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The Lesser of Two Evils: New York's New HIV/AIDS Partner Notification Law and Why the Right of Privacy Must Yield to Public Health

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THE LESSER OF TWO EVILS: NEW YORK'S NEW HIV/AIDS PARTNER NOTIFICATION LAW AND WHY THE RIGHT OF PRIVACY MUST YIELD TO PUBLIC HEALTH

The information gathering and surveillance activities of the . . . Government have expanded to such an extent that they are becoming a threat to several of every American's basic rights, the rights of privacy, speech, assembly, association, and petition of Government.

–Arthur Miller, Professor of Law, Harvard University, addressing the Senate Government Operations Committee.[1]

It was a lie. . . . Everything. My whole life. . . . Sometimes I just wish he were here—so I could kill him! . . . I want to wring his goddamn neck. I want to yell at him: 'How could you do this to us?' I want to tell him I'm scared . . . .

–"Marlene," 35, mother, widow, HIV-positive, describing her feelings toward her late husband, who infected her with the disease before succumbing to it himself.[2]

INTRODUCTION

In July of 1998, New York State enacted a new Title III to Article 21 of the Public Health Law, dedicated exclusively to the Human Immunodeficiency Virus ("HIV").[3] Taken together, the assorted provisions of Title III amount to a bold new partner notification scheme for New York,[4] complementing the State's previous partner notification statutes, yet greatly advancing the

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[1] Prof. Miller's remarks were included in the Committee's Report on Privacy and the Privacy Act. The Privacy Act of 1974, S. REP. NO. 93-1183, at 7 (1974), *reprinted in* 1974 U.S.C.C.A.N. 6916, 6922, *quoted in* United States v. Westinghouse Elec. Corp., 638 F.2d 570, 576 (3d Cir. 1980).

[2] Andrea Peyser, *Widow: My Life Was a Lie*, N.Y. POST, Feb. 8, 1993, at 5.

[3] *See* N.Y. PUB. HEALTH LAW §§ 2130–2139 (McKinney Supp. 1999). Title III was approved July 7, 1998, and became effective on January 3, 1999. *See* Act of July 7, 1998, ch. 163, 1998 N.Y. Sess. Laws 584 (McKinney 1999).

[4] *See* discussion *infra* Part III.

degree of State involvement in the notification process.[5] Unlike New York's prior partner notification laws, and unlike a substantial majority of notification laws in place throughout the nation,[6] Title III imposes an affirmative duty on physicians to report the names of their HIV-positive patients to the State Department of Health.[7] Thereafter, the Department will undertake contact tracing and notify the sexual and needle-sharing partners of the reported infected individual.[8]

New York is not the first state to implement a mandatory names-reporting system of partner notification. A handful of others have similar statutes in place.[9] Perhaps no state in this class, however, shares the volatile political climate of New York generally, nor specifically with respect to government involvement in AIDS/HIV prevention.[10] Since its application to

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[5] New York's statutes pertaining to HIV disclosure enacted prior to Title III did not go so far as to impose affirmative duties on physicians, or anyone else, to report those infected, or to inform sexual or needle-sharing partners. *See* N.Y. PUB. HEALTH LAW § 2782(4)(a) (McKinney 1993 & Supp. 1999) (*allowing* doctors to warn sexual partners of infected individuals that they may have been exposed to HIV, but not *requiring* that they do so). Another Act does impose mandatory testing for newborns and requires that results be disclosed, but that statute is limited in scope, as it is confined to newborn children. *See* N.Y. PUB. HEALTH LAW § 2500-f (McKinney Supp. 1999).

[6] *See supra* note 5; discussion *infra* Part II.

[7] *See* N.Y. PUB. HEALTH LAW § 2130(1) (McKinney Supp. 1999) ("Every physician or other person authorized by law to order diagnostic tests or make a medical diagnosis, or any laboratory performing such tests shall immediately [upon determining that such person is infected with HIV or has an HIV-related illness] report such case to the commissioner [of the Department of Health].").

[8] *See* N.Y. PUB. HEALTH LAW § 2133(1) (McKinney Supp. 1999) ("Every municipal health commissioner or the department's district health officer, upon determination that such reported case or, any other known case of HIV infection merits contact tracing in order to protect the public health, shall personally or through their qualified representatives notify the known contacts of the protected individual.").

[9] *See* MICH. COMP. LAWS § 333.5131(5)(b) (1992 & Supp. 1999); TEX. HEALTH & SAFETY CODE ANN. § 81.051(g)(2) (West Supp. 1999); discussion *infra* Part IV(c).

[10] Sponsors of the new partner notification bill in New York were barraged with letters and memoranda in opposition to the law by a diverse assortment of lobbyists and interest groups. *See, e.g.*, Position Paper on A. 6629/S. 4422 and A. 8861/S. 6051 from the Asian & Pacific Islander Coalition on HIV/AIDS Inc. 1–2 (undated) (on file with author) (urging that Title III be rejected and resources diverted to pre-existing voluntary partner notification measures); Memorandum in Opposition to Mandatory Partner Notification from the Empire State Pride Agenda 1 (Mar. 1998) (on file with author) (stating that the Pride Agenda is "strongly opposed" to Title III); Letter from P. Wayne Mahlke, President, Lesbian & Gay Democratic Club of Queens, to Hon. Nettie Mayersohn, New York State Assembly (June 2, 1998) (on file with author) (urging Assemblywoman Mayersohn to withdraw the partner notification

HIV, partner notification has met with fierce opposition by a vocal, extremely organized lobby of AIDS-positive persons, as well as an overwhelming cadre of gay and lesbian advocacy groups.[11] Such groups are extremely active in New York, and many vehemently opposed the passage of Title III.[12] Because Title III contemplates mandatory partner notification rather than voluntary notification, many opponents have branded the law as too intrusive upon the privacy of those infected with AIDS/HIV, describing it as inexcusably "coercive."[13]

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bill); Memorandum in Opposition to A. 6629-A/S. 4422-A from the Social Concerns Commission and the AIDS Ministry of the Episcopal Diocese of New York (undated) (on file with author) (urging that Title III be defeated). Other organizations opposed to the law include the American Civil Liberties Union Lesbian and Gay Rights Project, New York Civil Liberties Union, ACT UP New York, Harlem Congregation for Community Improvement (HCCI), HIV Law Project, and Catholic Charities Community & Residential Services. *See* Media Release from Stephen Soba et al. 3–4 (Apr. 29, 1998) (on file with author).

[11] *See* Lawrence O. Gostin, (Hon.) & James G. Hodge, Jr., *The "Names Debate": The Case for National HIV Reporting in the United States*, 61 ALB. L. REV. 679, 696 (1998) [hereinafter Gostin & Hodge, *Names Debate*] (discussing the early implementation of names reporting and the almost immediate opposition that ensued).

[12] *See supra* note 10. The bone of contention for many opponents is the mandatory, rather than voluntary nature of Title III's provisions, and the possible effect of deterring persons from voluntarily seeking HIV testing. For example, Amy Herman, the Executive Director of the New York AIDS Coalition, has declared that "[t]he New York AIDS Coalition and its members do not oppose partner notification; it opposes mandatory partner notification. There is a significant difference between the two." Amy Herman, *Keep HIV Partner Notification Voluntary*, DAILY GAZETTE, May 5, 1998, (Letters to the Editor) at 33A.; *see also* Letter from the Council of AIDS Program Directors and the Council of HIV Ambulatory Care Clinical Directors, The New York Academy of Medicine, to Hon. Richard N. Gottfried, Chairman, New York State Assembly Committee on Health 2 (May 8, 1998) (on file with author) (stating that mandatory notification may deter people from seeking testing); Memorandum of Opposition to A. 6629/S. 4422 (Mayersohn/Velella) from the Gay Men's Health Crisis 1 (undated) (on file with author) (urging better training of health care providers under current voluntary notification program); Memorandum in Opposition to Mandatory Reporting and Notification of HIV/AIDS Status from the National Organization for Women, New York State (Mar. 23, 1998) (on file with author) (stating that mandatory notification "will ultimately deter individuals from seeking diagnostic testing and health care"); The Social Concerns Commission and the AIDS Ministry of the Episcopal Diocese of New York, *supra* note 10, at 1 ("The Commission strongly supports voluntary notification... [r]equiring mandatory notification, specifically one which reports names, creates an enormously suspicious and hostile environment which will certainly work against the goal of educating and treating those with HIV.").

[13] *See* Herman, *supra* note 12, at 33A ("[L]awmakers wish to create a mandatory one-time program—which is viewed by many as coercive... ."); The National Organization for Women, New York State, *supra* note 12 (characterizing

Indeed, it seems apparent that mandatory HIV partner notification represents a degree of intrusion into the personal matters of infected individuals. Some critics have likened the state imposing compulsory HIV testing and disclosure measures to an Orwellian "Big Brother," posing serious threats to our fundamental rights of privacy.[14] Striking justifications for such a dramatic legislative initiative as Title III, however, are found in the cold hard numbers measuring the dangers and proliferation of this disease. In recent years, New York State has come to have more AIDS cases than any other state in the country,[15] and the disease threatens to permanently injure the demographic composition of New York's population.[16] Faced with dual crises of the abridgement of our liberties and medical emergency, one instinctively undertakes a personal calculus, weighing the State's purpose in enacting an aggressive partner notification law and the individual's interest in preserving his privacy with respect to his AIDS/HIV status. In a testament to

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mandatory notification as "a flagrant violation of an individual's right to privacy"); Soba et al., *supra* note 10, at 1 ("The [mandatory notification] bill would create a coercive, government-directed partner notification program for HIV."); *see also* American Civ. Liberties Union, *ACLU AIDS Project Report: HIV Partner Notification, Why Coercion Won't Work, Mar. 1998* (visited Nov. 13, 1999) <http://www.aclu.org/issues/aids/hiv_partner.html> [hereinafter *ACLU AIDS Project Report*] ("[T]he ACLU adamantly opposes state-mandated coercive partner notification, including plans that require individuals with HIV to provide the names of their partners to public health authorities and/or require public heath authorities to notify partners without the consent of the patient.").

[14] *See generally* Kellie E. Lagitch, Note, *Mandatory HIV Testing: An Orwellian Proposition*, 72 ST. JOHN'S L. REV. 103 (1998) (discussing the constitutional implications of mandatory HIV testing).

[15] *See* Miriam R. Albert, *Selling Death Short: The Regulatory and Policy Implications of Viatical Settlements*, 61 ALB. L. REV. 1013, 1024 n.54 (1998) (providing numbers of reported AIDS cases through mid-1997 in all fifty states). New York had 108,756 confirmed cases of AIDS through December 1996, the highest of any of the states that had reported 5,000 or more AIDS cases. *See* NEW YORK STATE DEP'T OF HEALTH, AIDS IN NEW YORK STATE: 1997 EDITION 59 (1997). The state with the next highest number of confirmed AIDS cases was California, with 98,157, and Florida came in third with 58, 911. *See id.* It seems that New York's more stringent partner notification statute is a reflection of its extremely high AIDS rates in comparison with the rest of the United States. *See supra* note 41.

[16] *See* Chris Norwood, *Mandated Life Versus Mandatory Death: New York's Disgraceful Partner Notification Record*, 20 J. COMMUNITY HEALTH 161, 165–66 (1995) (explaining that Blacks and Latinos comprise a dramatically disproportionate number of AIDS cases in New York and that unprecedented rates of mothers dying from AIDS in New York City are leading to one of the largest mass orphanings in history).

the law's tendency to reflect natural human reasoning, the applicable case law on privacy and AIDS/HIV contemplates just such a solution to the problem. In the absence of a Supreme Court decision on AIDS/HIV disclosure, the federal circuit and district courts have applied a balancing test, weighing state and individual interests against one another.[17]

This Note seeks to contribute to the discourse on AIDS/HIV partner notification with a decidedly narrow focus: To demonstrate why New York's Title III should survive a right of privacy challenge, based on current federal precedent. If this Note assists either the opponents of Title III in assessing their options for a challenge to the law, or the proponents of Title III in crafting a defense to a privacy challenge, then this somewhat specific objective will have been satisfied. In short, this Note takes the position that, within the framework of the dominant balancing test used in federal courts to review issues of AIDS/HIV disclosure, New York State's interest in enacting Title III sufficiently outweighs the infected individual's privacy interest in maintaining the confidentiality of his status. Whereas notification laws of such an aggressive nature represent a troubling new incursion into our liberties, the choice to implement such laws has been made necessary by the relentless assault of an unforgiving killer. The choice is one that

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[17] *See, e.g.*, Doe v. City of New York, 15 F.3d 264, 269 (2d Cir. 1994) (explaining that resolution of a claim would require weighing a plaintiff's privacy interest in avoiding disclosure of his HIV status against the city's interest, which must be substantial); Harris v. Thigpen, 941 F.2d 1495, 1515 (11th Cir. 1991) (stating that an inmate's "limited personal privacy interest[]" must be balanced against the State Department of Correction's decision to segregate HIV-positive inmates from the other, unaffected inmates); P.F. v. Mendres, 21 F. Supp. 2d 476, 483 (D.N.J. 1998) (stating that the court's task is to balance an individual's expectation of privacy regarding his HIV status with the governmental interest in disclosing such information) (citing Murray v. Pittsburgh Bd. of Educ., 759 F. Supp. 1178, 1182 (W.D. Pa. 1991)); Doe v. Town of Plymouth, 825 F. Supp. 1102, 1107–08 (D. Mass. 1993) (same); Doe v. City of Cleveland, 788 F. Supp. 979, 985 (N.D. Ohio 1991) (stating that not *all* information is protected from disclosure, but information relating to AIDS is fundamental enough to be protected, and finding that Doe's privacy interest in non-disclosure was not outweighed by governmental interest); Woods v. White, 689 F. Supp. 874, 876 (W.D. Wis. 1988) (noting that "[c]ourts have defined the scope of privacy rights on a case-by-case method, balancing the individual's right to confidentiality against the governmental interest in limited disclosure," and stating such balance is not required when the prison medical personnel "make no claim that any important public interest was served in their discussion of plaintiff's positive test for the AIDS virus").

necessarily burdens the conscience, yet it is, ultimately, the election of the lesser of two evils.

Part I of this Note provides a brief background on the rise of the AIDS dilemma and the development of partner notification. Part II establishes a context in which to view New York's Title III and mandatory names reporting by reviewing the norms in partner notification laws nationwide. Part III provides a detailed description of Title III and its numerous provisions. Part IV examines the constitutional right of privacy, generally, and as it pertains to the individual right to the avoidance of disclosure of personal information, including the disclosure of one's AIDS/HIV status. Finally, Part V applies the dominant right of privacy balancing analysis to Title III and endeavors to identify and weigh New York State's interest in enacting this legislation and the individual's interest in avoiding disclosure.

I. AIDS, GENERALLY, AND THE DEVELOPMENT OF PARTNER NOTIFICATION

The term "AIDS" is an acronym for "acquired immunodeficiency syndrome," a disease characterized by the gradual decease of the body's immune system.[18] It is generally accepted that the disease is caused by the human immunodeficiency virus, or HIV.[19] A person may live with HIV for several years before developing the family of symptoms identified with AIDS.[20] Although recent developments in medicine have brought measured success in suppressing cases of HIV treated early,[21] those cases which do develop into AIDS

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[18] *See* JOSH POWELL, AIDS AND HIV-RELATED DISEASES: AN EDUCATIONAL GUIDE FOR PROFESSIONALS AND THE PUBLIC 5 (1996).

[19] *See id.*

[20] *See id.* at 17. The actual latency period for HIV infection is hard to pin down. The amount of time it takes for HIV-positive individuals to display symptoms of AIDS has increased dramatically over the past twelve years. In 1986, it was believed that HIV developed into full-blown AIDS in less than two years. By 1992, the latency period had become as long as fifteen years. *See* ROBERT S. ROOT-BERNSTEIN, RETHINKING AIDS: THE TRAGIC COST OF PREMATURE CONSENSUS 55 (1993).

[21] New combination drug treatments commonly referred to as "cocktails" have been very successful in suppressing, but not killing HIV. In many cases, these cocktails have helped prevent persons with HIV from becoming sick as a result of their illness. *See AIDS Treatments Cheaper Than Believed*, WASH. POST, Dec. 24, 1998, at A9, *available in* 1998 WL 22542950 (noting cocktails "have proved powerfully effective"); *FDA Approves AIDS Drug for Use Against Hepatitis B*, CHI. TRIB., Dec. 17, 1998, at 7, *available in* 1998 WL 23516406 (noting Epivir can

remain relatively untreatable, and the condition is almost always fatal.[22]

HIV transmission is possible only upon the presence of three factors: "(1) a point of exit from the infected individual, (2) a mechanism to transport the virus to another person, and (3) a point of entry into a second body."[23] HIV is transmitted most frequently through sexual contact,[24] while a large number of cases also emerge from the shared use of hypodermic needles.[25] Although anal sex is particularly conducive to the spread of the illness,[26] transmission may also occur via vaginal intercourse[27] or, to a lesser extent, oral sex.[28] Generally, heterosexual intercourse poses a greater risk of transmission to women than it does to men.[29]

Since its initial documentation in the late 1970s,[30] the number of AIDS cases worldwide and in the United States has increased dramatically.[31] By a recent estimate, there are 22.6 million cases, globally.[32] It is no wonder then that a number of

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suppress the HIV virus and has been approved for usage against hepatitis B). *But see* Richard A. Knox, *Some Patients Controlling HIV After Stopping Drug Cocktail*, BOSTON GLOBE, Jan. 26, 1999, at A8, *available in* 1999 WL 6045080 (stating that when HIV-infected patients stop taking their "cocktails" the virus quickly returns to pretreatment levels).

[22] *See* John W. Ward et al., *Current Trends in the Epidemiology of HIV/AIDS*, *in* THE MEDICAL MANAGEMENT OF AIDS 3, 6 (Merle A. Sande, M.D. & Paul A. Volberding, M.D. eds., 5th ed. 1997).

[23] POWELL, *supra* note 18, at 33.

[24] *See id.* at 34; RICHARD D. MUMA ET AL., HIV MANUAL FOR HEALTH CARE PROFESSIONALS 8–10 (1994); Wayne R. Cohen, *An Economic Analysis of the Issues Surrounding AIDS in the Workplace: In the Long Run, the Path of Truth and Reason Cannot Be Diverted*, 41 AM. U. L. REV. 1199, 1205 (1992) (listing primary means of HIV virus transmission); Michael A. Grizzi, Recent Developments, *Compelled Antiviral Treatment of HIV-Positive Pregnant Women*, 5 U.C.L.A. WOMEN'S L.J. 473, 479 (1995) (discussing forms of HIV virus transmission and dangers of perinatal transmission).

[25] *See* MUMA, *supra* note 24, at 10; POWELL, *supra* note 18, at 39; Cohen, *supra* note 24, at 1206–07; Grizzi, *supra* note 24, at 479.

[26] *See* POWELL, *supra* note 18, at 36.

[27] *See id.* at 38.

[28] *See id.* at 37–38.

[29] *See id.* at 38.

[30] *See* MUMA, *supra* note 24, at 7.

[31] *See id.*; *see also* Ward, *supra* note 22, at 3–4 (discussing AIDS incidence in the early 1990's and explaining fluctuations); *id.* at 11 (describing the magnitude of the epidemic and its worldwide transmission).

[32] *See HIV/AIDS: Recent Developments and Future Opportunities: Hearing on S. 353 Before the Senate Comm. on Labor and Human Resources*, 105th Cong. 49

states throughout the United States have taken measures to slow the further spread of the disease. Partner notification as we know it today was developed initially in the 1930s, as a means of controlling the spread of the problematic venereal diseases of that era, most notably syphilis.[33] After some initial trepidation by the states,[34] various partner notification models to be used in the fight against AIDS found their way to the books.[35] Although there are several different approaches to partner notification, what these laws share in common is the objective of informing those most at risk of contracting HIV—sexual partners and hypodermic needle-sharing partners of persons already infected.[36]

AIDS and HIV partner notification has been the subject of much controversy. AIDS is an unusually politicized disease, in that certain discrete groups, which already consider themselves somewhat marginalized by society, have seen a disproportionatel y high incidence of infection.[37] Gay and lesbian organizations, in particular, have perceived many partner notification measures to be intrusive and violative of the privacy interests of infected individuals,[38] a substantial number of whom are gay men.[39]

(1997) (presentation by Anthony S. Fauci, M.D., Dir., Nat'l Inst. of Allergy and Infectious Diseases, Nat'l Insts. of Health).

[33] *See* Roger Doughty, *The Confidentiality of HIV-Related Information: Responding to the Resurgence of Aggressive Public Health Interventions in the AIDS Epidemic*, 82 CAL. L. REV. 111, 118–19 (1994) (surveying public health strategies for communicable diseases in general); Lawrence O. Gostin & James G. Hodge, Jr., *Piercing the Veil of Secrecy in HIV/AIDS and Other Sexually Transmitted Diseases: Theories of Privacy and Disclosure in Partner Notification*, 5 DUKE J. GENDER L. & POL'Y 9, 16 (1998) [hereinafter Gostin & Hodge, *Piercing the Veil*] (discussing the origins of "contact tracing" in partner notification); *ACLU AIDS Project Report*, *supra* note 13, at ch. II.

[34] Apprehension followed from the fact that partner notification schemes were vehemently opposed by many gay rights organizations. *See* Gostin & Hodge, *Piercing the Veil*, *supra* note 33, at 25.

[35] *See id.* at 25–26 (discussing the contemporary practice of contact tracing).

[36] *See generally id.*; *see also* Doughty, *supra* note 33, at 118; *ACLU AIDS Project Report*, *supra* note 13, at ch. I.

[37] *See* Doughty, *supra* note 33, at 118; *see also supra* notes 10, 12.

[38] *See* Gostin & Hodge, *Names Debate*, *supra* note 11, at 696–97 (discussing the inception of the modern AIDS epidemic and early attempts at AIDS name reporting). Ronald S. Johnson, Managing Director for Public Policy for The Gay Men's Health Crisis (GMHC), the nation's oldest and largest AIDS organization, has stated that the New York State Department of Health's draft regulations for partner notification laws "will interfere with efforts to provide services to people living with HIV and hamper our ability to reduce HIV infection rates among at-risk populations." *GMHC Opposes New York State Health Department's Draft*

Advocacy groups have aggressively campaigned against many partner notification measures.[40] New York State is one of the nation's leaders in sheer numbers of AIDS cases.[41] The class of advocacy against partner notification in New York appears to be

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Regulations on Partner Notification, Mar. 12, 1999 (visited Aug. 6, 1999) <http://www.thebody.com/gmhc/pr/mar1299.html>. He felt that "[t]hese regulations pose a threat to our attempt to encourage testing for those at risk and treatment for those already diagnosed as HIV positive." *Id.* The gay rights group ACT UP believes that any kind of partner notification would lead to discrimination in employment, housing, and health care. *See* Matthew V. Sharp, *HIV Name Reporting Rears Its Ugly Head, Nov. 20, 1997* (visited Aug. 6, 1999) <http://www.actupgg.org/BAR.art 112097.html>. The San Francisco AIDS Foundation believes that "[a] mandatory notification program would violate the trust between... partners." *Toward 2000: An HIV/AIDS Policy Agenda for California HIV Testing and Reporting* (visited Aug. 6, 1999) <http://www.sfaf.org/policy/caagenda99/testing.html>.

[39] *See* POWELL, *supra* note 18, at 34–37.

[40] *See* Gostin & Hodge, *Names Debate*, *supra* note 11, at 696; *see also supra* note 38 and accompanying text (discussing gay activist groups' reactions to partner notification laws). In addition, many non-gay groups oppose partner notification laws. The National Organization for Women (N.O.W.) opposes partner notification laws on the grounds that they will exacerbate the AIDS crisis in New York by deterring individuals from seeking diagnostic testing and health care. *See* The National Organization for Women, *supra* note 12. The New York Academy of Medicine similarly believes that partner notification laws will deter people from being tested for HIV and could promote domestic violence when partners are informed by strangers of potential exposure. *See* The Council of AIDS Program Directors and HIV Ambulatory Care Clinical Directors, The New York Academy of Medicine, *supra* note 12, at 2. The American Psychological Association Policy Action Network for Women Living with HIV/AIDS (PANWHA) opposes any kind of partner notification because it would place an unnecessary financial burden on states and divert resources from other, more effective HIV prevention strategies. *See Policy Action Network for Women Living with HIV/AIDS (PANWHA) Opposes the So-called 'HIV Prevention Act of 1997'* (visited Nov. 13, 1999)<http://www.apa.org/ppo/coburn.html>. PANWHA posits that mandatory notification of women's HIV-positive status to their male sexual partners will lead to physical and emotional abuse. *See id.* There are groups, however, that support partner notification as an effective measure in reducing the spread of AIDS. The Journal of the American Medical Association, for example, states that partner notification could be crucial in "breaking the chain of transmission." *JAMA Women's Health STD Information Center Report Partner Notification and Management of Sex Partners* (visited Nov. 13, 1999) <http://www.amaassn.org/special/std/treatmnt/guide/stdg3408.htm>.

[41] *See* Gostin & Hodge, *Names Debate*, *supra* note 11, at 710 (explaining that New York and California have more AIDS cases than any other state). The U.S. Department of Health and Human Services, HIV/AIDS Surveillance Report indicated that, as of December 1998, there were 128,675 reported cases of AIDS in New York and 110,056 cases in California. These two states combined account for over one third of the 664,921 total reported cases of AIDS. In fact, the combined figure tops the next seven highest totals combined (New Jersey, Pennsylvania, Texas, Florida, Georgia, Illinois, and Maryland). *United States HIV & AIDS Statistics by State* (visited Sept. 25, 1999) <http://www.avert.org/usastats.htm>.

quite high. It is against this backdrop which New York introduced Title III of the Public Health Law.

II. PARTNER NOTIFICATION LAWS, GENERALLY

In order to understand the manner in which New York's Title III differs from the status quo in partner notification, it is necessary to examine the more common partner notification schemes in operation in other states.[42] A review of these statutes reveals substantial diversity in approach from one state to the next.[43] Nevertheless, several broad categories of partner notification methods do become clear. At the outset, it should be noted that many states have statutes which utilize multiple partner notification methods alternatively.[44] Furthermore, there are some approaches which do not belong in any one category.[45]

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[42] *See* Gostin & Hodge, *Piercing the Veil*, *supra* note 33, at 27–32, 47–51 (enumerating a complete list of partner notification statutes in use throughout the United States); *ACLU AIDS Project Report*, *supra* note 13 (same).

[43] For example, New Jersey permits partner notification only upon a court order. *See* N.J. STAT. ANN. § 26:5C-9(a) (West 1996). In contrast, California allows physicians to notify spouses, sexual partners, and needle-sharing partners directly, requiring no court order. *See* CAL. HEALTH & SAFETY CODE § 121015(a) (Deering 1997). There is also diversity amongst the statutes on the issue of whether a physician has an affirmative duty to warn. For example, Michigan has created an affirmative duty for physicians and local health officers to notify the partner. *See* MICH COMP. LAWS § 333.5131(5)(b) (West 1998). Physicians in West Virginia have no such duty. *See* W. VA. CODE § 16-3c-3(e) (1998).

[44] New York itself has several different forms of partner notification on the books. Among them are what this Note terms a "Notification by Petition" provision, a "Permissive Direct Notification" provision, and, of course, the new Title III. *See* N.Y. PUB. HEALTH LAW §§ 2785, 2782(4), 2130–2139 (McKinney 1993 & Supp. 1999) (respectively). New York also has a law requiring HIV testing of all newborn which allows for limited disclosures. *See* N.Y. PUB. HEALTH LAW § 2500-f (McKinney Supp. 1999); Assemblywoman Nettie Mayersohn, *The "Baby AIDS" Bill*, 24 FORDHAM URB. L.J. 721, 721–22 (1997) (discussing the Bill's background and the need to disclose that a baby has tested HIV-positive). Other states that allow for partner notification both by a physician and by court order include Pennsylvania and Louisiana. *See* LA. REV. STAT. ANN. §§ 40:1300.14 E(1), 40:1300.15 (West 1992); PA. STAT. ANN. tit. 35, §§ 7608–7609 (West 1993).

[45] For example, Colorado's enactments are not partner notification laws per se. They are, nevertheless, laws designed to curb the spread of HIV, requiring infected individuals to cease and desist from certain specified conduct (presumably sexual activity) if so ordered by the authorities, and allowing uncooperative individuals to be temporarily incarcerated for noncompliance. *See* COLO. REV. STAT. §§ 25-4-1406–25-4-1407 (1998); *see also* ME. REV. STAT. ANN. tit. 22, § 810 (West 1992) (allowing for incarceration of an HIV infected person who becomes an imminent danger to public health); N.D. CENT. CODE § 23-07.4-01 (1991 & Supp. 1997).

The broad categories of partner notification laws are identified and discussed below.

A. *Notification by Petition*

Certainly the least intrusive means of partner notification is what might be termed "Notification by Petition." Under this approach, an individual may petition a court to disclose another person's HIV/AIDS status, notwithstanding traditional confidentiality protections concerning one's medical condition.[46] Although, generally this recourse is not explicitly limited to sexual or needle-sharing partners of the subject in question,[47] certainly a spouse or partner of a person suspected to have HIV or AIDS could file such a petition. Accordingly, this is a means of partner notification.[48]

Whereas some codes are vague or silent as to the legal standards involved,[49] most provide some guidance as to what courts should, or must consider, in reaching their determinations.[50] Commonly, statutes permit the courts to order disclosure of the subject's AIDS/HIV status where the petitioner has shown a "compelling need" for the information.[51] States such

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[46] *See, e.g.*, DEL. CODE ANN. tit. 16, § 1203(a)(10)(a) (1995); N.J. STAT. ANN. § 26:5C-9(a) (West 1996); OHIO REV. CODE ANN. § 3701.243(C)(1)(b) (Anderson 1997); PA. STAT. ANN. tit. 35, § 7608 (West 1993); W. VA. CODE § 16-3C-3(a)(9) (1998).

[47] For example, Ohio's provision states: "*Any* person or government agency may seek access to or authority to disclose the HIV test records of an individual...." OHIO REV. CODE ANN. § 3701.243(C)(1) (Anderson 1997) (emphasis added).

[48] In its survey of nation-wide partner notification laws, the ACLU includes several citations to petition-style statutory provisions. *See ACLU AIDS Project Report*, *supra* note 13.

[49] For example, North Carolina apparently allows judicial orders of disclosure, without positing any standards of review: "[AIDS/HIV status] information shall not be released or made public except under the following circumstances... (6) Release is made pursuant to a subpoena or court order." N.C. GEN. STAT. § 130A-143 (1995); *see also* ME. REV. STAT. ANN. tit. 5, § 19203-D(2)(E) (West 1989); OKLA. STAT. tit. 63, § 1-502.2(A)(1) (Supp. 1999).

[50] *See infra* notes 53–65 and accompanying text.

[51] "The court may issue an order granting the plaintiff access to or authority to disclose the [HIV/AIDS] test results only if the court finds by clear and convincing evidence that the plaintiff has demonstrated a compelling need for disclosure of the information that cannot be accommodated by other means." OHIO REV. CODE ANN. § 3701.243(C)(1)(b) (Anderson 1997); *see also* DEL. CODE ANN. tit. 16, § 1203(a)(10)(a) (1995); N.D. CENT. CODE § 23-07.4-01(4) (SUPP. 1997) (allowing a court ordered disclosure of someone's HIV/AIDS status to his partners only upon clear and convincing evidence that disclosure is necessary); PA. STAT. ANN. tit. 35, § 7608 (West 1993); W. VA. CODE § 16-3C-3(a)(9) (Supp. 1999).

as Delaware,[52] Ohio,[53] Pennsylvania,[54] and West Virginia[55] measure whether a need is "compelling" through virtually identical balancing tests. Ordinarily, the courts must "weigh the need for disclosure against the privacy interest of the individual and the public interests which may be harmed by disclosure."[56] These "public interests" which may be harmed are specifically identified in some states as the deterrence of future voluntary AIDS/HIV testing by the public, and the engendering of discrimination.[57]

Although New Jersey[58] and Washington[59] purport to use a "good cause" standard rather than the nominally more stringent "compelling need" approach, those states utilize comparable, if not more exacting balancing tests.[60] Michigan[61] and the District of Columbia[62] opt for less defined but, perhaps, more flexible standards. The District of Columbia, for instance, permits a court to order disclosure simply when the court finds "upon clear and convincing evidence . . . that disclosure . . . is essential to safeguard the physical health of others."[63]

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[52] *See* DEL. CODE ANN. tit. 16, § 1203(a)(10)(a) (1995).

[53] *See* OHIO REV. CODE ANN. § 3701.243(C)(1)(b) (Anderson 1997).

[54] *See* PA. STAT. ANN. tit. 35, § 7608(c) (West 1993).

[55] *See* W. VA. CODE § 16-3C-3(a)(9)(i) (1998).

[56] PA. STAT. ANN. tit. 35, § 7608(c) (West 1993); *see also* FLA STAT. ch. 381.004 (3)(e)(9)(a) (1999); LA. REV. STAT. ANN. § 40:1300:15 E (West 1992).

[57] *See* FLA. STAT. ch. 381.004 (3)(e)(9)(a) (1999); OHIO REV. CODE ANN. § 3701.243 (C)(1)(b) (Anderson 1997).

[58] *See* N.J. STAT. ANN. § 26:5C-9(a) (West 1996).

[59] *See* WASH. REV. CODE § 70.24.105(f) (1998 & Supp. 1999-2000).

[60] New Jersey contemplates that, "[a]t a good cause hearing the court shall weigh the public interest and need for disclosure against the injury to the person who is the subject of the record, to the physician-patient relationship, and to the services offered by the program." N.J. STAT. ANN. § 26:5C-9(a) (West 1996); *see also* WASH. REV. CODE § 70.24.105(f) (1998 & Supp. 1999-2000) ("In assessing good cause, the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services.").

[61] *See* MICH. COMP. LAWS § 333.5131(3)(a) (1992 & Supp. 1999).

[62] *See* D.C. CODE ANN. § 6-117(b)(1)(B) (1995).

[63] *Id.* Similarly, Michigan permits an order to disclose only when the court has determined: (i) "[t]hat other ways of obtaining the information are not available or would not be effective;" and "(ii) [t]hat the public interest and need for the disclosure outweigh the potential for injury to the patient." MICH. COMP. LAWS § 333.5131(3)(a) (1992 & Supp. 1999). Other states that have flexible standards include Ohio and North Carolina. *See* N.C. GEN. STAT. § 130A-143(4) (1995) (listing circumstances in which AIDS test results may be released, including when "[r]elease is necessary to protect the public health"); OHIO REV. CODE ANN. § 3701.243(C)(1)(b) (Anderson 1997) ("The court may issue an order granting . . .

Whatever standard is used to determine whether disclosure is appropriate, most statutes of this variety expressly limit the range of information the court may in fact disclose. Several states compel their courts to "guard against unauthorized disclosure by specifying the persons who may have access to the information, the purposes for which the information shall be used, and prohibitions against future disclosure."[64] Washington, Michigan, and New Jersey further limit the scope of disclosure by requiring that courts consider and make determinations as to which *portions* of a sought record may be disclosed.[65] Petitioners must endure the costly and time-consuming nature of the court system, negotiate unwelcoming balancing tests and face even further limitation tailored to protect individuals infected with AIDS/HIV. Thus, it seems clear that notification by petition is not the most rapid or efficient means of partner notification.

B. Permissive Direct Physician Notification

The most frequently encountered partner notification method might be labeled "Permissive Direct Physician Notification."[66] A number of states permit direct partner notification by physicians, including California,[67] Florida,[68] Illinois,[69] Alabama,[70] Connecticut,[71] Georgia,[72] Iowa,[73] Montana,[74]

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authority to disclose the test results only if the court finds by clear and convincing evidence that the plaintiff has demonstrated a compelling need for disclosure . . . .").

[64] OHIO REV. CODE ANN. § 3701.243(C)(1)(c) (Anderson 1997); *see also* DEL. CODE ANN. tit. 16, § 1203(a)(10)(e) (1995).; N.J. STAT. ANN. § 26:5C-9(a) (West 1996); PA. STAT. ANN. tit. 35, § 7608(h)(4) (West 1993).

[65] *See* WASH. REV. CODE § 70.24.105(f) (1998 & Supp. 1999-2000) (providing in part: "An order authorizing disclosure shall: (i) Limit disclosure to those parts of the patient's record deemed essential to fulfill the objective for which the order was granted . . . ."). Michigan has a similar provision, as does New Jersey and Pennsylvania. *See* MICH. COMP. LAWS § 333.5131(3)(b) (1992 & Supp. 1999); N.J. STAT. ANN. § 26:5C-9(a) (West 1996); PA. STAT. ANN. tit. 35, § 7608(h)(1) (West 1993).

[66] A considerable number of states utilize this method. *See infra* notes 67–82 and accompanying text.

[67] *See* CAL. HEALTH & SAFETY CODE § 121015(a) (Deering 1997).

[68] *See* FLA. STAT. ch. 455.674(1) (1999), *amended by* 1999 Fla. Laws ch. 99-8 §220.

[69] *See* 410 ILL. COMP. STAT. 305/9(a) (1999).

[70] *See* ALA. CODE § 22-11A-38(d) (1997).

[71] *See* CONN. GEN. STAT. § 19a-584(b) (1999). Connecticut's statute is somewhat more limited than most. It provides that a physician may directly notify a known partner of an infected individual's HIV status only if both the infected individual and the partner are under the physician's care. *See id.* If the partner is not under

Pennsylvania,[75] Kansas,[76] Rhode Island,[77] South Carolina,[78] Virginia,[79] Tennessee,[80] Washington,[81] and West Virginia.[82]

Statutes utilizing this method permit physicians to notify the sexual or drug needle-sharing partners of infected individuals of the pertinent risks of exposure.[83] The information flows directly from the doctor who has discovered the infection (via testing procedures, etc.) to those individuals who are at risk

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the physician's care, then the physician's only means of notification is to report the matter to a public health officer. *See id.* The health officer, in turn, may notify the partner. *See id.*

[72] *See* GA. CODE ANN. § 24-9-47(g) (1995).

[73] *See* IOWA CODE § 141.6 (1999).

[74] *See* MONT. CODE ANN. §50-16-1009(3) (1997). Montana's statute is somewhat ambiguous as to the degree of authority it confers upon physicians to disclose, and may only permit the physician to solicit the cooperation of the infected individual, providing that "[i]f the subject is unable or unwilling to notify all contacts, the health care provider may ask the subject to disclose voluntarily the identities of the contacts and to authorize notification of those contacts." *Id.*

[75] *See* PA. STAT. ANN. tit. 35, § 7609(a) (West 1993).

[76] *See* KAN. STAT. ANN. § 65-6004(b) (1992 & Supp. 1998), *amended by* 1999 Kan. Sess. Laws 109 §4.

[77] *See* R.I. GEN. LAWS § 23-6-17(2)(v) (1996).

[78] *See* S.C. CODE ANN. § 44-29-146 (Law. Co-op. Supp. 1998).

[79] *See* VA. CODE ANN. § 32.1-36.1(A)(11) (Michie 1997).

[80] *See* TENN. CODE ANN. § 68-10-115 (1996) (providing that "[a] person who has a reasonable belief that a person has knowingly exposed another to HIV may inform the potential victim without incurring any liability").

[81] *See* WASH. REV. CODE § 70.24.105(2)(h) (1998 & Supp. 1999-2000).

[82] *See* W. VA. CODE § 16-3C-3(d) (1998).

[83] For example, Georgia law states:

> When the patient of a physician has been determined to be infected with HIV and that patient's physician reasonably believes that the spouse or sexual partner or any child of the patient, spouse, or sexual partner is a person at risk of being infected with HIV by that patient, the physician may disclose to that spouse, sexual partner, or child that the patient has been determined to be infected with HIV, after first attempting notify the patient that such disclosure is going to be made.

GA. CODE ANN. § 24-9-47(g) (1995). Another example may be found in the laws of Kansas, which provide:

> [A] physician who has reason to believe that the spouse or partner of a person who has had laboratory confirmation of HIV infection or who has AIDS may have been exposed to HIV and is unaware of such exposure may inform the spouse or partner of the risk of exposure.

1999 Kan. Sess. Laws 109 §4 (amending KAN STAT. ANN. § 65.6004(b) (1992 & Supp. 1998)); *see also* CAL. HEALTH & SAFETY CODE § 121015(a) (Deering 1997) ("[N]o physician and surgeon . . . shall be held criminally or civilly liable for disclosing to a person reasonably believed to be the spouse, or to a person reasonably believed to be a sexual partner or a person with whom the patient has shared the use of hypodermic needles . . . that the patient has tested positive on a[n] [HIV detection] test . . . .").

of contracting the disease.[84] These statutes tend to explicitly exempt physicians from any civil or criminal liability for their disclosures, provided that the disclosing physician has complied with any other requirements which may be imposed.[85] In marked contrast to Notification by Petition methods, the courts are not involved. That is, these acts, on their faces, confer a limited authority upon physicians to make carefully defined disclosures, without requiring judicial orders.[86]

The question of paramount importance is, under precisely what circumstances is partner notification permitted? Each state has its own answer.

The authority to disclose seems to be at its broadest in those states which permit notification to certain persons simply by virtue of the nature of their relationship to the infected individual.[87] Most notably, California's statute suggests such an approach.[88] In that state:

> [N]o physician ... who has the results of a confirmed positive [AIDS/HIV] test ... of a patient under his care shall be held criminally or civilly liable for disclosing to a person reasonably believed to be the *spouse*, or to a person reasonably believed to be a *sexual partner* or a *person with whom the patient has shared the use of hypodermic needles* ... that the patient has tested positive ....[89]

Similarly, Kansas authorizes disclosure to spouses and sexual partners but makes no comparable provision for needle-sharing contacts.[90] Virginia tailors its act even more narrowly,

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[84] *See, e.g.*, CAL. HEALTH & SAFETY CODE § 121015(a) (Deering 1997); GA. CODE ANN. § 24-9-47(g) (1995); KAN. STAT. ANN. § 65.6004(b) (1992 & Supp. 1998), *amended by* 1999 Kan. Sess. Laws 109 §4.

[85] "Any physician who discloses ... information in accordance with the provisions of this section in good faith and without malice shall have immunity from any liability, civil or criminal, that might otherwise be incurred or imposed in an action resulting from such disclosure." KAN. STAT. ANN. § 65-6004(d) (Supp. 1998), *amended by* 1999 Kan. Sess. Laws Ch. 109 §4; *see also* ALA. CODE § 22-11A-38(f) (1997); CAL. HEALTH & SAFETY CODE § 121015(a) (Deering 1997); FLA. STAT. ch. 455.674(1) (1999), *amended by* 1999 Fla. Laws ch. 99-8 §220; 410 ILL. COMP. STAT. 305/9(a) (1999); PA. STAT. ANN. tit. 35, § 7609(c)-(d) (West 1993); S.C. CODE ANN. § 44-29-146 (Law. Co-op. Supp. 1998).

[86] These provisions are entirely bereft of any reference to the courts.

[87] *See infra* notes 88–98 and accompanying text.

[88] *See* CAL. HEALTH & SAFETY CODE § 121015 (Deering 1997).

[89] *Id.* § 121015(a) (emphasis added).

[90] *See* 1999 Kan. Sess. Laws 109 §4 (amending KAN STAT. ANN. § 65.6004(b) (1992 & Supp. 1998)).

permitting notification only to spouses.[91] In contrast, South Carolina permits notification to both spouses and other "contacts."[92]

The majority of direct partner notification states do not share this approach of permitting disclosure to certain relations of the patient without further qualification. Rather, the more common approach is to promulgate an ethical standard of sorts, at which it becomes *appropriate* to disclose, regardless of what relations of the patient may be informed.

Several states impose some variation of the same standard, focusing primarily on the physician's opinion of the threat posed. Alabama, for instance, permits disclosure to a "third party" in cases "where there is a foreseeable, real or probable risk of transmission of the disease."[93] Some states offer less refined qualifications for the degree of risk required, such as Georgia[94] and Washington.[95] Others, however, formulate slightly more stringent standards, such as Iowa's "imminent danger" test,[96]

[A] physician who has reason to believe that the spouse of a person who has had a positive reaction to an AIDS test, laboratory confirmation of HIV infection or who has AIDS . . . and is unaware of such exposure may inform the spouse or partner of the risk of exposure. The information shall be confidential and shall not be disclosed by such spouse or partner to other persons . . . .

Id.

[91] *See* VA. CODE ANN. § 32.1-36.1(A)(11) (Michie 1997). The act is seemingly broader, providing 12 categories of persons to whom disclosures may be made. These categories, however, encompass mainly legal representatives, health care department providers/staff or researchers. With respect to *personal* relationships only the parents of a minor or the spouse are mentioned. *See id.* § 32.1-36.1(A)(10)-(11).

[92] S.C. CODE ANN. § 44-29-146 (Law. Co-op. Supp. 1998). "Contact" is defined as "the exchange of body products or body fluids by sexual acts or percutaneous transmission." *Id.*

[93] ALA. CODE § 22-11A-38(d) (1997).

[94] *See* GA. CODE ANN. § 24-9-47(g) (1995). The nature of the risk involved here is not clearly defined. Disclosure to spouses, sexual partners, and children of the patient is permitted when the "physician reasonably believes [that such people are] at risk of being infected with HIV by that patient." *Id.*

[95] *See* WASH. REV. CODE § 70.24.105(2)(h) (1998 & Supp. 1999-2000). Notice may be given to "[p]ersons who, because of their behavioral interaction with the infected individual, have been placed at risk for acquisition of a sexually transmitted disease." *Id.*

[96] IOWA CODE § 141.6(3)(c)(1) (1999). One condition for disclosure to sexual and needle-sharing partners is that "[a] physician for the infected person is of the good faith opinion that the nature of the continuing contact poses an imminent danger of human immunodeficiency virus infection transmission to the third party." *Id.*

and Rhode Island's "clear and present danger" standard.[97] To render disclosure permissible, Tennessee, uniquely, requires only that a disclosing party have a "reasonable belief that a person has knowingly exposed another to HIV."[98] Furthermore, the right to disclose in Tennessee is not confined to physicians.[99]

Still other states determine the point at which notification is appropriate by examining more explicitly the conduct of the infected individual subsequent to the discovery of infection. In Florida, for instance, physicians may not notify sexual and needle-sharing partners of the infected individual unless such individual refuses to "refrain from engaging in sexual or drug activity in a manner likely to transmit the virus," after the physician has recommended that the individual cease such activity.[100] Illinois permits notification if, upon "a reasonable time after the patient has agreed to make the notification, the physician has reason to believe that the patient has not provided the notification."[101]

It is common for direct notification statutes to incorporate some protections of the interests of the infected individual. For example, a number of states require that the physician forewarn the patient that a notification is going to be made, in order to provide the patient with an opportunity to personally notify partners.[102] The majority of states in this group, including, California,[103] Connecticut,[104] Iowa,[105] and Pennsylvania,[106] offer

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[97] R.I. GEN. LAWS § 23-6-17(2)(v) (1996). "A physician: (v) [m]ay inform third parties with whom an AIDS-infected patient is in close and continuous contact, including but not limited to a spouse; if the nature of the contact, in the physician's opinion, poses a clear and present danger of AIDS transmission to the third party. . . ." *Id.*

[98] TENN. CODE ANN. § 68-10-115 (1996).

[99] *See id.* (permitting any "person" to avail herself of the statute subject to its other provisions).

[100] FLA. STAT. ch. 455.674(1)(b) (1999), *amended by* 1999 Fla. Laws ch. 99-8 §220.

[101] 410 ILL. COMP. STAT. 305/9(a) (1999).

[102] *See* CAL. HEALTH & SAFETY CODE § 121015(b) (Deering 1997); CONN. GEN. STAT. § 19a-584(b)(2) (1999); GA. CODE ANN. § 24-9-47(g) (1995); IOWA CODE § 141.6(3)(c)(2) (1999); PA. STAT. ANN. tit. 35, § 7609(a)(3) (West 1993).

[103] "The physician and surgeon shall notify the patient of his intent to notify the patient's contacts prior to any notification." CAL. HEALTH & SAFETY CODE § 121015(b) (Deering 1997).

[104] "A physician may warn or inform a known partner of a protected individual if . . . the physician has informed the protected individual of his intent to make such disclosure to the partner. . . ." CONN. GEN. STAT. § 19a-584(b) (1999).

clauses which unequivocally require that the infected individual actually *receive* such notice *prior to* any disclosure to third parties.[107] A less common formulation is found in Georgia, where it is sufficient for the physician to *attempt* to notify the patient that a disclosure is going to be made.[108]

More importantly, several states forbid the physician from actually divulging the identity of the infected person when making the disclosure.[109] Hence, in California, a physician may inform a partner of the infected individual that he or she has had sexual or needle-sharing contact with a person who has tested positive for AIDS/HIV, but "no physician . . . shall disclose any identifying information about the individual believed to be infected."[110] Similar measures are taken in Connecticut,[111] Pennsylvania,[112] and West Virginia.[113] Several states are silent or ambiguous, however, as to whether a patient's identity may be disclosed,[114] while others specifically provide that the identity of the infected individual *may* be revealed.[115]

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[105] A physician may notify third parties "[w]hen the physician believes in good faith that the infected person, despite strong encouragement, has not and will not warn the third party and will not participate in the voluntary partner notification program." IOWA CODE § 141.6(3)(c)(2) (1999).

[106] "[A] physician may disclose confidential HIV-related information if all of the following conditions are met: . . . (3) [t]he physician has counseled the subject regarding the need to notify the contact, and the physician reasonably believes the subject will not inform the contact. . . ." PA. STAT. ANN. tit. 35, § 7609(a) (West 1993).

[107] *See supra* notes 103–106.

[108] "[T]he physician may disclose to that spouse, sexual partner, or child that the patient has been determined to be infected with HIV, after first *attempting* to notify the patient that such disclosure is going to be made." GA. CODE ANN. § 24-9-47(g) (1995) (emphasis added).

[109] *See* CAL. HEALTH & SAFETY CODE § 121015(a) (Deering 1997); CONN. GEN. STAT. § 19a-584(b) (1999); PA. STAT. ANN. tit. 35, § 7609(b) (West 1993); W. VA. CODE § 16-3C-3(d) (1998).

[110] CAL. HEALTH & SAFETY CODE § 121015(a) (Deering 1997).

[111] "The physician or public health officer shall not disclose the identity of the protected individual or the identity of any other partner." CONN. GEN. STAT. § 19a-584(b) (1999).

[112] "When making such disclosure to a contact, the physician shall not disclose the identity of the subject or any other contact." PA. STAT. ANN. tit. 35, § 7609(b) (West 1993).

[113] "The name or identity of the person whose HIV test result was positive is to remain confidential." W. VA. CODE § 16-3C-3(d) (1998).

[114] A number of statutes do not clearly define just what may be disclosed. In particular, these do not expressly state whether the infected individual's identity should be revealed, or protected. *See* FLA. STAT. ch. 455.674 (1999), *amended by*

In some states, further protections expressly forbid notified partners from sharing or disclosing the information they have received from the physician, concerning the infected individual.[116] Washington, for example, provides that notified spouses or partners are to be furnished with the following written admonition upon notification:

> This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.[117]

Perhaps the most important feature these statutes share in common is the *permissive* nature of the physician's authority. Under these acts, the physician has no legal *duty* to notify partners of the infected individual.[118] Disclosure is merely permitted. As such, the physician may, if he or she so chooses, remain silent as to a patient's condition. In this respect, Permissive Direct Notification differs substantially from

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1999 Fla. Laws ch. 99-8 §220; 410 ILL. COMP. STAT. 305/9 (1999); KAN. STAT. ANN. § 65-6004 (1992 & Supp. 1998), *amended by* 1999 Kan. Sess. Laws 109 §4.

[115] "[T]he department or a physician may reveal the identity of a person who has tested positive for the human immunodeficiency virus infection pursuant to this subsection only to the extent necessary to protect a third party from the direct threat of transmission." IOWA CODE § 141.6(3)(c)(2) (1999); *see also* WASH. REV. CODE § 70.24.105(2)(h) (1998 & Supp. 1999-2000).

[116] *See* WASH. REV. CODE § 70.24.105(5) (1998 & Supp. 1999-2000); W. VA. CODE § 16-3C-3(b) (1998 & Supp. 1999).

[117] WASH. REV. CODE § 70.24.105(5) (1998 & Supp. 1999-2000).

[118] Virtually every statute in this category contains a provision expressly declaring that the physician has no legal duty to notify, or shall incur no civil or criminal liability for failure to notify. For example, California provides: "This section is permissive on the part of the attending physician . . . [n]o physician has a duty to notify any person of the fact that a patient is reasonably believed to be infected by the probable causative agent of acquired immune deficiency syndrome." CAL. HEALTH & SAFETY CODE § 121015(c) (Deering 1997); *see also* ALA. CODE § 22-11A-38(f) (1997); CONN. GEN. STAT. § 19a-584(b) (1999); FLA. STAT. ch. 455.674(2) (1999), *amended by* 1999 Fla. Laws ch. 99-8 §220; 410 ILL. COMP. STAT. 305/9(a) (1999); IOWA CODE § 141.6(3)(c)(2) (1999); KAN. STAT. ANN. § 65-6004(c) (1992 & Supp. 1998), *amended by* 1999 Kan. Sess. Laws 109 §4; PA. STAT. ANN. tit. 35, § 7609(c) (West 1993); VA. CODE ANN. § 32.1-36.1(D) (Michie 1997); W. VA. CODE § 16-3C-3(e) (1998 & Supp. 1999).

mandatory names-reporting laws,[119] such as New York's Title III.[120]

C. *Permissive Names Reporting*[121]

Another significant permissive partner notification model allows physicians to report the names of their HIV-positive patients to a state health agency, whereupon the agency undertakes the task of notifying the infected individual's at-risk sexual or needle-sharing partners.[122] Unlike Direct Physician Notification, the state itself becomes an active player in the notification process and necessarily becomes aware of the infected individual's HIV-positive status.[123] A state, however, may offer this method of notification to physicians in conjunction with and as an alternative to Direct Physician Notification.[124] States utilizing permissive names reporting include California,[125] Georgia,[126] West Virginia,[127] Maryland,[128] Arizona,[129] Hawaii,

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[119] *See* discussion *infra* Part III.

[120] *See* N.Y. PUB. HEALTH LAW §§ 2130–2139 (McKinney Supp. 1999).

[121] The term "names reporting" is used by many commentators to describe systems in which physicians are permitted or required to forward the names of their HIV-positive patients to a public health agency. *See* Gostin & Hodge, *Names Debate*, *supra* note 11, at 696–97; Gostin & Hodge, *Piercing the Veil*, *supra* note 33, at 26–27; Doughty, *supra* note 36, at 118–20.

[122] This result may be accomplished through separate, yet interconnected statutes. For instance, one Indiana law permits physicians to report an infected individual (and the identities of his at-risk partners) if the physician has reasonable cause to believe that the individual poses a serious danger to the health of others. *See* IND. CODE § 16-41-7-3(b)(1)-(2) (1993-98). Meanwhile, another Indiana law permits the state health agency receiving the report to notify specified at-risk persons. *See* IND. CODE § 16-41-7-4(c) (1993-98).

[123] For example, in Georgia:

> [w]hen mandatory and nonanonymous reporting of confirmed positive HIV tests to the Department of Human Resources is determined by that department to be reasonably necessary . . . [any] legal entity which orders an HIV test for another person shall report to the Department of Human Resources the name and address of any person thereby determined to be infected with HIV.

GA. CODE ANN. § 24-9-47(h)(2) (1995).

[124] California, for instance, permits disclosure to either at-risk partners, *or* the county health officer, in the same statutory provision. *See* CAL. HEALTH & SAFETY CODE § 121015(a) (Deering 1997).

[125] *See id.* § 121015(a), (d).

[126] *See* GA. CODE ANN. § 24-9-47(h)(1), (3).

[127] *See* W. VA. CODE § 16-3C-3(a) (1998 & Supp. 1999) (describing when the identity of a person upon whom an HIV-related test is performed can be revealed); *id.* § 16-3C-3(d) (stating HIV results may be revealed to certain persons, but the name or identity of the person whose test result is positive remains confidential).

[128] *See* MD. CODE ANN., HEALTH-GEN. I § 18-337(b), (d) (Supp. 1998).

[130] and Indiana.[131] As with other partner notification methods, there is some variation in approach from state to state.

Some states, such as California, West Virginia, and Georgia, permit a physician to report the infected individual's name simply upon the determination that the patient is HIV-positive.[132] In these states no further standard is imposed, nor is a perceived risk to others required in order to justify names reporting. In contrast, Maryland permits physicians to report names of infected individuals only when an individual informed of his " HIV-positive status . . . refuses to notify [his] sexual and needle-sharing partners."[133] Similar standards are followed in Arizona and Hawaii.[134] Indiana, more broadly, permits reporting where the infected individual may be deemed a "serious and present danger to the health of others."[135]

Some states also expressly allow physicians to report the identities of the at-risk partners.[136] Hence, in Arizona, "it is not an act of unprofessional conduct for a physician to report . . . the name of a patient's spouse or sex partner or a person with whom the patient has shared hypodermic needles . . . ."[137] States that do not use such a method may utilize a procedure known as "contact tracing," in which a state health agency attempts to solicit, from the infected individual, a list of his sexual and needle sharing contacts, as well as investigate to ascertain those

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[129] *See* ARIZ. REV. STAT. ANN. § 32-1860(A) (West 1992).

[130] *See* HAW. REV. STAT. § 325-101(a)(4) (1993 & Supp. 1996).

[131] *See* IND. CODE § 16-41-7-3(b)(1)-(2) (1993-98); *id.* § 16-41-7-4(c) (1993-98).

[132] *See* CAL. HEALTH & SAFETY CODE § 121015(a) (Deering 1997) ("[N]o physician . . . shall be held criminally or civilly liable for disclosing . . . to the county health officer, that [a] patient has tested positive [for HIV]."); GA. CODE ANN. § 24-9-47(h)(1) (1995) ("[A] physician having a patient who has been determined to be infected with HIV may disclose to the Department of Human Resources: (A) The name and address of that patient."); W. VA. CODE § 16-3C-3(a) (1998 & Supp. 1999) ("No person may disclose . . . the identity of any person upon whom an HIV-related test is performed, or the results . . . except to . . . (6) The bureau or the centers for disease control.").

[133] MD. CODE ANN., HEALTH-GEN. I § 18-337(b) (1994).

[134] *See* ARIZ. REV. STAT. ANN. § 32-1860(A) (West 1992); HAW. REV. STAT. § 325-101(a)(4)(B) (1993 & Supp. 1996).

[135] IND. CODE § 16-41-7-3(b)(1)(A) (1993-98).

[136] *See* ARIZ. REV. STAT. ANN. § 32-1860(A) (West 1992); GA. CODE ANN. § 24-9-47(h)(1)(C) (1995); HAW. REV. STAT. § 325-101(a)(4)(B) (1993 & Supp. 1996) ("Any determination by a physician to disclose or withhold disclosure of an index patient's sexual contacts to the department of health . . . which is made in good faith shall not be subject to penalties . . . .").

[137] ARIZ. REV. STAT. ANN. § 32-1860(A) (West 1992).

contacts not reported by the individual.[138] In the end, the state may generally "alert any persons reasonably believed to be a spouse, sexual partner, or partner of shared needles" of the risk of exposure.[139] Some states forbid health agencies from revealing to informed partners the identity of the infected individual.[140]

It is valuable to stress once more that states in this class do not impose any *duty* on physicians to report the names of their HIV-positive patients.[141] Reporting is simply permitted, and the decision to do so on the part of the doctor is strictly voluntary.

III. NEW YORK'S TITLE III PARTNER NOTIFICATION LAW: MANDATORY NAMES REPORTING

The new Title III to Article 21 of the New York Public Health Law[142] supplements New York's pre-existing, less-aggressive partner notification measures.[143] The law's purpose, as described by its sponsors, is to "protect spouses, sexual and needle sharing partners and other contacts of persons testing positive for HIV by permitting public health officials to notify them that they may have been placed at risk of contracting HIV and that they should be tested."[144] Some of the political thrust to enact Title III seems to have come from the furor over the recent case of Nushawn Williams, an HIV-positive New York City man who knowingly infected several women throughout upstate New York.[145]

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138 *See* Gostin & Hodge, *Piercing the Veil*, *supra* note 33, at 25, 32.

139 CAL. HEALTH & SAFETY CODE § 121015(d) (Deering 1997); *see also* GA. CODE ANN. § 24-9-47(h)(1) (1995) (requiring the state's Department of Human Resources to both contact and provide counseling for the at-risk spouse of an HIV infected person); W. VA. CODE § 16-3C-3(d) (1998 & Supp. 1999).

140 *See* CAL. HEALTH & SAFETY CODE § 121015(d) (Deering 1997); W. VA. CODE § 16-3C-3(d) (1998 & Supp. 1999).

141 *See* ARIZ. REV. STAT. ANN. § 32-1860(C) (West 1992); CAL. HEALTH & SAFETY CODE § 121015(c) (Deering 1997); GA. CODE ANN. § 24-9-47(h)(3) (1995) (stating "a physician . . . *may* disclose") (emphasis added); MD. CODE ANN., HEALTH-GEN. I § 18-337(b) (1994 & Supp. 1998) (stating "the . . . physician *may* inform the local health officer") (emphasis added).

142 N.Y. PUB. HEALTH LAW §§ 2130–2139 (McKinney Supp. 1999).

143 *See supra* note 5.

144 Memorandum in Support of Legislation from the New York State Assembly 1 (undated) (on file with author).

145 *See* New York Assemblywoman Mayersohn, Statement on Partner Notification Bill A6629 2 (Mar. 24, 1998) (on file with author). Assemblywoman Mayersohn describes recent attention paid to the Williams case, and bemoans the

The most striking feature of Title III is that it imposes an affirmative duty on all licensed physicians to report the names of their patients testing positive for HIV. As the Act reads, "[e]very physician or other person authorized by law to order diagnostic tests or make a medical diagnosis, or any laboratory performing such tests shall immediately . . . report such case to the [public health] commissioner."[146] Although compulsory names reporting of those with certain medical conditions is not a first for New York,[147] this is the first time such a measure has been taken with respect to HIV. A similar provision in Title III applies to coroners and medical examiners, contemplating that if such individuals discover that a deceased person was afflicted with HIV or AIDS at the time of his death, they, likewise, are obligated to report the matter to the health commissioner.[148]

After a physician, or other practitioner covered by the Act, informs the health department of a patient's HIV-positive status, the commissioner promptly forwards the report to "the health commissioner of the municipality where such disease, illness or infection occurred."[149] This report must include, if available, the names of any "contacts" of the infected individual.[150] A "contact" is defined in the Public Health Law as "an identified spouse or

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absence of any responsibility on the part of doctors who discover that their patients have HIV. *See id.*; *see also* Lynda Richardson, *Wave of Laws Aimed at People with H.I.V*, N.Y. TIMES, Sept. 25, 1998, at A1 (discussing the controversy surrounding the Williams incident). Some, however, believe that the New York legislation would have done nothing to prevent the infections spread by Williams, as many of Williams' victims had already been infected by the time he learned of his own infection. *See* JoAnn Wypijewski, *The Secret Sharer: Sex, Race, and Denial in an American Small Town*, HARPER'S MAG *See* JoAnn Wypijewski, *The Secret Sharer: Sex, Race, and Denial in an American Small Town*, HARPER'S MAGAZINE, July 1998, at 35. In addition, Williams went by a host of aliases that would have made reporting largely ineffective. *See id.* The Williams case is not unique, and similar cases in other jurisdictions have been the catalyst for state officials seeking state resources for the purpose of deterring individuals like Williams. *See* Susan Levine, *Behavior of HIV Carriers Poses Dilemma*, WASH. POST, Aug. 6, 1999, at B1.

146 N.Y. PUB. HEALTH LAW § 2130(1) (McKinney Supp. 1999).

147 *See id.* § 2222 (McKinney 1993 & Supp. 1999) (requiring physicians report to local health officers the names of those who have contracted tuberculosis); *id.* § 2401 (requiring physicians to report to the Department of Health the names of those afflicted with cancer).

148 *See id.* § 2132 (McKinney Supp. 1999) ("If a coroner, pathologist, medical examiner, or other person qualified to conduct an examination of a deceased person discovers that at the time of death the individual was afflicted with . . . HIV infection, he or she shall report the case promptly . . . .").

149 *Id.* § 2130(2).

150 *Id.* § 2130(3).

sex partner of the protected individual, a person identified as having shared hypodermic needles . . . with the protected individual or a person who the protected individual may have exposed to HIV under circumstances that present a risk of transmission of HIV, as determined by the commissioner."[151]

Once the report has been referred to the local or municipal heath authority, that agency has an affirmative duty to undertake partner notification.[152] First, if the referral included the names of any contacts residing in the local agency's jurisdiction, the local agency must approach those contacts.[153] Second, if the local health authority determines that it is necessary, it may commence contact tracing to ascertain the identities of other contacts of the infected individual.[154] Title III mandates that the Health Department develop protocols to screen and protect likely victims of domestic violence, who, as infected individuals or contacts, may be subject to abuse as a result of a notification.[155]

The notification itself is to be made in person, unless circumstances prevent it.[156] The contact is informed of the nature of HIV, generally, the known routes of HIV transmission, actions which can limit further transmission, and local facilities and organizations which can provide HIV-related care, medical treatment and counseling.[157] One of Title III's most important features is what may *not* be disclosed to the contact: The identity of the infected individual.[158] Furthermore, the health authority may not disclose to the contact the name of any other contact of the infected individual.[159] To generally safeguard the confidentiality of the infected individual's HIV-positive status, Title III provides that "[a]ll reports or information secured by the department, municipal health commissioner or district health officer under the provisions of this title shall be confidential

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151 *Id.* § 2780(10) (McKinney 1993), *amended by id.* (McKinney Supp. 1999).

152 *See* N.Y. PUB. HEALTH LAW § 2131 (McKinney Supp. 1999) (requiring that a health officer make a good faith effort to identify a contact of possible exposure to HIV).

153 *See id.*

154 *See id.* § 2133(1).

155 *See id.* § 2137.

156 *See id.* § 2133(4).

157 *See id.* § 2133(2). In addition, as circumstances warrant, a contact is informed of the risks of prenatal and perinatal transmission. *See id.*

158 *See id.* § 2133(3).

159 *See id.*

except in so far as is necessary to carry out the provisions of this title."[160] Disclosures may only be made to those parties identified herein.[161]

It is clear that Title III, in requiring rather than permitting notification, and in channeling records of persons' HIV-positive status through the control of the state government, elevates partner notification to a more aggressive degree than nearly any state in the United States.[162] As previously discussed, the political opposition to Title III was substantial and furious. Given New York's volatile political climate with respect to issues of AIDS/HIV and disclosure, it seems highly probable that a challenge to Title III will be forthcoming in one form or another. Although much is made of the detrimental impact of partner notification on confidentiality,[163] confidentiality is a statutory creature in New York.[164] That is to say, if the legislature can create it, the legislature can destroy it, or, as the case may be here, restrict it. Challengers, therefore, would likely resort to constitutional grounds. Although the right of privacy might be an attractive basis of attack to such parties, for the reasons set forth below, Title III should survive a right of privacy challenge.

IV. THE CONSTITUTIONAL RIGHT OF PRIVACY

A. Generally

Although the Constitution is, by its nature, an ambiguous instrument which confounds "black letter" application,[165] few

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[160] *Id.* § 2135.

[161] *See id.* § 2134.

[162] Michigan, however, has a somewhat similar statute. *See* MICH. COMP. LAWS § 333.5131 (1992 & Supp. 1999).

[163] *See* Doughty, *supra* note 33, at 163–75 (examining the grave personal consequences that a breach of confidentiality has on disclosure of AIDS/HIV).

[164] In fact, New York has a statute contemplating confidentiality of HIV-related information. It provides:

> No person who obtains confidential HIV related information in the course of providing any health or social service or pursuant to a release of confidential HIV related information may disclose or be compelled to disclose such information, except to . . . the protected individual . . . an agent or employee of a health facility [or] . . . a federal, state, county or local health officer . . . .

N.Y. PUB. HEALTH LAW § 2782 (McKinney 1993 & Supp. 1999).

[165] As Chief Justice Marshall wrote, the Constitution's nature:

> requires, that only its great outlines should be marked, its important objects designated, and the minor ingredients which compose those objects be deduced from the nature of the objects themselves. That this idea was entertained by

constitutional protections have proven to be as elusive in meaning and scope as the so-called right of privacy.[166] Perhaps this is due in part to the fact that the Constitution itself does not explicitly guarantee any right of privacy,[167] but, rather, the right has been found, time and again, to exist *implicitly* within several express guarantees of the Bill of Rights.[168] As the Supreme Court explained in *Griswold v. Connecticut*,[169] "specific guarantees in the Bill of Rights have penumbras, formed by emanations from those guarantees that help give them life and substance."[170] These penumbras coalesce to create "zones of privacy,"[171] which, with respect to certain human activities, confer upon individuals a "right to be let alone"[172] and undisturbed by intrusive state regulation. The *Griswold* Court borrowed from the penumbras of the First Amendment's right of association,[173] the Third Amendment's prohibition against the

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the framers of the American constitution, is not only to be inferred from the nature of the instrument, but from the language.

M'Culloch v. Maryland, 17 U.S. 316, 407 (1819).

[166] *See* Lagitch, *supra* note 14, at 109; 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, 869 (1993) (citing Roe v. Wade, 410 U.S. 113, 152 (1973) in a discussion of the right to privacy versus mandatory HIV testing and disclosure).

[167] *See* Roe v. Wade, 410 U.S. 113, 152 (1973) (finding zones of privacy to exist under the Constitution, although the Constitution itself makes no explicit mention of a right to privacy); Curnin, *supra* note 166, at 869 (noting the Supreme Court's difficulty in defining the contours of a right to privacy).

[168] *See* Griswold v. Connecticut, 381 U.S. 479, 485–86 (1965) (holding that "zones of privacy" generated from various provisions of the Bill of Rights rendered invalid a Connecticut statute prohibiting the use of contraceptives); *see also* Paris Adult Theatre I v. Slaton, 413 U.S. 49, 65 (1973) (stating that the Court's "prior decisions recognizing a right to privacy guaranteed by the Fourteenth Amendment included only personal rights that can be deemed fundamental or implicit in the concept of ordered liberty") (citations and internal quotation marks omitted).

[169] 381 U.S. 479 (1965).

[170] *Id.* at 484 (citing Poe v. Ullman, 367 U.S. 497, 516–22 (Douglas, J., dissenting)).

[171] *Griswold*, 381 U.S. at 484.

[172] Olmstead v. U.S., 277 U.S. 438, 478–79 (1928) (Brandeis, J., dissenting) (finding the right to be "the most comprehensive of rights and the [one] most valued by civilized men"); *see also* Bolger v. Youngs Drug Prods. Corp., 463 U.S. 60, 77–78 (1983) (Rehnquist, J., concurring) (finding that individuals have a legitimate "right to be let alone" in the privacy of the home); Roach v. City of Evansville, 111 F.3d 544, 550 (7th Cir. 1997) (rejecting plaintiff's claim of a right to privacy by casting it as a general right to be left alone from unwanted intrusion of the government); Brandborg v. Lucas, 891 F. Supp. 352, 359 (E.D. Tex. 1995) (stating that the right to privacy is best described as the "right to be let alone").

quartering of soldiers,[174] the Fourth Amendment's protections against unreasonable searches and seizures,[175] and Fifth Amendment's self-incrimination clause[176] to fashion what might be called a constitutionally guaranteed "right of marital privacy"[177] sufficient to invalidate a Connecticut statute prohibiting the use of contraceptives by married persons.[178]

Over the years, there has been some difficulty in determining what types of human activities reside within these constitutionally protected "zones of privacy." It appears well-settled that "only personal rights that can be deemed 'fundamental' or 'implicit in the concept of ordered liberty,' are included in this guarantee of personal privacy."[179] Protected activities tend to reflect some notion of traditional American values, and more than one opinion has urged that the right "specially protects those fundamental rights and liberties which are, objectively, 'deeply rooted in this Nation's history and tradition.' "[180] As such, those rights which have been deemed "fundamental" tend to revolve around a certain class of similar

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[173] *See* U.S. CONST. amend. I ("Congress shall make no law respecting . . . the right of the people peaceably to assemble . . . . "); *Griswold*, 381 U.S. at 484.

[174] *See* U.S. CONST. amend. III ("No Soldier shall, in time of peace be quartered in any house, without the consent of the Owner . . . ."); *Griswold*, 381 U.S. at 484.

[175] *See* U.S. CONST. amend IV ("The right of the people to be secure . . . against unreasonable searches and seizures . . . ."); *Griswold*, 381 U.S. at 484.

[176] *See* U.S. CONST. amend V ("No person shall be held to answer for a capital, or otherwise infamous crime unless on a presentment or indictment of a Grand Jury . . . nor shall be compelled . . . to be a witness against himself, nor be deprived of life, liberty, or property, without due process of law . . . ."); *Griswold*, 381 U.S. at 484–85.

[177] *Griswold*, 381 U.S. at 486 (Goldberg, J., and Brennan, J., concurring).

[178] The Court explained that the law in question "seeks to achieve its goals by means having a maximum destructive impact upon [the marital] relationship." *Id.* at 485.

[179] Roe v. Wade, 410 U.S. 113, 152 (1973) (internal citation omitted); *see also* Planned Parenthood v. Casey, 505 U.S. 833, 846–47, 951 (1992) (discussing fundamental rights under the Fourteenth Amendment and defining "liberty"); Cruzan v. Director, Missouri Dep't of Health, 497 U.S. 261, 278 (1989) (holding that an incompetent patient has the right to die provided there is clear and convincing evidence that it was his wish to do so).

[180] Washington v. Glucksberg, 521 U.S. 702, 720–21 (1997) (citing Moore v. City of East Cleveland, 431 U.S. 494, 503 (1977) (plurality opinion)); *see also Moore*, 431 U.S. at 504 n.12 (reiterating the importance of both history and tradition as sources for supplying content to the Constitutional concept of due process); Palko v. Connecticut, 302 U.S. 319, 325–26 (1937) (explaining that those rights protected are "implicit in the concept of ordered liberty," such that "neither liberty nor justice would exist if they were sacrificed").

activities. Matters pertaining to marriage,[181] child-bearing,[182] child-rearing,[183] and family relationships[184] are typically viewed as "fundamental" rights protected within the zones of privacy.

Of course, even where there is a right of privacy in a particular form of conduct, that right is not absolute. As the court noted in *Roe v. Wade*,[185] "[t]he Court's decisions recognizing a right of privacy also acknowledge that some state regulation in areas protected by that right is appropriate . . . a State may properly assert important interests in safeguarding health, in maintaining medical standards, and in protecting potential life."[186]

B. The Right of Privacy in Personal Information

The aforementioned rights of marriage, child-bearing, child rearing, etc., are described by many courts as privacy rights of "independence in making certain kinds of important

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[181] *See* Zablocki v. Redhail, 434 U.S. 374, 391 (1978) (invalidating a Wisconsin law which required non-custodial parents with obligations to pay child support, to obtain court permission before marrying); Loving v. Virginia, 388 U.S. 1, 12 (1967) (invalidating a statute prohibiting interracial marriage); *Griswold*, 381 U.S. at 485–86 (holding that the marital relationship is within the zone of privacy).

[182] *See Planned Parenthood*, 505 U.S. at 877 ("[A] law designed to further the State's interest in fetal life which imposes an undue burden on the woman's decision before fetal viability [is unconstitutional.]") (citation omitted); *Roe*, 410 U.S. at 154 (concluding that "the right of personal privacy includes the abortion decision, but . . . this right is not unqualified and must be considered against important state interests in regulation"); Eisenstadt v. Baird, 405 U.S. 438, 453 (1972) ("If the right of privacy means anything, it is the right of the *individual*, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.") (citations omitted).

[183] *See Planned Parenthood*, 505 U.S. at 851 (opining that the "law affords Constitutional protection to personal decisions relating to marriage, procreation, contraception, family relationships, child rearing and education"); Paris Adult Theatre I v. Slaton, 413 U.S. 49, 65 (1973) (recognizing that the right to privacy encompasses "personal intimacies" such as child-rearing). Legislation too directly interfering with a parent's right to raise a child as he or she sees fit, in matters such as education, has been invalidated by the Court. *See* Pierce v. Society of Sisters, 268 U.S. 510, 534–35 (1925) (holding that an Oregon law requiring children to attend public schools was unconstitutional).

[184] *See Moore*, 431 U.S. at 499 (invalidating a city ordinance which required that all occupants of a dwelling must be of the same nuclear family, such that a woman had been in violation of the ordinance by living with her two grandsons).

[185] 410 U.S. 113 (1973).

[186] *Id.* at 153–54.

decisions."[187] Such rights are well-established and clearly defined by the Supreme Court.[188] A second type of privacy interest protected by the Constitution is what has been described as "the individual interest in avoiding disclosure of personal matters," or the right of privacy in personal information.[189] The nature of this aspect of the right is less defined.[190]

This prong of the right of privacy finds its origins in *Whalen v. Roe*,[191] a case which evaluated the constitutionality of a New York State statute bearing a certain resemblance to Title III. The act considered in *Whalen* required all physicians prescribing certain drugs to report to the New York State Department of Health the name, address, and age of the patient receiving the prescription, as well as the drug and dosage.[192] The statute was challenged by a group of patients regularly receiving the prescription drugs in question, as well as physicians who routinely prescribed the drugs.[193] The challengers alleged that the Act threatened both varieties of their right of privacy—the interest in independence in making certain kinds of important decisions, and the interest in avoiding disclosure of personal

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[187] Whalen v. Roe, 429 U.S. 589, 599–600 (1977) (footnote omitted). *See* Nixon v. Admin. of Gen. Servs., 433 U.S. 425, 457 (1977) (finding that public officials, including Presidents, have constitutionally protected privacy rights in matters of personal life); United States v. Westinghouse Elec. Corp., 638 F.2d 570, 577 (3d Cir. 1980) (recognizing that an interest in making certain decisions independently is a privacy interest warranting constitutional protection).

[188] *See supra* notes 181–86.

[189] *Whalen*, 429 U.S. at 599 (footnote omitted); *Nixon*, 433 U.S. at 457; *Westinghouse*, 638 F.2d at 577.

[190] It appears at this point that *Whalen* and *Nixon* are the Court's only expressions of this aspect of the right of privacy.

[191] 429 U.S. 589 (1977). *Whalen* is recognized as the source of the right to privacy in avoiding disclosure of personal matters in *Nixon*. *See* 433 U.S. at 457; *see also* Doe v. Southeastern Pa. Transp. Auth. (SEPTA), 72 F.3d 1133, 1137–38 (3d Cir. 1995) (holding that there is a constitutional right to privacy in one's prescription record because one has an interest in avoiding disclosure of personal information); *Westinghouse*, 638 F.2d at 577 (holding that an employee's medical records which may contain personal facts are entitled to privacy protection); Gruenke v. Seip, No. 97-5454, 1998 U.S. Dist. LEXIS 16439, at *34-35 (E.D. Pa. Oct. 21, 1998) (recognizing the right to be free from disclosure of personal matters).

[192] *See Whalen*, 429 U.S. at 593. Physicians were to report the prescription of drugs such as "opium and opium derivatives, cocaine, methadone, amphetamines and methaqualone [which] . . . have accepted uses in the amelioration of pain and in the treatment of epilepsy, narcolepsy, hyperkineoia, schizo-affective disorders and migraine headaches." *Id.* at 593 n.8.

[193] *See id.* at 595.

matters.[194] Although the Court casually recognized the latter interest, with little explanation,[195] it declined to find privacy violations on either theory.[196] The Court considered a number of factors which weighed in favor of New York, including the statute's prohibition of public disclosure of the identities of any of the patients,[197] and "the State's vital interest in controlling the distribution of dangerous drugs."[198]

The *Whalen* opinion is frequently credited with fashioning a balancing test in which the state's interest in the disputed legislation is weighed against the individual's privacy interest,[199] but this test, in fact, was formally articulated after *Whalen,* in *Nixon v. Administrator of General Services.*[200] In *Nixon,* the Supreme Court confirmed *Whalen*'s recognition of the privacy interest in avoiding disclosure of personal matters.[201] The Court, however, did not go so far as to hold that former President Richard Nixon's privacy rights were impermissibly violated by a federal requirement that he submit various materials pertaining to his presidency to national archivists, even though some of those materials were records of personal conversations and

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[194] *See id.* at 599–600. The challengers argued that both interests were "impaired by [the] statute" because "[t]he mere existence in readily available form of the information about patients' use of [the particular] drugs create[d] a genuine concern that the information [would] become publicly known and that it [would] adversely affect their reputations." *Id.* at 600. They further claimed that this concern would deter patients from using these drugs, and discourage doctors from prescribing them. *See id.* Accordingly, the threat of improper disclosure implicated the right of privacy in personal information, while the Act's deterrent aspects affected "the making of decisions about matters vital to the care of their health." *Id.*

[195] *See id.* at 599. Curiously, the Court's only cited authority for the privacy interest in avoiding disclosure of personal matters was the work of Professor Kurland. *See id.* at 600 n.24. Professor Philip B. Kurland was a "constitutional scholar," who was a consultant to the Senate Judiciary Committee at the time of Watergate. He taught law for 43 years at the University of Chicago, and died of pneumonia on April 6, 1996 after undergoing treatment for heart problems. *See* David Binder, *Philip B. Kurland, 74, Scholar Who Ruled on Nixon Tapes,* N.Y. TIMES, Apr. 18, 1996, (Obituaries), at B9.

[196] *See id.* at 600-06.

[197] *See id.* at 594-95.

[198] *Id.* at 598.

[199] *See* Lagitch, *supra* note 14, at 111 n.55.

[200] 433 U.S. 425 (1977).

[201] As the Court stated, "[o]ne element of privacy has been characterized as 'the individual interest in avoiding disclosure of personal matters . . . .' " *Id.* at 457 (quoting *Whalen,* 429 U.S. at 599).

dealings.[202] In reaching its decision, the *Nixon* Court explained that "the claim must be considered in light of the specific provisions of the Act, and any intrusion must be weighed against the public interest in subjecting the Presidential materials of appellant's administration to archival screening."[203]

Whalen and *Nixon* appear to represent the whole of Supreme Court jurisprudence on the so-called right of privacy in personal information.[204] Lower federal courts, however, including several Circuit Courts of Appeals, have had occasion to visit similar issues, and have routinely applied a balancing analysis modeled on the *Whalen-Nixon* test.[205] The Third Circuit

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[202] The Court explained that the privacy claim in *Nixon* was in fact weaker than that asserted in *Whalen*, because, "unlike *Whalen*, the Government will not even retain long-term control over such private information." *Nixon*, 433 U.S. at 458–59.

[203] *Id.* at 458 (citation omitted).

[204] Even in the most recent decisions, these opinions are routinely cited in tandem as the origin of the right of privacy in nondisclosure of personal matters, and as the only Supreme Court rulings on the right. *See* Bloch v. Ribar, 156 F.3d 673, 683–84 (6th Cir. 1998) (discussing the evolution of the constitutional right to privacy rooted in the Fourteenth Amendment); Kutler v. Carlin, 139 F.3d 237, 238–39 (D.C. Cir. 1998) (applying the analysis set out by *Nixon);* Doe v. Southeastern Pa. Transp. Auth. (SEPTA), 72 F.3d 1133, 1137–38 (3d Cir. 1995) (explaining that the Supreme Court in *Whalen* gave individuals a limited right of privacy in their medical records); Doe v. Wigginton, 21 F.3d 733, 740 (6th Cir. 1994) (explaining that both *Whalen* and *Nixon*, when read out of context, lend credence to the plaintiff's argument that he has a constitutional right to privacy); Borucki v. Ryan, 827 F.2d 836, 839–45 (1st Cir. 1987) (relying on *Whalen* and *Nixon*, the court held that the information contained in the plaintiff's psychiatric file was not protected by the confidentiality branch of the constitutional right of privacy, reversing a previous court ruling); Williams v. Price, 25 F. Supp. 2d 623, 627–28 (W.D. Pa. 1998) (discussing both *Nixon* and *Whalen* as a basis for the court's decision that the plaintiff did not have a constitutional right to private communications with his attorney); Middlebrooks v. State Bd. of Health, 710 So.2d 891, 892 (Ala. 1998) (discussing the right of privacy implicated by a disclosure of one's medical records based on *Whalen*).

[205] *See SEPTA*, 72 F.3d at 1138–41 (explaining that the right to privacy should be weighed against the state's interests and articulating key factors to be assessed prior to performing the balancing test); Fraternal Order of Police, Lodge No. 5 v. City of Philadelphia, 812 F.2d 105, 116 (3d Cir. 1987) (holding that disclosure of personal matters was required by applicants to the Philadelphia police department's special investigation unit, after assessing that the interests of the government outweighed the privacy interest of the applicants); Barry v. City of New York, 712 F.2d 1554, 1559 (2d Cir. 1983) (clarifying that a balancing test approach is "in keeping both with the Supreme Court's reluctance to recognize new fundamental interests requiring a high degree of scrutiny for alleged [privacy] infringements, and the Court's recognition that some form of scrutiny beyond rational relation is necessary to safeguard the confidentiality interest"); United States v. Westinghouse Elec. Corp., 638 F.2d 570, 577–78 (3d Cir. 1980) (formulating factors to be

case of *United States v. Westinghouse Electric Corporation*[206] has enjoyed a special prominence in the development of the law in this area.[207] In that case, the court examined the privacy implications of a workplace safety investigation undertaken by the National Institute for Occupational Safety and Health ("NIOSH") of a Westinghouse plant in Pennsylvania.[208] The investigation required that Westinghouse turn over the medical records of a number of present and past employees who had worked in the plant.[209] Westinghouse refused to relinquish these records.[210] In determining that the NIOSH investigation was justified and did not constitute an impermissible privacy violation,[211] Judge Sloviter recognized the existence of a constitutionally protected right of privacy in one's medical

considered in weighing the interests); Faison v. Parker, 823 F. Supp. 1198, 1201 (E.D. Pa. 1993) (stating that the privacy right in non-disclosure of medical records is not absolute, and discussing in detail the balancing test as described by the court in *Westinghouse*); Woods v. White, 689 F. Supp. 874, 875–76 (W.D. Wisc. 1988) (noting that many federal courts have misconstrued *Whalen* to find that a right to privacy does exist, and courts have used the balancing test to define the extent to which such a right exists. *But see* J.P. v. DeSanti, 653 F.2d 1080, 1091 (6th Cir. 1981) (criticizing the widespread use of the balancing test by holding "that not all rights . . . of private information are of constitutional dimension, so as to require balancing government action against individual privacy").

206 638 F.2d 570 (3d Cir. 1980).

207 *Westinghouse* is discussed or emulated in a considerable proportion of federal cases contemplating AIDS/HIV disclosure. *See SEPTA*, 72 F.3d at 1139–40 (enumerating the seven factors that should be fully assessed before deciding whether the method used by an employer to monitor an employee's prescription coverage was an invasion of privacy); Doe v. City of New York, 15 F.3d 264, 267 (2d Cir. 1994) (explaining that the *Westinghouse* court held the right to confidentiality included "the right to protection regarding information about the state of one's health"); *Faison*, 823 F. Supp. at 1205 (holding that disclosure of plaintiff's HIV status in a pre-sentencing report did not violate her constitutional right to privacy because the *Westinghouse* factors balanced in favor of such disclosure); Doe v. Borough of Barrington, 729 F. Supp. 376, 382 (D.N.J. 1990) (holding that in light of the *Westinghouse* factors, "the Constitution protects plaintiffs from governmental disclosure of . . . infection with the AIDS virus"); *Woods*, 689 F. Supp. at 876 (explaining that since defendant did not assert a claim of important public interest, there was no need to apply the *Westinghouse* balancing test).

208 *See Westinghouse*, 638 F.2d at 572–73.

209 *See id.* NIOSH's concern was that these employees may have been exposed to toxic substances in certain areas of the plant. *See id.* at 572. The records requested included reports of physical examinations given to employees at the time they were hired, encompassing x-rays as well as the results of hearing, sight, and blood tests. *See id.* at 572 n.1.

210 *See id.* at 573.

211 *See id.* at 578–79.

records,[212] and carefully examined the balancing formula attributed to *Whalen* and *Nixon*.[213] Sloviter identified several factors that should be considered in weighing the competing interests of the state and the individual.[214] These factors are: (1) the type of record requested by the government; (2) the information it contains or might contain; (3) "the potential for harm in any subsequent nonconsensual disclosure"; (4) the injury which disclosure may cause to "the relationship in which the record was generated"; (5) the adequacy of measures in place to prevent unauthorized disclosure; (6) the need for the government's access to the information; and (7) "whether there is an express statutory mandate, articulated public policy, or other recognizable public interest militating toward access."[215] The *Westinghouse* factors have been given substantial deference by a multitude of courts.[216]

C. *The Right of Privacy and AIDS / HIV Disclosure*

The Supreme Court has not yet ruled on any issue pertaining to AIDS/HIV status disclosure.[217] A number of lower courts, however, have examined AIDS/HIV disclosure in one context or another. Although no federal court appears to have ruled on the constitutionality of an AIDS/HIV partner

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[212] *See id.* at 577.

> There can be no question that an employee's medical records, which may contain intimate facts of a personal nature, are well within the ambit of materials entitled to privacy protection. Information about one's body and state of health is [a] matter which the individual is ordinarily entitled to retain within the 'private enclave where he may lead a private life.'

Id. (quoting United States v. Grunewald, 233 F.2d 556, 581–82 (2d Cir. 1956) (Frank, J., dissenting), *rev'd*, 353 U.S. 391 (1957)).

[213] *See Westinghouse*, 638 F.2d at 577–78.

[214] *See id.* at 578.

[215] *Id.*

[216] *See supra* note 207.

[217] Circuit Courts of Appeals analyzing the issue find Supreme Court precedent only in *Whalen*, which dealt with medical records, and not specifically AIDS or HIV status. *See, e.g.*, Doe v. Southeastern Pa. Transp. Auth. (SEPTA), 72 F.3d 1133, 1137 (3d Cir. 1995) (stating that the right to privacy according to *Whalen* fell into two categories; "an individual's interest in independence in making certain decisions, [and] . . . an interest in avoiding disclosure of personal information"); Doe v. City of New York, 15 F.3d 264, 267 (2d Cir. 1994) (articulating the distinction made by *Whalen* between the right to confidentiality in regards to personal information and the right to autonomy and independence in decision-making, ultimately holding that under *Whalen* the plaintiff had a constitutional right to confidentiality in his HIV status).

notification law,[218] the cases approach unanimity on the question of whether there is, in fact, a constitutionally protected privacy interest in avoiding disclosure of one's AIDS/HIV status—so far as these courts are concerned, the right exists.[219] The majority of cases dealing with such disclosure conduct their analyses in the *Whalen-Nixon* framework, weighing the state action of disclosure against the infected individual's privacy interest in maintaining confidentiality.[220] A number of these cases qualify their

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[218] The majority of cases in the federal court system have dealt with the constitutionality of prisoners or individuals in police custody. *See* Faison v. Parker, 823 F. Supp. 1198, 1207 (E.D.Pa. 1993) (holding that the plaintiff, an inmate at a State correctional facility, was not denied a constitutional right when her AIDS status was disclosed in a pre-sentencing report); Nolley v. County of Erie, 776 F. Supp. 715, 731 (W.D.N.Y. 1991) (holding that prison inmates are protected by a constitutional right of privacy regarding their HIV status and that "convicted prisoners do not forfeit all constitutional protections") (quoting Bell v. Wolfish, 441 U.S. 520, 545 (1979)); Woods v. White, 689 F. Supp. 874, 876–77 (W.D. Wisc. 1988) (holding that an incarcerated plaintiff retained the right to privacy over his AIDS status, regardless of his status as a convicted felon). *But see* Middlebrooks v. State Bd. of Health, 710 So. 2d 891, 892-893 (Ala. 1998) (concluding, in dicta, that an Alabama notification law was not in violation of a plaintiff's right to privacy); Lampart v. State of Connecticut, No. 95-322-668, 1995 Conn. Super. LEXIS 2976, at *1, *6 n.2 (Conn. Super. Ct. Oct. 17, 1995) (specifying the information a public health officer must relay to the partner of an individual who is either known to be or might be infected with HIV or AIDS); Santa Rosa Health Care Corp. v. Garcia, 964 S.W.2d 940, 943 (Tex. 1998) (explaining that a Texas notification law which required the results of an HIV test to be released to a spouse *"if the person tests positive for AIDS and HIV infection,* antibodies to HIV, or infection with any other probable causative agent of AIDS," did not come into effect until after the plaintiff's spouse tested positive for AIDS).

[219] *See* Doe v. City of New York, 15 F.3d 264, 267 (2d Cir. 1994) ("Individuals who are infected with the HIV virus clearly possess a constitutional right to privacy regarding their condition."); Harris v. Thigpen, 941 F.2d 1495, 1514 (11th Cir. 1991) ("[T]here are few decisions over which a person could have a greater desire to exercise control, than the manner in which he reveals [an HIV] diagnosis to others."); Doe v. Town of Plymouth, 825 F. Supp. 1102, 1107 (D. Mass. 1993) ("[T]his court finds that plaintiff has a constitutional right to privacy which encompasses nondisclosure of her HIV status."); Doe v. City of Cleveland, 788 F. Supp. 979, 985 (N.D. Ohio 1991) ("While not all information would be protected by the constitution from disclosure, this Court believes that information relating to AIDS . . . is of a fundamental enough nature to be protected."); *Nolley*, 776 F. Supp. at 730 ("We nevertheless believe and assume . . . that . . .[HIV-positive] prisoners enjoy some significant constitutionally-protected privacy interest in preventing the non-consensual disclosure of their HIV-positive diagnoses . . . ."); Doe v. Borough of Barrington, 729 F. Supp. 376, 382 (D.N.J. 1990) ("This court finds that the Constitution protects plaintiffs from governmental disclosure of their . . . infection with the AIDS virus.").

[220] *See, e.g.*, Doe v. City of New York, 15 F.3d 264, 269 (2d Cir. 1994) (explaining that further fact determination was required in order to weigh state versus individual interests); Doe v. Town of Plymouth, 825 F. Supp. 1102, 1108 (D.

balancing tests with some variation on the *Westinghouse* factors.[221] Proceeding from this analysis, several courts have found impermissible violations of the right in question.

Among them is the United States District Court for the District of New Jersey, in *Doe v. Borough of Barrington*.[222] In *Barrington*, "Mr. Doe" was arrested after being pulled over in a routine vehicle stop.[223] At the time of the arrest, Doe warned the police officers that he was HIV-positive, and that they should be careful in searching him, because he had "weeping lesions."[224] One of the arresting officers later revealed Mr. Doe's identity and HIV-positive status to an acquaintance of the Doe family.[225] This acquaintance, whose children attended school with the Doe children, became alarmed, and contacted other parents with children in this common school, as well as members of the news media.[226] By the next day, eleven parents had removed nineteen children from the school,[227] presumably fearing HIV infection. The Does claimed that they were thereafter "shunned by the community" and brought an action for invasion of privacy, pursuant to 42 U.S.C. § 1983.[228]

Citing *Whalen* and *Westinghouse*, the court recognized the existence of a constitutional right protecting the Doe family from the disclosure of Mr. Doe's condition,[229] explaining that "[t]he

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Mass. 1993) (asserting that the circumstances surrounding disclosure are key to balancing the state's interest in disclosure against the plaintiff's right to confidentiality); *Faison*, 823 F. Supp. at 1201–02 (stating that the disclosure of plaintiff's HIV status in her pre-sentence report outweighed her privacy interests, and that this information was necessary for her children to receive adequate services once she was incarcerated).

221 *See, e.g.*, *SEPTA*, 72 F.3d at 1140; *Faison*, 823 F. Supp. at 1201; *see also supra* note 207 and accompanying text.

222 729 F. Supp. 376 (D.N.J. 1990).

223 *See id.* at 378.

224 *Id.*

225 *See id.* at 378–79.

226 *See id.* at 379.

227 *See id.*

228 *Id.* Doe had died shortly after the suit was filed. *See id.* at 379 n.3. The court, however, permitted the Doe family to proceed with this action because the "hysteria surrounding AIDS extends beyond those who have the disease. The stigma attaches not only to the AIDS victim, but to those in contact with AIDS patients . . . ." *Id.* at 384 (citation omitted). Hence, the court concluded, "[t]hose sharing a household with an infected person suffer from disclosure just as the victim does. Family members, therefore, have a substantial interest in keeping this information confidential." *Id.* at 385.

229 *See id.* at 382.

sensitive nature of medical information about AIDS makes a compelling argument for keeping this information confidential."[230] The court noted, however, that "[a]n individual's privacy interest in medical information and records is not absolute,"[231] and proceeded to weigh the societal interest in disclosure against the privacy interest of the Doe family.[232] The disclosing police officer had apparently revealed Mr. Doe's condition for the purpose of warning the family's acquaintance and safeguarding her from contracting the disease.[233] The court found that even though this objective represented an *appropriate* state aim,[234] it was not served by the officer's disclosure, as it was commonly understood even at the time of the incident in question that AIDS cannot be transmitted by casual contact.[235] Accordingly, the court held that the state had not advanced a "compelling interest," for the disclosure and it amounted to a violation of privacy rights.[236]

The Northern District of Ohio reached a similar conclusion in *Doe v. City of Cleveland*.[237] In that case, another "Doe" was arrested for stabbing a friend. The arresting officers, on the basis of a tip, came to suspect that Doe had AIDS.[238] Doe was

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[230] *Id.* at 384.

[231] *Id.* at 385.

[232] *See id.*

[233] *See id.* The police officer warned the acquaintance, who had just had contact with Mrs. Doe, that Mr. Doe had AIDS, and that the acquaintance should "wash with disinfectant." *Id.*

[234] *See id.* ("While prevention of this deadly disease is clearly an appropriate state objective, this objective was not served by [the officer's] statement that [the acquaintance] should wash with disinfectant.").

[235] *See id.*

[236] *Id.*

[237] 788 F. Supp. 979 (N.D. Ohio 1991).

[238] *See id.* at 981. The tip had come from Doe's stabbing victim. *See id.* In fact, Doe did not have AIDS. *See id.* The Cleveland Police Department had rules regarding the disclosure of arrestees' private information, that stated such information should be treated as confidential and should not be released to third parties absent an arrestee's consent. *See id.* There was an exception, however, for the arrest of " 'persons suspected of, or found to be suffering from . . . AIDS.' " *Id.* at 982 (citation omitted). Thus, although Doe was only suspected of having AIDS and there was no verification (by a laboratory test) of his condition, some disclosure was allowed. The police department's order only allowed for disclosure to be made to the City Health Department, any other agency that received custody of the arrestee or any prosecutor or judge assigned to the case. *See id.* The court did not find these rules unconstitutional on their face. *See id* at 986. Thus, although the police officer may have applied the statute in an unconstitutional manner, Doe couldn't succeed on a § 1983 claim against the city because it required a showing that "the

not charged with any crime, and was released.[239] An unidentified police officer, however, forwarded a note to Doe's place of work[240]—a McDonald's restaurant—stating that Doe had AIDS.[241] Doe was confronted with this note by his employers, and fired because he was suspected of having the disease.[242] Doe filed suit claiming that the publication to McDonald's of the allegation that he was suspected of having AIDS, deprived him of his Fourteenth Amendment right to liberty and privacy.[243] Once again, a balancing test between the government's interest in disclosure and the individual's need for privacy was contemplated,[244] with the court concluding that because "there was no legitimate governmental interest to be served by disclosure of the information to McDonald's,"[245] the conduct itself impermissibly transgressed Doe's privacy interest.[246] The court, however, declined to hold the City of Cleveland liable for the wrongful conduct of its police officers.[247]

In contrast to the decisions discussed above, which found AIDS/HIV disclosure to violate an individual's right to privacy, there is federal authority upholding instances of AIDS/HIV disclosure as legitimate and permissible. Prison HIV policies were at issue before the Eleventh Circuit in *Harris v. Thigpen*.[248] In *Harris*, an Alabama law required that all state and local

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constitutional deprivation was the result of the implementation of an *unconstitutional city policy*." *Id.* (emphasis added). The only other theory upon which the city could be held liable for a section 1983 violation was if it "failed to properly train the officers and such failure 'reflects the deliberate indifference to the constitutional right of its inhabitants.' " *See id.* (quoting City of Canton v. Harris, 489 U.S. 378 (1989)). Doe didn't have sufficient evidence to succeed on this theory. *See infra* notes 246–47 and accompanying text.

239 *See* Doe v. City of Cleveland, 788 F. Supp. 979, 981 (N.D. Ohio 1991).

240 The note read: "Even though AIDS cannot be transmitted by contact it is unfortunate that [Doe] is associated with McDonald's. I feel the person in charge should know in case it can help you in any way. Please; [sic] and I trust you will keep this information confidential." *Id.* (alteration in original).

241 *See id.*

242 *See id.*

243 *See id.* at 983.

244 *See id.* at 985.

245 *Id.*

246 *See id.*

247 The court found that the police conduct was not the product of any deficient policies or training schemes utilized by Cleveland, but rather "the result of one officer's malicious circumvention of Cleveland's policy." *Id.* at 986; *see also supra* note 238.

248 941 F.2d 1495 (11th Cir. 1991).

prison inmates be tested for AIDS/HIV and other infections diseases,[249] and those testing positive for AIDS or HIV were assigned to segregated HIV wards.[250] The court found that the segregation policy was "a reasonable infringement in light of the inmate interests at stake . . . and the difficult decisions that the [correctional authority] must make in determining how best to treat and control . . . the spread of a communicable, incurable, always fatal disease."[251] Thus, although the court recognized that the segregation involved "a measure of non-consensual disclosure of an inmate's seropositive status,"[252] the balancing analysis[253] required that the policy be upheld.[254]

Outside of the prison context, the Third Circuit examined AIDS/HIV disclosure in *Doe v. SEPTA*.[255] In *SEPTA*, a public employee alleged violations of his privacy rights stemming from the discovery of his HIV-positive status from a workplace prescription drug program and subsequent disclosures of his status to several of his managers.[256] Notwithstanding the disclosures to Doe's managers, the court concentrated its analysis on the prescription plan itself, which is, by its structure, what enabled the employers to discover Doe's condition. Applying the *Westinghouse* factors, the court balanced the competing interests[257] to hold that the public employer's "need for access to employee prescription records . . . when the information disclosed is only for the purpose of monitoring the

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[249] *See id.* at 1499 n.2.

[250] *See id.* at 1500.

[251] *Id.* at 1521.

[252] *Id.* at 1514.

[253] *See id.* at 1515 (noting that it must "balance the limited personal privacy interests . . . of the seropositive inmates, with those legitimate interests that underlie the . . . decision to segregate such inmates from the general prison population").

[254] *See id.* at 1521. In contrast to the Eleventh Circuit's decision in *Harris*, a pair of notable district court cases found certain prison disclosure policies to violate the privacy rights of inmates. *See* Nolley v. County of Erie, 776 F. Supp. 715, 733 (W.D.N.Y. 1991) (finding prison's policy of placing red stickers on an inmate's documents and personal items, to indicate HIV-positive status, violated the inmate's constitutional right to privacy because it was "not reasonably related to legitimate penological interests"); Doe v. Coughlin, 697 F. Supp. 1234, 1236-37 (N.D.N.Y. 1988) (holding that mandatory relocation to an HIV-positive dormitory violated prisoners' right to privacy due to the substantial risk that the inmates diagnosis would be revealed to family members and friends); *see also supra* note 219.

[255] 72 F.3d 1133 (3d Cir. 1995).

[256] *See id.* at 1135–37.

[257] *See id.* at 1139–43.

plans by those with a need to know, outweighs an employee's interest in keeping his prescription drug purchases confidential."[258]

V. NEW YORK'S TITLE III AND THE RIGHT OF PRIVACY

Applying the dominant analysis for issues pertaining to the right of privacy in avoiding disclosure of personal information, it is necessary to identify and weigh the individual's privacy interest in nondisclosure of his HIV-positive status against New York State's interest in enacting Title III. Given their widespread esteem, the *Westinghouse* factors will inform the balancing analysis undertaken here.

A. The Individual's Privacy Interest in Avoiding Disclosure of AIDS/HIV Status.

Since its appearance on the radar screen of the American consciousness in the early 1980s,[259] AIDS has been met with widespread fear and loathing by the public.[260] Contributing to the anxiety, no doubt, is the infectious, incurable, and fatal nature of the disease.[261] Many people, of course, simply fear transmission. AIDS, however, unlike other deadly diseases, has also come to be associated with certain "deviant" or "immoral" behaviors.[262] Very early in the course of popular exposure to the disease, public perception segregated those infected into "innocent" and "guilty" camps.[263] The "innocent" included hemophiliacs receiving tainted blood transfusions, female

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[258] *Id.* at 1143.

[259] *See* Jeffrey Weeks, *Love in a Cold Climate*, *in* SOCIAL ASPECTS OF AIDS 10, 11 (Peter Aggleton & Hilary Homans eds., 1988) (reporting that the AIDS virus was first encountered in the United States in 1981).

[260] *See id.* at 11-12. According to Weeks, the acute "moral panic" and anxiety surrounding AIDS is attributable to a genuine fear of the disease, as well as its associations with a number of generally disfavored social phenomena, including the erosion of the American family unit and the inversion of sexual mores. *Id.* at 12.

[261] One writer has suggested that because AIDS is incurable, lethal and "lodges itself within the very cells on which we rely for protection against the invasion of germs," AIDS maintains a unique posture in tormenting the public, and that "AIDS . . . resulting from the HIV infection, is the ultimate symbol of our vulnerability." ANGELA MOLNOS, OUR RESPONSES TO A DEADLY VIRUS: THE GROUP-ANALYTIC APPROACH 10 (1990).

[262] Weeks, *supra* note 259, at 12 (noting that "[t]here is a typical stereotyping of the main actors as peculiar types of monsters").

[263] *Id.*

partners of bisexual men, and children born to infected mothers.[264] The "guilty" included a much larger proportion of those stricken: drug addicts, so-called "promiscuous" heterosexuals, and homosexual men.[265] Contributing to this phenomenon were serious distortions by the news media which, according to some commentators, accentuated the connections between AIDS and such controversial behaviors as recreational drug use and homosexual activity, in order to cultivate sensationalistic reporting.[266] The result was the attachment of a devastating stigma to a devastating illness.

Discrimination against persons with AIDS has become a serious concern. It is common for infected individuals to be denied medical treatment, employment, or service by any number of public accommodations.[267] Recently, the Supreme Court held that people with HIV are protected as "disabled" within the meaning of the Americans with Disabilities Act (ADA),[268] an Act designed "for the elimination of discrimination against individuals with disabilities."[269] Persons with AIDS or HIV are undoubtedly in need of such protection. Many people, even now, remain ignorant of how HIV is spread, with some still fearing transmission by casual contact.[270] Such fears have led to numerous incidents of workplace discrimination, prompting suits by those alleging to have been dismissed on the basis of being infected.[271] Moreover, persons whose HIV/AIDS status has been

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[264] *Id.*

[265] *Id.*

[266] *See* Kaye Wellings, *Perceptions of Risk—Media Treatment of AIDS*, *in* SOCIAL ASPECTS OF AIDS 83 (Peter Aggleton & Hilary Homans, eds., 1988).

[267] *See* Gostin & Hodge, *Names Debate*, *supra* note 11, at 724.

[268] *See* Bragdon v. Abbott, 118 S.Ct. 2196, 2207 (1998) (determining that an HIV infection constitutes a disability under the Americans with Disabilities Act since it is a physical impairment that hinders a person's "major life activit[ies]"); *see also* American With Disabilities Act, 42 U.S.C. § 12102(2) (1994) (defining "disability" as "(A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual; (B) a record of such impairment; or (C) being regarded as having such an impairment").

[269] 42 U.S.C. § 12101(b)(1).

[270] *See* POWELL, *supra* note 18, at 82 (noting one doctor's disbelief at the public's lack of knowledge regarding HIV transmission); Wellings, *supra* note 266, at 90–93 (discussing various early AIDS causation theories).

[271] *See* Runnebaum v. Nationsbank of Maryland, 123 F.3d 156, 161 (4th Cir. 1997) (holding, in an employment discrimination case, that asymptomatic HIV was not a disability within the meaning of the ADA), *overruled by* Bragdon v. Abbott, 118 S.Ct. 2196 (1998); Monroe v. Wal-Mart Stores, Inc., No. 97-C-506, 1998 U.S. Dist. LEXIS 4169, *14 (N.D. Ill. Apr. 1, 1998) (denying summary judgement to an

revealed to a large circle of peers sometimes report, in lieu of aggressive discrimination, a subtle sense of alienation, as those with whom they were once close withdraw for fear of contracting the disease.[272]

The interest in avoiding disclosure is even greater for those persons who also happen to be members of particular subpopulations. AIDS has taken a disproportionate toll on African Americans and Hispanics,[273] not to mention homosexual men, who are perhaps the most over-represented.[274] Such groups are subject to an indeterminate degree of discrimination even absent HIV infection, and the addition of AIDS to the equation has a tendency to exacerbate their difficulties.[275]

AIDS-infected employee who claimed that he was discriminated against based on his condition); Huck v. Mega Nursing Servs., Inc., 989 F. Supp. 1462, 1465 (S.D. Fla. 1997) (dismissing discharged HIV-positive employee's suit); Hernandez v. Prudential Ins. Co. of America, 977 F. Supp. 1160, 1168 (M.D. Fla. 1997) (denying summary judgment against an HIV infected employee claiming discrimination because of his condition). Similarly, patrons of establishments have been excluded from such due to their HIV status. *See* 12th Street Gym, Inc. v. General Star Indemnity Co., 93 F.3d 1158 (3d Cir. 1996).

[272] *See, e.g.*, Doe v. Southeastern Pa. Transp. Auth. (SEPTA), 72 F.3d 1133, 1137 (3d Cir. 1995) (noting plaintiff's allegation that after disclosure of his HIV-positive status in the office, his co-workers socialized with him less frequently, they rarely ate the baked goods he brought to the office, and the office seemed lonelier than it had before); Nancy Rivera Brooks, *Work Force Diversity; Fond Fairwells; Companies and Colleagues are Helping the Seriously Ill Work and Die with Dignity*, L.A. TIMES, May 16, 1994, at 11 (suggesting that managers should prevent "subtle discrimination by co-workers such as coffee cups that are washed separately"); *Gay Pair "Try to be Good Role Models" —Couple Take [sic] Keen Interest in Gay Issues*, TORONTO STAR, Feb. 15, 1992, at K10, *available in* 1992 WL 6525706 (noting that many homosexual couples, with or without AIDS face "discrimination —often subtle"); Julia Lawlor, *HIV-Infected Workers Get Little Support*, USA TODAY, Nov. 11, 1991, at 1B, *available in* 1991 WL 6768984 (discussing subtle forms of discrimination in the workplace).

[273] *See* Norwood, *supra* note 16, at 165. In 1993, 69% of those diagnosed with HIV in New York City were either African-American or Hispanic. *See id.*

[274] *See* MUMA, *supra* note 24, at 8 (noting that even though gay men no longer represent the majority of AIDS cases in the United States, they still remain high on the list, and as late as 1992, represented a staggering 57% of all cases in the U.S.); *see also* POWELL, *supra* note 18, at 34–36 (discussing the gay male population and the spread of AIDS); Cary Savitch, *Public Health Needs Mandatory AIDS Testing; How Many Lives Will Be Sacrificed at the Alter of Privacy?*, ST. LOUIS POST-DISPATCH, Feb. 12, 1998, at C15, *available in* 1998 WL 3319374 (reporting that "57[%] of new AIDS cases in the U.S. are gay men").

[275] *See* Weeks, *supra* note 259, at 11 (stating that AIDS has become "a battlefield for conflicting moral and political values").

Homosexuals in particular have experienced violent hate crimes since the proliferation of AIDS.[276]

Opponents of New York's Title III urge that the sense of fear New York homosexuals experience with respect to homophobia would be greatly augmented by the requirement that HIV-positive individuals' names be reported to the State.[277] Others protest that this variety of "forced" partner notification will devastate the personal relationships of those with the disease, without sensitivity to the time and care needed to make such a life-changing decision as that of informing a partner of this serious news.[278] Indeed, there is no question that divulging to a spouse or a sexual partner that one has AIDS would put a

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[276] *See* POWELL, *supra* note 18, at 138–40 (providing specific examples of hate crimes); Patrick Heck, *Sexual Minorities; Include Gays in Hate Crime Protection*, VIRGINIAN–PILOT, May 4, 1999, at B9, *available in* 1999 WL 7163853 (noting a 1999 study documenting 58 anti-gay hate crimes in Virginia); Hugo Martin, *Gays Form Patrols to Battle Hate Crimes; Self-Defense: With Attacks on Homosexuals Increasing, The West Hollywood Effort is Part of a Mobilization Throughout the Southland*, L.A. TIMES, Dec. 3 1991, at B1, *available in* 1991 WL 2198647 (discussing the increase of anti-gay hate crimes by 42% in Los Angeles, New York City, San Francisco, Chicago, Boston and Minneapolis–St. Paul in 1990). The degree of violence directed at homosexuals was vividly rendered in the recent case of Matthew Shepard, a gay Wyoming college student who was bound and beaten by two attackers, and later died from his injuries. Mr. Shepard was not reported to have either AIDS or HIV. *See* Allan Lengel, *Thousands Mourn Student's Death; Beating in Wyoming Sparks New Push for Hate-Crimes Laws*, WASH. POST, Oct. 15, 1998, at A7, *available in* 1998 WL 16562476 (discussing how Shepard's death caused a rally for a hate-crimes bill); *Wire Stories*, PORTLAND OREGONIAN, Nov. 15, 1998, at A2, *available in* 1998 WL 20387389 (explaining how Shepard's death led to a reform campaign).

[277] *See* Letter from Paula L. Ettelbrick, Legislative Counsel, New York's Lesbian and Gay Political Advocacy Organization, to the Hon. Nettie Mayersohn, New York State Assembly Member, Assembly Sponsor of Title III (May 1, 1998) (on file with author) (arguing that the passage of Title III would preclude HIV infected individuals from seeking treatment). Ms. Ettelbrick writes, "Gay men and lesbians, who already feel their lives and interests are compromised by homophobia and discrimination, would be particularly threatened by the prospect of having to openly reveal that they are gay to a governmental authority." *Id.*

[278] *See* The Empire State Pride Agenda, *supra* note 10, at 1 (contending that Title III will cause HIV infected individuals to avoid care). "Before the patient has time to deal with the diagnosis and the impact such a diagnosis will have on his life, the health department will be allowed to knock on the door, phone, mail to or otherwise contact their spouse and other sexual partners." *Id.* Furthermore, "[i]t is difficult to escape the feeling that this bill deals with HIV infected patients not as people with a serious disease and a number of life-changing choices that may take time, but rather as criminals." *Id.*

profound strain on the relationship, if not cause its outright destruction.[279]

Hence, the infected individual's interest in avoiding disclosure of his AIDS/HIV status to the State or to his sexual partners resides in the threat of discrimination native to HIV infection, and the potential loss of personal relations. Indeed, as the Eleventh Circuit explained in *Harris*:

> The threat to family life and ... close ties with others ... is quite real when an AIDS victim's diagnosis is revealed. Ignorance and prejudice concerning the disease are widespread; the decision of whether, or how, or when to risk familial and communal opprobrium and even ostracism is one of fundamental importance.[280]

B. New York State's Interest in Enacting Title III

Currently there are between 650,000 and 900,000 Americans infected with HIV.[281] The Centers for Disease Control estimate that at least 43,000 people become infected with HIV each year.[282] In 1997, New York State led the United States in the number of AIDS cases, with 113,549, edging out the nation's other large AIDS locus, California, which had 101,569 cases.[283]

The incidence of AIDS infection is growing more rapidly among women than any other group in the United States.[284] In

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[279] In one particularly illustrative and perhaps typical case, a young couple called off their wedding when they discovered that the man was HIV-positive, but the woman was not. *See* Jim Yardley, *Breaking the H.I.V. Chain: Counselors Battle Spread of Infection—and Despair*, N.Y. TIMES, Jan. 25, 1998, at 27.

[280] Harris v. Thigpen, 941 F.2d 1495, 1514 (11th Cir. 1991) (quoting Doe v. Coughlin, 697 F. Supp. 1234, 1237-38 (N.D.N.Y. 1988).

[281] *See* Carrie Donovan, *AIDS Screening*, WASH. POST, June 22, 1999, at Z20, *available in* 1999 WL 17010114 (citing the Center for Disease Control and Prevention); *see also* Erika Perrone Tatum, Note, *The Impact of the Americans With Disabilities Act on AIDS Discrimination in the Workplace*, 19 AM. J. TRIAL ADVOC. 623, 623 (1996) (noting that as of 1990, approximately one million Americans – one out of every 250 – were infected with HIV).

[282] *See* Michele M. Contreras, Note, *New York's Mandatory HIV Testing of Newborns: A Positive Step Which Results in Negative Consequences for Women and Their Children*, 20 WOMEN'S RTS. L. REP. 21, 22 (1998) (discussing New York's so-called "AIDS Baby Bill").

[283] *See* Albert, *supra* note 15, at 1024 n.54 (providing a statistical analysis of AIDS cases throughout the United States).

[284] *See* Contreras, *supra* note 282, at 21 (citing Eileen M. McKenna, Note, *The Mandatory Testing of Newborns for HIV: Too Much, Too Little, Too Late*, 13 N.Y.L. SCH. J. HUM. RTS. 307, 317 (1997)).

1993, AIDS and AIDS-related ailments were the fourth leading cause of death among women between the ages of 25 and 44.[285] That same year, AIDS was the "leading cause[] of death among women in fifteen of the 135 largest cities in the United States."[286] As of 1993, at least 25,000 women in New York were infected with HIV, and the percentage of new female AIDS cases due to heterosexual transmission, as opposed to needle-sharing transmission, rose to 30.7%.[287] Approximately "eighty five percent of women with AIDS are of childbearing age."[288] Consequently, the CDC estimated that in 1992, the seventh leading cause of death for children between the ages of one and four was AIDS, transmitted perinatally from infected mothers.[289] New York State itself accounts for one quarter of the nation's pediatric AIDS/HIV cases,[290] 87% of which are attributable to New York City alone.[291] Furthermore, estimates indicate that up to 50,000 children will be orphaned in New York City by the loss of their mothers to AIDS over the next several years.[292] This is probably the largest orphaning of children ever to occur in a single American city.[293]

Many people at risk of contracting HIV from their partners have no idea they are in danger, and many infected individuals find it difficult to tell partners on their own.[294] A recent study of HIV-positive persons found that approximately 66% of its participants remained sexually active after infection, and about 40% did not disclose their HIV-positive status to all of their

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[285] *See* Contreras, *supra* note 282, at 21 (citing Lawrence K. Altman, *AIDS is Now the Leading Killer of Americans from 25 to 44*, N.Y. TIMES, Jan. 31, 1995, at C7).

[286] Contreras, *supra* note 282, at 21.

[287] *See* Nina Bernstein, *When Women Aren't Told Their Lovers are Dying of AIDS*, N.Y. NEWSDAY, Feb. 3, 1993, at 52, *available in* 1993 WL 11351755 (contending that many women in New York are not aware of the great risk of contracting AIDS).

[288] Contreras, *supra* note 282, at 21 (citing McKenna, *supra* note 284, at 318).

[289] *See* Contreras, *supra* note 282, at 21 (footnote omitted).

[290] *See id.* at 21–22.

[291] *See id.* at 22.

[292] *See* Norwood, *supra* note 16, at 166. Other estimates place the number of children to be orphaned in New York City over the next five years at 30,000. *See* David J. Lansner, *Recent Legislation in Child Welfare, 1988-97, in* CHILD ABUSE, NEGLECT AND THE FOSTER CARE SYSTEM 1998; EFFECTIVE SOCIAL WORK AND THE LEGAL SYSTEM; THE ATTORNEY'S ROLE AND RESPONSIBILITIES 507, 576 (1998).

[293] *See* Norwood, *supra* note 16, at 166.

[294] *See* Bernstein, *supra* note 287, at 52 (expressing that these are "two hard truths about a decade's worth of efforts to halt the epidemic").

sexual partners.[295] Moreover, two-thirds of these individuals reported that they did not always use condoms.[296] Strangely, according to the study, infected individuals seem least likely to inform their spouses or other long term partners.[297] Not surprisingly, the reasons for such apprehension include a fear of rejection by the partner, shame, and anxiety about the stigma attached to AIDS.[298] A similar study by the CDC found that 70% of partners were not informed by those testing HIV-positive.[299]

New York is no exception to these disturbing patterns. In 1993, there were approximately 18,000 positive HIV tests in New York City.[300] That same year, there were only 350 partner notifications via the City's voluntary Department of Health partner notification program.[301] In 1991, of 25,896 people who voluntarily sought HIV testing in New York, only 933 reported that they had been cautioned to do so by their partner.[302] In fact, New York has seen the least partner notification of any major AIDS location in the United States, and possibly the least notification per infected individual as well.[303] It is important to bear in mind here that these poor results have been harvested notwithstanding New York's previous notification by petition[304] and direct physician notification provisions.[305] In particular,

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[295] *See* Michael Woods, *HIV-positive Still Having Sex: Study*, SOUTH BEND TRIB., Feb. 9, 1998, at a3.

[296] *See* Brenda Coleman, *Study Finds Many People with AIDS Virus Don't Tell Sex Partners, Feb. 9, 1998* (visited Jan. 22, 2000) <http://www.onlineathens.com/1998/020998/0209.a3sex.html>.

[297] *See* Woods, *supra* note 295, at a3.

[298] *See id.*

[299] *See* Bernstein, *supra* note 287, at 52. Yet another study by the University of North Carolina found that as few as 7% of sex partners were informed by infected individuals. *See id.*

[300] *See* Norwood, *supra* note 16, at 161.

[301] *See id.* According to the New York State Health Department, there were approximately 12,000-15,000 HIV-positive tests in New York in 1996, and less than 400 partner notifications. *See* Legislative Memorandum from the League of Women Voters of New York State in Support of A. 6629 - A / S. 4422 - A to the Members of the Assembly (June 16, 1998) (on file with author).

[302] *See* Bernstein, *supra* note 287, at 52. The article does not specify whether the partner was infected.

[303] *See* Norwood, *supra* note 16, at 164.

[304] *See* N.Y. PUB. HEALTH LAW § 2785(2) (McKinney 1993). "A court may grant an order for disclosure of confidential HIV related information upon an application showing [certain needs and public safety concerns]." *Id.*

[305] *See* N.Y. PUB. HEALTH LAW § 2782(4) (McKinney 1993). "A physician may disclose confidential HIV related information [so long as four statutory conditions are met]." *Id.*.

New York's permissive direct notification provision is limited, allowing doctors to notify partners of infected individuals only when they believe the contact is at a significant risk of exposure to the disease, *and* that the patient himself will not inform the partner.[306] In New York's crowded and overworked hospitals, it is nearly impossible for physicians to take the time or make the personal investment necessary to determine that an infected patient is unlikely to inform his partner.[307] Hence, New York's approach to partner notification thus far, relying on petition and permissive methods, has been largely ineffective in controlling the spread of AIDS.[308]

This is especially dispiriting if one understands the potential in an effective partner notification program. It is imperative to notify at-risk partners early, particularly women, because HIV is not easily transmitted through heterosexual intercourse in the first few years after a man has been infected.[309] The virus becomes increasingly transmissible, however, as his immune system begins to deteriorate.[310] Typically, this pattern yields a period of five years or more, in which it is possible to save the majority of partners from infection.[311] Furthermore, even for those partners who have been infected, early notification will prolong and possibly save lives, as the most recent drug treatments are most effective when begun early in HIV development.[312] In spite of these invaluable opportunities, it appears that the pre-Title III system in New York continually fails, and healthy people are being infected with HIV by

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306 *See id.* at § 2782(4)(a)(2)-(3); Norwood, *supra* note 16, at 164.

307 *See* Norwood, *supra* note 16, at 164–65.

308 *See* Bernstein, *supra* note 287, at 52 (suggesting that New York lacks the political will to emphasize partner-notification strategies). In 1993, CDC partner notification authority Dr. Kathleen Toomey expressed that New York's approach was underdeveloped. *See id.* Furthermore, in its entire first year, New York's law permitting doctors to refer partner notification duties to the state was not utilized even once. *See id.*

309 *See* Norwood, *supra* note 16, at 166.

310 *See id.*

311 *See id.*

312 *See* Avram Goldstein, *Williams Considers Listing HIV Names; Opponents Prefer Database of Numbers*, WASH. POST, Aug. 16, 1999, at B1, *available in* 1999 WL 23298410 (noting effectiveness of "lifesaving HIV drugs depends on starting therapy early"); Denise Mann, *HIV Going Undiagnosed in Some Women, Study Says*, DALLAS MORNING NEWS, Aug. 21, 1998, at C3, *available in* 1998 WL 13096660 (noting "cocktails . . . are most effective when they are started early").

knowingly-infected persons whom they love and trust.[313] The state of the crisis is best captured in the words of one commentator: "It is unprecedented in modern health history to know so absolutely that literally thousands of people are at risk of a fatal disease and not take ordinary public health measures which can significantly slow its spread."[314]

C. *Balancing the Interests*

One of the key *Westinghouse* factors to be considered in a balancing analysis such as this is whether "there is an express statutory mandate, articulated public policy, or other recognizable public interest militating toward access" to the information in question.[315] It is submitted that the serious AIDS problem in New York constitutes a "recognizable public interest militating toward access." The policy concerns driving Title III are abundant and clear—lives are in danger, but may be saved. New York has been devastated by AIDS more than any other state. If mandatory names reporting is justifiable anywhere, it is in New York. Accordingly, the "degree of need for access," another *Westinghouse* factor,[316] is also great.

Another crucial *Westinghouse* consideration is "the adequacy of safeguards to prevent unauthorized disclosure."[317] Title III expressly prohibits the disclosure of the HIV-related information to any party other than the health authorities, the infected individual himself, and the endangered contact.[318] Moreover, Title III does not permit the disclosure of the infected individual's identity to the notified contact.[319] In *Whalen*, the

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[313] Newspaper articles throughout the 1990s are laden with heart-breaking accounts. Such is the case of Barbara Williams of Brooklyn, a mother of five, who has AIDS. Williams contracted the disease from her boyfriend of three years, who knew he was infected. Williams had unprotected sex with her boyfriend throughout the relationship, but explained that she would have insisted on the use of a condom had she known of his condition. Ironically, Williams was a frequent attendee of AIDS prevention meetings, and was well aware of the means of transmission. This only lends greater support to her claim that she would have exercised caution, had she any reason to suspect there was a danger. *See* Shelley Pannill, *HIV Bill Would Change Rules of Confidentiality*, BRONX BEAT, Apr. 28, 1997, at 1; *see also* Peyser, *supra* note 2, at 5.

[314] Norwood, *supra* note 16, at 165–66.

[315] United States v. Westinghouse Elec. Corp., 638 F.2d 570, 578 (3d Cir. 1980).

[316] *Id.*

[317] *Id.*

[318] *See* N.Y. PUB. HEALTH LAW § 2134 (McKinney Supp. 1999).

[319] *See* N.Y. PUB. HEALTH LAW § 2133(3) (McKinney Supp. 1999).

Supreme Court upheld New York's drug prescription reporting law which, like Title III, involved the Department of Health's collection and administration of the information in question. The Court was impressed by the Act's prohibition of unwarranted disclosures,[320] and the majority explained that "New York's statutory scheme, and its implementing administrative procedures, evidence a proper concern with, and protection of, the individual's interest in privacy."[321]

Whereas "the potential for harm in any subsequent nonconsensual disclosure"[322] of an individual's HIV-positive status is substantial, this factor cannot overcome the considerable need for an aggressive partner notification law in New York. Title III simply appears to be necessary. Indeed, it appears that the band has played on quite long enough in New York.[323] There is no doubt that, with this law, the community ventures into disturbing territory. It is a legislative maneuver which is necessarily accompanied by trepidation and remorse, and it is not to be celebrated by any particular political wing. In a transaction in which we may save lives only at the cost of making more terrifying the ordeal of those who wrestle every day with a disease most of us would rather not think about, we are not faced with an option to choose an unequivocal "good." Hence, New York's new partner notification law, although necessary, represents the lesser of two evils.

CONCLUSION

Title III of Article 27 of the New York Public Health Law is sustainable under a constitutional right of privacy analysis. Although the individual's interest in nondisclosure of his HIV-positive status is substantial, it is outweighed by New York's profound interest implementing new measures to slow the spread of a devastating disease.

Benjamin F. Neidl

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320 *See* Whalen v. Roe, 429 U.S. 589, 594, 605 (1977).

321 *Id.* at 605.

322 *Westinghouse*, 638 F.2d at 578.

323 *See generally* RANDY SHILTS, AND THE BAND PLAYED ON (1987) (chronicling the early spread of the AIDS epidemic in the U.S.).