Privacy, Privilege and the Right to Know: Disclosure of AIDS/HIV Status in the Physician-Patient Relationship

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PRIVACY, PRIVILEGE AND THE RIGHT TO KNOW: DISCLOSURE OF AIDS/HIV STATUS IN THE PHYSICIAN-PATIENT RELATIONSHIP

“I like my privacy as well as the next one, but I am nevertheless compelled to admit that government has a right to invade it unless prohibited by some specific constitutional provision.”1

The right of privacy,2 although not expressly mentioned in the United States Constitution, has been recognized as a fundamental right3 by the United States Supreme Court.4 The scope of this right has been shaped by the Court’s evaluation of governmental

1 Griswold v. Connecticut, 381 U.S. 479, 510 (1965) (Black, J., dissenting). Justice Black disagreed with the judgment and rationale offered by the Court in holding unconstitutional a Connecticut law prohibiting the use of birth control. Id.

2 See Black’s Law Dictionary 1195 (6th ed. 1990). Right of Privacy is defined as:
The right to be let alone; the right of a person to be free from unwarranted publicity; and right to live without unwarranted interference by the public in matters with which the public is not necessarily concerned . . . and such right prevents governmental interference in intimate personal relationships or activities, freedoms of individual to make fundamental choices involving himself, his family, and his relationship with others. Id; see also Ronald D. Rotunda et al., Treatise on Constitutional Law: Substance and Procedure § 18.26-18.30 (1986) (describing evolution of privacy right in Supreme Court decisions).

3 See Black’s Law Dictionary, supra note 2, at 674. Fundamental rights are:
[t]hose rights which have their source, and are explicitly or implicitly guaranteed, in the federal Constitution . . . Challenged legislation that significantly burdens a “fundamental right” . . . will be reviewed under a stricter standard of review. A law will be held violative of the due process clause if it is not closely tailored to promote a compelling or overriding interest of government. Id; see also Price v. Cohen, 715 F.2d 87, 93 (3d Cir. 1983) (defining fundamental rights).

4 See Griswold, 381 U.S. at 482 (declaring “penumbra of privacy” exists for individuals); Roe v. Wade, 410 U.S. 113, 152 (1973) (stating that although Constitution does not explicitly mention it, right of personal privacy exists); Union Pac. Ry. Co. v. Botsford, 141 U.S. 250, 251 (1891) (stating right to possession and control over one’s own self is fundamental right). See generally Ronald D. Rotunda et al., Treatise on Constitutional Law: Substance and Procedure § 18.26-18.30 (1986) (discussing progression of “right to privacy” in Supreme Court); Samuel D. Warren & Louis D. Brandeis, The Right to Privacy, 4 Harv. L. Rev. 193, 193 (1890) (introducing concept, although in context of tort law, of “right to be let alone”).
interferences into personal matters. As the Court began to strike down substantive legislation, it carved out privacy protections.

A current issue in medical science raises once again the question of how far-reaching the veil of privacy will extend. The contemporary challenge confronting privacy rights is the confidentiality laws surrounding the plague of AIDS. Government must strike a balance between the infected individual's right to keep his illness confidential and the overriding public policy concern of stemming the spread of the virus.

5 See, e.g., Weeks v. United States, 232 U.S. 383, 393 (1914) (holding that victim of unlawful search and seizure under Fourth Amendment had right to recover property); Boyd v. United States, 116 U.S. 616, 622, 630 (1886) (interpreting Fourth and Fifth Amendments as protecting sanctity of home and privacies of life).

6 See, e.g., Skinner v. Oklahoma, 316 U.S. 535, 541 (1942) (establishing that family and procreation involve "basic civil rights of man"); Pierce v. Society of Sisters, 268 U.S. 510, 534-55 (1925) (holding that statute compelling parents to send children to public school was unreasonable interference with parents' liberty in raising children); Meyer v. Nebraska, 262 U.S. 390, 400 (1923) (finding statute prohibiting education in language other than English violated Fourteenth Amendment); see also Loving v. Virginia, 388 U.S. 1, 12 (1967) (holding that Fourteenth Amendment "requires that the freedom of choice to marry not be restricted by invidious racial discriminations"). But cf. Buck v. Bell, 274 U.S. 200, 208 (1927) (upholding sterilization statute).


8 See Gary H. Loeb, Protecting the Right to Informational Privacy for HIV-Positive Prisoners, 27 COLUM. J. L. & Soc. PROBS. 269, 317-18 (1994) (asserting HIV status of prisoners should be kept confidential and disclosure is unconstitutional); Rodger Doughty, Comment, The Confidentiality of HIV-Related Information: Responding to the Resurgence of Aggressive Public Health Interventions in the AIDS Epidemic, 82 CALIF. L. REV. 111, 123 (1994) (discussing AIDS as threat to right to privacy especially for homosexuals); Joseph S. Goode, Note, Perspectives on Patient Confidentiality in the Age of AIDS, 44 SYRACUSE L. REV. 967, 980 (1993) (claiming threat of AIDS hysteria emphasizes importance of maintaining patient's right to privacy). See generally The HIV/AIDS Epidemic: The First 10 Years, 40 MORTALITY & MORBIDITY Wkly. REP. 191 (1991) (noting World Health Organization has concluded that eight to ten million adults and one million children worldwide are HIV infected or have AIDS, and by year 2000, forty million people may be infected with HIV or have AIDS).


10 See Roe v. Wade, 410 U.S. 113, 155-56 (1973) (stating that privacy rights are not violated when medical records are not kept confidential if there is compelling state interest); United States v. Westinghouse Elec. Corp., 638 F.2d 570, 577-78 (3d Cir. 1980) (asserting that disclosure of medical records for reasons of public health does not automatically infringe on privacy rights); Doe v. Barrington, 729 F. Supp. 376, 385 (D.N.J. 1990) (declaring privacy of medical information is not absolute and disclosure of AIDS test results requires
This Note asserts that an individual's right to privacy must be considered in relation to the pressing societal demand for public health and safety. Part One examines the common law development of the right to privacy, with emphasis on the tension between individual rights and public welfare. Part Two focuses on the nature of privacy in the physician-patient relationship and, specifically, the rights of individuals with AIDS. Special attention is paid to situations where ethics might dictate that all HIV-infected persons, especially those engaged in a medical relationship, disclose their status before seeking or performing invasive medical procedures. Part Three examines New York's treatment of babies born with AIDS and the resulting invasion of the mother's right to privacy, by analyzing the "AIDS Baby" Bill and Public Health Law § 2500-f, passed into law in June, 1996, which attempted to address this growing problem. Finally, this Note concludes that legislative action is the sole means of achieving that which ethical considerations require: full disclosure by all infected individuals who may put another at risk.

I. THE CONSTITUTIONAL RIGHT TO PRIVACY

A. The Post-Civil War Era

The right to privacy, not expressly enumerated in the Constitution but fashioned by the Supreme Court, is somewhat tenuous. The right to privacy, however, has become a recognized compelling state interest; see also Colella, supra note 7, at 62-63 (discussing need to strike balance between individuals right to privacy and government's right to intrude for benefit of public good); Steven Eisenstat, An Analysis of the Rationality of Mandatory Testing for the HIV Antibody: Balancing the Governmental Public Health Interests With the Individual's Privacy Interest, 52 U. PriT. L. Rev. 327, 382 (1991) (suggesting mandatory AIDS testing implicates both public health and personal privacy issues); Jeff Glenney, Note, AIDS: A Crisis in Confidentiality, 62 S. Cal. L. Rev. 1701, 1703 (1989) (discussing pros and cons of limited disclosure of AIDS status allowed by legislation); Marjorie H. Lawyer, Note, HIV and Dentistry, Vol. U. L. Rev. 297, 319-36 (1994) (discussing balancing tests which determine whether patient's HIV status may be released without patient's consent).


12 See generally Richard A. Posner, The Uncertain Protection of Privacy by the Supreme Court, 1979 Sup. Ct. Rev. 173, 214 ("the objection [to the privacy cases] is . . . that they
right enjoyed by American citizens. In general, the Supreme Court did not even touch upon individual’s rights, much less an express right to privacy, until after the Civil War. After the ratification of the Civil War amendments, the Supreme Court became more concerned with individual rights that protected one’s privacy. The earliest cases that touched on privacy issues did so in terms of protection from illegal search and seizure. These have no basis in any meaningful conception of privacy in any provision of the constitution’); Robert C. Clothier III, Comment, Meeting the Challenge to Privacy Rights By Employees Drug Testing: The Right of Nondisclosure, 1988 U. CHI. LEGAL F. 213, 213 (describing definition of right to privacy as “uncertain” and “indefinite”); Mark A. Racanelli, Note, Reversals: Privacy and the Rehnquist Court, 81 GEO. L.J. 443, 444 (1992) (describing right to privacy as uncertain in nature).


See GERALD GUNTHER, CONSTITUTIONAL LAW 397 (12th ed. 1991). In the time between the ratification of the Constitution and the Civil War, the Supreme Court had primarily concerned itself with the structure of the United States government, along with a few other types of challenges, such as habeas corpus and ex post facto hearings. Id. See generally LEONARD W. LEV, LEGACY OF SUPPRESSION: FREEDOM OF SPEECH AND PRESS IN EARLY AMERICAN HISTORY 6 (1960) (stating that “[fireedom of speech could not become a civil liberty until . . . the people were considered the source of sovereignty, the masters rather than the servants of the government”). Note that the court never enunciated a specific “right to privacy” until Griswold. See Griswold, 381 U.S. at 482 (declaring right to privacy); Roe v. Wade, 410 U.S. 113, 152 (1973) (stating though no specific right to privacy in Constitution, Griswold specifically enumerated such right).

U.S. CONST. amend. XIII (abolishing slavery); U.S. CONST. amend. XIV (providing due process and equal protection); U.S. CONST. amend. XV (granting universal right to vote for all male citizens).


See, e.g., Boyd, 116 U.S. at 617-18 (finding plaintiff was victim of seizure and subsequent forfeiture of his property); see also Agnello v. United States, 289 U.S. 20, 33-34 (1925) (holding seizure of illegal narcotics without warrant in house several blocks from arrest was inadmissible as incidental to arrest and thus unconstitutional); Gouled v. United States, 255 U.S. 298, 311 (1921) (holding seizure of paper by person following directions of governmental agent to be unconstitutional); Silverthorne Lumber Co. v. United States, 251 U.S. 385, 392 (1920) (holding seizure of papers from corporation without warrant to be
cases held that although an overriding governmental interest may exist in support of searches and seizures without warrants, the Fourth and Fifth Amendments protected an individual from an "unreasonable search and seizure." Moreover, the Court noted that this protection extended to the "indefeasible right of personal security, personal liberty and private property." Almost half a century later, this fledgling personal right was confirmed in the landmark case of *Olmstead v. United States*. The Court found that a purpose behind the Fourth and Fifth Amendments was to

violation of constitutional rights); Weeks v. United States, 232 U.S. 383, 390 (1914) (holding seizure of papers from defendant's property without warrant to be violation of defendant's constitutional rights); *Ex parte Jackson*, 96 U.S. 727, 733 (1877) (holding same).

18 U.S. CONST. amend. IV. The Fourth Amendment states that:

The right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures, shall not be violated, and no Warrants shall issue, but upon probable cause, supported by Oath or affirmation, and particularly describing the place to be searched, and the persons or things to be seized.

Id.; U.S. CONST. amend. V. The Fifth Amendment states, in pertinent part, that "[n]o person . . . shall be compelled in any criminal case to be a witness against himself, nor be deprived of life, liberty, or property, without due process of law . . . ." *Id.*

19 *Boyd*, 116 U.S. at 624. The court held the statute was unconstitutional because it made the production of a person's private papers compulsory, as compared to other laws which require production of material evidence, like stolen or forfeited goods, which are not of a personal nature. *Id.* at 622-23. The search at issue was found unreasonable, based on the Court's balancing of the interests of the state against the rights of the individual. *Id.* at 627; *see also Agnello*, 269 U.S. at 32-33 (stating that searches of houses require warrants); *Gouled*, 255 U.S. at 308-11 (declaring warrants must be lawfully obtained to legally search houses); *Silverthorne Lumber*, 251 U.S. at 390-92 (holding that information retrieved in illegal searches cannot be used by searcher); *Ex Parte Jackson*, 96 U.S. at 733 (stating warrant must be issued to inspect another's mail).


21 277 U.S. 438 (1928), overruled by *Katz v. United States*, 389 U.S. 347 (1967). In *Olmstead*, the plaintiffs were found guilty of violating the National Prohibition Act, implicated mostly through recorded conversations the government had acquired by a possibly illegal wiretap. *Id.* at 455-56. The Court questioned whether this was actually an illegal search and seizure as defined by common law, and examined the cases discussed *supra* note 5, but nonetheless concluded that a balancing test should apply here. *Id.* at 458-65. *See generally William J. Stuntz, Privacy's Problem and the Law of Criminal Procedure*, 93 MICH. L. REV. 1016, 1030-36 (1995) (discussing role of Fourth and Fifth amendments in development of right to privacy); Daniel E. Will, Note, "Dear Diary - Can You Be Used Against Me?": *The Fifth Amendment and Diaries*, 35 B.C. L. REV. 965, 970 (1994) (discussing how protection of privacy springs from the Fourth and Fifth Amendments as described in *Boyd*).
preserve an individual's right "to be let alone" without jeopardizing a potentially superior state interest.²²

In addition to privacy protections found under the Fourth and Fifth Amendments, the Court has determined that the Fourteenth Amendment can also be interpreted to protect individual zones of privacy.²³ In a series of significant cases, the Court expanded the scope of the Fourteenth Amendment's liberty protection to the practice of one's profession,²⁴ the right to bear children,²⁵ the rear-

²² See Wheaton v. Peters, 33 U.S. 591, 634 (1834) (stating "the defendant asks nothing — wants nothing, but to be let alone until it can be shown that he has violated the rights of another").

²³ Olmstead, 277 U.S. at 468. The Court did not deem the interception of telephone calls in this manner a violation of the Fourth Amendment, but rather decided in favor of the governmental interest in furthering the purposes behind Prohibition. Id. But see Olmstead, 277 U.S. at 473 (Brandeis, J., dissenting). Justice Brandeis stated that "a principle to be vital must be capable of wider application than the mischief which gave it birth". Id. (quoting Weems v. United States, 217 U.S. 349, 373 (1910)). It is significant to note that three justices dissented in this case, claiming that the majority interpreted the Amendments too strictly, and that this was an example where the individual should be protected. Id. at 471, 485, 488.


²⁶ See Meyer, 262 U.S. at 399. The plaintiff, a German language professor, was arrested for violating a Nebraska statute which proscribed teaching any language other than English to any child who had not passed the eighth grade. Id. at 396-97. The Court recognized that there is a certain liberty of person created by the Fourteenth Amendment which overlaps with the state's police power to regulate for the public interest. Id. at 399-400.

²⁷ See Skinner, 316 U.S. at 536. The Court held that an Oklahoma statute requiring sterilization of only certain classes of repeatedly convicted felons was unconstitutional. Id. at 536-41. The Court decided the case on equal protection grounds under the Fourteenth Amendment because the statute did not apply to all felons. Id. at 541. The Court commented that procreation was a fundamental individual right with which the government should not tamper. Id. at 541. But see Buck v. Bell, 274 U.S. 200, 208 (1927) (permitting governmental interference in child-rearing by sterilization of mentally retarded women).
ing of children,28 and the right to freely associate.29 The most significant aspect of the Court’s rationale in each of these cases is its adherence to the balancing test developed in earlier cases.30 The balancing test requires the Court to weigh the state’s need to protect the general welfare through its police power against an individual’s right to prevent unnecessary governmental interference.31 The Court has recognized that an individual should be protected from the state’s use of “arbitrary, unreasonable and unlawful interference” in personal matters.32 Only

28 See Pierce, 268 U.S. at 534. The challenged Oregon statute penalized parents or guardians in the state who refused to send their children to public school. Id. at 530. The plaintiff was a private school with religious affiliations, whose students were forced to withdraw pursuant to the statute. Id. at 532. The Court held that “the liberty of parents and guardians to direct the upbringing and education of children under their control” arises from the Fourteenth Amendment. Id. at 534-35.

29 NAACP, 357 U.S. at 462. The NAACP was brought into state court for causing irreparable injury to the citizens of Alabama, and consequentially Alabama requested a list of all NAACP members. Id. at 451. The NAACP refused to release the list, claiming that the state was abusing its power when it compelled disclosure of the membership lists. Id. at 452. Past disclosure of members had occasioned economic reprisal, loss of employment, threat of physical coercion and other hostile acts by the public against the members. Id. at 452-62. While the court acknowledged that the state had not directly infringed on any one particular constitutional right, its request hindered a citizen’s right to freely associate, given the racially charged atmosphere of Alabama. Id. at 462-63. But see New York ex rel. Bryant v. Zimmerman, 278 U.S. 63, 75-76 (1928). This case held that the request for, and granting of, a list of members of the Ku Klux Klan was constitutional because prevention of dangerous, violent and illegal acts by KKK was a sufficient state interest to overcome individual members’ rights. Id. at 76.


31 See, e.g., Meyer, 262 U.S. at 399. The Meyer court stated:

[The Fourteenth Amendment] denotes not merely freedom from bodily restraint but also the right of the individual to contract, to engage in any of the common occupations of life, to acquire useful knowledge, to marry, establish a home and bring up children, to worship God according to the dictates of his own conscience, and generally to enjoy those privileges long recognized at common law as essential to the orderly pursuit of happiness by free men.

Id. (citations omitted).

when an overriding state interest exists can this right be infringed.\textsuperscript{33}

B. The Genesis of the Constitutional Right to Privacy: Griswold v. Connecticut

The Supreme Court's privacy jurisprudence culminated in the seminal case of \textit{Griswold v. Connecticut},\textsuperscript{34} when the Court expressly announced the existence of the right to privacy.\textsuperscript{35} The Supreme Court considered a Connecticut statute which prohibited the use of contraception by married couples.\textsuperscript{36} The Court declared that the law violated the right to privacy, as gleaned from the Bill of Rights and from common law.\textsuperscript{37} The \textit{Griswold} Court relied primarily on the First Amendment as the source of the right to pri-

\textsuperscript{33} See \textit{NAACP}, 357 U.S. at 461-62. The court said, "This Court has recognized the vital relationship between freedom to associate and privacy in one's associations . . . the crucial factor is the interplay of governmental and private action, for it is only after the initial exertion of state power represented by the production order that private action takes hold." \textit{Id.} at 462-63. For further discussion of the development of the right to privacy through the balancing tests described in \textit{Meyer, Pierce, Skinner,} and \textit{NAACP}, see generally G. Sidney Buchanan, \textit{The Right of Privacy, Past Present, and Future}, 16 OHIO N.U. L. REV. 403, 415, 485 (1989) (discussing \textit{Meyer, Pierce,} and \textit{Skinner}'s right to privacy as right of freedom from unreasonable governmental intrusion but there are relevant state interests to be balanced against this individual right) and Gormley, supra note 13, at 1394 (discussing these cases as creating right to privacy and balancing test).

\textsuperscript{34} 381 U.S. 479 (1965).


\textsuperscript{36} See \textit{Griswold}, 381 U.S. at 480. The petitioner in this case was a doctor who prescribed contraception for a married couple. \textit{Id.} Both the doctor and the couple were charged with violating a Connecticut statute which prohibited the prescription, and subsequent use of contraceptives. \textit{Id.} Petitioner claimed that these statues violated his Fourteenth Amendment rights. \textit{Id.} at 481; see also Lackland H. Bloom, Jr., \textit{The Legacy of Griswold}, 16 OHIO N.U. L. REV. 511, 513 (1989) (describing right to privacy as defined in \textit{Griswold} as springing from First, Third, Fourth, Fifth, Ninth and Fourteenth Amendments); David Helscher, \textit{Griswold v. Connecticut and the Unenumerated Right of Privacy}, 15 N. ILL. U. L. REV. 33, 35 (1994) (describing \textit{Griswold} decision as protecting liberty interests springing from specific sections of Bill of Rights and Fourteenth Amendment).

\textsuperscript{37} See \textit{Griswold}, 381 U.S. at 485-86. The court exclaimed, "[w]ould we allow the police to search the sacred precincts of marital bedrooms for telltale signs of contraceptives? The very idea is repulsive to the notions of privacy surrounding the marriage relationship." \textit{Id.}; Bloom, supra note 36, at 532 (explaining \textit{Griswold} decision started emphasis on maintaining individual's privacy in things intimate); Helscher, supra note 36, at 46 (describing how right to privacy preserves human dignity resting in maintaining privacy in intimate affairs). See generally William M. Beany, \textit{The Constitutional Right to Privacy in the Supreme Court}, 1962 SUP. CR. REV. 212, 214 (predicting advent of Court's creation of right to privacy); Erwin N. Griswold, \textit{The Right to be Let Alone}, 55 NW. U. L. REV. 216, 220 (1960) (describing potential of definitive right to privacy).
privacy, but found that the Fourth, Fifth, Ninth and Fourteenth amendments also played a role. The Court acknowledged an extension of the state's police power to invade the marital bedroom was unjustified when balanced against an individual's interest in protecting this "sacred" area of privacy. In subsequent years, the Court applied this balancing test when considering the right to marry freely and the right of privacy for unmarried people in the use of contraceptives.

C. Roe v. Wade and its Progeny

Roe v. Wade cemented the right to privacy. The plaintiff, a pregnant single woman, questioned the constitutionality of a Texas statute which criminalized abortion, claiming that the state statute prohibiting interracial marriages violated the Equal Protection and Due Process clauses of the Fourteenth Amendment.

38 Griswold, 381 U.S. at 482-84. Significantly, the Court cited Pierce v. Society of Sisters, Meyer v. Nebraska, and NAACP v. Alabama as cases which were instrumental in defining the right to privacy. Id. at 482-83. The Court also discussed the Third, Fourth, Fifth and Ninth Amendments as other constitutional provisions that may be tied to the First Amendment to demonstrate this right to privacy. Id. at 484-85. For a later discussion of the right to privacy as it pertains to the Fourth and Fifth Amendments in a search and seizure context, see Terry v. Ohio, 392 U.S. 1, 9 (1968) (holding individual may possess reasonable expectation of privacy) and Katz v. United States, 389 U.S. 347, 350-51 (1967) (holding reasonable expectation of privacy exists for individual); Elkins v. United States, 364 U.S. 206, 222 (1960) (limiting constitutional protection to unreasonable searches and seizures); see also Bloom, supra note 36, at 513 (discussing importance of various constitutional amendments to privacy right as defined in Griswold); Helscher, supra note 36, at 36 (discussing Griswold holding of Fourteenth Amendment's importance in right to privacy).

39 Griswold v. Connecticut, 381 U.S. 479, 485-86 (1965). But see id. at 527 (Stewart and Black, JJ., dissenting) (labeling statute "uncommonly silly law," but finding no grounds to hold it unconstitutional).

40 See Loving v. Virginia, 388 U.S. 1, 2-3 (1967). The petitioner contended that a state statute prohibiting interracial marriages violated the Equal Protection and Due Process clauses of the Fourteenth Amendment. Id. at 2. The Court noted that regulation of marriage was exclusively within the state's control but still subject to constitutional guidelines. Id. at 7. Since no overriding state interest would overcome this constitutional protection, the Virginia statute in Loving was found unconstitutional, and the right to marry was a freedom recognized as inviolable for all Americans. Id. at 10-11; see also Maynard v. Hill, 125 U.S. 190, 205 (1888) (holding marriage under exclusive state control); Naim v. Naim, 87 S.E.2d 749, 755 (1955) (holding control over marital affairs is proper governmental objective).

41 See Eisenstadt v. Baird, 405 U.S. 438, 447 (1972). The petitioner asserted that a state statute that prohibited the distribution of contraceptives to unmarried persons, unless by a doctor or pharmacist, violated the Fourteenth Amendment. Id. The Court rejected the state's goal in enacting the statute of discouraging premarital sex. Id. at 448. The Court concluded that the right to privacy recognized in Griswold belonged to the individual, regardless of marital status. Id. at 498-99.

ute violated her right to privacy as guaranteed under the First, Fourth, Fifth, Ninth and Fourteenth Amendments. The Court, after examining the historical background surrounding abortion laws and the state interest behind the Texas abortion statute, decided that the constitutional right to privacy was broad enough to encompass a woman's decision whether or not to terminate her pregnancy. The Court noted, however, that this right is not unqualified and must be considered against important state interests in regulating abortions. Essentially, the Court again applied the important balancing test developed nearly 100 years before.

In Planned Parenthood of Missouri v. Danforth the Court revisited the scope of privacy in the context of abortion. Several
physicians who performed abortions challenged a state law which severely restricted the new-found right to have an abortion. The Court indicated that privacy rights recognized in *Roe* should be tempered by the duty to protect potential human life. Consequently, an important factor in the Court's analysis of the constitutionality of the statute was the balancing of the privacy rights of the mother "against important state interests in regulation."

The Supreme Court reapplied the balancing test in *Planned Parenthood v. Casey*, strengthening the state's police power to regulate abortions. In *Casey*, the Court increased state power to regulate abortions when the fetus is viable, stating that at viability, "the State's interest in fetal life is constitutionally adequate" over the mother's right to an abortion. The standard of review here was lessened to test whether the legislation places an "undue burden" on the individual.

(discussing how *Danforth* Court specifically discussed fathers' right to decide fate of fetus, exercising balancing test of mother's rights against those of father and state).

*Danforth*, 428 U.S. at 56-59. The Missouri legislation contained several clauses that regulated and controlled all abortions within Missouri. *Id.* at 56. These regulations included written consent requirements, civil and criminal penalties for the doctor if the fetus died, and similar sanctions against the parents if the fetus survived the attempted abortion. *Id.* at 58-59.

*Id.* at 60-61. The "pregnant woman cannot be isolated in her privacy' for she 'carries an embryo and, later, a fetus . . . [t]he woman's privacy is no longer sole and any right of privacy she possesses must be measured accordingly'. *Id.* (quoting *Roe v. Wade*, 410 U.S. 113, 159 (1973)).

*Id.* at 61 (quoting *Roe*, 410 U.S. at 154); see Sharrin, supra note 51, at 1388 (discussing balancing test applied in *Danforth* compared to prior abortion cases); Walters, supra note 51, at 175 (comparing *Danforth* to other abortion cases and use of balancing test). It is significant to note at this time that the real issue behind some of these statements is how the court defined 'viability', or when a fetus becomes life. *Id.* In *Roe*, viability occurs after the second trimester, or, 28 weeks, which is when the fetus could live outside the mother's womb, even though it might require artificial support. *Danforth*, 428 U.S. at 63. The issues behind *Roe* and *Planned Parenthood* are also the issues at the heart of the "AIDS Baby" Bill controversy, but viability is not an underlying issue. See infra Part III (discussing issues from *Roe* and *Planned Parenthood* with the "AIDS Baby" Bill).

*Casey*, 505 U.S. 833 (1992); see McClard, supra note 45, at 2050-53 (discussing impact of *Casey* on *Roe* decision).

*Casey*, 505 U.S. at 898 (commenting that state power over regulating abortions is greater than husband's right over wife); see also McClard, supra note 45, at 2050-53 (discussing impact of stare decisis of *Roe* on *Casey* decision).

*Casey*, 505 U.S. at 835-36.

*Id.* at 860. The Court explained that they were not overruling *Roe*, but merely modifying the actual moment when the state's right to interfere outweighs the mother's individual right to have an abortion. *Id.* "It is a constitutional liberty of the woman to have some freedom to terminate her pregnancy . . . The woman's liberty is not so unlimited, however, that from the outset the State cannot show its concern for the life of the unborn . . . and at a later point in fetal development the State's interest in life has sufficient force so that the right . . . can be restricted." *Id.* at 868; see Valerie J. Pacer, Note, *Salvaging the Undue Burden Standard — Is it a Lost Cause? The Undue Burden Standard and Fundamental Rights Analysis*, 73 Wash. U. L.Q. 295, 303 (1995) (discussing how *Casey* first applied un-
In *Casey*, the Court, after applying the balancing test, gave states more power to intervene in the abortion arena when the interests of the fetus are implicated. The Court has applied the balancing test in other medical situations and the balance has tipped in favor of the state in those cases. The Court’s rationale in the two cases that follow should be applied by legislatures when addressing the privacy issues behind confidentiality and disclosure in the area of AIDS.

In *Jacobson v. Massachusetts*, the plaintiff claimed that a statute requiring smallpox vaccination was unconstitutional. The Court weighed the state police power to protect the public against the rights of the individual, and concluded that public protection

due burden standard in evaluating state regulation intruding on adult’s fundamental rights); see also Alan Brownstein, *How Rights Are Infringed: The Role of Undue Burden Analysis in Constitutional Doctrine*, 45 Hastings L.J. 867, 878-92 (1994) (clarifying proper analysis under undue burden standard as looking to both legislative purpose and effect on individual’s right to choose abortion). For an interesting analysis of the potential ethical consequences of the Casey decision when considering state police power, see generally Linda C. McClain, “Irresponsible” Reproduction, 47 Hastings L.J. 339, 366 (1996) (stating Casey offers “the most elaborate justification to date for a protected realm of personal decisionmaking premised on the requirements of personhood and moral responsibility, while upholding state measures designed to steer such decisionmaking against abortion in name of encouraging ‘wise’ (or responsible) exercise of reproductive liberty.”) (footnote omitted).


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<th>See Whalen v. Roe, 429 U.S. 589, 598 (1977) (mandating certain individuals must forego certain privacy rights when there is a greater benefit to whole society by disclosure); Jacobson v. Massachusetts, 197 U.S. 11, 25 (1905) (discussing health, peace and well-being of population-at-large is more important than individual’s right to act contrary to societal norm).</th>
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Id. The challenged Massachusetts statute required all residents to be vaccinated for smallpox. Id. at 12. Petitioner claimed that this law violated his rights as held generally under the preamble to the Constitution. Id. at 12-14. Petitioner contended that the statute violated his constitutional rights that are secured by the preamble and the Fourteenth Amendment. Id. at 13-14, 22.

*Jacobson*, 197 U.S. at 25-27. The court said:

The possession and enjoyment of all rights are subject of such reasonable conditions as may be deemed by the governing authority of the country essential to the safety, health, peace, good order and morals of the community. Even liberty itself, the greatest of all rights, is not unrestricted license to act according to one’s own will. It is only freedom from restraint under conditions essential to the equal enjoyment of the same right of others. Then it is liberty regulated by law.

*Id.* at 26-27 (quoting *Crowley v. Christensen*, 137 U.S. 86, 89 (1890)).
against a potential smallpox epidemic outweighed the individual’s right to refuse the vaccination.64 The Court applied the privacy right balancing test in another medical context when it evaluated a New York Statute requiring individuals receiving certain prescription drugs to register with the state.65 Whalen v. Roe66 held that the state’s broad police power encompassed the authority to mandate filing of prescription drug forms with the state and, therefore, the requirement was not an impermissible invasion of the patient’s right to privacy.67 The rationale applied in these cases should apply when considering the right of doctors to know the HIV-status of patients and the right of infants to know their own HIV-status versus the patients’ and mothers’ right of privacy not to disclose.68

The right to privacy concerning AIDS-confidentiality protection and disclosure requirements should be treated as a state matter


65 See Whalen v. Roe, 429 U.S. 589, 598 (1977) (reversing Roe v. Ingraham, 403 F. Supp. 931 (S.D.N.Y. 1975) and holding New York drug registration statutes is constitutionally permissible infringement into individual’s right of privacy by weighing patient’s right to confidentiality against state’s interest in preventing illicit drug use); see also Harris v. McRae, 448 U.S. 297, 312 (1980) (discussing whether state statute limiting funds for state-funded abortion violated constitutional right to privacy); Carey v. Population Servs. Int’l, 431 U.S. 678, 685-86 (1977) (balancing minor’s right to privacy concerning contraceptives against state’s interest in discouraging illicit sexual conduct between minors under sixteen years of age).

66 429 U.S. at 589.

67 Id. at 602 (recognizing that there are many occasions when disclosure of medical information is necessary in areas of health care and these invasions do not constitute impermissible intrusion of privacy).

as the Court treated Casey, Jacobson, and Whalen. Additional legislative action is required in the area of health care disclosure requirements for the individuals involved in the physician-patient relationship, and for newborn babies testing positive for HIV, to prevent the precipitous spread of AIDS in these high-risk situations.

II. THE PHYSICIAN-PATIENT RELATIONSHIP

The physician-patient relationship is highly respected in American society. Our legal system similarly recognizes the importance of this relationship by affording the physician-patient privilege. This privilege, however, is not absolute. The qualified

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69 Many states have drafted and passed statutes that protect an HIV or AIDS-infected individual's right to keep his health status private. See, e.g., CAL. HEALTH & SAFETY § 120980 (West 1996) (statute penalizing unauthorized disclosure of AIDS status); CONN. GEN. STAT. § 19a-583 (West 1995) (restricting release of AIDS information); GA. STAT. § 24-9-47 (1996) (limiting disclosure of AIDS status); ILL. STAT. ANN. ch. 410 § 305/9 (Smith-Hurd 1996) (forbidding disclosure of AIDS status except under limited circumstances); IOWA REV. STAT. § 1300.11 (West 1995) (describing intent to restrict disclosure of AIDS status); N.Y. PUB. HEALTH LAW §§ 2781, 2782 (Mckinney 1996) (requiring maintenance of confidentiality of individual HIV or AIDS-infected status with certain very limited exceptions); OHIO REV. CODE ANN. § 3701.243 (Baldwin 1996) (restricting release of AIDS information); PENN. STAT. ANN. 35 § 7602 (West 1995) (discussing legislative intent against disclosure of AIDS information).


71 See 84 N.Y. JUR. 2d Physicians, Surgeons, and Other Healers § 133 (1995) (stating that since medical practitioner is learned in medical field, patient must rely heavily on doctor's advice); see also T.C. Smith & T.L. Thompson, The Inherent, Powerful Therapeutic Value of a Good Physician-Patient Relationship, PSYCHOSOMATICs, Mar-Apr 1993, at 1. See generally Glen O. Gabbard & Carol Nadelson, Professional Boundaries in the Physician-Patient Relationship, 273 JAMA 1445 (1995) (noting that physician's power position is a result of factors including higher levels of education, socioeconomic status and inherent social power).

72 See, e.g., N.Y. CIV. PRAC. L. & R. § 4504 (McKinney Supp. 1995) (stating that in New York, confidential information disclosed by patients to physicians, dentists, podiatrists, chiropractors or nurses is protected by virtue of relationship, unless protection is specifically waived by patient); see also Wanda E. Wakefield, Annotation, Physician-Patient Privilege as Extending to Patient's Medical or Hospital Records, 10 A.L.R. 4th 552, 557 (1994) (stating that physician-patient privilege exists to encourage a patient to be forthcoming with information so that physician can effectively treat patient). See generally 84 N.Y. JUR. 2d
nature of the privilege reflects the realization that even this relationship must occasionally yield to the public welfare.\textsuperscript{74}

Specifically, the spread of AIDS has prompted something of a metamorphosis in the physician-patient relationship.\textsuperscript{75} As a result of this tragic disease, an increasing number of doctors are themselves becoming HIV-positive.\textsuperscript{76} A recent Maryland case illustrates this unprecedented transformation of the traditional physician-patient relationship.\textsuperscript{77} In Doe v. University of Maryland Medical System Corporation,\textsuperscript{78} the plaintiff doctor was fired because of his HIV-positive status.\textsuperscript{79}
Dr. "Doe," a neurosurgical resident at the University of Maryland Medical System Corporation, was stuck with a needle during the performance of his duties, and subsequently tested positive for HIV. The hospital's expert panel put forth recommendations that Dr. Doe refrain from certain invasive procedures and rigorously follow infection control procedures. Hospital administrators refused to follow these recommendations. Instead, they permanently suspended the doctor from surgical practice when he refused their offer of alternative residency opportunities. 

Upholding the decision of the district court, the Fourth Circuit found that Dr. Doe's HIV-positive status posed a significant health risk to his patients, despite the possibility of his taking extra precautions. The court held that, contrary to Dr. Doe's argument, the hospital did not violate the Rehabilitation Act or the Americans with Disabilities Act by discriminating against an otherwise qualified individual with a disability.

This case arose in a constantly changing atmosphere of confusion with regard to disclosure by HIV or AIDS infected health care workers and would not relinquish his surgical position to assume alternative responsibilities within his profession. This incident occurred while Dr. Doe was treating an individual who may have been infected with the HIV virus. The court notes, however, that it is not known whether Dr. Doe became infected from this incident, or whether he became infected at some prior time.

The panel recommended that Dr. Doe be permitted to continue his surgical responsibilities, with the exception of those procedures requiring the use of exposed wire which was deemed too risky. The panel further proposed measures to be taken if Dr. Doe's blood ever came in contact with a patient's non-intact skin.


The court stated:

We hold that Dr. Doe does pose a significant risk to the health and safety of his patients that cannot be eliminated by reasonable accommodation... Thus, even if Dr. Doe takes extra precautions (such as wearing two pairs of gloves, making stitches with only one hand, and using blunt-tipped, solid-bore needles) some measure of risk will always exist because of the type of activities in which Dr. Doe is engaged.


Doe v. University of Md. Medical Sys. Corp., 50 F.3d 1261, 1266 (4th Cir. 1995). Collectively, these statutes prohibit discrimination by a public entity against otherwise qualified individuals on the basis of a disability. Doe's claims at his trial alleged violations under § 504 of the Rehabilitation Act and Title II of the Americans with Disabilities Act. Id. at 1262. Collectively, these statutes prohibit discrimination by a public entity against otherwise qualified individuals on the basis of a disability. Id. at 1264 nn.7-8. The court determined that the risk to the patients of HIV transmission was too great to be eliminated by "reasonable accommodation" and therefore, the hospital did not violate either the Rehabilitation or the Americans with Disabilities Acts. Id. at 1267.
States are dictating varying policies concerning both HIV-positive and AIDS-infected health care workers. While other states have compulsory HIV testing, New York does not impose mandatory testing, either for health care workers or for patients. The guidelines set forth by the Centers for Disease Control explains in part these varying responses.

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89 See generally Eisenstat, supra note 10, at 328 (noting states have proposed variety of testing schemes).

90 See, e.g., Plaza v. Estate of Wisser, 626 N.Y.S.2d 446, 452 (1st Dep't 1995) (holding that while mandatory testing of those suspected to have venereal disease is required by Public Health Law § 2300, individuals who are suspected of having HIV are not required to undergo testing); Kevin J. Curnin, Note, Newborn HIV Screening and New York Assembly Bill No. 6747-B: Privacy and Equal Protection of Pregnant Women, 21 Fordham Urb. L.J. 857, 860 (1994) (citing Report of Subcommittee on Newborn HIV Screening of New York State AIDS Advisory Council 5 (Feb. 10, 1994) indicating lack of mandatory HIV testing).


[E]ach State Public Health Official shall . . . certify to the Secretary of Health and Human Services that guidelines issued by the Centers for Disease Control, or guidelines which are equivalent to those promulgated by the Centers for Disease Control concerning recommendations for preventing the transmission of the human immunodeficiency virus and the hepatitis B virus during exposure prone invasive procedures, except for emergency situations when the patient's life or limb is in danger, have been instituted in the State. State guidelines shall apply to health professionals practicing within the State and shall be consistent with Federal law.

Id.; see also Johnson, supra note 88, at 481-82 (indicating that Congress has not enacted legislation requiring HIV testing for health care workers, but that CDC guidelines require states to adopt practice guidelines).
A. Centers for Disease Control (CDC) Guidelines and The New York Response

The Centers for Disease Control (CDC), partially in response to the hysteria resulting from rare but well-publicized cases of HIV transmission from health-care workers to patients, promulgated guidelines designed to stay the spread of the HIV virus. The CDC guidelines compel states to enact responsive guidelines which may either mirror or be stricter than those prescribed by the CDC, and additionally, dictate punishment for non-compliance. New York has enacted legislation mandating training for health care workers regarding infection control and precautions to prevent transmission of HIV.

In New York tort law, the transmission of HIV constitutes a toxic tort. Nonetheless, New York health law does not statuto-

93 See Jane H. Barney, Comment, A Health Care Worker’s Duty to Undergo Routine Testing for HIV/AIDS and to Disclose Positive Results to Patients, 52 LA. L. REV. 933, 935 (1992) (noting heightened public awareness of risk of contracting AIDS from HIV-infected health-care workers as result of infection of Kimberly Bergalis by her dentist); P. Dean Brinkley, Comment, Health Care Worker’s Legal Duty to Disclose HIV-Positive Status to Patients Before Performing Invasive Procedures, 29 TULSA L.J. 429, 429-30 (1993) (highlighting Kimberly Bergalis as first documented patient to contract AIDS virus from health care worker); see also Jennifer Hertz, Comment, Physicians With AIDS: A Proposal for Efficient Disclosure, 59 U. CHI. L. REV. 749, 750 n.6 (1992) (citing Centers for Disease Control, Possible Transmission of Human Immunodeficiency Virus to a Patient During an Invasive Dental Procedure) in 39 MORBIDITY AND MORTALITY WKLY RPT 489 (July 27, 1990) and concluding that alleged HIV transmission from dentist to three patients has renewed debate concerning disclosure of HIV-status by physicians); Peter Pallot, 1,300 Offered AIDS Test After Dentist Kept on Working, THE DAILY TELEGRAPH (London), Jan. 11, 1995, at 7 (discussing AIDS-infected dentist who continued treating patients after being requested not to do so by his treating physician).

94 See 42 U.S.C. § 300ee-2 (Law. Co-op. 1995). The guidelines are for the “Prevention of Transmission of Human Immunodeficiency and Hepatitis B Viruses During Invasive Procedures.” Id. The guidelines require all states to enact either the CDC guidelines for the prevention of disease transmission, or guidelines which are substantially equivalent. Id. These guidelines are required to be followed by health professionals performing invasive procedures. Id.

95 Id.

96 Id. The guidelines provide for state ineligibility for assistance under the Public Health Service Act, 42 U.S.C. § 301 (1995), until the Secretary has provided the requisite certification. Id.

97 See N.Y. EDUC. LAW § 6505-b (McKinney 1995) (mandating dentists, registered and licensed nurses, optometrists, podiatrists, and dental hygienists complete training appropriate to their practice to control HIV infection in workplace); N.Y. PUB. HEALTH LAW § 239 (McKinney 1995) (requiring classes and training in HIV infection control methods for physicians and physician assistants).

98 See Plaza v. Estate of Wisser, 626 N.Y.S.2d 446, 451 (1st Dep’t 1995). The court, relying on the authority of DiMarco v. Hudson Valley Blood. Servs., 541 N.Y.S.2d 521 (1st Dep’t 1989) and Prego v. City of New York, 541 N.Y.S.2d 995 (2d Dep’t 1989), extended the application of CPLR 214-c to actions for recovery for latent injuries caused by exposure to AIDS contaminated blood. Id. The court further noted that it is “irrelevant whether the virus was transmitted via blood through a transfusion or via semen as a result of sexual contact.” Id.
rily consider AIDS to be a sexually transmitted disease. The New York Public Health Law purposely omits HIV from the list of sexually transmissible diseases for varying public policy reasons. The overriding public policy reason for keeping HIV off the list of transmissible diseases is the high value that New York places upon the privacy of its citizens.

The First Department, by acknowledging AIDS as a toxic tort, seems to analogize AIDS to other torts like exposure to asbestos or diethylstilbestrol (DES). The New York Commissioner of Health must designate certain diseases as "sexually transmitted." The statute directs the Commissioner to put forth a list of sexually transmissible diseases, such as gonorrhea and syphilis, to achieve the goal of Article 23 which is the care, treatment and control of sexually transmissible diseases. See also New York State Soc'y of Surgeons v. Axelrod, 77 N.Y.2d 677, 686 (1991). The Commissioner of Health's decision to keep HIV infection off the list of sexually transmissible diseases was unanimously affirmed by the New York Court of Appeals. The Health Commissioner is not required to list every sexually transmissible disease, but instead should make determination after considering attendant circumstances of disease. The court held that designating HIV infection as a communicable or sexually transmissible disease ultimately would be detrimental to the public health, since to do so would trigger reporting requirements. The court agreed with the respondent's argument that these reporting requirements would serve to deter infected individuals from testing and treatment, and therefore would have an overall detrimental effect on public health. Reporting could also trigger discriminatory treatment of infected individuals.

See generally Tischler v. DiMenna, 609 N.Y.S.2d 1002, 1004 (Sup. Ct. 1994) (stating that "[i]n New York, for policy reasons against involuntary testing, AIDS is not listed by the state health authorities as a sexually transmittable disease, though it is communicable through sexual contact."); Roth v. New York Blood Ctr., 596 N.Y.S.2d 639, 643 (Sup. Ct. 1993) (emphasizing legislative intent underlying Public Health Code, article 27-F, which defines confidential HIV related information, was to ensure confidentiality so publication of results would not be bar to testing); New York State Soc'y of Surgeons, 77 N.Y.2d at 685 (noting that placement of diseases onto list of sexually transmitted diseases may trigger statutory reporting provisions); see also Doe v. Roe, 588 N.Y.S.2d 236, 241 (Sup. Ct. 1992) (stating that Axelrod determination to keep HIV off transmissible disease list was rationally based on public policy to encourage voluntary testing). But see N.Y.A. 2799, 219th Sess. (1995) (proposed bill designating AIDS and HIV as both communicable and sexually transmissible disease therefore invoking public health protection measures).

Privacy rights,\textsuperscript{102} medical records,\textsuperscript{103} and confidentiality of HIV-related information\textsuperscript{104} are all statutorily protected in New York. New York's HIV confidentiality statute is among the most stringent in the nation.\textsuperscript{105} New York courts have rarely permitted forced disclosure of AIDS or HIV status.\textsuperscript{106} One of the only instances where disclosure of HIV status is mandated is at the request of a sex crime victim.\textsuperscript{107}

Although a statutory arsenal of privacy protections exists, there is clearly an imbalance in the application of those protections.\textsuperscript{108}

\textsuperscript{102} See N.Y. CIV. RIGHTS LAW §§ 50-51 (McKinney 1992) (prohibiting use of person's "name, portrait or picture" without written consent and granting relief for violations thereof).

\textsuperscript{103} See N.Y. CIV. PRAC. L. & R. § 4504 (McKinney 1992) (providing that confidential information exchanged between doctor and patient is privileged); see also MacDonald v. Clinger, 446 N.Y.S.2d 801, 804 (4th Dep't 1982) (noting common law cause of action exists for physician's breach of confidentiality).

\textsuperscript{104} See N.Y. PUB. HEALTH LAW § 2782(1) (McKinney 1993) (providing that no one may disclose or be compelled to disclose HIV-related information unless specifically authorized by this article).


\textsuperscript{106} See People v. Durham, 553 N.Y.S.2d 944, 947 (Sup. Ct. 1990). The court held that a defendant who divulged his status to his victim during a sexual attack could not subsequently invoke his constitutional privilege of privacy. \textit{Id.}; People v. Thomas, 529 N.Y.S.2d 429, 431 (Schoharie County Ct. 1988). The court permitted the State to obtain a blood specimen from defendant convicted of rape and sodomy to determine whether he had been exposed to AIDS virus. \textit{Id.} The court reasoned that the victim's right to know whether she may have been exposed to the AIDS virus outweighed the intrusion upon the defendant of a routine blood test. \textit{Id.; see also} Plaza v. Estate of Wissner, 626 N.Y.S.2d 446, 454 (1st Dep't 1995). The court held that N.Y. Public Health Law § 2782(c) "supersedes" the doctor-patient privilege when a compelling need is shown for the disclosure of HIV-related information regarding a patient. \textit{Id.}

\textsuperscript{107} See, e.g., N.Y. CRIM. PROC. LAw § 390.15 (McKinney 1995). This law took effect on August 1, 1995. \textit{Id.} It requires HIV-related testing at the victim's request in cases where the defendant is convicted of "an act of 'sexual intercourse' or 'deviate sexual intercourse'" as defined elsewhere in the penal law. \textit{Id.}

Health care workers are afforded less privacy rights than ordinary citizens.\textsuperscript{109} It would seem that health status disclosures should not require communication only by the physician to his patient. Ethical, if not equitable, considerations mandate that where patients are aware of their HIV-positive status, they should be required to inform the health care workers who treat them.\textsuperscript{110}

B. Extending Mandatory Disclosure to Patients as Well as Doctors

Probabilities of actually transferring the AIDS virus would seem to indicate that physicians bear a greater risk of accidental infection than do their patients.\textsuperscript{111} The average patient goes to the doctor several times a year and, on the average, probably will not see more than a couple of different physicians on those occasions.\textsuperscript{112} The average physician, however, depending on his area

\textsuperscript{109} See Estate of Behringer v. Medical Ctr. at Princeton, 592 A.2d 1251, 1283 (N.J. Super. Ct. Law Div. 1991) (concluding that “patient’s rights must prevail” and therefore mandating physicians must disclose their own HIV-status to their patients as part of informed consent procedure); Debra A. Abbott, Comment, Workplace Exposure to AIDS, 48 Md. L. Rev. 212, 213-14 (1989) (noting privacy protections for patients force health care workers to either accept risk of infection as part of doing job or to assume every patient is AIDS-infected and take requisite precautions with all patients); Singleton, supra note 108, at 1253, 1271 (stating California health care workers have no legal means to compel patient HIV-testing despite occupational exposure to blood or body fluids of patient); see also Faya v. Almaraz, 620 A.2d 327, 334, 338-39 (Md. 1993) (declining to say that AIDS-infected surgeon had no duty to obtain informed consent from his patients prior to surgery, and further that patients’ fear of contracting HIV was compensable injury).

\textsuperscript{110} See ILL. ANN. STAT. ch. 410, § 325/5.5 (Smith-Hurd 1993) (permitting infected patient to inform health care provider and vice versa before Health Department takes measures to notify parties); Mo. ANN. STAT. § 191.656(5) (Vernon 1996) (requiring HIV-infected individuals disclose status to any health care professional from whom they seek help); see also Taub, supra note 73, at 332 (noting statutory exemption to confidentiality of patient’s HIV-status exists in some states for health care workers exposed to infected individuals).

\textsuperscript{111} Doe v. University of Md. Medical Sys. Corp., 50 F.3d 1261, 1263 n.5 (4th Cir. 1995) (stating “[t]here is to date no documented case of an HIV-positive surgeon transmitting the virus to a patient, even through there are a number of known cases of HIV-positive surgeons operating on patients”); see also In re Behringer v. Medical Ctr. at Princeton, 592 A.2d 1251, 1279 (N.J. Super. 1991) (stating “[t]he risk of infection from surgeon to patient is much lower than in the opposite direction”); David C. Wyld et al., The Right to Know and the Right to Privacy: HIV Testing and Health Care Management, HEALTH CARE SUPERVISOR, March 1992, at 56 (noting there have been several dozen cases of health care workers becoming HIV-positive after coming into contact with infected blood at work).

\textsuperscript{112} See Simone Sandier, Health Service Utilization and Physician Income Trends, 10 HEALTH CARE FINANCING REV. 33 (1989) (noting survey by National Center for Health Statistics that quotes figure of 5.3 patient visits per year to physician); G.L. Weiss and C.A. Ramsey, Regular Source of Primary Medical Care and Patient Satisfaction, QUALITY REV. BULL., June 1989, at 180 (noting increased patient satisfaction when maintaining continuity with single physician). See generally N.R. Bell, Continuity of Care: Opportunity for Residents to See Repeat Patients, CANADIAN FAM. PHYSICIAN, Nov. 1995, at 1880 (finding residents had repeat contact with 25.9% of patients seen during four month period).
of specialty, will likely see thousands of different patients each year.\(^{113}\) Thus, physicians statistically bear the greater risk of exposure.\(^{114}\) It would, therefore, seem that the statutory protections for individuals with infectious diseases would tip in favor of those most likely to be the susceptible partner in the relationship — the doctor. Presently, however, this is not the case and most privileges of confidentiality favor the patient.\(^{115}\)

Additionally, the respective positions in the relationship between the patient and physician would also seem to support this conclusion. A surgical patient lying open on an operating table, a woman in the process of natural childbirth, or an emergency room patient all would be more likely to spill infected blood than a prop-

\(^{113}\) See Stephany Boyd, Buckport Health Center Plans to Double its Size, BANGOR DAILY NEWS, October 19, 1996 (describing expansion of health facility where six physicians will see 22,000 patients in 1996); Phillip Lutz, Health Clinics Strain to Meet New Demands, N.Y. TIMES, May 19, 1996, at Long Island Weekly p.1 (stating fourteen Long Island county clinics treated 102,300 patients in 1995); Dan Monk, Health Center Faces Fund-Raising Test, CINCINNATI BUS. COURIER, Feb. 5, 1996, at 15 (noting Cincinnati Health Network oversees seven health clinics that treated 90,200 patients in 1995); Sandier, supra note 112 (noting that number of visits for general practitioners in United States in 1986 was 6,723).

\(^{114}\) See Doe v. Roe, 588 N.Y.S. 2d 236, 242 (Sup. Ct. 1992) (stating that patient undergoing intrusive physical exam poses equal risk of transmitting this deadly disease to unsuspecting health care worker who may subsequently transmit virus to others); AIDS From An M.D.? Not Likely, Say Three Studies of HIV-Positive Doctors and Their Patients, TIME, Apr. 26, 1993, at 17 (citing three studies of J.A.M.A. which found doctors are more likely to contract AIDS virus from patient than vice versa); Wayne, supra note 93, at 938-39 (stating doctor is more likely to be exposed to patient’s body fluids than vice versa and therefore physician bears greater risk); Wyld et al, supra note 111, at 56 (stating that “[t]here have been several dozen documented cases of health care workers seroconverting due to exposure to HIV-infected blood or bodily fluids in the work setting”).

\(^{115}\) See Ala. CODE § 22-11a-51 (1996) (requiring health care provider obtain informed consent of patient prior to testing individual for HIV infection); Conn. Gen. STAT. ANN. § 19a-582 (West 1996) (requiring oral or written informed consent of patient prior to HIV testing); Del. Code Ann. § 1202 (1995) (stating no HIV-related testing may be performed without prior informed consent of individual); Ga. Code Ann. § 24-9-47 (1996) (requiring information about individual’s HIV status remain confidential); Haw. Rev. Stat. § 325-16 (1995) (requiring written consent before administering HIV test); Mo. Ann. Stat. §191.656 (Vernon 1996) (stating information relating to person’s HIV status be kept confidential); Pa. Stat. Ann. tit. 35, § 7607 (1995) (limiting disclosure of individual’s HIV status); see also Behringer, 592 A.2d at 1283 (holding doctrine of informed consent demands physicians disclose HIV-positive status because patients’ rights far outweigh individual physician’s right to perform procedures); Doe, 50 F.3d at 1262 (holding that although plaintiff physician did not need to obtain informed consent from his patients, he was appropriately fired from his job by defendant hospital); Taub, supra note 73, at 331 (noting confidentiality statutes protecting patients require that physician obtain patient’s informed consent before testing patient for HIV-infection); Abbott, supra note 109, at 213 (noting current public health practice is to protect privacy of infected patients by maintaining strictest level of confidentiality). See generally N.Y. PUB HEALTH LAW Art. 27-F (safeguarding confidentiality of patient’s HIV-related data in medical records).
erly scrubbed surgeon,\textsuperscript{116} who with his sterile uniform and gloves takes necessary precautions to prevent such an occurrence.\textsuperscript{117} Recently, the incident involving Greg Louganis drew public attention to the plight of a physician treating an AIDS patient.\textsuperscript{118} Mr. Louganis suffered a laceration from a diving accident in the 1988 Olympics and was treated by an Olympic physician.\textsuperscript{119} He accepted treatment from the physician, but did not disclose his HIV-positive status until early in 1995.\textsuperscript{120} His failure to disclose his status at the time he received emergency treatment has sparked much debate as to whether he was a hero or a selfish patient.\textsuperscript{121} Louganis ultimately came forward as a public figure to

\textsuperscript{116} See In re Behringer v. Medical Ctr. at Princeton, 592 A.2d 1251, 1279 (N.J. Super. 1991). The court noted that while it is impossible to calculate accurately the actual risk of HIV transmission from surgeons to patients, surgeons who get cut do not necessarily expose patients to their blood, and even if they did, the quantity involved is so minuscule as to warrant a negligible result. \textit{Id.} The court further stated that since the surgeon is in significant contact with patient's blood and organs during a procedure, the cumulative risk of HIV transmission to the surgeon is higher. \textit{Id.} at 1279-80.

\textsuperscript{117} See Barry R. Furrow, \textit{AIDS and the Health Care Provider: The Argument for Voluntary HIV Testing}, 34 \textit{Vill. L. Rev.} 823, 834, 836 (1989) (conceding that health care workers are at increased occupational risk as compared to other professions and noting needle stick injuries have infected at least fifteen health care workers); Larry Gostin, \textit{Hospitals, Health Care Professionals, and AIDS: The "Right to Know" The Health Status of Professionals and Patients}, 48 \textit{Md. L. Rev.} 12, 18 (1989) (noting risk of HIV transmission from patient to physician in emergency room setting is an occupational risk); see also Oddi, supra note 76, at 1423 (stating probability of HIV transmission from patient to physician is significantly greater than vice versa).


\textsuperscript{119} See Dennis Byrne, \textit{Character and Nobility Take a Dive}, \textit{Chi. Sun-Times}, Feb. 28, 1995, at 21 (noting that doctor who stitched Louganis' wound at 1988 Olympics was unaware of Louganis' positive HIV-status because of Louganis' failure to inform him); Louganis Describes Panic Because of Injury, AIDS, supra note 118, at C1 (quoting Greg Louganis as stating that Dr. Jim Puffer, Olympic Team doctor, was "digging around, trying to find the wound" after Louganis hit his head on diving board); Charles Walston, \textit{Hitting the Board}, \textit{Pitt. Post-Gazette}, March 26, 1995, at D1 (noting most Americans have seen videotape of Louganis' Olympic accident and diver that followed Louganis at Olympics, Mark Bradshaw, did not see any blood on diving board or in pool).

\textsuperscript{120} See Jane R. Eisner, \textit{Lessons of Greg Louganis' Life}, \textit{Bergen Record}, Mar. 14, 1995, at B7 (describing Louganis as "selfish competitor" who could have made transmission impossible if treating physician knew to wear gloves).

\textsuperscript{121} See Byrne, supra note 119, at 21 (stating if Louganis' accident had been in Illinois, he would be guilty of violating Health Care Worker Notification Act, pending in Illinois legislature and requiring patients to notify health-care workers of HIV-status before seeking treatment); Eisner, supra note 120, at B7 (distinguishing between Louganis as "hero" and Louganis as "cad"); cf. Joe Drape, \textit{With His Secrets in the Open, Louganis Says, "I'm Not Alone"}, \textit{Atlanta J. and Const.}, Mar. 6, 1995, at 6C (noting Louganis' increased popularity and position of increased sympathy from public); Cookie Walter, \textit{Louganis Fairness}, Chl.
promote education on the subject of AIDS. Nonetheless, because of the stigma of AIDS, he put his treating physician in a potentially life-threatening situation by not disclosing his positive status at the time of the emergency treatment.

Situations like that of Greg Louganis dictate that further action is required to protect health care workers. AIDS is a dangerous disease. We must protect our doctors from potential exposure during their treatment of patients. By protecting doctors, we will in turn protect other patients whom the doctor treats.

Federal and state legislatures appear reluctant to require mandatory HIV testing and disclosure for doctors, and are clearly reluctant to require testing for patients. As a result, courts and


See Eisner, supra note 120, at B7 (describing breadth of Louganis’ public appearances from People magazine to television appearances with Barbara Walters and Oprah Winfrey); see also Drape, supra note 121, at C6 (discussing overwhelming public support of Louganis at Louganis’ book signings); LOUGANIS & MARCUS, supra note 118, at 1 (discussing disclosure of HIV status).

See Barney, supra note 93, at 938-39 (noting doctors’ exposure to patients’ body fluids puts physicians at risk); Drape, supra note 121, at C6 (explaining that Louganis funded his own medical expenses totalling hundreds of thousands of dollars, rather than seeking insurance reimbursement which entailed risk of his illness becoming public); Jane R. Eisner, Privacy vs. Disclosure; Let’s Expand on the Louganis Debate, PHOENIX GAZETTE, Mar. 11, 1995, at B7 (stating that Louganis’ story should encourage fair debate regarding right to privacy versus obligation to disclose HIV-positive status for protection of others); LOUGANIS Describes Panic Because of Injury, AIDS, supra note 118, at C1 (Louganis states people who came in direct contact with his blood were at risk).

See ILL. ANN. STAT. ch. 410, § 325/5.5 (Smith-Hurd 1993) This statute permits investigation by the Health Department into allegations of HIV or AIDS infection. Id. The statute further authorizes notification of individuals that came into contact with infected persons, including both doctors who performed invasive procedures on an infected individual and to patients who have been treated by an infected health care provider. Id; see also Harrison L. Rogers, Jr., The Medical Profession and AIDS, 10 J. OF LEGAL MED. 1, 1 (1989) (asserting that there should be mutual disclosure of HIV status in physician-patient relationship). See generally Russo, supra note 105, at 9 (stating that health care provider in emergency situation will not have any information on patient’s HIV status because most people have not been tested, and if they have been tested, results are not available in an emergency situation).

See Eisenstat, supra note 10, at 327 (stating that testing is thought to be necessary to protect public health from further transmission of HIV virus); Gostin, supra note 117, at 20-21 (recognizing risks of transmission from patient to physician and advocating mutual screening to curb overall levels of transmission); Eisner, supra note 123, at B7, “As long as infection with the HIV virus confers an apparent death sentence, those who have it must also consider the safety of others to a degree not demanded in other instances.” Id; see also Norman Daniels, HIV-Infected Health Care Professionals: Public Threat or Public Sacrifice, MILBANK Q., Mar. 22, 1992, at 3 (noting that many professional health care associations have insisted that physicians and dentists have “duty to treat” all patients, including those who are HIV-infected); Taub, supra note 73, at 343 (discussing conflicting needs of doctors, HIV-infected individuals, and public, and urging abolishing confidentiality requirements to curb spread of AIDS).

See, e.g., W. VA. CODE § 16-3C-2 (1996) (stating physician or dentist can request patient submit to HIV-related testing, but test is voluntary); N.Y.S. 88, 215th Sess. (1993)
legal scholars have debated whether disclosure by a physician, for his patient's benefit, should be made compulsory through the doctrine of informed consent. The doctrine of informed consent allows a patient to make a fully informed decision regarding his illness based on all the available knowledge and risks surrounding his procedure. Some jurisdictions already compel doctors to obtain the informed consent of their patients when engaging in medical activity where there is a potential risk of transmission of HIV from an infected surgeon to a patient. The same standard should also apply where there is a risk of transmission from a patient to his physician.

(proposing amendment of Public Health Law to create duty to disclose for both health care workers and patients, but on which no action has been taken for two years); Anonymous Fireman v. Willoughby, 779 F. Supp. 402, 418 (N.D. Ohio 1991) (upholding city's mandatory testing of firefighters and paramedics for AIDS as part of annual physical exam); see Denatale & Parrish, supra note 108, at 751 (noting several legislatures and courts have addressed legal responsibilities of physician to patient transmission, but no forum has considered patient's legal duty to warn health care workers); Singleton, supra note 108, at 1253 (noting California law does not permit health care worker to compel patient to be tested for HIV after suffering occupational exposure to patient with unknown HIV status, but acknowledging Proposal 96 permits emergency service workers ability to compel testing of person who may have exposed them). See generally Russo, supra note 105, at 9 (discussing New York's confidentiality statute).

See, e.g., Logan, supra note 108, at 483 (stating that three recent appellate court cases indicate emerging trend towards requiring HIV-infected physicians to disclose HIV status to patients); Michelle W. DeBarge, Note, The Performance of Invasive Procedures by HIV-Infected Doctors: The Duty to Disclose Under the Informed Consent Doctrine, 25 CONN. L. REV. 991, 993 (1993) (noting that risk of HIV-infection is material risk to patient and should require informed consent of patient before treatment commences); N.Y.A. 4516, 218th Sess. (1995) (compelling HIV or AIDS infected health care professionals to obtain consent prior to performing procedures); see also Oddi, supra note 76, at 1446-53 (arguing doctrine of informed consent should apply to HIV-positive patients).

See BLACK'S LAW DICTIONARY 779 (6th ed. 1990). Informed consent is defined as: a general principle of law that a physician has a duty to disclose what a reasonably prudent physician in the medical community in the exercise of reasonable care would disclose to his patient as to whatever grave risks of injury might be incurred from a proposed course of treatment, so that a patient, exercising ordinary care for his own welfare and faced with a choice of undergoing the proposed treatment, or alternative treatment, or none at all, may intelligently exercise his judgment by reasonably balancing the probable risks against the probable benefits.

Id.; see also In re Behringer v. Princeton Medical Ctr., 592 A.2d 1251, 1278 (N.J. Super. 1991) (determining that "medical information or a risk of a medical procedure is material when a reasonable patient would be likely to attach significance to it in deciding whether or not to submit to the treatment").

See, e.g., Behringer, 592 A.2d at 1280 (noting New Jersey's strong commitment to fully informed patients as reason to invoke doctrine of informed consent); see also Tex. HEALTH & SAFETY CODE ANN. § 85.201 (West 1991) (stating that informed consent doctrine also applies to health care workers). See generally De Barge, supra note 127, at 993 (noting doctors with HIV pose material risk to patient and informed consent should be required for physician to disclose HIV-positive status to patients).

See MO. ANN. STAT. § 191.656 (Vernon 1995) (mandating patients who test positive for HIV-infection disclose that fact to any other health care professional from whom he seeks health care services); Doe v. Roe, 588 N.Y.S.2d 236, 241 (Sup. Ct. 1992) (holding
C. Disadvantages of Mandatory Disclosure

In evaluating the potential risks and liabilities of mandating full disclosure in the physician-patient relationship, it is necessary to consider the disadvantages to the persons who must disclose their HIV-positive status.131 Opponents of disclosure argue that mandatory testing and contact tracing132 would discourage HIV-infected individuals from cooperating with public officials because of the stigma attached to disclosure.133 Ostracism and discrimination are known consequences of positive HIV status made public.134 These fears may be allayed, however, because the patients have duty to inform physician of HIV status; Gostin, supra note 117, at 32 (noting testing patients for HIV in health care settings with patient's informed consent poses no legal or ethical difficulties); Oddi, supra note 76, at 1449 (noting HIV-positive patient should also get informed consent from treating physician because justice is not served when health care workers are in unequal position of risk that could be easily avoided); Rogers, supra note 124, at 1 (advocating mutual disclosure of HIV-positive and AIDS status in physician-patient relationship).


132 See New York State Soc'y of Surgeons, 77 N.Y.2d at 685-86 (describing futile effect of contact tracing for HIV-infected individuals, because of delayed testing due to latent development of symptoms).

133 See Nolley v. Erie, 776 F. Supp. 715, 734-35 (W.D.N.Y. 1991) (holding constitutional violations of inmate who was segregated from the general population, denied access to law library and church services, and ostracized by policy of placing red stickers on her possessions); Hunter v. Enquirer/Star, Inc., 619 N.Y.S.2d 268, 269 (1st Dep't 1994) (finding meritorious defamation claim existed when defendant portrayed plaintiff as having intimate contract with HIV-infected individual and imputing to plaintiff "loathsome or communicable disease"); 119-121 East 97th St. Corp. v. New York Comm'n on Human Rts., 642 N.Y.S.2d 638, 640 (1st Dep't 1996) (finding damages award of $100,000 for mental anguish was supported by evidence of tenant who experienced electricity interruptions, break-ins, telephone harassment, shouting that he should die painful death, and disclosure to his employer that he was HIV-positive); Petri v. Bank of N.Y. Co., 582 N.Y.S.2d 608, 611-12 (N.Y. Sup. Ct. 1992) (holding cause of action existed for employee unreasonably discharged when employer mistakenly perceived him to be HIV-positive); see also New York State Soc'y of Surgeons v. Axelrod, 77 N.Y.2d at 686 (acknowledging that intravenous drug users would be less likely to seek treatment and homosexuals would fear discrimination in housing, health care and employment if their HIV-positive status were to be made public).

134 119-121 East 97th Street Corp., 642 N.Y.S.2d at 640, 644 (affirming conclusion of administrative law judge that landlord unlawfully discriminated against HIV-positive tenant finding defendant promulgated "agenda of spite, malice and bias, acted upon over an extended period of time, resulting in the severe emotional and mental abuse of a tenant, seriously ill with AIDS . . ."); see Bruce Alpert, Gay Adults' Moms Push Bill Ending Job Bias, TIMES PICAYUNE, Mar. 21, 1996, at A17. Parents of gay children lobbied for anti-discrimination legislation. Id. One parent stated, "If people can be legally fired in 42 states, including Louisiana, just for being gay or lesbian." Id; Joyce Purick, Looking Back At A Conflict on Gay Rights, N.Y. TIMES, Mar. 21, 1996, at B1. The author notes the passage in New York of civil rights legislation banning discrimination against homosexuals in areas
tient's HIV status remains confidential and protected by the physician-patient privilege.\textsuperscript{135} 

The goal of mutual protection for both patient and physician, through full disclosure of HIV status by each party could be achieved if the legislature models disclosure rules after the principle relied upon in the New Jersey case, \textit{In re Quinlan}.\textsuperscript{136} The \textit{Quinlan} court, weighing the issues involved in removing a woman from life support, considered the competing personal and professional ethics of a treating physician.\textsuperscript{137} If doctors and patients acted in the best interests of each other rather than for purposes of self-protection, there would be no need to legislate a solution to this issue.\textsuperscript{138} Such altruism is rare, however,\textsuperscript{139} and because the legislature has remained silent, New York courts have been forced to step in and address these issues.\textsuperscript{140}

including housing and employment. \textit{Id.} Discrimination complaints made to the Human Rights Commission based on sexual orientation have increased over the last six years. \textit{Id.} 

\textsuperscript{135} See Doe v. Roe, 599 N.Y.S.2d 350, 352-53, 357 (4th Dep't 1993) (noting New York's strong public policy concern for health of its citizens as reflected in confidentiality protections for HIV and AIDS sufferers found in New York statutory scheme and finding no separate consideration necessary to mandate confidentiality of HIV status in physician-patient relationship); Doe v. Roe, 588 N.Y.S.2d 236, 241 (Sup. Ct. 1992) (observing statutory environment prohibits doctors from sharing knowledge of patient's HIV status with other health care providers); Taub, supra note 73, at 332 (noting AIDS confidentiality statutes simply reinforce physician's ethical duty to maintain confidentiality as per physician-patient privilege); N.Y. PUB. HEALTH LAW § 2782 (McKinney 1993) (listing rare exceptions when health-care providers can disclose confidential medical information); Wakefield, supra note 72, at 557 (stating that physician-patient privilege encompasses both oral testimony by physician and release of patient's treatment records kept by physician or hospital). 


\textsuperscript{137} \textit{Id.} at 668. "[T]here must be a way to free physicians, in the pursuit of their healing vocation, from possible contamination by self-interest or self-protection concerns which would inhibit their independent medical judgments for the well-being of their . . . patients." \textit{Id.}

\textsuperscript{138} See Sandra N. Hurd, \textit{States Legislate HIV Issues for the Workplace}, EMPLOYMENT TESTING-LAW & POL'Y REPORTER, May 1992, at 53 (describing various passed and proposed legislative initiatives regarding AIDS and HIV); see also Eisenstat, supra note 10, at 340 (assessing governmental interest in mandatory screening); Christina Kent, "Most Litigated Disease" Impacts Public Health Policy, AMERICAN MED. NEWS, Aug. 12, 1996, at 6 (noting legal system is increasingly settling AIDS related cases of varied issues including insurance, privacy, compensation rights and AIDS education in schools). 

\textsuperscript{139} See Daniels, supra note 125, at 3. The author notes that professionals in the health care industry have may have a moral if not legal obligation to disclose their HIV-status. \textit{Id.} The author suggests that the controversy over mandatory disclosure can be quelled by appealing to this professional obligation of a physician. \textit{Id.;} Brinkley, supra note 93, at 429-30 (noting case of Florida dentist accused of infecting Kimberly Bergalis and four additional patients with HIV has caused increased public concerns over HIV transmission from health care workers to patients); Letter from Kathy Roberts to Editor, \textit{PEOPLE}, Mar. 27, 1995, at 4 (expressing disgust at Greg Louganis for putting himself before others by not disclosing HIV status to treating physician).

\textsuperscript{140} See Doe v. Roe, 588 N.Y.S.2d 236, 241-42 (Sup. Ct. 1992) (discussing obligation of patient to disclose HIV-status to physician). \textit{See generally} Kent, supra note 138, at 6 (stat-
D. The Judicial Solution:Patients Do Have A Duty to Disclose

At least one New York court has held that a legal duty exists, by virtue of the New York Public Health Law, requiring patients aware of their HIV-positive status to disclose their condition to a treating physician. The New York Public Health Law provides many positive benefits and protections to persons with AIDS, but does not insulate HIV or AIDS-infected individuals from the consequences of infecting others negligently or maliciously.

In Doe v. Roe, the plaintiff patient brought an action against his treating physician for revealing his HIV-positive status to the Pennsylvania Bureau of Worker’s Compensation. The Doe court addressed several interesting questions concerning privacy, holding that the patient has a duty to disclose HIV-positive status to his physician. The court determined that the duty arises not as a result of the patient having a duty per se to a physician, but rather out of the patient’s engaging in behavior which elevates the risk of transmitting a deadly communicable disease to an unknowing health care provider, who may further unwittingly that over two thousand lawsuits have been commenced since AIDS epidemic began with courts settling many AIDS-related issues including discrimination, insurance, and AIDS curriculum in schools).

See Doe, 588 N.Y.S.2d at 241 (stating that N.Y.CôMP. CODES R. & REGS. tit. 10 § 63.5[j] “does not negate any legal duty on a patient’s behalf to disclose a known HIV infection to the treating doctor”).

See N.Y. PUB. HEALTH LAW art. 27-F § 2780 (McKinney 1993) (mandating silence from health and social service workers who obtain confidential HIV-related information in course of business and that disclosure can only occur when compelling need arises).

See Doe, 588 N.Y.S.2d at 242. Public health law protecting confidentiality is not a blanket which to shield patients negligently or knowingly transmitting HIV. Id; see also Maharam v. Maharam, 510 N.Y.S.2d 104, 107 (1st Dep’t 1986). The plaintiff wife brought several claims against her husband for transmitting genital herpes to her. Id. at 105. The court held that there is a duty to disclose a communicable illness, and that failure to do so is equivalent to fraudulent concealment. Id. at 107. The court further held that this duty to disclose, given the relationship of trust between the parties, can also be predicated on N.Y. PUB. HEALTH LAW § 2307, which makes intercourse with knowledge of an infectious venereal disease a misdemeanor. Id. See generally Richard C. Schoenstein, Note, Standards of Conduct, Multiple Defendants, and Full Recovery of Damages in Tort Liability for the Transmission of Human Immunodeficiency Virus, 18 Hofstra L. Rev. 37, 50 (1989) (evaluating duty of care owed by HIV-positive persons to others as factor in determining negligence).

588 N.Y.S.2d at 236, aff’d as modified 599 N.Y.S.2d 350 (4th Dep’t 1993).

Doe v. Roe, 588 N.Y.S.2d 236, 239-40 (Sup. Ct. 1992). Dr. Roe, complying with request by Worker’s Compensation Board, forwarded complete copy of patient’s medical records which included, among other things, his HIV-positive status. Id. at 240.

Id. at 240. Plaintiff’s five claims included negligence per se, breach of confidentiality, breach of oral contract, breach of implied contract, and invasion of privacy. Id.

147 Id. at 241-42.
tingly transmit it to others. The Doe court aptly described the ethical and equitable arguments supporting the legal duty for patients to disclose HIV status and mandated disclosure. In requiring patient disclosure, the Doe Court acted on an issue unaddressed by the Legislature. It is evident that the judiciary has been forced to resolve an issue that is better left to the legislature.

E. New York's Legislative Proposals Consider Mandatory Disclosure

The controversy over privacy rights has clouded the public policy goals of disclosure. The overriding public policy interest that governs this debate is protection of the public health against the spread of this deadly disease. Several bills addressing this

148 See id. at 242 (analogizing intrusive physical exam to sexual activity and finding that former poses same risk of HIV transmission to uninformed physician as latter).

149 Doe v. Roe, 588 N.Y.S.2d 236, 242 (Sup. Ct. 1992). The court holds that the legal duty to disclose arises:

out of not only moral and ethical considerations, but out of logic, common sense and medical evidence as well, with regard to the general health of society and its physician caretakers. To hold otherwise would be to improvidently elevate policy and the political aspects of this fatal disease over the medically proven health dangers of exposure to HIV infected blood, semen, saliva, etc., and to demonstrated risks of transmission to unknowing and unprepared recipients.

Id. at 241 (court imposes absolute duty on patient to disclose any positive knowledge of HIV infection).

150 Id. at 239 (prefacing holding that patients are responsible to disclose HIV status by stating that court decided many sensitive issues of first impression with respect to patient's rights and physician-patient privileges under Public Health Law Article 27-F); see also Kenneth C. Davis, Judicial, Legislative, and Administrative Lawmaking: A Proposed Research Service for the Supreme Court, 71 MINN. L. REV. 1, 1 (1986) (noting that Constitution explicitly grants legislative power to Congress and legislative lawmaking is superior to judicial lawmaking); Major Charles B. Hernicz, The Civil Rights Act of 1991: From Conciliation to Litigation — How Congress Delegates Lawmaking to the Courts, 141 MIL. L. REV. 1, 7-8 (1993) (noting that 1991 Civil Rights Act failed to define terms and goals in its amendments, thereby delegating Congress' authority to shape law to courts who ignore Congress' intention); Larry Kramer, The Lawmaking Power of the Federal Courts, 12 PACE L. REV. 263, 264, 266-67 (1992) (stating that notion of lawmaking by federal judges runs contrary to principles on which U.S. was founded, and justice is better served when clear lines of authority are heeded).

152 See Goode, supra note 8, at 970 (acknowledging public policy must address balancing act between privacy rights of AIDS patients with rights of society to be informed); Turkington, supra note 7, at 875 (noting positive values of preserving integrity of physician-patient relationship and maintaining confidentiality of patient data collides with public policy goals of government in preserving public safety and saving lives); cf. Eisenstat, supra note 10, at 327 (arguing mandatory testing does not comport with sound public health policy).

153 Doe v. Roe, 599 N.Y.S.2d 350,352-53 (4th Dep't 1993) (describing New York's strong public policy concerns as indicated by legislative intent of enacting Article 27-F guarantee-
issue have been introduced in the New York legislature.\textsuperscript{154} Assembly Bill 377\textsuperscript{155} seeks to modify section 2130 of the Public Health Law by limiting the full confidentiality blanket currently provided by the statute.\textsuperscript{156} The proposed bill would require the reporting of an HIV or AIDS diagnosis to the Health Commissioner of the municipality where the illness occurred.\textsuperscript{157} Additionally, proposed section 2134 would permit a physician or law enforcement officer to report to the Health Commissioner a suspected case of HIV or AIDS if the potentially infected individual acts without regard for the health and safety of the public.\textsuperscript{158}

These bills, however, do not appear to encourage or mandate disclosure.\textsuperscript{159} Assembly Bill 4516,\textsuperscript{160} introduced in February of 1995, appears to be the most comprehensive change to the Public Health Law in the area of mandatory disclosure.\textsuperscript{161} The bill would amend the confidentiality and disclosure section of the Public Health Law\textsuperscript{162} to mandate New York health care professionals\textsuperscript{163} who know they have AIDS, an HIV infection, HIV-related illness
or a positive HIV-related test to refrain from performing invasive procedures.\textsuperscript{164}

This bill differs in a significant way from a comparable bill introduced just two years earlier.\textsuperscript{165} In 1993, New York State Senate Bill 88\textsuperscript{166} similarly proposed to modify the confidentiality and disclosure section of the Public Health Law by mandating disclosure by HIV-infected health-care professionals and requiring the informed consent of a patient in order to perform an invasive procedure.\textsuperscript{167} More importantly, New York State Senate Bill 88\textsuperscript{168} compelled patients to disclose their HIV-positive status to a physician or dentist before an invasive procedure is performed upon them.\textsuperscript{169} This section of the amendment is noticeably absent, however, from the currently proposed version of the bill.\textsuperscript{170}

The legislature, continually addressing the issue of disclosure in the physician-patient relationship for the last five years,\textsuperscript{171} seems

\textsuperscript{164} See id. § 2782-A(3). The bill states:

"any health care professional who has tested positive, or who has been diagnosed as having HIV infection, AIDS, or HIV-related illness shall abstain from performing invasive procedures which pose an identifiable risk of transmission and shall restrict his or her normal professional activities to those activities that pose no identifiable risk to any patient, unless prior to performing an invasive medical procedure, the HIV-infected health care professional discloses his or her sero-positive status and proceeds only [with] written informed consent."

\textsuperscript{165} See N.Y.S. 88, 215th Sess. (1993) (requiring disclosure by physicians with informed consent to perform procedures, and disclosure by patients to physicians).


\textsuperscript{167} See id. § 2782-A(1) and § 2782-A(2) (defining "invasive procedures" and commanding physicians and dentists licensed in New York and performing invasive procedure to disclose any knowledge of existing HIV infection or positive HIV test results).


\textsuperscript{169} See id. § 2782-A(3). This section proposed that "every person having AIDS, an HIV infection, an HIV related illness or a positive HIV related test shall have the duty to disclose the presence of such disease or of such positive test to any dentist or physician who will perform an invasive procedure upon such patient." Id; cf. N.Y.A. 4178, 215th Sess. (1993). The Assembly version of the bill, introduced on February 25, 1993 shortly after the Senate version, only prescribed disclosure by the physician and omitted any mention of patient disclosure. Id. § 2782-A(3).


to be aware of the potential risks of transmission and benefits of disclosure. By failing to include patient disclosure in the most recently proposed version, the legislature appears to have made a deliberate choice to relieve patients of the duty to disclose HIV status found by the court in Doe v. Roe.172 The Doe court even recognized that it, rather than the legislature, was setting health care policy in New York State.173

III. QUESTIONS OF PRIVACY AND THE NEW YORK “AIDS BABY” BILL

The debate over the “AIDS Baby” Bill, a modified version of which was enacted by the New York Legislature in June, 1996, is another matter requiring balancing between the state’s interests in preserving the public health and safety, and the privacy of an individual. The AIDS tragedy takes on a new and chilling meaning when babies are born infected with the HIV virus.174 New York tests every newborn child for HIV infection.175 Until June, 1996, this information was used only for statistical purposes, and

172 588 N.Y.S.2d 236, 241-42 (Sup. Ct. 1992) (finding patient’s duty to disclose HIV-infection to treating physician to avoid negligently or fraudulently transmitting disease).

173 Doe v. Roe, 588 N.Y.S.2d at 239. The court stated, “Many various and sensitive issues of first impression have necessarily been decided by this Court with respect to the patient’s rights and remedies under . . . Public Health Law Article 27-F.” Id; see also Davis, supra note 151, at 1, 3 (noting that judicial lawmaking is inferior to legislative lawmaking and large volume of cases appealed highlights uncertainty of judge-made law); Arthur D. Hellman, Error Correction, Lawmaking, and the Supreme Court’s Exercise of Discretionary Review, 44 U. PITT. L. Rev. 795, 796 (1983) (stating that lawmaking by courts occurs when cases cannot be resolved by applying existing rules).


neither the child nor the treating physician ever learned the results.\textsuperscript{176}

The New York legislature attempted to remedy this situation through Public Health Law § 2500-f, a form of Assembly Bill No. 6684, commonly known as the "AIDS Baby" bill.\textsuperscript{177} Public Health Law § 2500-f presently allows the limited disclosure of the infant's HIV status upon the decision of the State Health Commissioner.\textsuperscript{178} This is a weak compromise when the original bill sought to automatically disclose positive HIV results to the treating physician who could immediately treat the child's HIV infection.\textsuperscript{179} This grave difference between the passed law

\textsuperscript{176} See N.Y. PUB. HEALTH LAW § 2781 (McKinney 1996) (requiring individual's consent prior to HIV testing). Presently, infants are automatically tested for HIV upon birth, so consent is not currently required. Id.; N.Y. PUB. HEALTH LAW § 2500-a (requiring mandatory HIV test for all newborn infants); see also Michael L. Closen, Mandatory Disclosure of HIV-Blood Test Results to the Individual Tested: A Matter of Personal Choice Neglected, 22 LOY. U. CHI. L. J. 445, 447-48 (1991) (discussing mandatory testing and right not to be informed of results).


\textsuperscript{178} See N.Y. PUB. HEALTH LAW § 2500-f (McKinney 1996). The enacted version of § 2500-f reads:

\textit{Human Immunodeficiency Virus; testing of newborns}

1. In order to improve the health outcomes of newborns, and to improve access to care and treatment for newborns infected with or exposed to human immunodeficiency virus (HIV) and their mothers, the commissioner shall establish a comprehensive program for the testing of newborns for the presence of HIV and/or the presence of antibodies to such virus.

2. The commissioner shall promulgate regulations governing the implementation of the program required pursuant to subdivision one of this section, including the administration of testing, counseling, tracking, disclosure of test results pursuant to section twenty-seven hundred eighty-two of this chapter, follow-up reviews, and educational activities relating to such testing.

\textit{Id.}

\textsuperscript{179} Compare N.Y. PUB. HEALTH LAW § 2500-f (McKinney 1996) (legislating right to test newborns and to release results subject to State Health Commissioner's approval and regulations), with N.Y.A. 6684-B, 218th Sess. (1995) (proposing additional section to § 2500-a of Public Health Law requiring that physicians refer HIV-positive infants to HIV-related services within reasonable time after receipt of positive test results), and N.Y.A. 6684-A, 218th Sess. (1995) (proposing amendment to AIDS confidentiality statute permitting notification to baby's mother of HIV test results of infant). The language of Assembly Bills 6684-A and 6684-B is much stronger than the actual passed legislation of N.Y. PUB. HEALTH LAW § 2500-f. See N.Y. PUB. HEALTH LAW § 2500-f (McKinney 1996). The undeniable benefit to HIV-infected newborns of immediate medical care has been weighed against the overriding confidentiality concerns of disclosure; see, e.g., AIDS, WOMEN AND THE NEXT GENERATION 29-31 (Ruth R. Faden et al. eds., 1991) (discussing improving AIDS medical care for women); Goldstein, supra note 174, at 612 (discussing impact of drug AZT on pregnant HIV-positive women); Post, supra note 174, at 170-78 (discussing benefits of early care in HIV-positive babies).
and the original bill has been the source of a firestorm of debate.\textsuperscript{180}

In the original "AIDS Baby" Bill, the mother's right to privacy, statutorily protected by New York's AIDS Confidentiality law,\textsuperscript{181} was juxtaposed against the state interest in protecting the health of the infant and the public at large.\textsuperscript{182} This balancing caused intense debate over privacy rights implicated in the "AIDS Baby" Bill.\textsuperscript{183} This debate was complicated by the fear that mandatory testing could discourage women at high risk for HIV-infection from seeking prenatal medical care.\textsuperscript{184}

At the heart of the problem lies the question of the mother's right to privacy. Testing for AIDS is a form of search and seizure, which is prohibited by the Fourth and Fifth Amendments.\textsuperscript{185} It is

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\textsuperscript{180} Compare Test All Newborns For AIDS, NEWSDAY, Apr. 21, 1991, at 31 (arguing for disclosure of infant's HIV-status), with Catherine A. Lynch, Don't Test Newborns for AIDS, NEWSDAY, May 19, 1991, at 43 (arguing against disclosure as violative of confidentiality of mothers HIV-status). See generally infra notes 182-184 (discussing fierce debate between proponents for rights of infected infant and advocates of general right to privacy of mother).

\textsuperscript{181} See N.Y. PUB. HEALTH LAW § 2782 (McKinney 1996).


\textsuperscript{183} See Richard Goldstein, Spare the Mother, Save the Child, VILLAGE VOICE, June 7, 1994, at 24 (discussing debate over rights of mother versus rights of child); Peter Hellman, Should It Be A Crime to Treat This Baby for AIDS?, N.Y. MAG., Feb. 21, 1994, at 25 (debating whether mother's rights outweigh infant's rights); John Riley, Focus on: Mandatory AIDS Tests Pain of Knowing Doctor, Clinician Disagree on Testing Moms, Newborns, NEWSDAY, July 25, 1993, at 15 (discussing doctor's dilemma over non-disclosure of HIV status).


\textsuperscript{185} See Olmstead v. United States, 277 U.S. 438, 465 (1928) (holding plaintiff's Fourth and Fifth amendment rights violated); see also Will, supra note 21, at 972 (explaining roots
an invasive medical procedure that usually requires consent before it can be performed.\textsuperscript{186} In addition, New York has specific confidentiality statutes in place to prevent the spread of test results regarding the patient's AIDS status.\textsuperscript{187} In the case of AIDS babies, however, there is a legitimate state interest served in disclosing HIV results — babies can be treated and transmission prevention controls can be implemented.\textsuperscript{188}

An additional interest is implicated at this juncture, because assessing the health of an innocent newborn implicates the mother's privacy rights. In \textit{Roe} and \textit{Casey}, the Court's rationale considered the state's interest in regulating abortions differently during each part of the pregnancy.\textsuperscript{189} \textit{Roe} dictates that the right to an abortion is not absolute\textsuperscript{190}, and there is a compelling state interest to protect the life of the unborn child from the point of viability until birth.\textsuperscript{191} The state interest espoused in the "AIDS Baby" Bill, and attempted in Public Health Law § 2500-f, is to affirmatively protect the child already born HIV-positive and living without sup-
Certainly this interest can be no less compelling than the interests preserved in *Casey*. This timid law seems to be a half-measure that does not even address, let alone resolve, the problem of properly balancing the mother’s right to privacy against the infant’s right to a healthy life. This new law still neglects the interest of the one individ-

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193 See *Casey*, 505 U.S. at 860 (restricting right to choose abortion to pre-viability of fetus); see also Goldstein, *supra* note 174, at J.C. (discussing additional limits on individual rights after *Casey*); Judges, *supra* note 59, at 1432 (discussing limitations imposed by *Casey*); Pacer, *supra* note 58, at 303 (describing reevaluation of extent of right of private after *Casey*).


195 In fact, the groups that had been at loggerheads over the AIDS Baby Bill are now all claiming victory over the passage of Section 2500-f. See Nat Hentoff, *The New Tuskegee Experiment: Infected Has a Right to be Told— No Matter What the ACLU Says*, *VILLAGE VOICE*, Oct. 1, 1996, at 8 (illustrating different conflicts between ACLU, NOW, Gay Men’s AIDS Crisis Center, and original bill sponsor Assemblywoman Mayersohn never resolved); Tom Precious, *Mothers to Learn if Infants Have HIV*, *TIMES UNION* (Albany), June 6, 1996, at A1 (reporting Mayersohn, proponent of bill, and Assemblyman Silver, opponent of bill, claiming § 2500-f victory for each); Holly Taylor, *Pataki Announces 2 Programs to Cope with AIDS*, *TIMES UNION* (Albany), June 27, 1996, at A7 (reporting Pataki claiming victory over blinded AIDS testing problems in past, but Mayersohn complaining law is small step in avoiding “medical abuse in its cruelest form”).

ual who cannot speak for herself — the infant. It seems what works smoothly politically will circumvent a moral standard.

CONCLUSION

The optimal resolution of the schism between disclosure and privacy would require an environment where HIV-infected people felt safe enough from the stigma of AIDS to disclose their illness to the health care workers who treat them. This is necessary for the health and safety of those workers, and in some instances, the health of themselves and their infants. What is clear, however, is that the New York Legislature should not continue to avoid this issue. The legislature has succumbed to quick and easy political compromises, and as a result, the courts must resolve the practical human issues.

In an imperfect world, citizens may not be motivated by respect and concern for others. It appears statutory regulation is necessary to force altruism and require that citizens conform with recommended precautions in order to stem the spread of HIV-infection.

The overriding state concern of preserving public health and welfare should take precedence over the right of all individuals to withhold knowledge of HIV-infection. Otherwise, the well-intended right to privacy, which protects individual citizens, may eventually collapse the society that created it.

Grace Kathleen Hogan & Nicole Wertz