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CONFIDENTIALITY, WARNING, AND AIDS: A PROPOSAL TO PROTECT PATIENTS, THIRD PARTIES, AND PHYSICIANS

INTRODUCTION

When we visit a physician, most of us expect that information about our medical condition will be kept confidential. This comports with our notions of privacy and the special relationship of trust we have with a physician. We also expect that our physicians will protect us from contracting diseases.

These expectations have been elevated to duties of confidentiality and warning by the medical profession¹ and by law.² But judicial

1. See, e.g., Hippocratic Oath, reprinted in G. GRABER, A. BEASLEY & J. EADDY, *ETHICAL ANALYSIS OF CLINICAL MEDICINE* 77 (1985); AMERICAN MEDICAL ASSOCIATION, *PRINCIPLES OF MEDICAL ETHICS* (1980), reprinted in G. GRABER, *supra*, at 85.

2. E.g., CAL. CIV. CODE § 56.10 (West 1983); COLO. REV. STAT. § 25-1-802 (1985); ILL. ANN. STAT. ch. 91½, para. 805 (Smith-Hurd 1981). The law, following medical ethics, accepts confidentiality as a fundamental duty of physicians which arises from the physician-patient relationship. "Instances of unconsented disclosures are to be regarded as exceptions to the general norm of confidentiality and require special justification, such as an important public purpose." THE PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH 37 (1983), quoted in G. GRABER, *supra* note 1, at 71; see, e.g., *Mikel v. Abrams*, 541 F. Supp. 591, 597 (W.D. Mo. 1982) (right to privacy includes right to have medical information kept confidential from the general public); *Hammonds v. Aetna Casualty & Sur. Co.*, 243 F. Supp. 793, 801 (N.D. Ohio 1965) (public policy supports duty of confidentiality based on fiduciary nature of physician-patient relationship); *Simonsen v. Swenson*, 104 Neb. 224, 227, 177 N.W. 831, 832 (1920) (testimonial privilege and licensing statutes provide a policy basis for supporting a general duty of confidentiality); *MacDonald v. Clinger*, 84 A.D.2d 482, 487, 446 N.Y.S.2d 801, 805 (4th Dep't 1982) (fiduciary nature of physician-patient relationship supports duty of confidentiality); *Clark v. Geraci*, 29 Misc. 2d 791, 793, 208 N.Y.S.2d 564, 567 (Sup. Ct. Kings County 1960) (duty of confidentiality based in statute, common usage, and medical ethics). The general duty to warn people about exposure to contagious diseases has long been established at common law. See, e.g., *Gammill v. United States*, 727 F.2d 950, 954 (10th Cir. 1984) ("A physician may be found liable for failing to warn a patient's family, treating attendants, or other persons likely to be exposed to the patient, of the nature of the disease and the danger of exposure.") (emphasis in original); *Davis v. Rodman*, 147 Ark. 385, 391, 227 S.W. 612, 614 (1921) (physicians have a duty to "exercise reasonable care to advise members of the family and others, who are liable to be exposed [to the disease] . . ."); *Simonsen*, 104 Neb. at 228, 177 N.W. at 832 (physician has "qualified privilege" to disclose confidential information to prevent the spread of a contagious disease); *MacDonald*, 84 A.D.2d at 487, 446 N.Y.S.2d at 805 (unauthorized disclosure is justified to prevent harm when a patient is dangerous to himself or others); *Clark*, 29 Misc. 2d at 793, 208 N.Y.S.2d at 567 (duty to report a communicable disease overrides confidentiality); *Berry v. Moench*, 8 Utah 2d 191, 197, 331 P.2d 814, 817-18 (1958) ("Where life, safety, well-being or other important interest is in jeopardy, one

and statutory guidelines are often unclear.³ As a result, the "clash between two important social interests—confidentiality . . . and protection . . . is left to the physician to resolve, and the physician may be held responsible for his resolution."⁴ The tension between these duties and the lack of clarity of their scope in the law has created a crisis of conflicting ethical, legal, and human considerations for physicians.

The advent of the Acquired Immune Deficiency Syndrome (AIDS) crisis has revealed this tension in a particularly tragic way. Failing to warn an unsuspecting person about exposure to the virus can lead to fatal contraction of the disease. Yet disclosure of medical information of a person with AIDS, already a tragic situation, can bring even more desperate consequences such as loss of friends, employment, and housing.⁵ This terrible dilemma must be resolved by a physician who is, himself, placed in a position of potentially inescapable liability whichever choice he makes. The ethical difficulty and the potentially grave economic consequences of such decisions may lead physicians to refuse to treat AIDS patients, reduce the availability of already scarce medical facilities for people with AIDS, and raise medical costs even further.

Part I examines the development of physicians' duties of confidentiality and warning. Part II analyzes the conflict of these duties on physicians in the case of the AIDS crisis in New York. Part III suggests guidelines for AIDS legislation which relieves the conflict on

having information which could protect against the hazard, may have a conditional privilege to reveal information for such purpose . . ."). This duty has been extended to include warnings about dangerous patients who are likely to act violently due to emotional illnesses. *See, e.g., Tarasoff v. Regents of the Univ. of Cal.*, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976) (therapist has a duty to warn third parties of foreseeably dangerous acts of their patients); *see also Lipari v. Sears, Roebuck & Co.*, 497 F. Supp. 185 (D. Neb. 1980) (therapist must take whatever steps are reasonably necessary to protect potential victims of his patient); *McIntosh v. Milano*, 168 N.J. Super. 466, 403 A.2d 500 (1979) (psychiatrist has duty to protect against foreseeable injuries caused by patients).

3. Gellman, *Prescribing Privacy: The Uncertain Role of the Physician in the Protection of Patient Privacy*, 62 N.C.L. REV. 255, 266 (1984).

4. *Id.* at 284. The problem of potentially conflicting duties of confidentiality and warning has recently been centered in psychiatric medicine. *See, e.g., Note, Duty to Warn Versus Duty to Maintain Confidentiality: Conflicting Demands of Mental Health Professionals*, 20 *SUFFOLK U.L. REV.* 579 (1986).

5. *See, e.g., Leonard, Employment Discrimination Against Persons with AIDS*, 19 *CLEARINGHOUSE REV.* 1292 (1986); Matthews & Neslund, *The Initial Impact of AIDS on Public Health Law in the United States—1986*, 257 *J. A.M.A.* 344 (1987); Address by Alan R. Nelson, *Prevention and Control of AIDS—An Interim Report*, *The National Convention of the American Medical Association (July 1987)*, *printed in Report of the Board of Trustees, Report FY (A-87) [hereinafter "Interim Report"]*.

physicians while protecting the interests of patients infected with the virus and the interests of third parties potentially exposed to it. In conclusion, some positive implications of the suggested approach will be noted.

I. HISTORICAL DEVELOPMENT OF PHYSICIANS' DUTIES

A. Generally

Western medicine has accepted the general duty of confidentiality since its inception as an organized discipline. The Hippocratic Oath which all doctors have affirmed since approximately 400 B.C. states:

"What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself holding such things shameful to be spoken about."⁶

In spite of this long tradition, common law never recognized a duty of confidentiality for physicians.⁷ On the contrary, this duty is a statutorily created affirmative duty. Federal law on confidentiality is minimal.⁸ In general, the federal government leaves regulation of health care to the states, including the duty of confidentiality.⁹ In 1829, New York enacted the first statute creating a duty of confidentiality for physicians.¹⁰ Since then, virtually every state has enacted confidentiality statutes,¹¹ although "tremendous variation exists."¹²

6. Hippocratic Oath reprinted in G. GRABER, *supra* note 1.

7. Annotation, *Doctor-Unauthorized Disclosure*, 48 A.L.R. 4th 668, 674 (1986).

8. Gellman, *supra* note 3, at 267. See generally FED. R. CIV. P. 26 (1986) (recognizes testimonial privilege for physicians); 42 C.F.R. § 2.1 (1986) (statutory authority regarding confidentiality of drug abuse patient's treatment records); 42 C.F.R. § 2.2 (1986) (statutory authority regarding confidentiality of alcohol abuse patient's treatment records).

These last two regulations describe detailed rules for disclosure, leading one commentator to suggest that the need for special confidentiality rules for such records indicates that the usual rules for protecting confidentiality of medical records are "too weak to satisfy a class of patients who can reasonably be expected to be concerned about confidentiality" and reveals the "intense pressure to make medical records available for other purposes." Gellman, *supra* note 3, at 277.

9. *Jacobson v. Massachusetts*, 197 U.S. 11, 25 (1905) (under the police power, the states have the authority "to enact . . . 'health laws of every description' . . ."); see generally Gellman, *supra* note 3, at 275.

10. Gellman, *supra* note 3, at 272.

11. *Id.*

12. *Id.* at 278. Several states have legislated confidentiality of patient information through statutes. For examples of statutes providing for general confidentiality of patient research, see CAL. CIV. CODE § 56.10 (West 1980) (disclosure of medical information by providers); COLO.

Courts have found the basis of confidentiality in statutory law as well as in expectations of trust and privacy in the physician-patient relationship. In an early case,¹³ the Nebraska Supreme Court recognized that the "relation of physician and patient is necessarily a highly confidential one."¹⁴ The court found that state testimonial privilege and licensing statutes provide a policy basis for a general duty of confidentiality owed by physicians to patients.¹⁵ However, the court allowed an unauthorized disclosure based on a physician's qualified privilege to disclose information to prevent the spread of a contagious disease.¹⁶

A federal district court in Ohio¹⁷ stated that even if there is no statute creating a duty of confidentiality on physicians, public policy requires the duty of "implied secrecy" in the physician-patient relationship.¹⁸ The court presciently found three bases for holding physicians liable for unjustified disclosure of confidential information, even without a statute: breach of contract, breach of a fiduciary relationship, and breach of an implied promise of secrecy or confidentiality.¹⁹

REV. STAT. § 25-1-802 (1982) (patient records in custody of individual health care providers); ILL. ANN. STAT. ch. 91½, para. 805 (Smith-Hurd 1981) (written consent for disclosure of records and communications). For examples of statutes concerning the licensing requirements of physicians, see COLO. REV. STAT. § 13-90-107(1)(d) ("A physician . . . shall not be examined without the consent of his patient as to any information acquired in attending the patient . . ."); ILL. ANN. STAT. ch. 110, para. 8-802 (Smith-Hurd 1981) ("No physician or surgeon shall be permitted to disclose any information he or she may have acquired in attending any patient in a professional character . . ."); N.Y. CIV. PRAC. L. & R. 4504(a) (McKinney 1977) (confidential information privileged). For examples of statutes concerning reports to public health officials, see ILL. ANN. STAT. ch. 126, para. 21 (Smith-Hurd 1981) (communicable disease reports kept confidential); N.Y. PUB. HEALTH LAW § 206 (McKinney 1971) (medical research data collection reports kept confidential).

13. *Simonsen v. Swenson*, 104 Neb. 224, 177 N.W. 831 (1920) (refusal to find a physician liable for an unauthorized disclosure warning to a patient's landlady concerning the possibility of syphilis contamination of her premises).

14. *Id.* at 227, 177 N.W. at 832.

15. *Id.*

16. *Id.* at 228, 177 N.W. at 833.

17. *Hammonds v. Aetna Casualty & Sur. Co.*, 743 F. Supp. 793 (N.D. Ohio 1965) (a cause of action may be stated against an insurance company which induced a physician to divulge confidential information in violation of a physician's fiduciary relationship with a patient).

18. *Id.* at 796. The court stated that public policy fosters confidentiality not only because of the fiduciary physician-patient relationship, but also in order to promote the best interest of the patient in trusting his or her welfare to the skill of a physician and to acknowledge the need for frankness in creating a "climate for recovery." *Id.* at 797.

19. *Id.* at 801.

More recently, confidentiality has been found to be an element covered by the right of privacy. A federal court in Missouri,²⁰ citing earlier state cases, held that the right to privacy included the right to have medical information kept confidential from the general public,²¹ but that a person is entitled to know the medical status of his or her spouse.²²

It is clear that the duty of a physician to keep patient information confidential may be based on statute, on the contractual or fiduciary nature of the physician-patient relationship, or on the privacy rights of patients. However, the duty is not absolute and its scope has never been unlimited.²³

A physician's duty to warn endangered third parties, based in the common law of negligence, places a limit on the duty of confidentiality.²⁴ The general rule was stated in an Arkansas case:²⁵ physicians have a common law duty "not to negligently do any act that would tend to spread the infection."²⁶ At the least, physicians have a duty to "exercise reasonable care to advise members of the family and

20. *Mikel v. Abrams*, 541 F. Supp. 591 (W.D. Mo. 1982) (dismissal of a suit alleging invasion of privacy against a physician who divulged information to a patient's spouse at the spouse's request).

21. *Id.* at 597.

22. *Id.* at 598.

23. The American Medical Association acknowledges the limited nature of confidentiality in its medical ethics: "A physician . . . shall safeguard patient confidences within the constraints of the law." American Medical Association, *Principles of Medical Ethics* § IV (1980). These "lawful constraints" take the form of statutory exceptions and common law duties which override individual interests in confidentiality in favor of public health and safety. Common limits on physicians' duty of confidentiality include: statutes mandating reports of communicable diseases, e.g., COLO. REV. STAT. § 25-4-402 (1982); suspected criminal activity, e.g., COLO. REV. STAT. § 12-36-135 (1985) (reports of gunshot wounds, powder burns, firearm or sharp instrument wounds believed to be involved in criminal acts), COLO. REV. STAT. § 19-10-104 (1986) (reports of child abuse or neglect), N.Y. SOC. SERV. LAW § 413 (McKinney 1983) (reports of suspected child abuse); the needs of medical research, e.g., CAL. CIV. CODE § 56.10(c)(7) (West 1982), N.Y. PUB. HEALTH LAW § 206(1)(j) (McKinney 1971); medical diagnosis, e.g., CAL. CIV. CODE § 56.10(c)(1) (West 1982); waivers by the patient, e.g., COLO. REV. STAT. § 13-90-107(d)(1981), ILL. ANN. STAT. ch. 110, para. 8-802 (Smith-Hurd 1984), N.Y. CIV. PRAC. L. & R. 4504(a) (McKinney 1963); marital privilege, e.g., *Mikel v. Abrams*, 541 F. Supp. 591 (W.D. Mo. 1982), *Curry v. Corn*, 52 Misc. 2d 1035, 277 N.Y.S.2d 470 (Sup. Ct. Nassau County 1966); but see *MacDonald v. Clinger*, 84 A.D.2d 482, 446 N.Y.S.2d 801 (4th Dep't 1982); and information provided to third party payors, e.g., CAL. CIV. CODE § 56.10(c)(2) (West 1982).

24. RESTATEMENT (SECOND) OF TORTS §§ 314-315 (1986). There is generally no duty to rescue someone from harm, but a special relationship may give rise to a duty to aid or assist. *Id.*

25. *Davis v. Rodman*, 147 Ark. 385, 227 S.W. 612 (1921) (suit against physician claiming negligent failure to warn family about typhoid dismissed for failure to show proximate cause).

26. *Id.* at 391, 277 S.W. at 614. The court stated: "[O]ne who by reason of his professional relation is placed in a position where it becomes his duty to exercise ordinary care to protect

others, who are liable to be exposed thereto, of the nature of the disease and the danger of exposure."²⁷

The duty to warn is well established²⁸ and overrides any statutory duty of confidentiality.²⁹ Thus, even though statutes prescribe a duty of confidentiality for physicians rooted in the bedrock of the physician-patient relationship, that duty is superseded by the even more rudimentary common law duty to warn, which holds a physician "liable for his negligence in permitting persons to be exposed to infectious or communicable diseases to the injury of the persons so exposed."³⁰

B. *Physicians' Duties in New York*

New York led the way in establishing confidentiality of patient information by statute in 1829.³¹ Since then, New York legislation³² and case law³³ have reflected general trends. In fact, the New York Court of Appeals has not ruled on an issue of medical confidentiality and warning in over forty years.³⁴ As a result, there is uncertainty as to the scope of these duties because of apparent ambiguity in the lower court rulings.³⁵ In addition, while lower court opinions evince

others from injury or danger, is liable in damages to those who are injured by reason of his failure to exercise such care." *Id.* at 392, 277 S.W. at 614.

27. *Id.* at 391, 227 S.W. 614.

28. *See supra* note 2.

29. The privilege of confidentiality ends "where the public peril begins." *Tarasoff v. Regents of the Univ. of Cal.*, 17 Cal. 3d 425, 442, 551 P.2d 334, 347, 131 Cal. Rptr. 14, 27 (1976).

30. 61 AM. JUR. 2D *Physicians & Surgeons* § 245 (1981).

31. Gellman, *supra* note 3, at 272.

32. Statutory law in New York provides for confidentiality of patient information by private physicians through a testimonial privilege statute N.Y. CIV. PRAC. L. & R. 4504 (McKinney 1977); under certain reporting statutes, e.g., N.Y. PUB. HEALTH LAW § 2306 (McKinney 1985) (reports of sexually transmissible diseases kept confidential); and medical research provisions, e.g., N.Y. PUB. HEALTH LAW § 206(1)(j) (McKinney 1985).

33. Confidentiality may be based on a variety of theories. *See, e.g., MacDonald v. Clinger*, 84 A.D.2d 482, 446 N.Y.S.2d 801 (4th Dep't 1982) (fiduciary nature of the physician-patient relationship); *Doe v. Roe*, 93 Misc. 2d 201, 400 N.Y.S.2d 668 (Sup. Ct. N.Y. County 1977) (privacy and public policy).

The duty of confidentiality may be overridden by marital privilege or a duty to warn. *See, e.g., Mikel v. Abrams*, 541 F. Supp. 591 (W.D. Mo. 1982) (marital privilege overrules confidentiality in physical disease case); *MacDonald*, 84 A.D.2d 482, 446 N.Y.S.2d 801 (marital privilege overrides confidentiality generally, but in psychiatric cases confidentiality supersedes unless there is danger to a spouse); *Clark v. Geraci*, 29 Misc. 2d 791, 208 N.Y.S.2d 564 (Sup. Ct. Kings County 1960) (duty to report disease overrides confidentiality).

34. *New York City Council v. Goldwater*, 284 N.Y. 296, 31 N.E.2d 31 (1940).

35. Confidentiality may be based on fiduciary relationship or privacy. *Compare MacDonald*, 84 A.D.2d at 483-87, 446 N.Y.S.2d at 803-05 (claim of breach of confidentiality may be based on fiduciary relationship, not privacy) *with Doe*, 93 Misc. 2d at 212-13, 400 N.Y.S.2d at 675-76 (confidentiality based in privacy as well as fiduciary relationship). Confidentiality may

concern about extending or imposing onerous duties on physicians for fear of adversely affecting health care and costs, the legislature has not significantly clarified the scope of the duties of confidentiality and warning.

One New York court³⁶ found a "duty of secrecy" owed by physicians to patients based in statutory law, common usage, and medical ethics.³⁷ Other courts found the duty of confidentiality based on privacy³⁸ and on the contractual³⁹ and fiduciary nature of the physician-patient relationship.⁴⁰ However, the duty is not absolute and is limited by countervailing public interests justifying unauthorized disclosure.⁴¹

Most New York courts accept a general common law duty on physicians to warn persons foreseeably endangered by their patients.⁴² The duty does not extend to the general public or unforeseeable victims.⁴³ It does extend to a spouse, family members, and others whom the physician reasonably believes may be exposed to a communicable

be limited by a duty to warn. Compare *MacDonald*, 84 A.D.2d at 487, 446 N.Y.S.2d at 805 (duty to warn overrides confidentiality) [and] *Clark*, 29 Misc. 2d at 793, 208 N.Y.S.2d at 567 (duty to warn and also duty to report communicable disease override confidentiality) with *Wojcik v. Aluminum Co. of Am.*, 18 Misc. 2d 740, 745, 183 N.Y.S.2d 351, 357 (Sup. Ct. Erie County 1959) (duty to warn may be discharged by compliance with reporting statute with no need for physician to actually warn endangered family members).

36. *Clark*, 29 Misc. 2d at 791, 208 N.Y.S.2d at 564.

37. *Id.* at 792, 208 N.Y.S.2d at 567 ("[D]isclosure is plainly reprehensible as indicated by the statutory law. . . , accepted usage and the Hippocratic oath").

38. See, e.g., *Doe v. Roe*, 93 Misc. 2d at 218, 400 N.Y.S.2d 668, 679-80 (Sup. Ct. N.Y. County 1977) (injunction issued against further distribution of a book by a psychiatrist which revealed former patient's conversations from therapy to protect patient from violations of privacy). The Supreme Court of New York County noted that confidentiality is based in the right to privacy of psychiatric patients, who must reveal intimate details in therapy. *Id.* at 213, 400 N.Y.S.2d at 676.

39. See, e.g., *id.* at 210-11, 400 N.Y.S.2d at 674-75.

40. See, e.g., *MacDonald v. Clinger*, 84 A.D.2d 482, 487, 446 N.Y.S.2d 801, 805 (4th Dep't 1982) (confidentiality based on fiduciary psychiatrist-patient relationship); *Doe*, 93 Misc. 2d at 218, 400 N.Y.S.2d at 679 (confidentiality based on fiduciary psychiatrist-patient relationship).

41. See, e.g., *MacDonald*, 84 A.D.2d at 488, 446 N.Y.S.2d at 804 (disclosure justified for marital privilege or dangerousness); *Clark v. Geraci*, 29 Misc. 2d at 791, 793, 208 N.Y.S.2d 564, 567 (Sup. Ct. Kings County 1960) (warning or reporting a communicable disease justified to safeguard the security of the government or the safety of the public).

42. See, e.g., *Purdy v. Public Adm'r. of Westchester*, 127 A.D.2d 285, 514 N.Y.S.2d 407 (2d Dep't 1987) (physicians and psychiatrists have duty to warn only those foreseeably endangered by a patient's disease) *appeal dismissed in part, granted in part*, 70 N.Y.2d 720, 513 N.E.2d 1301, 519 N.Y.S.2d 640 (1987); *MacDonald*, 84 A.D.2d at 487, 446 N.Y.S.2d at 805 (physicians and psychiatrists have duty to warn those endangered by patient's disease); *Clark*, 29 Misc. 2d at 793, 208 N.Y.S.2d at 567 (physicians have duty to warn others of possible exposure to communicable disease).

43. *Purdy*, 127 A.D.2d at 289, 514 N.Y.S.2d at 410.

disease by a patient⁴⁴ (e.g., sexual partners or health care workers attending the patient). However, at least one court has implied that the duty to warn may be discharged by reporting the relevant information to the public health authorities who are expressly charged with taking measures to prevent the spread of communicable diseases.⁴⁵

An Erie County Supreme Court⁴⁶ recognized that physicians have a duty to exercise care in "advising and warning members of the family and others who are liable to exposure . . . from the disease."⁴⁷ However, the court actually holds only that "as physicians it was their duty upon discovering that plaintiff had tuberculosis, a communicable disease, to report that fact to the local authorities from whom plaintiff presumably would have learned of his condition."⁴⁸ The court leaves unclear whether the standard of reasonable care in a physician's duty to warn is satisfied by compliance with the reporting statute, or whether the duty is independent, as traditional common law would have it.⁴⁹ So long as the New York Court of Appeals has not ruled on the issue, it remains open and unclear. The lack of clarity leaves physicians without reliable guidelines for resolving the dilemma of conflicting duties in treating patients with dangerous, communicable diseases.

II. CONFIDENTIALITY, WARNING AND AIDS

Acquired Immune Deficiency Syndrome (AIDS) is "a secondary immunodeficiency syndrome caused by a virus and characterized by severe immune deficiency resulting in opportunistic infections . . . in individuals without prior history of immunologic abnormality."⁵⁰ The condition is believed to be caused by the Human Immu-

44. *MacDonald*, 84 A.D.2d at 487, 446 N.Y.S.2d at 805.

45. *Wojcik v. Aluminum Co. of Am.*, 18 Misc. 2d 740, 183 N.Y.S.2d 351 (Sup. Ct. Erie County 1959).

46. *Id.*

47. *Id.* at 746-47, 183 N.Y.S.2d at 358 (*quoting* 70 C.J.S. *Physicians & Surgeons* § 48 (1958)) (physician has a duty to warn family members against contracting the disease, to "avoid doing any act which would tend to spread the infection, and to take all necessary precautionary measures to prevent its spread . . .").

48. *Id.* at 745, 183 N.Y.S.2d at 357.

49. *Compare Wojcik*, 18 Misc. 2d at 745, 183 N.Y.S.2d at 357 (duty to warn may be discharged by reporting disease to authorities) *with* *Clark v. Geraci*, 29 Misc. 2d 791, 793, 208 N.Y.S.2d 564, 567 (Sup. Ct. Kings County 1960) (duty to warn is a different obligation than duty to report disease to authorities).

50. B. BERKOW & A. J. FLETCHER, *THE MERCK MANUAL OF DIAGNOSIS AND THERAPY* 238 (15th ed. 1987).

nodeficiency Virus (HIV).⁵¹ The HIV virus is transmitted through exchange of body fluids (e.g., blood, semen) and is not contagious through casual contact.⁵² There is currently no cure or immunization for the HIV virus.⁵³

The United States Public Health Service estimates that 1.5 million people in the United States are infected with the HIV virus, 35,000 of whom have been diagnosed with AIDS.⁵⁴ It has also been estimated that there may be 3 to 4 million HIV-infected people in the United States by 1991 (approximately 1 in 70).⁵⁵ Many people die within two years of being diagnosed with AIDS; almost all die within five years of diagnosis.⁵⁶ AIDS is a 100% fatal disease.⁵⁷

The prevention and control of AIDS, like that of any contagious disease involves two concerns: "First, the person who is afflicted with the disease needs compassionate treatment Second, and of critical importance, the uninfected must be protected."⁵⁸ Confidentiality is crucial to compassionate treatment of those infected with AIDS. Along with grim statistics, fatal prognoses, and horrific diseases, persons with AIDS are afflicted with social opprobrium, stigma, and discrimination because of others' irrational fear and

51. Wong-Staal, Shaw, Hahn, Salahuddin, Popovic, Markham, Redfield & Gallo, *Genomic Diversity of Human T-lymphotropic Virus Type III (HTLV-III)*, 229 *SCIENCE* 759, 762 (1985). HIV virus can cause three states of infection: AIDS (Acquired Immune Deficiency Syndrome), a severe form of infection accompanied by rare malignancies, unusual forms of pneumonia, and/or neurologic lesions; ARC (AIDS-Related Complex), a mild form of infection associated with flu-like symptoms and rapid weight loss; and seropositivity, a condition where there is no disease at all but the individual's blood shows "positive" for antibodies to the HIV virus. *Id.*

52. Sande, *Transmission of AIDS, The Case Against Casual Contagion*, 314 *NEW ENG. J. MED.* 380 (1986) (The modes of transmission are through intimate sexual contact, sharing of intravenous needles, blood and blood part transfusions, and sometimes from mother to child though uterine contact pre-birth and through breast-feeding.).

53. NEW YORK STATE DEP'T OF HEALTH, *ACQUIRED IMMUNE DEFICIENCY SYNDROME*. 100 *QUESTIONS AND ANSWERS*, Q. 56 & 59, at 9 (1987) [hereinafter *QUESTIONS AND ANSWERS*].

54. Interim Report, *supra* note 5; AIDS DISCRIMINATION UNIT, NYC COMM'N ON HUMAN RIGHTS, *AIDS AND PEOPLE OF COLOR: THE DISCRIMINATORY IMPACT* 19 (1986) [hereinafter *AIDS DISCRIMINATION UNIT*].

55. New York State accounts for 31% of all reported AIDS cases, with over 10,000 cases diagnosed. *QUESTIONS AND ANSWERS*, *supra* note 53, Q. 34 & 40, at 6. The New York City Commissioner of Health, Stephen C. Joseph, estimates that 500,000 people in New York City have already been infected with the HIV virus. Joseph, *A Strategy Against AIDS*, *Newsday*, Feb. 5, 1987, at 80, col. 4.

In New York City, AIDS is the leading cause of death for males aged 25-44 and females aged 25-29. It is the second leading cause of death for women aged 30-34. *AIDS DISCRIMINATION UNIT*, *supra* note 54, at 19.

56. Bayer, *The AIDS Crisis*, 11 *J. HEALTH POL., POL'Y & L.* 172 (1986).

57. *Id.*

58. Interim Report, *supra* note 5, at 4.

prejudice.⁵⁹ Persons with AIDS and those only suspected of having it (including children) have lost friends and family, housing, employment, medical insurance, and have been denied admission to schools and nursing homes.⁶⁰ Compassion for their plight requires strict confidentiality of AIDS patients' records.

Moreover, the "ability of the health care community to maintain the confidentiality of patient information and restrict its use to only those purposes essential for maintenance of health is . . . vital to an effective program of preventing and controlling AIDS."⁶¹ The key to such a preventive measure, in the absence of a cure or vaccine, is behavioral change by those infected and those at risk.⁶² Behavioral change is accomplished only through education, counseling, and knowledge.⁶³ "Knowledge that a person is infected with the AIDS virus can be the crucial predicate to changing behavior."⁶⁴ Testing for an antibody to the HIV virus is an imperfect but available medical tool for identifying those infected with the virus, providing motivation for behavioral change, offering treatment where possible, and warning endangered third parties. The "vast majority of public health officials, including the Centers for Disease Control and the Surgeon General"⁶⁵ have been joined by the American Medical Association in recommending voluntary confidential testing,⁶⁶ public

59. Leonard, *supra* note 5, at 1292-93; Interim Report, *supra* note 5, at 4.

60. Matthews & Neslund, *supra* note 5, at 345-50 (1987).

61. Interim Report, *supra* note 5, at 15.

62. *Id.* at 13.

63. *Id.* at 6.

64. *Id.* at 8.

65. *Id.* at 10.

66. Health care authorities agree that mandatory testing is infeasible, too costly, and counter-productive to preventive strategies. Joseph, *supra* note 55; Centers for Disease Control, *Additional Recommendations to Reduce Sexual and Drug-Related Transmission of Human T-lymphotropic Virus Type III/Lymphadenopathy-Associated Virus*, 35 MORBIDITY AND MORTALITY WEEKLY REP. 152 (March 14, 1986); QUESTIONS AND ANSWERS, *supra* note 53, Q. 83, at 14.

In addition to considerations of civil liberties, management of a national program of mandatory testing, and costs for extensive testing all of which militate against large-scale, mandatory testing, there are also problems with the reliability and usefulness of the test itself.

The test now being used to detect the presence of anti-bodies elicited by HIV viral antigens is an enzyme-linked immunosorbent assay—the ELISA (or EIA) test. Because the ELISA test was developed to protect the blood supply, the cutoff between reactive and non-reactive values was set very low to capture all true-positives. The price of such sensitivity is a loss of specificity. In high-risk populations there will be comparatively few false-positives. In low-risk populations, however, as many as 90% of the small number of initially reactive results will be false-positives. To distinguish true-positives, it is necessary to repeat the ELISA and to use an independent, supplemental test such as the Western blot.

education, and counseling as the most effective strategies for controlling the spread of the HIV virus.⁶⁷ Confidentiality is critical in encouraging voluntary cooperation with testing procedures, promoting early detection and treatment, and maintaining trust in our medical and public health care providers. Any successful effort aimed at controlling the virus and preventing its spread depends upon confidentiality of medical information.

Preventive measures also require that "those individuals who are not infected with the AIDS virus must have every opportunity to avoid transmission of the disease to them."⁶⁸ Aside from education and counseling, this includes warnings about possible exposure. "Given the life-or-death consequences, the unsuspecting third party should, as a general matter, be warned because there is no cure and because it may not be responsible to rely solely on the infected person to provide a suitable warning."⁶⁹

Currently, the Centers for Disease Control and all states require physicians to report any diagnosed case of AIDS to public health officials.⁷⁰ These reports, for epidemiologic and research purposes are protected from other uses by strict rules of confidentiality.⁷¹ And because of the serious social and economic repercussions which persons known or suspected of having AIDS face, reporting statutes do not authorize disclosure for warning third parties.⁷² Nevertheless, the common law duty of physicians to warn third parties about exposure to communicable disease supersedes their duty of confidentiality.⁷³ It is clear that foreseeable exposure to the HIV virus is exactly the sort of danger intended by the common law to initiate a duty to warn.⁷⁴

Bayer, Levine & Wolf, *HIV Antibody Screening*, 256 J. A.M.A. 1768, 1769 (1986) (footnotes omitted). Recently developed antigen tests remain experimental, "but their routine use is neither cost-effective nor practical. Further, antigen testing is subject to the same flaws and limitations as antibody testing." Closen, Connor, Kaufman & Wojcik, *AIDS: Testing Democracy—Irrational Responses to the Public Health Crisis and the Need for Privacy in Serologic Testing*, 19 J. MARSHALL L. REV. 835, 875 (1986).

67. Interim Report, *supra* note 5, at 6-10.

68. *Id.* at 4.

69. *Id.* at 16.

70. *Id.* at 11.

71. See generally The Protection of Human Subjects Regulations, 45 C.F.R. § 46 (1985) (requiring confidentiality of research by federal agencies and contractors).

For state confidentiality provisions for AIDS reports, e.g., CAL HEALTH & SAFETY CODE § 199.30 (West 1985); N.Y. COMP. CODES R. & REGS. tit. 10(A), § 24-1.2 (1985).

72. See, e.g., N.Y. COMP. CODES R. & REGS. tit. 10(A), § 24-1.2 (1985).

73. See *supra* notes 41-44 and accompanying text.

74. HIV-infection is a dangerous, communicable disease. As such, a case diagnosed by a physician gives rise to a duty to warn those persons foreseeably known to be in danger of

The social context of AIDS exacerbates the traditional tension between the duties of confidentiality and warning into a conflict. Warning third parties can result in severe emotional, medical, and economic repercussions for the patient already infected, leaving the physician open to a large damage suit for breach of confidentiality. Failing to warn can result in death for the third party and open the physician to an equally costly wrongful death suit. The conflict leaves physicians open to potentially inescapable liability. These conflicting duties present serious issues for medical practice as well as for the prevention and control of AIDS and cannot be left for the courts to resolve. Only legislation can offer clear guidelines which protect the confidentiality of patients, the health of third parties and society's interest in preventing the spread of the virus, while at the same time eliminating the conflict between physicians' duties.

II. AIDS LEGISLATION

The conflict between physicians' duties of confidentiality and warning as well as the problem of informing endangered third parties have generally been ignored by state legislation on AIDS.⁷⁵ New York, for example, has large numbers of people infected with the HIV virus and needs legislation to help control the spread of the virus. With only minimal legislation already enacted, it has the opportunity to address the issues of physician liability and conflict of duties in a way which promotes the interests of all concerned. Thus, New York offers a clear case to use for analyzing the shortcomings of current AIDS law, for examining alternatives, and for suggesting the most fruitful approach for enacting effective legislation.

New York law requires every physician to report cases of AIDS in accordance with communicable disease reporting statutes.⁷⁶ Even so, persons testing positive to the antibody for the HIV virus as well as those with AIDS-Related Complex (ARC) can infect others with the virus, a predicament not covered by the AIDS statute. These cases

75. While all states require reporting the AIDS cases for research and epidemiologic studies, this information is kept confidential, see *supra* notes 54 & 71. However, only two states have warning or contact tracing statutes: COLO. REV. STAT. § 25-4-401 (1987); Illinois Sexually Transmissible Disease Control Act, 1987 Ill. Legis. Serv. 85-681 (West).

76. N.Y. PUB. HEALTH LAW § 2101 (McKinney 1985). The regulation on AIDS states: "All cases or suspected cases of Acquired Immune Deficiency Syndrome (AIDS) shall be reported to the Commissioner of Health" and "shall be kept confidential." N.Y. COMP. CODES R. & REGS. tit. 10(A), § 24-1.1 (1985). Such reports "shall be used solely for the purposes of medical or scientific research or the improvement of the quality of medical care," which provides for confidentiality of AIDS case reports, and relieves physicians from liability for breaking confidentiality in making such reports. N.Y. PUB. HEALTH LAW § 206(1)(j) (McKinney 1971).

of potential transmission are protected as confidential medical records. Physicians are liable for breach of this confidentiality. Yet, because of the nature of the infection, physicians are also under the common law duty to warn endangered third parties of possible exposure to a communicable disease.⁷⁷ This is exactly the physician's dilemma and present legislation offers no guidelines for resolving it.

Adding cases of ARC and seropositivity to the reporting statute is not an alternative. The reports themselves are confidential and physicians are not liable for those reports.⁷⁸ However, reporting statutes are intended to collect data for epidemiologic studies and research.⁷⁹ They are not intended to create, nor do they create, a duty on public officials to warn endangered third parties.⁸⁰ In this case, physicians are relieved from liability in making a report, but are still under a statutory duty to keep the records confidential and a common law duty to warn third parties.⁸¹ Simple reporting statutes do not resolve the conflict of physicians' duties of confidentiality and warning. Instead they heighten it.⁸²

77. *See supra* note 74.

78. *See, e.g.*, N.Y. PUB. HEALTH LAW §§ 206(1)(j), 2101 (McKinney 1971 and Supp. 1985).

79. N.Y. PUB. HEALTH LAW § 206(1)(j) (McKinney 1971) (empowers the commissioner of health to conduct "scientific studies and research which have for their purpose the reduction of morbidity and mortality and improvement of the quality of medical care" and any information collected by the required reports to the commissioner "shall be used solely for the purposes of medical or scientific research or the improvement of medical care").

80. *Id.*

81. Statutes mandating reports of communicable diseases to public health authorities do not supersede the duty to warn. *See, e.g.*, COLO. REV. STAT. § 25-4-402 (1982); N.Y. PUB. HEALTH LAW § 2101 (McKinney 1985). Even under the unclear *Wojcik* ruling, compliance with a reporting statute which does not charge public officials with a duty to warn is not sufficient to discharge a physician's duty to warn endangered third parties. *Wojcik v. Aluminum Co. of Am.*, 18 Misc. 2d 740, 183 N.Y.S.2d 351 (Sup. Ct. Erie County 1959).

82. *Compare Tarasoff v. Regents of Univ. of Cal.*, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976) (physician has a duty to exercise reasonable care to protect others against dangers emanating from the patient's disease) with CAL. HEALTH & SAFETY CODE § 199.30 (West 1985) (research records of AIDS shall not be disclosed nor are they discoverable without written consent of the subject), CAL. HEALTH & SAFETY CODE § 199.37 (West 1985) (providing for fines (\$1,000-\$10,000) and up to 1 year in prison for willful or malicious disclosure) and CAL. HEALTH & SAFETY CODE § 199.45 (West 1985) (all public health records are confidential and shall not be disclosed without written authorization by the subject with fines of \$1,000-\$5,000 for willful or malicious disclosure). A similar conflict exists under New York law. *Compare MacDonald v. Clinger*, 84 A.D.2d 482, 487, 446 N.Y.S.2d 801, 805 (4th Dep't 1982) (even in psychiatric contexts requiring strict confidentiality, a duty to warn exists when "there is danger to the patient, the spouse, or another person") with N.Y. PUB. HEALTH LAW § 206(1)(j) (McKinney 1986) (any reports of AIDS made to authorities must be used "solely for the purpose of medical or scientific research").

Another alternative is to require reporting of all cases of AIDS, ARC, and seropositivity for the purpose of contact tracing by public officials.⁸³ This is the traditional procedure established by statute for warning third parties about exposure to contagious disease.⁸⁴ However, under traditional reporting statutes which include notification by public officials, physicians' duty to warn third parties is not relieved.⁸⁵ Generally, then, such statutes relieve physicians' liability for making reports, create a duty on public officials to trace contacts, but do not relieve physicians' duty to warn.

There are at least three other problems with this approach, however. First, commentators have suggested that contact tracing for HIV virus infection wrongly invades the privacy of persons infected with the HIV virus⁸⁶ and denies them equal protection under the law⁸⁷ because, without a cure or effective treatment, there is no significant public benefit which justifies such extreme violations. Second, while it may be feasible to contact trace in some areas with small numbers of HIV-infected persons, it is infeasible in areas like New York.⁸⁸ Above all, contact tracing by public officials may be counter-productive to efforts in controlling the spread of the HIV virus.⁸⁹ In particular, contact tracing depends on the willingness of infected persons to disclose intimate details to public officials whom they do not know and may not trust. People would be asked "to implicate themselves . . . friends and loved ones, in forms of behavior . . . that are illegal as well as stigmatizing" such as homosexuality,

83. Contact tracing is a "form of medical surveillance in which public health officials seek to discover the sexual partners of an index case (a known infected person) and then seek to prevent further spread of the disease, if possible, by treating those contacts." Gostin & Curran, *The Limits of Compulsion in Controlling AIDS*, 16 HASTINGS CENTER REP. No. 6, at 24-25 (Dec. 1986). For statutes mandating reports of AIDS cases for purposes of contact tracing see COLO. REV. STAT. § 25-21-1401-10 (Supp. 1987); Illinois Sexually Transmissible Disease Control Act, 1987 Ill. Legis. Serv. 85-681 (West).

84. See, e.g., N.Y. COMP. CODES R. & REGS. tit. 10(A), § 2.6 (1988) (health commissioner should investigate cases of communicable disease to locate sources and contacts of infections).

85. See *supra* note 81.

86. Gostin & Curran, *supra* note 83, at 26; Gray, *The Parameters of Mandatory Public Health Measures and the AIDS Epidemic*, 20 SUFFOLK U.L. REV. 505, 522 (1986).

87. Costa, *Reportability of Exposure to the AIDS Virus: An Equal Protection Analysis*, 7 CARDOZO L. REV. 1103, 1115-36 (1986); Note, *The Constitutional Rights of AIDS Carriers*, 99 HARV. L. REV. 1274 (1986).

88. In New York, contact tracing would be cost-prohibitive and the time involved in identifying, locating, and notifying contacts by the public health authorities would be so extensive as to be useless for preventing the spread of the disease. Joseph, *supra* note 55.

89. Bayer, Levine & Wolf, *supra* note 66, at 1773; see Centers for Disease Control, *supra* note 66; Gostin & Curran, *supra* note 83, at 29.

prostitution, and/or intravenous drug use.⁹⁰ People concerned with implicating themselves or others could be driven to give false information, leaving investigators no way to sort through the information.⁹¹ Most importantly, “[c]ontact tracing would drive high-risk groups and infected individuals away from, not toward, counseling and testing.”⁹² It threatens confidentiality, a critical part of prevention strategy.⁹³ This approach appeals to fears of the general public, not to rational legal concerns about civil liberties, reasonableness, and effective public policy.⁹⁴

There is another alternative for legislation. The American Medical Association, building on traditional communicable disease statutes, recommends five criteria for appropriate and effective legislation: 1) protection of confidentiality of patient information to the greatest extent possible; 2) protection of physicians from liability for breach of confidentiality or failure to warn under certain circumstances; 3) a method for warning unsuspecting third parties; 4) clear standards for physicians reporting to public health authorities; and 5) clear guidelines for public health authorities in contact tracing.⁹⁵ These criteria are necessary for protection of the interests of patients, third parties, and physicians. They conform to public policy interests in health and safety by affirming the need for both confidentiality and warning. Within the context of the need for cost-effective measures and cooperation rather than coercion as basic requirements for efforts in controlling the spread of AIDS, these criteria can be used to construct appropriate legislation.

90. Joseph, *supra* note 55.

91. *Id.*

92. *Id.*

93. *Id.*

94. Interim Report, *supra* note 5, at 17. Interestingly, the American Medical Association favors this type of statutory reform. However, it does so irresponsibly, for self-interest and protection. The American Medical Association proposes contact tracing should “reside in the public health authorities as well as in the infected person not in the physician.” *Id.* Further, statutes providing for contact tracing should also “protect physicians from liability for failure to warn the unsuspecting third party.” *Id.* This self-serving approach would certainly relieve physicians’ duty to warn and resolve their conflict. However, it would not serve patient interests in confidentiality and compassionate care which are preconditions to voluntary testing, early detection and treatment, and trust—the critical components of the American Medical Association’s own recommendation for effective preventive measures in controlling the spread of AIDS. *Id.* at 6-8. This view serves political needs for relieving the unfounded fear of contagion in the general public. It may even serve political interests in courting the powerful American Medical Association lobby, but it does not serve patient interests or the interests of public policy in controlling the spread of AIDS.

First, confidentiality must be maintained to the greatest extent possible given the need for research data and warning of exposed third parties. Reporting statutes must be separate from warning statutes. Reporting statutes should be expanded to include reports of ARC and seropositive cases. Because they are intended for collection of data for epidemiologic and research purposes, all such reports can be made completely confidentially, without patient identification.⁹⁶ Reporting statutes can then be used to obtain more extensive data while guaranteeing anonymity to patients.

Warning third parties requires some breaking of confidence. Any statute authorizing warnings must limit the amount and type of information to be divulged. Since the purpose of such a statute is to warn third parties about exposure, there is no *a priori* reason to inform either third parties or public officials of the identity of the patient. Also, the fewer people and computers which have information as to the identity and medical status of the patient, the less likely breaches are to occur, and the more complete confidentiality is. Finally, preserving the confidentiality of patient identity and medical status encourages both consent and cooperation by the patient and preserves the relationship of trust between patient and physician.

To maintain the maximum confidentiality, a warning statute must limit the information reported, encourage patient consent to disclosure, and provide clear guidelines for unauthorized disclosure of information by physicians. In protecting confidentiality, patient consent to disclosure is a valuable component in preserving the physician-patient relationship, in treatment considerations, and in obtaining reliable information from the patient for warning third parties. Patient consent to disclosure should be actively encouraged by the conditions for warning under warning statutes. This can be accomplished by a three-tiered procedure for providing information to public health authorities according to the degree of patient consent.

The first level preserves confidentiality completely with full consent of the patient to warning endangered third parties. At this level, the infected patient agrees to inform the physician of all third parties who might have been exposed to the HIV virus and gives consent

96. Numbers can be assigned to each case by the public health official receiving the report. Physicians and laboratories can use these numbers in any further reports. Currently, N.Y. PUB. HEALTH LAW § 2101(4) (McKinney 1985) authorizes reports of communicable disease by physicians which include: name, age, address, and disease as mandated by N.Y. COMP. CODES R. & REGS. tit. 10(A), § 2.10 (1988).

for the physician to inform and counsel them.⁹⁷ Full confidentiality can be guaranteed to the patient. The physician need only report that third party warnings have been completed.

The second level provides for the situations in which it is impossible or difficult for the patient to contact third parties but the patient consents to disclosure of the names of contacts and seeks to protect his own confidentiality or anonymity. This procedure is most likely to be used by those patients infected with HIV virus who are involved in high-risk behaviors which are also illicit or illegal. It protects the patients and their contacts from implication in such activities. Here, the patient informs the physician of the names and addresses of all third parties likely to be at risk from contact with the patient. The patient consents to the physician's disclosure of information to health officials for notification. However, the physician is not required to disclose the identity of the patient. This approach preserves confidentiality of patient information while encouraging patient cooperation and consent. In addition, it provides for obtaining more reliable information from the patient thus minimizing time and cost in tracing and informing third parties, effectively accomplishing the purpose of the warning statute.

The third level applies to situations in which the patient has refused consent and cooperation. Such individuals are likely to be intractable since they do not appreciate the significance or severity of their infection. At this level, the physician cannot expect to receive reliable information from the patient. There is, then, no point in the physician attempting to elicit such information about endangered third parties. In this case, the physician provides the name and address of the patient to public health officials. They can then contact the patient and use the state's resources and power in identifying and locating endangered third parties.⁹⁸

This three-tier approach maximizes confidentiality while accomplishing warning of third parties with a minimum of cost and time investment. In addition, it encourages cooperation, compassionate treatment, and trust because it allows the patient to control the disclosure of information and keep the information of his or her identity and status within the primary context of the physician-patient rela-

97. The patient could be required to bring the parties in to see the physician or to have them contact the physician independently. This process must be completed within a short period of time (e.g. 24-48 hours) to prevent increased exposure of third parties.

98. This procedure would also apply to those instances in which a patient has consented to contact third parties under the first tier, but those persons have not contacted the physician and the patient has not returned.

tionship. Clearly, it satisfies the first criterion of maximizing the confidentiality of patient information while recognizing the need to warn unsuspecting third parties of possible exposure.

Second, physicians must be protected from liability for both breach of confidentiality and failure to warn under notification statutes regarding AIDS. This three-tiered approach uses the well-established protection of informed patient consent in combination with a new suggestion for bifurcating physicians' duty to warn in the case of HIV-infected patients and exposed third parties. A physician is protected from liability for breach of confidentiality whenever a patient consents to the disclosure.⁹⁹ Where there is patient consent to the disclosure, there is no breach. Under the first and second tiers of this proposal, a physician is required to disclose information. Under the first level, a physician must inform third parties about possible exposure to the HIV virus, information known to the physician because of his or her knowledge about a patient within a confidential relationship. The second tier requires the physician to report to public health officials the names of all endangered third parties known to the physician. Both of these disclosures have patient consent as a prerequisite.¹⁰⁰ The simple, standard procedure of having the patient sign informed consent disclosure forms relieves the physician of liability for the disclosures. On the third level, the physician is required to disclose only the name of the patient. This is a disclosure not authorized by the patient. The notification statute must expressly relieve liability for this disclosure by the physician.¹⁰¹

Protection from liability for failure to warn is more problematic. At common law, a physician has a duty to warn known or reasonably knowable third parties who are foreseeably endangered through exposure to a contagious disease by a patient.¹⁰² Under the suggested approach, a physician has a duty to warn only those third parties he has reason to know are endangered by the patient and whom he has

99. Weldon-Linne, Weldon-Linne, & Murphy, *AIDS-Virus Antibody Testing: Issues of Informed Consent and Patient Confidentiality*, 75 ILL. B.J. 206, 208 (Dec. 1986). This is a longstanding protection of physicians under traditional communicable disease reporting statutes. See, e.g., ILL. ANN. STAT. ch. 126, para. 21(1) (Smith-Hurd Supp. 1987) (a medical practitioner making reports under communicable disease reporting statute is immune from suit for good faith reports).

100. In regard to the disclosure of third party names to health authorities, the physician has no duty of confidentiality to those third parties, as there is no physician-patient relationship creating such a duty. RESTATEMENT (SECOND) OF TORTS §§ 314(A), 315 (1965).

101. See, e.g., ILL. ANN. STAT. ch. 126, para. 21(1) (Smith-Hurd Supp. 1987).

102. See Note, *supra* note 4.

consent to inform.¹⁰³ While this approach does not abrogate the common law duty to warn per se, it does expressly limit the application of the duty to only those third parties known to the physician, able to be informed by the physician, and authorized by the patient to be informed.

The difficult case is one in which the physician should reasonably know about an endangered third party but the patient refuses to consent to informing that person (e.g., a patient's spouse). Under common law, the physician still had the duty to inform the person at risk.¹⁰⁴ This is the source of the conflict of physicians' duties of confidentiality and protection. In the case of HIV-infection, prevention of its spread depends on cooperation by the public and by patients; cooperation depends in large part on the guarantee of confidentiality; therefore, confidentiality must be protected when there is no significant corresponding interest. Since there are other effective measures for warning third parties and since maximization of confidentiality is important, the conflict between physicians' duties of confidentiality and warning should be resolved in favor of confidentiality rather than warning.

This bifurcated system, delineating a restricted duty to warn and a duty to report, relieves the conflict between the duties of confidentiality and warning by placing clear limits on the duty to warn which confine the duty to conditions of authorized disclosure of confidential information. The duty to report breaches confidentiality only in the case of an uncooperative patient. The proposed statute expressly relieves physicians from liability for this breach on the justification of the compelling state interest in the need to warn endangered (unknown) third parties. The duty to identify and warn these persons is charged to public officials, not physicians.

Some might object that, on its surface, such a system imposes an undue burden on physicians. On close inspection, this is not the case. Under the common law duty to warn, a physician may be obliged to take whatever steps are necessary to warn the party or prevent the harm.¹⁰⁵ Under this bifurcated approach, physicians need only in-

103. Beyond that group, a physician would have only a duty to report information. For third parties known but unable to be informed by the physician, the physician would have the duty to report their identities to public health authorities. When a patient refuses disclosure or information, a physician has a duty to report the patient's identity to officials for investigation.

104. See, e.g., *Simonsen v. Swenson*, 104 Neb. 224, 177 N.W. 831 (1920); see also *Gammill v. United States*, 727 F.2d 950 (10th Cir. 1984).

105. See, e.g., *McIntosh v. Milano*, 168 N.J. Super. 466, 489, 403 A.2d 500, 511-12 (1979) (duty to take whatever steps are reasonably necessary); *Wojcik v. Aluminum Co. of Am.*, 18

form persons who have contacted them. They are not obliged to take "whatever steps are necessary," nor are they required to contact anyone themselves. Complaints of onerous duty are empty in comparison to the benefits to those warned and the release from liability for physicians. This proposal resolves the unnecessary and unhelpful legally created conflict between the duties. By resolving the conflict, it relieves physicians from inescapable liability due to the impossibility of satisfying contradictory duties. But it does not protect physicians from liability due to their own willful or negligent breach or failure to warn.

Finally, general outlines for methods of warning, standards of disclosure, and guidelines for notification by public health authorities may be suggested. However, the details must be left to the needs and resources of the local jurisdiction.

The *purpose* of a warning statute is to inform and advise third parties about the danger they have been or are likely to be exposed to, not to force testing, treatment, or terror upon third parties. The *goal* of warning third parties is to provide them with every opportunity to avoid transmission of the disease.¹⁰⁶ "Warning" in the case of exposure to the HIV virus actually means notification of exposure to allow the person to be tested, receive counseling, and change his or her behavior.

Warning statutes are, in actuality, statutes providing notification of possible or likely exposure to the HIV virus to persons who may not otherwise realize their risk. The ideal context for notification is in the privacy of a trusted physician's office, with their intimate accompanying them. The suggested approach encourages this form of notification, followed immediately with expert advice and counsel from the physician. However, for those third parties for whom this context is impossible, public health authorities should provide effective notice in the least intrusive manner possible.¹⁰⁷ The particular method will depend on the numbers of notifications to be made, the area in which such third parties are located, the distance over which the notification must be made, and the resources of the public health department in the applicable jurisdiction. But in no event can the

Misc. 2d 740, 746-47, 183 N.Y.S.2d 351, 358 (Sup. Ct. Erie County 1959) (duty to take "all necessary precautionary measures") (quoting 70 C.J.S. *Physicians & Surgeons* § 48 (1958)).

106. Interim Report, *supra* note 5, at 4.

107. A letter or phone call may be insufficient for true notice. A personal visit to the third party by the public official may be necessary to guarantee notification and to offer the counseling and testing resources available in the area.

method of notification carry coercive requirements, sanctions, or penalties prescribing or proscribing behavior after notification.

This suggestion for notification of third parties attempts to provide a general outline whose specifics can be determined according to the needs of public health resources. It prefers private notice and counseling over public notification and stipulates a standard of "least intrusive measures" for notification while allowing public resources to set the particulars of public notification. This approach continues to encourage cooperation and trust between patients and physicians, discourages methods of notice which are intrusive or which increase fear, and permits public health authorities to consider issues of utilization of resources.

The standards for disclosures to public health authorities are determined by the purpose of the disclosure. Here, the purpose of a report is to enable public health officials to identify and warn endangered third parties. Any information known to the physician which assists officials in identifying and locating the persons in question must be reported. In this scheme, all relevant information must be reported either about third parties, when they cannot be informed by physicians, or about the patient, when he or she is uncooperative with the physician.¹⁰⁸ In the case of a cooperative patient when all third parties can be warned, no report is necessary. This approach balances patient confidentiality against the interests of endangered third parties.

Guidelines for public health authorities can only be roughly sketched. Notification is for the purpose of informing the person of possible exposure, providing basic information about the nature of the HIV virus and its transmission, and offering resources for testing, counseling, and further information. Procedures for notification should not be frightening or coercive. Methods of notification must be as unintrusive as possible. And the notification should not divulge any confidential information, including the name of the infected patient. These same guidelines must apply to the uncooperative patients questioned by public health officials in attempting to identify endangered third parties. Such questioning is invasive of privacy. It

108. These reports must be made as quickly as possible (e.g., within 24 hours of confirming the diagnosis). There is no reason they cannot be made by phone. However, in the interests of certainty and protection against liability, written reports should be made as well. As under other communicable disease notification reports, public health authorities may establish forms or criteria for reports. *See, e.g.,* N.Y. COMP. CODES R. & REGS. tit. 10(A), § 2.6 (1973). But, regardless of these criteria, physicians can only be required to report the information they have available.

can be justified only on the grounds of protecting unsuspecting persons endangered by the patient's behavior. The method and procedure for fulfilling this duty must be the least intrusive means necessary. However, since these persons are most likely to be recalcitrant and resistant, it must be left to public health officials to develop detailed procedures. These guidelines are very broad and must be filled in according to the needs and resources of local public health departments.

This three-tiered approach is the best alternative for protecting patient interests in confidentiality, third party interests in notification, physician interests in relief from inescapable liability, and public interest in controlling the spread of HIV-infection. It supports confidentiality, voluntary testing and behavior change, and trust in medical and health authorities, all of which are crucial to preventing the spread of the HIV virus.¹⁰⁹ These guidelines which provide for identifying, locating, and warning third parties, are both effective and sensitive to the need for equal protection and the "least intrusive means" standard. They also provide for differences in resources, location, and local needs to be considered in tailoring specific criteria or guidelines by local public health departments. This approach limits physicians' liability by charging them with a duty to warn only in conjunction with release from confidentiality, which avoids inescapable liability of traditional schemes and reduces concerns about medical care and costs.¹¹⁰

There are two outstanding advantages to this approach over others. First, it is compatible for use in areas which provide anonymous testing for HIV antibodies.¹¹¹ Anonymity can be maintained for those testing seropositive even though information about endangered third parties is taken. Second, and perhaps more important, this approach is flexible enough to be used without change in the event of medical development of effective treatment. It encourages and rewards voluntary testing and cooperation, thus providing for early intervention and treatment, just as it now provides for early

109. See *supra* notes 65-68 and accompanying text.

110. Such avoidance of inescapable liability relieves the very situation which the *Purdy* court sought to avoid by limiting psychiatrist's duty to warn: driving up costs of already expensive medical care; making adequate care even less available; pressuring physicians to become ultra-conservative in treatment, even though experimental techniques may be the best alternatives; and raising the possibility of physicians leaving medical practice. *Purdy v. Public Adm'r of Westchester*, 127 A.D.2d 285, 291-92, 514 N.Y.S.2d 407, 411 (2d Dep't), *appeal dismissed in part, granted in part*, 70 N.Y.2d 720, 513 N.E.2d 1301, 519 N.Y.S.2d 640 (1987).

notification to people at risk of infection. It represents the most hopeful approach to control the spread of the HIV virus.

CONCLUSION

The dual expectations on physicians to keep patient information confidential and to protect us from illness have always been in tension. That tension has been codified by law. Laws regarding contagious disease and common law obligations to warn third parties against dangerous or dangerously infected patients created a contradiction of duties for physicians, eventually leading to inescapable liability within the AIDS crisis. So long as litigation remained minimal, communicable diseases treatable, and legislation vague, the conflict was problematic only in rare or unusual cases. With the advent of AIDS, the conflict became a critical issue for patients, third parties, and physicians. Under the spectre of higher medical care costs, increased unavailability of care, and reduction in the adequacy of health care during a medical crisis, this contradictory liability has implications not just for those involved. The proposed notification program relieves the conflict of duties on physicians by providing for clear limits to the duties of confidentiality, warning, and reporting within a practice, and also helps to contain medical costs by removing at least one cause of medical malpractice litigation. Recognition of confidentiality and protection of others as co-requisite and interdependent duties of physicians acknowledges our own expectations and physicians' expectations. It supports a long tradition of medical ethics. Perhaps most significantly, legislation which removes this knot of conflict created and sustained by law is crucial to developing conditions for effective and compassionate medical care in the age of AIDS.

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ADDENDUM

In late August, 1988, while this comment was in publication, the New York State Legislature passed what is purported to be a comprehensive AIDS bill. Sponsored by Assemblyman Gottfried and Senator Dunne, the bill was signed into law on Sept. 1, 1988 by Governor Cuomo. (1988 N.Y. Laws 584.)

Among other provisions, the new law requires general confidentiality of HIV test results and patient information. However, it permits disclosure to specific groups, including: health care personnel for ad-

ministrative purposes as well as treatment needs; foster care and adoption agencies; correction, parole, and probation agencies; and insurers for purposes of third party payments. Of course, disclosure is permitted to public health officials under anonymous reporting laws, and to anyone else by court order or consent of the patient.

The law also provides for disclosure by physicians of possible exposure (or danger of infection) to third parties. In this respect, it appears to address third parties' rights to warnings about exposure as well as the conflict between physicians' duties of confidentiality and warning, the subject of this comment. However, closer inspection shows that this legislation merely relieves physicians of the duty to warn in favor of protecting the confidentiality of patient records at the expense of endangered third parties.

The law provides that a physician *may* disclose (§ 2784.4(a)), but is not *required* to disclose, information about possible exposure to HIV infection to "contacts" (spouse, sex partners, needlesharers) of the patient. The provision effectively abrogates the common law duty to warn owed by physicians to third parties. In fact, the legislation explicitly removes liability from physicians for failure to warn (§ 2783.3(a)). Rather than codifying the duty, as this comment urges, the law simply eliminates it in the context of HIV infection. The rights of third parties to be warned of exposure from patients known to be infected are virtually unprotected.

On the other hand, physicians are also relieved of liability for breach of confidentiality when warning contacts, under specific conditions. The law permits physicians to warn third parties, or to notify public health officials who warn third parties, when the physician reasonably believes: it is medically appropriate; the third party is at significant risk; and the patient will not notify the third party, after counseling by the physician on the need to do so (§ 2782.4(c)). Relieving physicians from liability for breach may seem to encourage third party warning, however, absent a *duty* to warn, such optimism is unwarranted.

First, the law's conditions provide ambiguous and inconvenient guidelines to a physician in deciding whether to exercise discretion to warn a third party. Before a physician may warn a third party, the physician must counsel the patient, in an attempt to get the patient to notify the contact personally. In some cases, this amounts to requiring a physician to argue with or persuade a patient about the importance of notification as opposed to confidentiality. Moreover, the guidelines require some basis for the physician to believe that a patient will not notify a third party. Therefore, the physician must

make a judgment regarding the reliability or veracity of a patient, even one whom the physician may never have seen before. Thus, because these criteria require informed judgments about patients and some investment of time with each patient, physicians are unlikely to exercise their discretion in warning third parties, except in the easiest cases, where a patient has a long-term relationship with the third party as well as a history of trust with the physician. As this comment points out, this is already common practice and, since the issue of liability rarely arises in these cases, the legislation will not have any significant impact on them.

Second, the issue of liability for breach of confidentiality usually arises in the more difficult cases, where the patient is intractable and/or engages in illicit or illegal behavior and where the third party is less likely to be aware of possible exposure. The criteria offered for disclosure in this bill do not address the harder cases. There is no duty created, on physicians or public health officials, to seek information about endangered third parties from patients (§ 2784.4(c)). And, in difficult cases, the patient has no reason to offer that information. Instead, as this comment argues, the patient often has significant reasons to refuse cooperation with contact notification programs. As a result, any meaningful contact notification program must encourage or require cooperation from the patient in identifying and locating endangered third parties. This law's provisions for physician disclosure or contact notification merely presuppose patient cooperation as a prerequisite to warning. Information about third parties must be either independently known to the physician or voluntarily disclosed by the patient. Thus, if the physician has no information or the patient declines to provide information, any inquiry for purposes of warning ends. Furthermore, there are no provisions for the physician to disclose patient information to public health officials for the purpose of interviewing a patient to ascertain whether any third parties are at risk. The law neither encourages nor requires patients or physicians to act affirmatively to notify endangered third parties. The law, therefore, fails to establish any sincere notification program because it has no significant impact on the easy cases and because it fails to address the more difficult ones.

Certain provisions of the legislation are welcome and overdue, particularly those respecting informed consent, anonymity, confidentiality, and mandatory counseling. Nevertheless, the law is not comprehensive because it fails to provide any meaningful program for warning third parties at risk of exposure. Rather, it is a boon to physicians and to uncooperative patients. Physicians are protected from

liability whether or not they notify third parties. Patients, even those most likely to spread infection because of personal attitudes or behavior, are protected by the shroud of confidentiality. And, like AIDS, the law provides no protection for those at risk of exposure who have been left uninformed by patients, physicians, and public health officials.

I had hoped that the passage of this legislation would have made this comment moot. Unfortunately, that is not the case. In fact, the legislation may have made the need to implement the suggestions offered in this comment even more pressing.