresa Pearson, had experienced anxiety and depression after the birth of her daughter Carly Ann.¹⁰⁸ She was hospitalized from April to early May of 1981, released, and then readmitted on May 27, 1981.¹⁰⁹ At the time of her second admission, Theresa was preoccupied with the notion that her husband was not Carly's father and wanted to put her up for adoption.¹¹⁰ On a number of occasions, Theresa was worried that she would hurt Carly.¹¹¹ On June 1, 1981, two notations were made in the hospital record: one that she related to a nurse her plan to kill Carly,¹¹² and the other, three hours later following hypnosis, that she was positive in her mood and wanted to keep the family intact.¹¹³ The staff psychiatrist primarily responsible for Theresa's care, believing that the conflicting notations indicated that Theresa had no fixed objective to harm Carly, worked out a program whereby Theresa would be released and her family would take care of Carly for one year.¹¹⁴ The family was informed of Theresa's potential for violence and was told not to leave her alone with Carly for any period of time, but not of her stated plan to kill Carly.¹¹⁵ Two weeks after Theresa's second release, she killed Carly with an aspirin overdose.¹¹⁶

Although the court ruled that a physician has the duty to take reasonable precautions to protect potential victims of mental patients, the

¹⁰⁴ See *Mahomes - Vinson v. United States*, 751 F. Supp. 913 at 921, n.10 (D. Kan. 1990) (citing cases from over 30 jurisdictions that have adopted a § 315 duty to warn.)

¹⁰⁵ *Charting a Course*, *supra* note 41, at 451.

¹⁰⁶ 39 Oh. St. 3d 86, 529 N.E. 2d 449 (1988).

¹⁰⁷ *Id.* at 93.

¹⁰⁸ *Id.* at 87.

¹⁰⁹ *Id.* at 87-8.

¹¹⁰ *Id.* at 88.

¹¹¹ *Id.*

¹¹² Theresa "had related to Debbie Oaten [one of the nurses] that she was planning on injecting her baby with something to kill it. Seems to have a definite plan. While relating this, she was calm, collected and appeared somewhat euphoric." *Id.*

¹¹³ "Wants very much to keep marriage and family intact. Spoke about not loving her baby (never called her by name) but talking positively at this time about giving that time to grow. States she doesn't want to hurt the baby. Many positive comments made. Realizes that working this problem out will be difficult but really wants to do so. Patient was calm, eye contact excellent. Mood seems elevated." *Id.*

¹¹⁴ *Id.* at 88-89.

¹¹⁵ *Id.* at 89.

¹¹⁶ *Id.* at 87.

precautions taken are deemed reasonable unless they were the result of bad faith or lack of a thorough evaluation of the patient's condition.¹¹⁷ The failure to warn was recognized by the court as a potential basis for liability under this rule.¹¹⁸

If the resolution of the conflict over whether to grant a physician the right to warn spouses of HIV victims was patterned after *Littleton*, the legislature would most likely have created an affirmative duty to warn. Under the *Littleton* rationale, a physician making a professional medical judgment would be forced to determine not only that a seropositive individual poses an immediate threat to his spouse or sexual partner but also that the only reasonable precaution available would be a warning. However, while the AIDS Bill granted physicians who warn partners of HIV-positive individuals good faith immunity like that created in *Littleton*,¹¹⁹ no duty was created. In fact, the decision to warn is entirely up to the physician, as there is no liability for the failure to warn.¹²⁰

So what formed the basis for the Legislature's decision to grant physicians the right to warn? Perhaps it was the desire to protect third parties at risk? This might have been a sufficient reason if such a strong need for confidentiality did not exist.

III. THE NEED FOR CONFIDENTIALITY

The cases involving contagious diseases or the mentally ill have held there to be a duty (or a privilege) to warn after determining that the need to maintain the confidentiality of the doctor/patient relationship was outweighed by the public benefit to be realized by the warning. Since the HIV epidemic began, however, it has become apparent that the treatment of HIV victims and the need for information are both adversely effected by public disclosures of HIV status.

A. Negative Consequences of the Release of HIV Test Results

When a person decides to submit to an HIV test, he is searching for the answer to an unknown, "am I infected?" What is already known is the answer to the question "How will the people around me react if I am?" For most victims the reactions are negative and have a far-reaching and usually devastating impact on their lives.

The discrimination faced by victims of HIV leads to the observation that "a person who is HIV infected may risk social death long before he

¹¹⁷ *Id.* at 99.

¹¹⁸ *Id.* at 100.

¹¹⁹ OHIO REV. CODE ANN. § 3701.244(D) (Anderson 1989).

¹²⁰ OHIO REV. CODE ANN. § 3701.244 (H) (Anderson 1989).

or she faces physical death.”¹²¹ Indeed, people who have had positive test results released have lost their jobs and their health insurance, have been evicted from their apartments,¹²² and have been threatened with violence.¹²³

In addition to discrimination against victims, the families and relatives of victims face discrimination.¹²⁴ There have been reports of children of HIV victims being barred from school and lovers of HIV victims being evicted.¹²⁵

Why are HIV patients subject to such treatment? Partly because of ignorance as to how the disease is spread,¹²⁶ and mostly because HIV is still considered by much of the population to be associated only with homosexuals and IV drug users.¹²⁷

The reasons for the discrimination, however, are not as important as the fact that it actually exists. This discrimination is threatening the effectiveness of public health programs designed to stop the spread of HIV.¹²⁸ According to Dr. Jonathan Mann, former director of AIDS programs for The World Health Organization (WHO), “wherever there is punishment for having a sexually transmitted disease, people don’t seek treatment in the health systems available.”¹²⁹ The existence of wide spread HIV discrimination underscores the need to keep results of HIV tests confidential.

¹²¹ TESTING AND PRIVACY, *supra* note 66, at 121.

¹²² See, Julie Kosterlitz, *Joining Forces*, 21 NATIONAL JOURNAL, No. 4 at 194 (Complaints of AIDS discrimination to the New York City Commission on Human Rights have been “roughly doubling each year since the commission began its AIDS program five years ago”).

¹²³ TESTING AND PRIVACY, *supra* note 66, at 112.

¹²⁴ See, e.g., Marlene Cimos, *Ostracized in Third wave of Bias; Loved Ones Latest Victims of AIDS discrimination*, LOS ANGELES TIMES, June 2, 1986, at 1, col. 5, [hereinafter *Ostracized*].

¹²⁵ *Id.*

¹²⁶ One in four still believes that you can get AIDS by being coughed or sneezed on; 20 percent, from a toilet seat; 10 percent, from jointly handling money; and 10 percent, by being touched by someone who has the disease. Robert Blendon & Karen Donelan, *Discrimination Against People With AIDS: The Public's Perspective*, 319 NEW ENG. J. MED. 1022, 1024 (1988) (data reported is from a review of 53 national and international opinion surveys between 1983 and 1988).

¹²⁷ One in 12 nationally say they are making efforts to avoid personal interaction with homosexuals. One quarter of the people would refuse to work with someone who has AIDS and believe employers should be able to fire a person merely because that person has AIDS. In these surveys thirty percent support the quarantining of HIV patients. Seventeen percent say those with HIV should be treated as those with leprosy by being sent to far-off islands and twenty-nine percent favor a tattoo for HIV patients. *Id.* at 1023-24.

¹²⁸ See generally, Philip Boffey, *Laws Urged to Protect Identities in AIDS Testing*, N.Y. TIMES, Feb. 25, 1987, at A18, col. 1; Jonathan Mann, Remarks at United Nations Press conference for World Health Organization AIDS program (May 28, 1988) [hereinafter WHO remarks].

¹²⁹ *Id.*

*B. The Need For Information And How
Confidentiality Affects That Need*

Another reason to keep an HIV positive individual's status confidential is the need for information. Since there is no vaccine for HIV as of yet, public efforts to stop the spread of the disease are limited to education that will lead to behavior modification among high-risk individuals.¹³⁰

These educational programs cannot begin in earnest, however, until policymakers and health officials augment their limited knowledge of this disease. According to the President's Commission, "[B]etter understanding of the true incidence and prevalence of HIV infection is critical and can be developed only through careful accumulation of data from greatly increased testing."¹³¹ Since current statutes call for mandatory HIV tests in only rare situations,¹³² the bulk of the data collected will be the result of voluntary testing programs.

An analysis of individuals tested in Ohio's anonymous testing centers in 1990 emphasizes the effect confidentiality has on those who are seeking testing. Between January 1, 1990 and December 7, 1990, over 10,000 people were tested anonymously in Ohio.¹³³ Of these, almost four percent (406 individuals) tested positive.¹³⁴ Slightly over forty-one percent (4,309) of those tested indicated that they wouldn't have taken the test if their name was recorded.¹³⁵ An additional 12.8% (1,343) responded that they were unsure if they would have been tested had they been required to give their names.¹³⁶ So, it's possible that more than half of the clients of Ohio's anonymous test centers might have been deterred if they weren't guaranteed strict confidentiality of their test results.

The seropositivity rate was highest, 4.7% (204) among those who said they wouldn't have been tested without anonymity; compared to 4.0% (53) of those who were unsure of the effect that anonymity had on their decision to get tested and 3.1% (149) among those who would have gone anyway.¹³⁷

Although the number of individuals who would have foregone HIV testing may not appear to be significant, these results are important for two reasons. First, in terms of real numbers, 204 HIV-positive individuals would not have known of their status had it not been for the assurance of confidentiality. Add the 53 infected individuals who might not have gotten tested and there would have been a possible 257 HIV positive

¹³⁰ OHIO'S TESTING PROGRAM, *supra* note 97, at 1.

¹³¹ THE PRESIDENTS COMMISSION, *supra* note 29, at XVIII.

¹³² See, e.g., OHIO REV. CODE ANN. § 3701.242(E) (Anderson 1989) (e.g. - In a medical emergency, by authorization of the head of a penal institution, because a health care provider or emergency service worker may have been exposed in the line of duty, by court order in connection with a criminal investigation).

¹³³ OHIO'S TESTING PROGRAM, *supra* note 97, at 5.

¹³⁴ *Id.* at Table 1.

¹³⁵ *Id.* at 5.

¹³⁶ *Id.*

¹³⁷ *Id.* at table 1.

people in Ohio in 1990 who would not have undergone important pre or post-test counseling or the one-on-one personalized education that is this state's primary strategy for HIV prevention.¹³⁸

At first blush, 257 HIV-positive individuals may not seem like a great many. However, the impact on the spread of the disease becomes significant when considering the fact that each of those 257 people would have had the ability to spread the disease to each of their sexual and/or needle sharing partners for the next ten years.

Second, Ohio's anonymous test centers allowed the state to test two groups that are already difficult to reach, gay/bisexual males and Intravenous drug users (IVDUs). Over half of the gay/bisexual males (1,588) noted that, without anonymity, they would have foregone testing. Almost half of the gay/bisexual IVDUs (48) would have done the same.¹³⁹ There were also an additional 357 gay/bisexual males unsure of the effect that anonymous testing had on their decision.¹⁴⁰

In 1990, Ohio's anonymous test centers were able to inform more than 10,000 people of their HIV status. More than 4,000 of them (41%) would not have gone if it weren't for the guarantee of confidentiality.

Yet, whether a testing program is in fact anonymous is only half of the battle when dealing with individuals who want the results kept secret. The other half is whether perspective testees believe that there will be secrecy. It is generally agreed that the success or failure of voluntary testing programs depends upon public perception of the confidentiality of those programs.¹⁴¹ The President's Commission noted that without the assurance that test results will be kept secret, individuals may be reluctant to come forward.¹⁴² Viewed in this light, confidentiality no longer represents merely the patient's interest in avoiding the effects of unauthorized disclosures, but the societal interest in fighting the HIV epidemic as well.¹⁴³

IV. ALTERNATIVES TO GRANTING PHYSICIANS THE RIGHT TO WARN

How could the Legislature have addressed the problem of spousal notification instead of granting physicians the right to warn? Physicians could have been a) required to disclose the results of a positive HIV test to an ignorant spouse or sexual partner or b) forbidden from disclosing this information.

¹³⁸ *Id.* at 9.

¹³⁹ *Id.* at Table 2.

¹⁴⁰ *Id.*

¹⁴¹ "The perception that confidentiality may be breached is keeping people who believe that they may have been exposed to the virus from seeking testing and counseling services." PRESIDENTS COMMISSION, *supra* note 29, at 74.

¹⁴² "The Commission heard from numerous witnesses who had been the target of discrimination as a result of a positive HIV antibody test. Some persons who fear such discrimination because of a positive test result or even admission that such a test is desired are choosing not to be tested." *Id.*

¹⁴³ "If the HIV-infected people are driven away, you are in fact undermining your entire strategy (to fight AIDS)." WHO remarks, *supra* note 128.

A. Duty To Disclose

One alternative could have been to require that physicians reveal the results of a positive HIV test to a patient's spouse or sexual partner. This duty would reflect the position of the Council on Ethical and Judicial Affairs of the American Medical Association:

Where there is no statute that mandates or prohibits the reporting of seropositive individuals to public health authorities and a physician knows that a seropositive individual is endangering a third party, the physician should (1) attempt to persuade the infected patient to cease endangering the third party; (2) if persuasion fails, notify authorities; and (3) if the authorities take no action, notify the endangered third party.¹⁴⁴

However, a duty to warn does not seem feasible for two reasons. First, it conflicts with the principles of Ohio's anonymous centers. Clients of the anonymous centers may not understand how their identity is safe, while nontest center physicians would actually have the duty to disclose this information. Second, to date, HIV victims have been overwhelmingly gay/bisexual males or IVDUs or both. To create an affirmative duty and require physicians to be able to locate partners of victims would be a tremendous burden. When considering, in addition, the latency period for HIV, the prospect of requiring a warning by physicians becomes virtually impossible. In fact, no state has created an affirmative duty to warn third parties.¹⁴⁵

B. Make Disclosures Unlawful

Although Ohio's statutory scheme allows for a physician to warn third parties at risk of HIV infection, the individuals most benefitting from these laws are the physicians.

While the physicians may make such a disclosure, they are not compelled to do so. Ohio Revised Code § 3701.244 (H) relieves a physician from liability if he knows that an individual is infected but does not tell his/her spouse.¹⁴⁶ In addition, a physician who makes a disclosure is not

¹⁴⁴ *Ethical Issues Involved in the Growing AIDS Crisis*, 259 JAMA 1360, 1361, Mar. 4, 1988.

¹⁴⁵ See, e.g., ARIZ. REV. STAT. ANN. § 32-1457(C) (1990); GA. CODE ANN. § 24-9-47(g) (1990) (doctor *may* disclose information to spouse); IND. CODE ANN. § 16-1-10.5 - 11.5(b)(2) (West 1991) (physician *may* notify person at risk); KAN. STAT. ANN. § 65-6004(c) (1990) (no duty created by § (b)); MD. GENERAL HEALTH CODE ANN., § 18-337(b)(1989) (doctor *may* inform an individual's sex and/or needle sharing partners).

¹⁴⁶ "(H) No person with knowledge that an individual other than himself has or may have AIDS, an AIDS-related condition, or a positive HIV test shall be held liable for failing to disclose that information to any person unless disclosure is expressly required by law." OHIO REV. CODE ANN. § 3701.244 (H) (Anderson 1989).

liable if it turns out that the patient was not in fact infected with HIV,¹⁴⁷ or if the third party was not the spouse or sexual partner.¹⁴⁸

Suppose that Mr. X was not married and that Miss Y, a good friend, accompanied him to the doctor's office. Mr. X tested positive and the physician, believing Miss Y to be Mr. X's sexual partner, told her of the result. Miss Y would know of Mr. X's tragedy and the physician would not be liable because he acted in good faith.¹⁴⁹

The Legislature may have been driven by the third persons' interests in being warned of possible infection. This seems unlikely, however, as the establishment of anonymous testing and the creation of a mere privilege to warn, rather than a duty, serve to hinder that interest.

If § 3701.243 were amended to prohibit spousal disclosures, the rights of third persons could still be served (possibly more efficiently) by partner notification programs.

C. Partner Notification Programs

Partner notification programs are means by which health officials alert endangered third parties of the possible risk of infection with a sexually transmitted disease (STD).¹⁵⁰ Partner Notification involves trained health department counselors encouraging the index case (the infected individual) to notify his/her partner(s) and offering to perform the notification, anonymously, if the index case is unwilling to do so.¹⁵¹ Notification of third parties is coupled with counseling and education on how to prevent further spread of the disease.¹⁵²

Much needed pre-test counseling might not be delivered to the third party as effectively (or maybe not at all) as the notifying physician may not have been trained in HIV - test counseling.¹⁵³ The pre-test time period is considered to be the most important time for counseling because an individual unaware of his HIV status may be more receptive to information at that time.¹⁵⁴ Indeed, the AIDS Bill expressly provided for the

¹⁴⁷ See, e.g., Rod Mickleburgh, *Blood Samples Swapped in AIDS test Mixup*, THE GLOBE AND MAIL, Dec. 26, 1991, at A4 (relating the story of a laboratory worker who switched his own blood with the sample of a patient. As a result, the patient was erroneously informed that he was HIV positive).

¹⁴⁸ "(D) A person who acts in good faith in accordance with section 3701.242 or 3701.243 of the Revised Code is not liable for damages in a civil action brought pursuant to this section." OHIO REV. CODE ANN. § 3701.244 (D) (Anderson 1989).

¹⁴⁹ *Id.*

¹⁵⁰ CENTERS FOR DISEASE CONTROL, THE NOTIFICATION OF SEX AND NEEDLE SHARING PARTNERS OF PEOPLE WITH HIV INFECTION (36815) (1987) (hereinafter *Notification*).

¹⁵¹ *Id.* at 1-2.

¹⁵² *Id.*

¹⁵³ PREVENTING AIDS, *supra* note 45, at 218, citing CDC guidelines for counseling and testing for HIV, and noting that the counselor should be "well informed about the various means of HIV transmission" and listing areas that should be discussed during the 15-20 minute pre-test question and answer period.

¹⁵⁴ *Id.*

creation of a confidential partner-notification system in Ohio.¹⁵⁵

There are concerns, however, that because of the differences between HIV and other STDs, that notification programs would be ineffective in the fight against HIV.

1. Potential Problems With Partner Notification Programs

One major difference is the fact that once individuals are notified of their risk, there is no cure that can be offered to them.¹⁵⁶ However, notification programs utilize the only means by which we can presently curb the spread of the disease; education geared at preventing high-risk behavior.¹⁵⁷ They also serve another important purpose in that they provide much needed information and the chance to treat individuals in the early stages of HIV.¹⁵⁸

Another major difference between HIV and other STDs covered by notification programs is the latency period associated with these other diseases. Since it is usually impossible to pinpoint the factual time of infection, "all contacts within a specific time period corresponding to the latency period of the disease are thought to be relevant."¹⁵⁹ With gonorrhea and syphilis, for example, this relevant time period is anywhere from two weeks to six months.¹⁶⁰ Notification in such cases will focus only on individuals with whom the index case has had sex in this time frame. With the latency period of HIV, however, contacts deemed at risk will be those having relations with the index case within the last ten years.¹⁶¹ It is not only improbable that contacts could be established within such a large time frame, but it would also be prohibitively costly to notify all such contacts. Thus, some states have altered the time frames to which they look in order to attempt to try and establish contacts.¹⁶²

The inability to reach all individuals at risk, however, should not defeat the existence of notification programs. This is because, for those contacts that will be reached, the goal of the notification program will be met.

¹⁵⁵ OHIO REV. CODE ANN. § 3701.241 (A)(3) (Anderson 1989).

¹⁵⁶ "[U]nlike STDS, there is at present no cure for HIV infection or AIDS. The only way to break the cycle of transmission is to change sexual and IV drug-use behavior." CONTACT TRACING, *supra* note 23, at 3.

¹⁵⁷ *Id.* at 2.

¹⁵⁸ "Early diagnosis of HIV infection is essential, not only for proper medical treatment and counseling of the infected person, but also for proper follow-up by the public health authorities. HIV infection . . . can be treated more effectively when detected early," PRESIDENT'S COMMISSION, *supra* note 29, at XVII.

¹⁵⁹ CONTACT TRACING, *supra* note 23, at 5.

¹⁶⁰ *Id.*

¹⁶¹ *Id.*

¹⁶² Colorado and Idaho which, in 1988, conducted active contact tracing programs, generally traced those who had sexual or needle-sharing contacts with the index case in the "most recent months" before an HIV positive test. *Id.* at 7.

That is, the contacts will be educated to curb their own behavior to prevent further spread of the disease. The most prohibitive factor, however, is the potential cost of a notification program. These programs sometimes require numerous man-hours for each contact and can be prohibitively expensive.¹⁶³

2. Partner Notification Programs Need Confidentiality To Be Effective

Because of the discrimination that faces victims of HIV, individuals need to know that their HIV status will be kept confidential. Since partner notification programs rely upon voluntary disclosure, they must be confidential to be effective.¹⁶⁴ The Ohio legislature, however, does not ensure this confidentiality. Although Ohio has provided for anonymous testing centers where confidentiality is guaranteed,¹⁶⁵ and for the creation of Partner Notification programs,¹⁶⁶ it still allows for the release of a positive HIV test to the individual's spouse or any sexual partner.¹⁶⁷

Permission to warn poses a direct threat to the effectiveness of any notification or voluntary testing program enacted by the state. Since the individuals submitting to these programs must believe that the information that they provide will remain confidential for their own safety and the safety of the individuals whose names they reveal,¹⁶⁸ confidentiality must be enforced.¹⁶⁹

V. CONCLUSION

Case law that has allowed for breaches of doctor/patient confidentiality has done so after determining that the release of the information would be an overall public benefit. However, the uniqueness of the HIV epidemic should be given due consideration. Prohibiting physicians from warning third parties may put the third parties at risk, but in the long run, it will ensure that greater strides are taken towards conquering HIV.

Because of the scope and nature of the HIV epidemic, it has been widely accepted that the best way to prevent the spread of the disease is by

¹⁶³ *Id.* at 6.

¹⁶⁴ *Id.* at 4.

¹⁶⁵ OHIO REV. CODE ANN. § 3701.241(B)(2) (Anderson 1989).

¹⁶⁶ OHIO REV. CODE ANN. § 3701.241 (A)(3) (Anderson 1989).

¹⁶⁷ See *supra*, note 2.

¹⁶⁸ See CONTACT TRACING, *supra* note 23, at 4.

¹⁶⁹ "The success of STD contact tracing programs has been due in large part to the record of public health officials in preserving the confidentiality of the information obtained. The Centers for Disease Control (CDC) estimates that approximately two million interactions occur per year between state or local health officials and the sexual contacts of persons diagnosed as having the most common venereal diseases, and in none of these official activities is the name of the source revealed." CONTACT TRACING, *supra* note 23, at 4.

educating the general public as to risk-reducing behavior.¹⁷⁰ The best way to learn how to fight the disease effectively is to gather information through increased testing.

Testing for HIV serves a two-fold purpose. First, it assists Health Department officials and researchers in obtaining much-needed information about the disease. Second, it lets the infected members of society know exactly who they are so they can alter their behavior, stop themselves from spreading the disease and begin available treatments. Encouraging voluntary testing is already high on the list of priorities of those in charge of battling HIV, as evidenced by the number of states (41 including Ohio) that provide for anonymous testing of infected individuals.¹⁷¹ By creating anonymous testing centers, the Ohio Legislature is implicitly admitting that the third party's right to know is outweighed by the need to gather information and to counsel those infected.

Unless the high-risk population can be assured that volunteering for an HIV test will not place them at great personal risk, they will not do so. By granting physicians the right to warn, the Ohio Legislature has placed voluntary testing and the effectiveness of the anonymous testing centers at risk.

Absent a clear mandate by the Legislature of the need for strict confidentiality, at-risk individuals may not trust the anonymity of such centers. It is not whether an anonymous center is actually confidential, but whether those it is designed to serve believe in its confidentiality. How can at-risk individuals reconcile the fact that the physicians and counselors at the anonymous centers are not allowed to disclose the information while their own private physician can? Individuals may also forego testing because they prefer that their own physician perform such a delicate test and are unwilling to risk the possible release of a positive result.

Viable alternatives exist that will help fight the spread of HIV. Programs can serve to notify third persons without relying on an individual physician's judgment as to who the right partner may be. These programs also provide the counseling that is needed when dealing with such sensitive information. Although partner notification programs exist in Ohio, lack of strict confidentiality reduces their effectiveness because they rely upon voluntary offerings of crucial information. Ohio should, therefore, eliminate the "spouse or any sexual partner" language from Ohio Revised Code § 3701.243 and expressly prohibit physicians from making such a disclosure.

Information and behavior modification are the State's only weapons against the spread of HIV. Without strict confidentiality of HIV-related information, neither will work to their full potential.

¹⁷⁰ "The lack of a preventive vaccine or drug to cure the disease means education and behavior modification are the only preventive measures currently available," OHIO'S TESTING PROGRAM, *supra* note 97, at 1.

¹⁷¹ *Id.* at 2.

