Mandatory HIV Partner Notification: Efficacy, Legality, and Notions of Traditional Public Health

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I. Introduction

For over fifteen years, many different people, communities and entities, both private and public, have worked to stem the tide of HIV transmission. AIDS education on many levels, HIV counseling and testing, and services for those infected have been made available by community-based organizations since the beginning of the AIDS epidemic, and later by governmental agencies. In the mid to late 1980's, voluntary HIV partner notification programs were introduced as a preventative measure that could be used to combat the spread of HIV.[1] The introduction of partner notification programs was based in part on the favorable evaluation of contact tracing, an earlier form of partner notification[2] used with other sexually transmitted diseases to successfully slow disease transmission though the general population.[3] Although many activists and organizations support voluntary HIV partner notification programs that assist infected individuals in contacting their sex or needle sharing partners by themselves or with the aid of public health officials, AIDS advocates have opposed mandatory HIV partner notification because it potentially compromises the confidentiality of participants' HIV status.[4] Advocates state that these confidentiality breaches cause serious ramifications in the lives of already suffering individuals.[5] Mandatory notification could cause people fearing a

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1. The United States Centers for Disease Control first emphasized partner notification as an essential component of HIV counseling in their 1986 program announcement. Marvin E. Bailey, *Developing a National HIV/AIDS Prevention Program Through State Health Departments*, 106 PUB. HEALTH REP. 695, 696 (Nov. 1991).

2. *See infra* Part III and note 26.

3. Ronald Bayer & Kathleen E. Toomey, *HIV Prevention and the Two Faces of Partner Notification*, 82 AM. J. PUB. HEALTH 1158, 1159 (1992) [hereinafter Bayer].

4. *See, e.g., AIDS Action Council Opposes HIV Prevention Act of 1997* (last modified Mar. 13, 1997) <http://www.thebody.com/aac/mar1397.html>; Michael Adams, *Testimony of the American Civil Liberties Union Foundation and the American Civil Liberties Union's Puerto Rico Chapter in Opposition to Regulation Number 87* (last modified March 19, 1997) <http//www.aclu.org/issues/aids/prtest.html>.

5. Numerous examples were reported of people with HIV having been subject to

confidentiality breach to avoid HIV testing, thereby cutting themselves off from social services and medical treatment they may need to survive.[6]

Recently a push for wide spread adoption of mandatory HIV partner notification has surfaced. Puerto Rico,[7] New York[8] and the federal government[9] have all recently introduced bills or initiatives that, if passed, would require the notification of sexual and needle sharing partners of all persons testing HIV positive that they had been exposed to the virus. Alternately, a physician or public health official would notify partners if the HIV positive person does not want to make the notification himself. Puerto Rico's "Regulation 87" would have fined HIV positive people $5000 for not providing the names of their partners.[10] The sponsors of these bills cite a growing concern for women and young people, especially in communities of color, who are unknowingly infected by their partners. The bills are also meant to prevent vertical transmission of the virus to fetuses during pregnancy.[11] New York Assemblywoman Nettie Mayersohn goes as far as to state, "(u)nder any circumstances, . . . , people have a right to know that their partners are infected and that they are at risk."[12]

This Article initially looks at the history of AIDS and partner notification, and then examines the theoretical, epidemiological, and legal issues presented by the application of mandatory partner notification to the HIV context.[13] It explores whether partner notification's successful use to stem the transmission of certain sexually transmitted diseases can be replicated as a HIV prevention

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discrimination, violence, and humiliation after disclosure in their communities of their HIV status. Brenda Seals, *The Overlapping Epidemics of Violence and HIV*, J. ASS'N NURSES AIDS CARE, Sept.-Oct. 1996, at 91.

6. *See* Adams, *supra* note 4.

7. Proposed Regulation 87. *See Puerto Rico Cancels HIV/Sex Partner Notification Plan*, ANDREWS AIDS LITIG. REP. June 13, 1997; Charles Henderson, *Puerto Rico Drops Plans For AIDS Name Reporting*, AIDS WEEKLY PLUS, June 2, 1997, at 15.

8. N.Y.A.B. 6629, 220th Leg., Reg. Sess. (N.Y. 1997); N.Y.S.B. 4422, 220th Leg., Reg. Sess. (N.Y. 1997).

9. H.R. 3937, 104th Cong., 2d Sess. (1996).

10. *See* Henderson and *Puerto Rico Cancels HIV/Sex Partner Notification Plan*, *supra* note 7.

11. *See Independent Women's Forum Hails HIV Prevention Act of 1997*, AIDS WEEKLY PLUS, Mar. 24, 1997, at 17; Memorandum from Assemblywoman Nettie Mayersohn to the New York State Assembly (Mar. 4, 1997).

12. Mayersohn, *supra* note 11 (emphasis in original).

13. For other academic commentary on HIV partner notification, *see, e.g.*, Sylvia Mayer Baker, *HIV: Reasons to Apply Traditional Methods of Disease Control to the Spread of HIV*, 29 HOUS. L. REV. 891; Bobbi Bernstein, *Solving the Physician's Dilemma: An HIV Partner-Notification Plan*, 6 STAN. L. & POL'Y REV. 127 (1995); Mary E. Clark, *AIDS Prevention: Legislative Options*, 16 AM. J.L. & MED. 107 (1990); 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 (1994); Bernard Friedland, *HIV Confidentiality and the Right to Warn–The Health Care Provider's Dilemma*, 80 MASS. L. REV. 3 (1995); Jeff Glenney, *AIDS: A Crisis in Confidentiality*, 62 S. CAL. L. REV. 1701 (1989); Sten L Gustafson, *No Longer the Last to Know: A Proposal for Mandatory Notification of Spouses of HIV Infected Individuals*, 29 HOUS. L. REV. 991 (1992); David P. T. Price, *Between Scylla and Charybdis: Charting a Course To Reconcile the Duty of Confidentiality and the Duty to Warn in the AIDS Context*, 94 DICK. L. REV. 435 (1990); Karen H. Rothenberg et. al., *The AIDS Project: Creating a Public Health Policy–Rights and Obligations of Health Care Workers*, 48 MD. L. REV. 93 (1989); Richard C. Turkington, *Confidentiality Policy for HIV-Related Information: An Analytical Framework for Sorting Out Hard and Easy Cases*, 34 VILL. L. REV. 871 (1989); Charles D. Weiss, *AIDS: Balancing the Physician's Duty to Warn and Confidentiality Concerns*, 38 EMORY L.J. 279 (1989).

measure, and the possible actual and legal ramifications of making HIV partner notification programs mandatory. This Article then concludes that since, at this point, HIV is a non-curable disease, partner notification will not be as effective with HIV as it was with other diseases. Additionally, mandatory HIV partner notification will hinder HIV prevention efforts because its efficacy is questionable, it is expensive and may siphon funds away from other HIV initiatives, and it will most probably deter people from HIV testing because they fear HIV status disclosure and confidentiality breaches. Moreover, this Article concludes that some aspects of mandatory HIV partner notification programs could be illegal, particularly if programs are not implemented with adequate procedural due process protections for the HIV-infected persons involved.

II. Overview of AIDS in the United States

The history of AIDS in the United States is generally thought to have begun in 1979 when several otherwise healthy, gay men living in New York City, Los Angeles and San Francisco contracted, and later died from diseases that were thought to be relatively benign.[14] Originally dubbed Gay Related Immunodeficiency, or GRID,[15] AIDS was initially only prevalent among homosexual men, Haitians, heroin addicts, and hemophiliacs.[16] By Thanksgiving of 1981, there were 244 known deaths due to AIDS.[17]

Today, the face of AIDS has changed. From 1981 through 1996, over 573,000 AIDS cases have been reported, 223,000 of these people are living today.[18] The virus is quickly infecting communities other than those initially affected: 57% of all people with AIDS today are non-white, 12% of all AIDS cases are contracted through heterosexual contact, and women account for 20% of all people with AIDS.[19] Even though heterosexual contact only accounts for a relatively small percentage of cases, this means of transmission constitutes the largest proportionate increase from last year.[20] Men who have sex with men (MSM),[21] however, still account for the largest number of prevalent cases at 44%, followed by intravenous drug users (IDUs) at 26%.[22]

In recent years, for the first time in the history of AIDS, deaths caused

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14. Jan Zita Grover, *AIDS: Keywords, in* AIDS: CULTURAL ANALYSIS /CULTURAL ACTIVISM 18 (Douglas Crimp ed., 1988).

15. *Id.*

16. This group was originally called the "4Hs" of AIDS. Hookers (prostitutes) were later added as a fifth "H". *See generally* Sander L. Gilman, *AIDS and Syphilis: The Iconography of Disease, in* AIDS: CULTURAL ANALYSIS /CULTURAL ACTIVISM, *supra* note 14, at 85-107.

17. Douglas Crimp, *in* AIDS: CULTURAL ANALYSIS/CULTURAL ACTIVISM, *supra* note 14, at 11.

18. *Update: Trends in AIDS Incidence, Deaths, and Prevalence–United States, 1996*, 46 MORBIDITY AND MORTALITY WKLY. REP. 165, 165, 169 (1997) [hereinafter MMWR].

19. *Id.* at 167, 169.

20. *Id.* at 169.

21. This high-risk category changed names from "gay or bisexual" to "men who have sex with men" because it includes men who engage have sexual contact with other men but do not identify as gay or bisexual. This is important when targeting prevention efforts so their effect can reach beyond the gay and lesbian community.

22. *Update: Trends in AIDS Incidence, Deaths, and Prevalence*, *supra* note 18, at 169 [hereinafter *Update: Trends in AIDS Incidence, Deaths, and Prevalence*].

by the disease have decreased.[23] This is largely thought to be a product of HIV testing and medical advances made to combat viral replication and similar advancements in the treatment of opportunistic infections associated with AIDS.[24] However, there has been a substantial increase in AIDS prevalence,[25] which means although people are living longer, new cases are still appearing. This indicates that for the time being medicine alone cannot combat the virus; prevention efforts such as education, testing, counseling, and voluntary partner notification, are still necessary to prevent more people from getting infected.

III. Overview of Partner Notification Programs

Partner notification, formerly known as contact tracing,[26] is credited to the Surgeon General Thomas Parran, the architect of the federal anti-venereal disease program.[27] In 1936, he addressed the National Conference on Venereal Disease Control stating, "Every case must be located, reported, its source ascertained and all contacts then informed about the possibility of infection, provided with a Wasserman test, and if infected, treated."[28] National contact tracing programs were firmly established for syphilis by the late 1940's when syphilis became easily treatable, first with arsphenamine and then with penicillin.[29] By tracing the sexual contacts of a person with a known infection of syphilis, asymptomatic individuals could be treated before further transmitting the disease to non-infected individuals. This effort was largely successful and the nation saw a decline in the prevalence of syphilis by the late 1950's.[30] Contact tracing has also been used to control the spread of antibiotic-resistant gonorrhea, endemic gonorrhea, chlamydia, hepatitis B, and sexually transmitted enteric infections with varying degrees of success.[31]

Partner notification has two main objectives. The first and primary goal is to interrupt the transmission of infectious diseases. This is traditionally done by finding and treating the patient's partner so he does not spread the disease any further. Once treated, these partners are requested to name their recent contacts so that they too can be treated.[32] The secondary function of partner notification

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23. For example, in the first half of 1997, the number of AIDS deaths dropped 60 percent in California. *In Brief, AIDS Deaths Down*, N.Y. BLADE NEWS, Jan. 23, 1997, at 12; 48 percent in Virginia; [AIDS Deaths Down by 48 % in First Half of '97], *Wash. Post*, Jan. 22, 1998, at D3; and 44 percent in the United States as a whole; *AIDS Deaths Fall Sharply; New Treatments Credited*, WASH. POST, Feb. 3, 1998, at A2.

24. *Update: Trends in AIDS Incidence, Deaths, and Prevalence*, *supra* note 18, at 171-172.

25. *Id.* at 171.

26. The CDC, US Public Health Service, and the Association of State and Territorial Health Officials changed the name from contact tracing to partner notification to include not only sex partners, but also needle sharing partners when tracking the transmission of HIV. *See Partner Notification for Preventing Human Immunodeficiency Virus (HIV) Infection–Colorado, Idaho, South Carolina, Virginia*, 37 MMWR 393 (1988); Bayer, *supra* note 3, at 1159.

27. Bayer, *supra* note 3, at 1159.

28. *Id.*

29. George W. Rutherford & Jean M. Woo, Editorial, *Contact Tracing and the Control of Human Immunodeficiency Virus Infection*, 259 J. Am. Med. Ass'n (JAMA) 3609 (1988).

30. *Id.*; *see also* Bayer, *supra* note 3, at 1159.

31. *Id.*

32. New York Law offers a further incentive for persons notified of their infection with a

is to locate and treat infected individuals to improve their health.[33] This was easy to do with diseases like gonorrhea[34] and syphilis[35] where a shot of penicillin (plus a gram of probenecid for gonorrhea treatment) was all it took to kill the infecting bacteria.[36] In summary, partner notification allowed the government to reduce the spread of the disease by reducing the pool of asymptomatic but infectious persons,[37] and improve the health of those it notified by treating the illness.

Partner notification is generally performed in one of two ways, by patient referral or provider referral.[38] Patient referral is performed when the infected person ("index patient") notifies his partner personally that he has been exposed to a particular disease.[39] Most counselors can assist the index patient in preparing for such a conversation by role-playing and discussing possible outcomes.[40] This technique is relatively inexpensive because the index patient does all the work; however, the physician or health department may not be able to tell whether the partner has actually been notified or not.[41]

Provider referral is performed when the doctor, public health official, or some other person associated with the testing process notifies the index patient's partner that he has been exposed to the virus.[42] This method of notification is good for a patient who does not want to confront a partner whom he may have infected, yet who wants the partner to know of the possible exposure.[43] Provider notification can be offered to patients who specifically ask for assistance, or it can be solicited by a physician, public health official, or mandated by law.[44]

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sexually transmitted disease to get treated. It is a violation of the public health law to knowingly be infected with a STD and not seek treatment. N.Y. PUB. HEALTH LAW § 2303 (McKinney 1993). But *see generally* Willard Cates, Jr. et al., *Partner Notification and Confidentiality of the Index Patient: Its Role in Preventing HIV*, 17 SEXUALLY TRANSMITTED DISEASES 113 (1990).

33. James T. Dimas & Jordan H. Richland, *Partner Notification and HIV Infection: Misconceptions and Recommendations*, 4 AIDS & PUB. POL'Y J. 206 (1989).

34. BERKOW, ROBERT, M.D., THE MERCK MANUAL, 1612-14 (14th ed. 1982).

35. *Id.* at 1616-24.

36. There are strands of sexually transmitted diseases that have mutated so they become resistant to traditional antibiotics. For example, a mutation of gonorrhea called PPNG not only is resistant to penicillin, but actually consumes and destroys it. GABRIEL ROTELLO, SEXUAL ECOLOGY: AIDS AND THE DESTINY OF GAY MEN 67 (1997). *See also* LAURIE GARRETT, THE COMING PLAGUE: NEWLY EMERGING DISEASES IN A WORLD OUT OF BALANCE 265-67, 411-56 (1994).

37. Michael W. Adler & Anne M. Johnson, *Contact Tracing for HIV Infection*, 296 BRIT. MED. J. 1420 (1988).

38. New York also has a hybrid option where you can tell your partner in the presence of a counselor. *Timing and Flexibility Crucial to Partner Notification Counseling*, 9 AIDS ALERT 13 (1994).

39. Dimas, *supra* note 33, at 206.

40. *Id.*

41. *Id.*

42. *Id.*

43. *Id.*

44. Partner notification can be mandated through the state legislature or enforced as a legal duty through the courts. The legislature can mandate the State Health Department to notify partners of persons who test HIV positive (*See, e.g.*, UTAH CODE ANN. 1953 § 26-6-3.5(1)(b)(1997), or the legislature can make the omission to notify past and present partners of exposure a crime for the index patient (*See, e.g.*, IND. CODE ANN. § 16-41-7-3 (West 1993), which makes it a misdemeanor for a person who tests HIV positive not to notify a partner of their status).

Courts have held under tort law that a physician has an affirmative duty to inform known

Provider referral can be very expensive because of the time and personal labor required to locate and counsel partners, but this approach ensures that a good faith attempt has been made to notify these partners and that the located partners receive professional counseling.[45] This article deals primarily with provider referral because it poses a greater risk for breach of confidentiality, both of the partner's HIV status and their possible membership in a high-risk behavior group; it is expensive, and lacks proven efficacy,[46] particularly on a large-scale mandatory basis.

IV. Historical and Theoretical Perspective on HIV Partner Notification

Public health measures evolved centuries ago to prevent the spread of disease amongst communities.[47] Early on, American society did not recognize as many individual liberties as it does today, and the government was permitted to institute severe measures, such as quarantine, for highly contagious diseases on a wide-spread scale.[48] As medical science and individual liberties became more sophisticated, the government implemented less restrictive public health measures. The frequent use of quarantines gave way to the more extensive use of screening, vaccinations, and other treatments to prevent illnesses from being communicated. However, medical science still cannot prevent the transmission of many diseases, and the government may force people to give up their personal liberties. For example, people in America are still quarantined in state facilities,[49] confined to their homes,[50] monitored to ensure medication is

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third parties of danger posed to them by their patients. This has been called the "duty to warn." The leading case in this area is Tarasoff v. Regents of California, 529 P.2d 553 (Cal. 1976). In *Tarasoff*, a psychotherapist was held to have a duty to warn his patient's ex-girlfriend that the patient was intending to kill her.

In Reisner v. Regents of California, 31 Cal. App. 4th 1195 (2nd Dist. 1995) *writ denied*, No. S045274 (Cal. May 18, 1995), *Tarasoff* was extended so that physicians have a duty to warn third parties of possible HIV exposure. In *Reisner*, the physician discovered ten days after he gave a blood transfusion to a patient that the blood contained HIV. The physician never told the patient or her parents about the tainted blood even though he continued to treat her. Three years later, the patient started dating the plaintiff, and they subsequently had unprotected sex. Two years after they started dating, the patient discovered she had AIDS and died a month later. The plaintiff, who later tested HIV positive, sued the physician for negligence in not warning him or the patient's parents that the patient was HIV positive. The court allowed such an action even though the plaintiff was unknown to the physician.

A similar conclusion was held in Garcia v. Santa Rosa Health Care Corp., 925 S.W.2d 372 (Tex. 1996). A blood products supplier was held to have a duty to warn a third party of potential HIV exposure through a recipient of defendant's tainted blood supply. Again, the provider had no knowledge at the time that the blood contained HIV and no knowledge that the plaintiff even existed.

45. Dimas, *supra* note 33, at 206.

46. *See* Andrew T. Pavia et al., *Partner Notification for Control of HIV: Results after 2 Years of a Statewide Program in Utah*, 83 AM. J. PUB. HEALTH 1418 (1993); *but see* Suzanne E. Landis et al., *Results of a Randomized Trial of Partner Notification in Cases of HIV Infection in North Carolina*, 326 NEW. ENG. J. MED. 101 (1992); Rutherford, *supra* note 29, at 3609-10.

47. Lawrence O. Gostin, *Traditional Public Health Strategies, in* AIDS LAW TODAY 59 (2nd ed. 1993).

48. *Id.* at 59, 62.

49. Forty-two states permit the commitment of people with contagious tuberculosis to treatment facilities. *See* Paula Mindes, *Tuberculosis Quarantine: A Review of Legal Issues in Ohio and*

ingested,[51] and excluded from private and public programs if not vaccinated.[52] The states, using the police powers they retained from the Federal government when the Union was formed,[53] still have considerable control over how we choose to protect ourselves from disease.

The states originally set up partner notification programs as an efficient method to slow the transmission of sexually transmitted diseases by tracking down and notifying infected individuals.[54] Although partner notification infringes on the privacy of individuals by requiring a limited disclosure of medical information, this limited disclosure was thought to be necessary to control the outbreak of disease. People were generally cooperative and eager to rid themselves of infection.[55]

HIV partner notification differs from contact tracing for other sexually transmitted diseases because there is no cure for HIV. The goal of HIV partner notification is not to slow transmission by curing infected persons, but to modify their behavior. When HIV-infected persons are subject to mandatory partner notification, they may not only be faced with behavioral counseling and urged to produce the names of their sexual and needle sharing partners, they may also be reported to the state government as a person with HIV as part of a statutory HIV reporting scheme created to better survey the progression of the AIDS epidemic.[56] These strategies remove control from the individual's life and place it in the hands of the government, causing people to feel dominated by the government and deterring them from seeking necessary medical treatment.[57] Possible disclosure of a person's HIV status may lead to discrimination and stigmatization from family and society.

Despite the questionable emphasis on the well being of third parties instead of the current patient, it has been argued that partner notification is necessary because the state has an obligation to try to reduce and eventually eliminate the transmission of HIV.[58] Because the traditional public health measure of contact tracing has proven very effective in stemming the transmission of syphilis, gonorrhea, and other sexually transmitted and contagious diseases,[59] states are using partner notification as a tool to combat

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Other States, 10 J.L. & HEALTH, 403, 409 (1996).

50. Thirty-three states permit authorities to isolate people with contagious tuberculosis in their homes. *See id.*

51. *See, e.g.*, 24 R.C.N.Y. HEALTH CODE § 11.47(d)(3) (authorizing the Commissioner of the City Department of Health to issue an order requiring persons with active tuberculosis to have anti-tuberculosis medication administered to them or taken by them under direct observation of a public health officer).

52. Forty-eight states currently have mandatory vaccination requirements for public school students. LuAnn A. Polito, *Containing the AIDS Virus*, 37 CLEV. ST. L. REV. 369, 384 n.119 (1989).

53. *See* Jacobson v. Commonwealth of Massachusetts, 197 U.S. 11, 24-25 (1905).

54. *See supra* notes 28-31 and accompanying text.

55. However, there were reports of public health officials withholding treatments from those who would not provide the names of their contacts. *See generally* Bayer, *supra* note 3, at 1159.

56. *See, e.g.*, MICH. COMP. LAWS ANN. § 333.5114(1) (West 1992) (requiring the reporting of the age, race, sex and county of residence of subjects that test positive for HIV to the local health department).

57. Doughty, *supra* note 13, at 167.

58. Bayer, *supra* note 3, at 1163.

59. *See* notes 29 and 30 and accompanying text.

HIV transmission.

Most states have promulgated statutes designed to ensure the confidentiality of medical information pertaining to AIDS,[60] so that HIV positive people will not fear public disclosure of their status after receiving care from medical or social services providers, whether private or publicly funded. However, with the new political pressure to pass mandatory HIV partner notification laws, these confidentiality laws are being revised to allow for HIV names reporting and partner notification programs.[61] This political pressure has been successful despite the emphasis of the Center for Disease Control and many other public health entities on ensuring absolute confidentiality as a precondition to achieving public health goals.[62] Although advocates of mandatory HIV partner notification laws claim there is no risk of confidentiality breaches as a result of these laws, newly diagnosed patients plausibly fear disclosure if their partners have had few sexual or needle-sharing relationships. In this situation, the state's confidentiality statutes offer infected individuals no protection because it is relatively easy for a partner to figure out the identity of the source of possible infection. Additionally, the partner who is notified has no obligation to keep HIV-related information about the person who possibly infected him confidential.

Although public health measures are generally less severe today, they are still restrictive and affect the personal liberties of a great many people. It is important to examine not only what restrictions upon personal liberties take place, but also upon whom these restrictions are placed. HIV and AIDS have from the outset largely affected already marginalized communities, such as sexual and ethnic minorities, intravenous drug users, and the incarcerated.[63] These populations are not only socially or economically challenged, but have little political representation. Therefore, any measure taken to prevent HIV transmission that restricts the personal liberties of infected individuals, such as mandatory HIV partner notification, results in the further subjugation of under-represented communities.

Political lobbies that exert pressure to end exorbitant government spending on AIDS prevention and research represent majority interests.[64] These lobbying institutions support prevention programs, such as mandatory notification, that benefit the majority in addition to the groups largely affected by HIV and AIDS. The political pressure they exert will most probably result in the

60. *See, e.g.*, 410 ILL. COMP. STAT. ANN. 305/9 (West 1997).

61. *See, e.g.*, N.Y. PUB. HEALTH LAW §§ 2130-2139 (McKinney 1997).

62. Bayer, *supra* note 3, at 1158.

63. The California Department of Health Services, Office of AIDS, Sacramento, reported clients served by state contractors were injection-drug users, men who have sex with men, inmates, high-risk youth, migrant farm-workers, persons who have sex for money or drugs, and heterosexuals at risk including women of childbearing age as target populations for HIV prevention and education programs. Rani Marx et al., *HIV Education and Prevention in California: Problems and Progress*, 12 AIDS & PUB. POL'Y J. 31, 34 (1997).

64. *See, e.g.*, James Driscoll, *AIDS vs. Education*, WASH. TIMES, Sept. 9, 1997, at A17 (citing the education lobby as a powerful lobby preventing additional allocations to the AIDS Drug Assistance Program); Eliot Marshall, *Lobbyists Seek to Reslice the NIH's Pie*, 276 SCIENCE 344 (reporting that other health-related organizations, such as the American Heart Association, the Juvenile Diabetes Foundation and the Parkinson's Action Network, are vying for some of the Federal funds allocated to AIDS).

removal of funding from non-intrusive prevention programs, in favor of inherently invasive programs like mandatory names reporting and partner notification, thereby further oppressing communities affected by HIV. Communities affected by HIV will be left with the choice of accessing HIV prevention and treatment programs, which might result in compromising their personal liberties, or forgoing prevention programs and risking a rise in community members infected with HIV. Viewed from this perspective, mandatory HIV partner notification looks less like an overall national policy to prevent HIV transmission, and more like a policy to further marginalize sexual and ethnic minorities, intravenous drug users, and incarcerated persons.

In summary, the issues surrounding mandatory partner notification are not confined to whether it is an effective public health measure. The private interests at stake beg questions about the risk of unauthorized disclosure, the possible harm from disclosure, the effect of partner notification on other health measures like testing and treatment, and who is affected. The answers to these questions are anything but clear, and yet these questions must be answered before any sort of complete and effective policy directing HIV partner notification can be formulated. However, as more factors appear in the debate, the essential questions stay the same: "Why do I have to tell anyone my HIV status?" versus "Why can't the state do whatever it takes to stop the spread of AIDS?" In other words, the individual's right to keep his or her personal life private must be balanced against the state's need to protect its citizens from dying.

V. Efficacy of Current HIV Partner Notification Strategies

There are three factors making HIV partner notification programs different from previous contact tracing efforts used to prevent the transmission of other STDs.[65] First, there are physiological differences in the diseases: HIV is not immediately detectable in the blood stream,[66] at this point in time it is still incurable,[67] and it is more frequently transmitted by behavior that is traditionally considered morally questionable, if not illegal.[68] Second, there are sociological

65. These factors refer to how the AIDS epidemic has evolved in the United States exclusively, and not other countries that have so similar, but some very different problems dealing with HIV and AIDS. *See, e.g.*, Seth Berkley, et al., *AIDS: Invest Now or Pay More Later*, 31 FIN. & DEV. 40 (June 1994) (examining developing country's government spending on HIV as compared to other diseases); J. Bryce et al., *Quality of Sexually Transmitted Disease Services in Jamaica: Evaluation of a Clinic-Based Approach*, 72 WORLD HEALTH ORG. BULL. 239 (1994) (analyzing methods to evaluate the monitoring of STD clinics in developing nations like Jamaica); Nancy Scheper-Hughes, *AIDS, Public Health, and Human Rights in Cuba*, 342 THE LANCET 965 (1993) (evaluating the containment of HIV through Cuba's policy of quarantining persons with HIV despite the inherent human rights infringements).

66. *See* Johan Ramsedt Giesecke, *Efficacy of Partner Notification for HIV Infection*, 338 THE LANCET 1096 (1991); Rutherford, *supra* note 29, at 3609.

67. *See* Pavia, *supra* note 46, at 1418; Landis, *supra* note 46, at 101.

68. *Notification of Syringe-Sharing and Sex Partners of HIV-Infected Persons–Pennsylvania 1993-1994*, 44 MMWR Mar. 24, 1995, at 202, 204. Cates, *supra* note 32, at 113-14. This, however, is not to belittle the stigma placed on persons in society who contract more traditional sexually transmitted diseases like syphilis and herpes. Indeed, the Medical Broadcasting Company has created a web site specifically to address the fear and humiliation that younger adults (and older

differences in how the diseases are spread; HIV was initially transmitted, and to a large part still is transmitted, within communities which have been difficult to reach through public health efforts.[69] Third, there are political differences in how individual states implement their HIV partner notification programs.[70] These differences have made HIV partner notification programs more time consuming,[71] more expensive,[72] and more controversial[73] than previous contact tracing programs.

A. *Physiological Effectiveness:*

Physiologically, the virology of HIV poses problems to traditional partner notification efforts because it makes HIV cases especially difficult to track through the population. A person may take anywhere from six weeks to three years or more to develop antibodies to HIV,[74] which is the primary detection method used by health professionals to determine whether someone has HIV.[75] Additionally, even when infected, a person with HIV can remain asymptomatic for four or five years.[76] Therefore, even if tested, an HIV positive person could think he is not HIV-infected, and consequently spread HIV to many people innocently. By the time the person tests positive and is asked to identify his

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adults as well) may face when they have contracted sexually transmitted diseases. *See Unspeakable: The Naked Truth About STDs* (visited Nov. 16, 1998) <http://www.unspeakable.com/truth.html>.

69. *Notification of Syringe-Sharing and Sex Partners of HIV-Infected Persons–Pennsylvania 1993-94*, *supra* note 68, at 202-204; Kevin D. Wells & Gerald L. Hoff, *Human Immunodeficiency Virus Partner Notification in a Low Incidence Urban Community*, 22 SEXUALLY TRANSMITTED DISEASES 377-79 (1995); Randolph F. Wycoff et al., *Notification of the Sex and Needle-Sharing Partners of Individuals With Human Immunodeficiency Virus in Rural South Carolina: 30-Month Experience*, 18 SEXUALLY TRANSMITTED DISEASES 217 (1991); Richard E. Hoffman et al., *Comparison of Partner Notification at Anonymous and Confidential HIV Test Sites in Colorado*, 8 AIDS & HUM. RETRO. 406, 409 (1995); John K. Watters, *HIV Test Results, Partner Notification, and Personal Conduct*, 346 THE LANCET 326 (1995).

70. Wells, *supra* note 69, at 377-79; Hoffman, *supra* note 69, at 406; Pavia, *supra* note 46, at 1422.

71. George W. Rutherford et al., *Partner Notification and the Control of Human Immunodeficiency Virus Infection; Two Years of Experience in San Francisco*, 18 SEXUALLY TRANSMITTED DISEASES 107 (1991); Stephen Crystal et al., *AIDS Contact Notification: Initial Program Results in New Jersey*, 2 AIDS EDUC. & PREV. 284 (1990).

72. David R. Holtgrave et al., *Human Immunodeficiency Virus Counseling, Testing, Referral, and Partner Notification Services, A Cost-Benefit Analysis*, 153 ARCH. INTERN. MED. 1225-30 (1993); Wells & Hoff, *supra* note 70, at 379.

73. Because of the stigma society has attached to people with HIV, the possibility of revealing the identity of an HIV-infected individual though partner notification programs, among other things, has made HIV partner notification more controversial than previous contact tracing programs. *See generally* Seals *supra* note 5; CDC *supra* note 68, at 204, Cates *supra* note 32, at 113.

74. Although most medical establishments report that HIV antibodies are detectable six to eight weeks after infection, (*see* Lutz Gurtler, *Difficulties and Strategies of HIV Diagnosis*, 348 THE LANCET 176 (1996); Elaine M. Sloand et al., *HIV Testing: State of the Art*, 266 JAMA 2861 (1991)), there are reports of gay men who tested negative three or more years after infection. David Holzman, *AIDS Antibodies Take Their Time*, 5 INSIGHT 46 July 10, 1989, at 46.

75. The test that most health officials use to determine whether someone has been infected with HIV is called the ELISA test which detects whether there are antibodies to HIV in the person's blood stream. Wells & Hoff, *supra* note 69, at 377-79; Hoffman, *supra* note 69, at 406-10.

76. Rutherford, *supra* note 29, at 3610; Adler, *supra* note 37, at 1420.

previous sex or needle sharing partners, the partners may be out of contact with this newly diagnosed individual.[77] Many reported partners of HIV infected people can never be located.[78] This lapse of time between infection and detection makes partner notification very difficult because it takes public health officials much more time and effort to track down partners of individuals who may have been infected years ago, than people exposed only a few weeks before.[79]

The other major physiological difference between HIV and other diseases previously subject to contact tracing is that currently HIV is an incurable and possibly fatal infection.[80] Thus, the goal of HIV partner notification is not to cure the infection, like previous diseases, but to change the behavior of the person notified.[81] If the person tests negative for HIV, the goal is to counsel that person so that he will not expose himself again to infection. If the person tests HIV positive, then the goal is to change his behavior so that he will not expose others to infection. Unfortunately, the behaviors associated with HIV transmission are not so easily modified.[82] To ensure no transmission of the virus during sex, the people involved must not share body fluid, which is usually accomplished by wearing a condom if the infected person or their partner is a man or using a dental dam if the infected person or their partner is a woman. However, sex with a condom or dental dam not only reduces physical pleasure, but can also reduce the spontaneity and emotional or "romantic" quality of the act. Therefore, sex with these protective devices may be less desirable for people primarily concerned with the physical pleasure derived from the act itself. Safer sex also requires a certain amount of preparation and financial resources. This may be a particular problem for younger people who may not plan their

77. *Id.*

78. *Id.*; *see generally* Adams, *supra* note 4.

79. Rutherford, *supra* note 29, at 3610.

80. Although there is no cure for HIV, different anti-retroviral therapies taken simultaneously are commonly thought of as the most effective drug treatment against the progression of HIV. This is achieved by combining drugs that combat HIV at different stages in its replication cycle, therefore making it harder for the virus to multiply and develop resistance to any individual drug. The most popular combination of drugs at this point are two nucleoside analogs with one protease inhibitor. This combination can vary by replacing the protease inhibitor with a non-nucleoside analog or adding a second protease inhibitor. Joel E. Gallant, *When to Start Therapy–And What to Start With*, POSITIVELY AWARE Jan./Feb. 1997, at 22-23.

David Ho, the director of the Aaron Diamond AIDS Institute, reportedly is considering treating newly infected patients by immediately placing them on combination therapy for a period of three years, after which the treatment is fully discontinued. He hopes to catch the virus early enough, before it accumulates in areas that drugs cannot reach through the bloodstream, and then eradicate the virus from the patient's system using combination therapy; although many suspect this approach is a possible "cure," it has yet to be clinically proven. Interview with Robert Z. Freidman, M.D., in New York, N.Y. (May 28, 1997). Other health officials surmise that it might take much longer for combination therapy to rid the body of HIV. Anne-Christine D'Adesky, *The Secret Life of HIV*, OUT, Feb. 1998, at 80, 83.

81. Rutherford, *supra* note 29, at 3610; Adler, *supra* note 37, at 1420.

82. In a Missouri study, persons who came to STD clinics were offered voluntary HIV testing. Of those who tested positive, 20% came back to the clinic within the next year for treatment of an STD, indicating that at least 1 out of 5 persons testing positive still engaged in high-risk behavior. Lee et al., *Voluntary Human Immunodeficiency Virus Testing, Recidivism, Partner Notification, and Sero-Prevalence in a Sexually Transmitted Disease Clinic: A Need for Mandatory Testing*, 17 SEXUALLY TRANSMITTED DISEASES 169, 171 (1990).

sexual experiences carefully,[83] or people in poverty who may not have enough money to afford condoms or dental dams.[84]

The other primary mode of HIV transmission, sharing needles, involves behavior that may be even more difficult to change.[85] Most people using intravenous drugs cannot suddenly stop using the drugs because they are physically and psychologically addicted.[86] The only immediate solution for many intravenous drug users is the sale or exchange of dirty needles for new or clean ones.[87] Needle exchange programs are controversial,[88] if not illegal, in most states,[89] and not readily available to the majority of the IDU population.[90] Without sterile needles, intravenous drug users must clean their syringes with bleach to kill any virus that might linger after injection.[91] This, however, is not a practical solution as many drug users forgo this method of prevention.[92] A long-term goal for many intravenous drug users might be to gain admittance into a drug treatment center.[93] However, drug treatment centers have a long wait for admittance and not all drug users want to go through treatment. These attitudes may preclude its use as an immediate and effective solution to correct dangerous behaviors leading to HIV transmission.[94]

Although not intrinsic to the physiology of the virus itself, there has been a great stigma attached to those in our society who have contracted HIV. Initially there was a great fear of contagion associated with AIDS.[95] However, now that the modes of transmission are clear, people who have AIDS or HIV are associated with the populations that have been most susceptible to the transmission of HIV, namely the gay male and intravenous drug using communities.[96] A person with AIDS is not only stigmatized because he has a

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83. A study of young gay men (ages 17-22) in San Francisco reported that 32.7% participated in unprotected anal intercourse within the past six months. Watters, *supra* note 69, at 326. This may reflect the need to increase HIV prevention efforts in schools. *See* School-Based HIV-Prevention Education–United States, 1996, 46 MMWR 760 (1996).

84. In a study of 224 people who were either homeless, chemically dependent but not in treatment, and/or mentally ill, only 26% reported using a condom at their last sexual intercourse. *Community-Based HIV Prevention in Presumably Underserved Populations–Colorado Springs, Colorado, July - September 1995*, 46 MMWR 152, 153 (1997).

85. *See* JEFF STRYKER & MARK D. SMITH, NEEDLE EXCHANGE: DIMENSIONS OF HIV PREVENTION ix, x (Jeff Stryker & Mark D. Smith eds., 1993).

86. The most popular drugs injected today are heroin, cocaine, and amphetamines; all are chemically addictive and produce withdrawal symptoms. *Id.* at xii.

87. Peter Lurie & Pamela DeCarlo, *Does HIV Needle Exchange Work?* (visited Feb. 11, 1999) <http://www.caps.ucbf.edu./capsweb/WEPrev.html>.

88. For a brief history of needle exchange programs in the US, *see generally* Sandra D. Lane, *A Brief History, in* NEEDLE EXCHANGE: DIMENSIONS OF HIV PREVENTION, *supra* note 85, at 1-9.

89. For a legal history of drug paraphernalia laws, *see generally* Lawrence Gostin, *Law and Policy, in id.* at 35-61.

90. Lurie & DeCarlo, *supra* note 87. There are approximately 113 needle exchange programs for more than one million people who inject drugs in the United States.

91. *Id.* at 2. Although using bleach is not always as safe as getting a new or sterilized needle.

92. *Id.*

93. *Id.*

94. Jane McCusker et al., *Admissions of Injection Drug Users to Drug Abuse Treatment Following HIV Counseling and Testing*, 109 PUB. HEALTH REP. 212, 217 (1994).

95. People have thought that one could catch AIDS through casual contact, such as toilet seats, etc. *See* Paula Treichler, *AIDS, Homophobia, and Biomedical discourse: An Epidemic of Signification, in* AIDS: CULTURAL ANALYSIS/ CULTURAL ACTIVISM, *supra* note 14, at 35.

96. Personal stigma can be increased by fear of incarceration as IV drug use and sodomy are

contagious and fatal disease, but also because people believe that he belongs to a high-risk group. People with AIDS have been fired from their employment,[97] denied housing,[98] refused custody of their children,[99] as well as denied services open to the general public.[100] Discrimination experienced by people with HIV has prevented HIV and AIDS from being treated like other STDs.[101] Fear caused by normal reporting and contact tracing methods has kept people with HIV from seeking testing and medical treatment, thus driving the disease underground.[102]

Partner notification programs depend on the cooperation of the infected person to be successful. If a person feels stigmatized by society, or does not want to subject his partners to that stigma, then his cooperation with the partner notification program could be affected,[103] perhaps more so if the person associates the partner notification counselor or program as a representative of the society that has stigmatized him. Cooperation is also greatly affected by how the person reacts to the news that he is infected with a life-threatening illness, which may launch the person into a long chain of depression and denial.[104] Therefore, many factors including preparation,[105] testing conditions,[106] and state laws,[107]

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illegal in many states. Crystal, *supra* note 71, at 286-87.

97. *See, e.g.*, Doe v. Univ. of Md. Med. Sys. Corp., 50 F.3d 1261, 1262-63 (4th Cir. 1995).

98. *See, e.g.*, Downtown Hosp. v. Sarris, 588 N.Y.S.2d 748, 751-52 (N.Y. Civ. Ct. 1992).

99. *See, e.g.*, Stewart v. Stewart, 521 N.E.2d 956, 958 (Ind. Ct. App. 1988).

100. In one such case, a Latina grandmother was unable to find a funeral home in which to bury her daughter who died of AIDS. *See* Amber Hollibaugh, *The Second Epidemic, in* AIDS: CULTURAL ANALYSIS/ CULTURAL ACTIVISM, *supra* note 14, at 127.

101. People with other sexually transmitted diseases, like syphilis and herpes, also experience stigma and fear of being labeled as someone who is, for example, promiscuous, adulterous, or not hygienic. *See Unspeakable: The Naked Truth About STDs*, *supra* note 68.

102. *See* New York State Soc'y of Surgeons v. Axelrod, 77 N.Y.2d 677 (N.Y. 1991). This case holds that the decision of the Commissioner of New York Dept. of Health not to classify HIV or AIDS as a sexually transmitted or communicable disease under N.Y. PUB. HEALTH LAW § 225(5)(h) and § 2231 was not arbitrary and capricious. The Commissioner's decision was based on grounds that the designation would subject persons suspected of having HIV to mandatory testing and contact tracing, discouraging cooperation of affected individuals, and would lead to the loss of confidentiality for those infected, and therefore was contrary to the public health.

103. Crystal, *supra* note 71, at 286.

104. Denial is a psychological defense mechanism that many people with HIV and AIDS use as a tool to cope with their current situation. Denial may be triggered by fear of discrimination, abandonment, or life changes due to being HIV positive. Obviously, those suffering from denial are less likely to tell their partners of their condition. James Monroe Smith, *When Knowing the Law is not Enough: Confronting Denial and Considering Sociocultural Issues Affecting HIV Positive People*, 17 HAMLINE J. PUB. L. & POL'Y 1 (1995).

105. Partner notification can be brought up during pre-testing, post-testing, and follow-up counseling. A New Jersey study suggests that raising the issue during pre-test counseling gives the index patient time to assimilate to the idea so that if they do test positive, it will not seem like a breach of confidentiality. However, mentioning partner notification during follow-up sessions may have better results because the patient may be too upset to deal with a request for partners when he first learns of his status. Crystal, *supra* note 71, at 286-87.

106. Patients testing at confidential test sites tend to be more cooperative than those testing at anonymous testing sites. Hoffman, *supra* note 69, at 406.

107. South Carolina saw a 51% decline in the number of gay men tested and a 43% decline in the number of positive test results after enacting mandatory name reporting, Crystal, *supra* note 72, at 287. Conversely, the demand for testing rose 50% overall, and 125% among gay men, when Oregon made anonymous testing available. *See* Landis, *supra* note 46, at 105. *But c.f.* Pavia, *supra* note 46, at 1422, reporting that both Utah and Colorado did not see a decrease in confidential or anonymous testing, or positivity rate after enacting mandatory name reporting.

might possibly affect the person's cooperation.

Beyond prejudice, an individual might fear physical consequences if the notified partner could possibly identify the infected person. Domestic violence is a significant concern for women with AIDS. Seventeen percent of all women and 25% of all Latina women with AIDS reported domestic violence in the home.[108] The correlation between drug addiction and domestic violence is also a factor when considering whether a woman should be forced to notify her partner of exposure to HIV.[109] A study done in Baltimore found that 45% of all health providers had female patients who expressed fears of violence resulting from disclosure of her status to her partner, and 18% of these providers' female clients expressed such concerns.[110] Therefore, if there is potential for domestic violence, that patient's situation should be considered in determining whether her partner should be notified.[111]

The physiology of HIV has therefore made it unique amongst sexually transmitted diseases. Its long incubation period, its incurability, and transmission patterns have frustrated traditional partner notification efforts. Because of these unique qualities, it seems that only in conjunction with other prevention efforts, such as counseling, referral, testing, education and protective legislation, can partner notification programs become an effective tool against the further spread of HIV.[112]

B. Sociological Effectiveness:

Sociologically and geographically, this country has been unevenly affected by HIV. Incidence of HIV is much higher in urban areas, like New York City, Los Angeles and San Francisco, which were considered the primary focal points for AIDS in the 1980s.[113] The incidence of AIDS is much lower in rural areas, some of which have not seen even a single case of HIV or AIDS.[114] Demographically, men who have sex with men and intravenous drug users have been the hardest hit by AIDS.[115] These two groups have been labeled at high-risk for possible transmission, along with hemophiliacs and prostitutes, although heterosexual women who are the sex partners of people in one of the aforementioned groups are quickly climbing into their own high-risk group.[116] People who have opposite-sex sex partners, do not use intravenous drugs, and do

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108. Richard L. North & Karen H. Rothenberg, *Partner Notification and the Threat of Domestic Violence Against Women with HIV Infection*, 329 NEW ENG. J. MED. 1194, 1195 (1993).

109. Karen H. Rothenberg & Stephen J. Paskey, *The Risk of Domestic Violence and Women with HIV Infection: Implications for Partner Notification, Public Policy, and the Law*, 85 AM. J. PUB. HEALTH 1569, 1570 (1995).

110. *Id.*

111. *See generally id.*; North, *supra* note 108; Seals, *supra* note 5.

112. *See generally* Holtgrave, *supra* note 72.

113. Grover, *supra* note 14, at 18.

114. *Partner Notification for Preventing Urban Immunodeficiency Virus*, *supra* note 26.

115. Crystal, *supra* note 71, at 286.

116. *Update: Trends in AIDS Incidence, Deaths, and Prevalence*, *supra* note 18, at 171-72 (the CDC has created a sub-classification of high risk groups to account for the higher rate of HIV infection among non-white participants within existing high risk groups as opposed to the lower HIV infection rate of white participants).

not have sex with people in high-risk communities[117] have been relatively unaffected by the virus, although recently the rate for heterosexual transmission is rising.[118]

There is an obvious link between these sociological and geographic distinctions; high incidence areas have a larger percentage of persons in high-risk groups than low incidence areas. New York and San Francisco are known for their large gay communities, and therefore, would naturally be the focal point of the AIDS epidemic in the 1980's when sex between men was the primary mode of transmission. However, high-risk groups may not behave similarly in different environments,[119] and partner notification programs may produce different results depending on the community served.[120] In the past ten years, there have been a few studies that can be used to measure the effect HIV partner notification programs have on different high-risk groups in different geographic areas. However, there have not been enough studies of this type, and the variation among the studied HIV partner notification programs is too great to come to any firm conclusions.

Statistically, the efficacy of partner notification programs can be measured in several ways. Since the immediate goal of partner notification is to alert a third party that he has been exposed to HIV, the simplest way to measure effectiveness would seem to be counting the number of successful notifications. However, there are several variables within partner notification programs by which success can be measured, making it difficult to compare them to determine which methods or programs are more effective.[121] Rather, these studies can be used to determine general patterns evidenced in partner notification programs instituted around the country.

Partner notification may promote greater behavioral changes in low incidence communities. In a New Jersey study, where there is a high incidence of HIV transmitted through intravenous drug use, 53% of partners contacted said that they were not surprised to hear that they had been exposed to the virus, and 68% of partners considered themselves to be at moderate or high risk for contracting HIV.[122] In a South Carolina study, where there is a low incidence of HIV, HIV positive people who were tested through partner notification programs reported a 80% decrease in partners, and HIV negative persons reported a 71%

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117. There is an overall absence of research on lesbians and HIV. HIV can be transmitted between women through vaginal secretions, unsterilized sex toys, and sharing syringes during intravenous drug use. In 1993, there was report of a lesbian couple that had contracted HIV without the influence of syringes or male sex partners. *Doctor: Two HIV-positive Lesbians Possibly Infected by Women*, ASSOCIATED PRESS (Aug. 29, 1993). Pressure to include lesbians in HIV prevention across the country has prompted HIV prevention groups, like the Gay Men's Health Crisis in New York City, to start prevention programs and groups targeted towards lesbians. Lisa Billowitz, *Who Gives a Damn?*, GAY COMMUNITY NEWS 3, Feb. 08, 1992. *See generally* Christopher Guly, *The Invisible Lesbian Face of AIDS*, ADVOCATE, Sept. 6, 1994, at 45; Carmen Vasquez, *The Myth of Invulnerability: Lesbians and HIV Disease*, 8 FOCUS 1, Sept. 1994, at 1.

118. *Update: Trends in AIDS Incidence, Deaths, and Prevalence*, *supra* note 18, at 171-72.

119. *See* Wells, *supra* note 69, at 378 (Kansas City: 81% of HIV positive persons named contacts). *But compare*, Crystal, *supra* note 71, at 289 (New Jersey: approximately 8% of HIV positive persons named contacts).

120. *Id.*

121. Pavia, *supra* note 46, at 1421.

122. Crystal, *supra* note 71, at 289.

decrease in partners.[123] Comparing these two studies, information about contracting and exposure to HIV had a much bigger effect on the behavior of persons notified in South Carolina, a low incidence community, as it did in New Jersey, a high incidence community.

Cooperation rates are also different for the separate high risk and sociological groups: gay and bisexual men are less likely to cooperate than heterosexual participants,[124] intravenous drug users (IDUs) are more likely to cooperate than non-IDUs,[125] white people are less likely to cooperate than non-whites,[126] men are less likely to cooperate than women,[127] and older people are less likely to cooperate than younger people.[128] This tendency is reflected in the number of partners referred by groups of high-risk index patients, and also in the characteristics of the people who refuse to give the names of any partners.[129] It has also been shown that the number of IDU partners located is twice as high as the number of partners of men who have sex with men (MSM).[130] This generally larger non-cooperation ratio among MSM can possibly be attributed to a greater distrust of public health authorities or a preference to notify partners without assistance.[131]

Another factor that affects the efficacy of partner notification programs is whether the index person chooses to be tested for HIV at an anonymous or a confidential testing site. Confidential testing sites have the name and number of the index patient on file, and therefore counseling and referral can continue after the patient's visit when she or he hears the HIV positive diagnosis.[132] Conversely, at anonymous testing sites, the counseling and referral for partner notification all happen during the same visit as the HIV diagnosis, which might diminish the effectiveness of the counseling. People using anonymous testing sites are shown to be less likely to cooperate with partner notification programs than those using confidential testing sites.[133] It has also been thought that anonymous testing sites are probably used by people who have a greater distrust of public health authorities,[134] and are therefore more resistant to any further relationship with the local health department. Hence, it is probably not a coincidence that the people shown to have the highest ratio of anonymous test site use are older, white, gay and bisexual men.[135]

An alternative and more effective method of using partner notification

123. Wycoff, *supra* note 69, at 220.

124. N.E. Spencer et al., *Partner Notification for Human Immunodeficiency Virus Infection in Colorado: Results Across Index Case Groups and Costs*, 4 INT. J. STD & AIDS 26, 30 (1993); Wells & Hoff, *supra* note 69, at 378; Giesecke, *supra* note 66, at 1098; Pavia, *supra* note 46, at 1419.

125. Pavia, *supra* note 46, at 1419.

126. *Id.*

127. *Id.*

128. *See id.*; Landis, *supra* note 46, at 103.

129. *Id.*; Spencer, *supra* note 128, at 30; Wells, *supra* note 69, at 378; Giesecke, *supra* note 66, at 1098; Pavia, *supra* note 46, at 1419.

130. Pavia, *supra* note 46, at 1419.

131. *Id.* at 1421; *see* Adams, *supra* note 4.

132. Hoffman, *supra* note 69, at 409.

133. *See* Hoffman, *supra* note 69, at 409; Pavia, *supra* note 46 at 1419; Landis, *supra* note 46 at 103.

134. *Id.*

135. Pavia, *supra* note 46.

focuses on low-risk groups in high incidence areas. This method targets partner notification services by making it available only for the people who would benefit from it most.[136] Targeting partner notification efforts towards people who are not in high-risk groups yet are in high incidence areas reaches people who are exposed to education or counseling efforts yet still do not consider themselves affected by HIV.[137] For example, the San Francisco Department of Health decided to concentrate their HIV partner notification efforts on heterosexuals, in particular women in their childbearing years, so as to limit vertical transmission of HIV to a fetus during pregnancy.[138] San Francisco chose to exclude gay and bisexual men from HIV partner notification programs because of the high level of knowledge about AIDS already in the community.[139] The study identified partner notification as a successful tool to target, counsel, and educate populations that do not consider themselves at risk.[140]

The efficacy of partner notification programs in particular communities is important because of the cost of the programs. Partner notification programs are extremely expensive, ranging from $94 to $5,600 per completed notification.[141] Studies show that effective partner notification programs are cheaper than the lifetime health care costs of a person with AIDS, and therefore are a justified expense.[142] However, if partner notification programs are not particularly effective in a given community, while other cheaper prevention programs are effective, it is questionable whether the expense is justified. In light of a 1989 New Jersey study showing that 53% of partners contacted were not surprised to learn of their exposure to HIV, at a cost of $2,260 for each contact, this money might have been better spent on other prevention efforts.[143] Education and counseling, like partner notification, also have an impact on modifying the behavior of people who are a risk for or who have HIV.[144] These programs might also be better equipped than partner notification programs to deal with related problems, such as drug addiction, denial and domestic abuse. Therefore, in states or areas of high incidence, like New Jersey, education and counseling efforts might have a better and longer lasting effect on changing the behavior

136. *See* Rutherford, *supra* note 71, at 108.

137. A U.S. Department of Health and Human Services report finds that for persons at no or low risk for infection, prevention programs that disseminate information, change attitudes (so that they aren't scared to get tested), and reinforce existing no or low-risk behavior are effective for that population. *See* Holtgrave, *supra* note 72, at 1225-30. However, if those programs are not available, partner notification may be the only way short of illness that a person may find out about his status.

138. Rutherford, *supra* note 71, at 107.

139. *Id.*

140. *Id.* at 109.

141. Cheryl Ellemberg, *HIV Partner Notification Activities in New York State: A Comparative Analysis*, 1996 AIDS INSTITUTE 4.

142. The Center for Disease Control estimates that for every one hundred notifications, twenty can be averted through counseling and testing linked to partner notification programs. This would translate into a net saving of twenty dollars for every one invested in partner notification. This estimate has raised a few eyebrows, but the CDC does calculate additionally that it would only take one notification in eighty attempts to have the notification pay for itself. *See* Holtgrave et al., *supra* note 72, at 1225-30; Chris Norwood, *Mandated Life Versus Mandatory Death: New York's Disgraceful Partner Notification Record*, 20 J. COM. HEALTH 161, 164 (1995).

143. Crystal, *supra* note 71, at 289,292.

144. Holtgrave, *supra* note 72, at 1225-30.

patterns of those at risk, in addition to being more cost effective.

C. *Political Effectiveness*:

States and localities play a politically significant role when they decide to implement effective or less effective partner notification programs. At this point, all fifty states have implemented some sort of HIV partner notification program,[145] usually through the efforts of the state and federal government.[146] Most current partner notification programs derive the authority to make notifications from statutes that create an exception to the general duty of health professionals to protect the confidentiality of a patient's medical records.[147] The power to make notifications is most frequently created through either general exceptions to confidentiality statutes that allow state health departments to use patients' medical information to control the progression of communicable diseases,[148] or exceptions allowing physicians and public health officers to specifically notify persons they suspect have been exposed to communicable diseases without releasing the identity of the infected individual.[149]

State statutes have adopted one of three general approaches to partner notification: optional, mandatory or direct authorization. The vast majority of states make the notification efforts by public health officials and physicians optional. If these officials and physicians choose to notify a partner, some states have implemented guidelines that must be followed before the notification occurs. Several states make HIV partner notification efforts by physicians and

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145. William L. Roper, *Current Approaches to Prevention of HIV Infections*, 106 PUB. HEALTH REPORTS 111, 114 (1991).

146. Under 42 U.S.C.A. §§ 300ff-27a, 46 (1998), states may not receive federal funding for AIDS prevention and services under the Ryan White Care Act unless they "carry out" an HIV spousal notification program. Certain funding restrictions also attach to partner notification and early intervention programs.

147. *See generally* BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 374-383 (3d ed. 1997) (explaining principles of confidentiality and disclosure in the physician-patient relationship).

148. *See* CAL. HEALTH & SAFETY CODE § 121025(b) (West 1998); COLO. REV. STAT. ANN. § 25-4-1404(b) (West 1998); DEL. CODE ANN. tit. 16, § 711 (1997); KY. REV. STAT. ANN. § 214.625(5)(c)(5) (Banks-Baldwin 1997); NEB. REV. STAT. § 71-503.01 (1997); NEV. REV. STAT. ANN. § 441A.220(5) (Michie 1997); N.C. GEN. STAT. § 130A-143(8) (1997); OKLA. STAT. ANN. tit. 63, § 1-502.2(A)(4) (West 1999); S.C. CODE ANN. § 44-29-135(c) (Law Co-op. 1997); S.D. CODIFIED LAWS § 34-22-12.1(3) (Michie 1998); TENN. CODE ANN. § 68-10-113(3) (1998); VT. STAT. ANN. tit. 18, § 1099; WYO. STAT. ANN. § 35-4-132 (Michie 1997).

149. *See* ALA. CODE § 22-11A-38(d) (1996); ARIZ. REV. STAT. ANN. § 36-664(B)(3) (West 1998); CONN. GEN. STAT. ANN. §§ 19a-584(a), (b) (West 1998); FLA. STAT. ANN. §§ 384.25(7)(b), 384.26(1) (West 1998); GA. CODE ANN. § 24-9-47(h)(3)(B) (1998); HAW. REV. STAT. § 325-101(a)(4) (1997); IDAHO CODE § 39-610(2) (1997); 410 ILL. COMP. STAT. 305/9(a) (West 1998); IND. CODE ANN. § 16-41-7-3(b)(2) (West 1998); KAN. STAT. ANN. § 65-6004(b) (1997); LA. REV. STAT. ANN. § 1300.14(E)(1) (West 1997); MD. CODE ANN., HEALTH-GEN. § 18-337(b) (1997); MINN. STAT. ANN. § 13.38(c) (West 1997); MISS. CODE ANN. § 41-23-1(9) (1998); MO. ANN. STAT. § 191.656.2(1)(d) (West 1997); N.Y. PUB. HEALTH LAW § 2782.4(a) (McKinney 1997); OHIO REV. CODE ANN. § 3701.241(A)(3) (Banks-Baldwin 1998); R.I. GEN. LAWS § 23-6-17(2)(v) (1997); TEX. HEALTH & SAFETY CODE ANN. § 81.103(b)(9) (West 1998); VA. CODE ANN. § 32.1-36.1(A)(11) (Michie 1997); WASH. REV. CODE ANN. § 70.24.105(2)(g) (West 1998); W.VA. CODE § 16-3C-3(d) (1997); WYO. STAT. ANN. §§ 35-4-133(b), (c) (1997).

public health officials mandatory, either to spouses of infected individuals,[150] or to all sexual and needle sharing partners.[151] On the other hand, some states do not have exceptions to their medical confidentiality statutes and must rely on the direct authorization of infected persons to make such contacts.[152] Some of these states mandate that their public health departments actively solicit the cooperation of HIV-infected people in their partner notification programs.[153]

Despite the careful drafting of current HIV partner notification statutes to include subtleties tailored towards a particular state's communities, these statutes could all change in the very near future. New York, as one of the states with the greatest incidence of AIDS, could start a wave of legislation by changing voluntary HIV partner notification programs to mandatory ones if the Valella/Mayersohn bill passes.[154] The same result would occur with the passage of the federal Coburn bill which conditions the states' receipt of Medicaid funding on the passage of legislation mandating HIV partner notification.[155] Many AIDS advocates feel that this would be counterproductive in the fight to slow HIV transmission and have started lobbying efforts and grass roots campaigns to stop these bills from passing into law.[156]

Whether voluntary or mandatory, all states' partner notification programs depend on the cooperation of HIV-infected people.[157] Only Puerto Rico has attempted to mandate participation by proposing a regulation that would have imposed $5,000 fines on infected persons who did not cooperate with the partner notification program. The bill was defeated during the eleventh hour at the urging of AIDS advocates, like the American Civil Liberties Union, as counter-productive to overall HIV prevention efforts.[158]

States make another political choice that affects partner notification: whether to allow anonymous testing for HIV antibodies as part of their sexually transmitted disease programs. States usually make this choice based on whether the state requires reporting of the names of all HIV positive persons to the state Department of Health.[159] Like mandatory partner notification, this issue is seen by most AIDS advocates as a probable deterrent to testing because people might fear government interference in their lives or a confidentiality breach.[160] Studies

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150. *See, e.g.*, OHIO REV. CODE ANN. § 3701.241(A)(3) (Banks-Baldwin 1998).

151. *See* IOWA CODE ANN. § 141.6(3) (West 1997); MICH. COMP. LAWS § 333.5131(5)(b) (West 1998); UTAH CODE ANN. § 26-6-3.5(1)(b) (1997).

152. *See* ALASKA STAT. § 18.05.042 (Michie 1997); ARK. CODE ANN. § 20-15-904 (Michie 1995); MONT. CODE ANN. § 50-18-109 (1996); N.D. CENT. CODE § 23-07.4-03 (1997); N.H. REV. STAT. ANN. § 141-F:8 (1996); N.J. STAT. ANN. § 26:5C-7 (West 1997); N.M. STAT. ANN. § 24-1-9.4 (Michie 1998); OR. REV. STAT. § 433.075 (1997); PA. STAT. ANN. tit. 35, § 7607 (West 1997); WIS. STAT. ANN. § 146.82 (West 1998).

153. *See, e.g.*, MD. CODE ANN., HEALTH GEN. § 18-336(e) (1997).

154. *See* Mayersohn proposed legislation, *supra* note 8.

155. H.R. 3937, 104th Cong., 2d Sess. (1996).

156. *See, e.g.*, AIDS Action Council, *supra* note 4; *The Big Lie*, GMHC IN BRIEF, Jan. 21, 1998 at 2.

157. An exception would be when the physician has knowledge of the partner of the infected individual, such as knowledge of a spouse or domestic partner.

158. *See* Henderson and *Puerto Rico Cancels HIV/Sex Partner Notification Plan, supra* note 7.

159. *See* Mayersohn proposed legislation, *supra* note 8.

160. For example, a public health worker recently used a local list of almost four thousand HIV-positive residents to screen dates for himself and his friends. He also allegedly gave this list to his ex-lover, and some undisclosed person sent this list to two Tampa Bay area newspapers. *See* Sarah

show that people who have received an HIV test would not have been tested if they thought their names would have been reported to the government.[161] Similarly, states that have eliminated anonymous testing or instituted mandatory name reporting have seen a reduction in the number of people tested or the rate of testing.[162] Some states are trying to bridge the gap by allowing for one or more anonymous test sites in legislation mandating name reporting.[163] There is clear evidence that partner notification efforts are more successful at confidential testing sites than anonymous testing sites, but that a higher level of testing occurs in states with anonymous testing sites.[164] Therefore, states should carefully study their population to see what proportion of anonymous to confidential testing sites will produce the highest participation in notification programs without compromising the number of people seeking HIV antibody tests.[165]

The success of HIV partner notification programs is ultimately measured by the behavioral change of people to put themselves at less risk for contracting or transmitting HIV. States must therefore carefully examine the efficacy of HIV partner notification in their particular communities, combined with other public health measures like HIV testing and case reporting, to determine whether making HIV partner notification mandatory will produce a positive behavioral change. Additionally, states should look at the cost incurred by their partner notification programs to determine whether HIV prevention funds could produce a better result if placed in other programs. Voluntary partner notification could still be cost effective if kept available for infected persons who want assistance in notifying their current or recent partners or targeting populations that other prevention programs will not reach.

VI. Legal Theories Behind HIV Partner Notification

Tippet, *A New Danger in the Age of AIDS; Florida Health Employee Accused of Sharing Names in Database*, WASH. POST, Oct. 14, 1996, at A4; *Sentence in AIDS Confidentiality Breach*, UNITED PRESS INT'L., Sept. 25, 1997.

161. *See* Adams, *supra* note 4.

162. W. J. Kassler et al., *Eliminating Access to Anonymous HIV Antibody Testing in North Carolina: Effects on HIV Testing and Partner Notification*, 14 J. ACQUIR. IMMUNE. DEFIC. SYNDR. HUM. RETROVIROL. 281 (March 1, 1997).

163. Utah law allows for one anonymous testing site in Salt Lake City. Pavia, *supra* note 46, at 1419. Missouri law allows for three anonymous testing sites, one of which is in Kansas City. Wells, *supra* note 69, at 378.

164. Hoffman, *supra* note 69, at 409. It is also not yet clear how HIV home testing will affect this relationship. Home testing might replace anonymous testing because of the increase in anonymity and convenience. The cost of the test, between $25 - $40, might be prohibitive to lower income individuals. Deborah L. Shelton, *Home HIV Tests Raise Issues of Counseling, Prevention*, AM. MED. NEWS, Mar. 18, 1996.

165. The ratio of persons who test positive from partner notification is higher than from random testing at clinics. *See* Pavia, *supra* note 46, at 1421. Therefore, there is an argument that more people who do not know they are positive would be discovered if partner notification plans were more heavily relied on even though less people would be tested. This argument would then need to be supported by evidence that persons receiving negative HIV test results are significantly less affected behaviorally than people receiving positive test results. Since the primary purpose of partner notification is to reduce transmission, if people are similarly affected behaviorally by a negative test result as a positive test result, then the most testing would be the ultimate prevention goal because the most people would be induced to change their behavior from high to low risk.

Mandatory partner notification statutes, targeted at HIV or other diseases, have never been challenged in the courts. However, other mandatory public health measures, particularly measures dealing with the reporting of private medical information have been the subject of judicial scrutiny. The leading case discussing the constitutionality of state public health measures is *Jacobson v. Massachusetts*.[166] In *Jacobson*, the respondent challenged a statute that mandated the vaccination of all persons against small pox. If a person did not get vaccinated he was subject to a $5 fine or imprisonment.[167] The United States Supreme Court held that the mandatory vaccination was not an infringement of the respondent's constitutional rights because "the police power of a state must be held to embrace, at least, such reasonable regulations . . . as will protect the public health and the public safety."[168] The Court further held that a state can only exercise its police power to preserve the public health so long as "no rule prescribed by a state, nor any regulation adopted by a local governmental agency acting under the sanction of legislation, shall contravene the Constitution of the United States, nor infringe any right granted or secured by that instrument."[169] The Court then looked at the necessity of these particular circumstances and whether or not the mode adopted by the state was so arbitrary in its effect on a particular person as to reach beyond what was reasonably required for the safety of the public. The Court saw the vaccination measures as necessary for the common good.[170] If the state's legislation were found to have an arbitrary and unreasonable effect on an individual, the Court stated that it would intervene for the protection of such a person.[171]

Although decided in 1905, *Jacobson* has never been directly overruled and is often cited when defining the scope of the state's police power. Strictly applying the *Jacobson* standard to mandatory HIV partner notification, a court would have to find a constitutionally protected liberty or right infringed by a notification statute to rule that the statute is unconstitutional. In the case of HIV partner notification, the constitutional right would arguably be the right to informational privacy. The court would need to look at the equities of the situation, and determine whether the statute is arbitrary or reasonably required for the safety of the public. The authors of *Health Care Law and Ethics*[172] have stated the *Jacobson* test in more modern language: "whatever liberty interest individuals have can be outweighed where the state has a compelling interest in protecting the public health, assuming the public health measure is appropriately tailored to meet that objective."[173]

Whether considering *Jacobson* or its more modern interpretation, the constitutional test for mandatory HIV partner notification centers around whether the notification is "reasonably required" or "appropriately tailored" for the safety of the public. Although courts have traditionally given states extreme

166. 197 U.S. 11 (1905).
167. *Id.* at 12.
168. *Id.* at 25.
169. *Id.*
170. *Id.* at 26-27.
171. *Id.* at 28.
172. WILLIAM J. CURRAN ET. AL, HEALTH CARE LAW AND ETHICS (5th ed. 1998).
173. *Id.* at 30.

latitude when legislating to protect the public health,[174] an argument could be made that the cost, rate of success, and rights infringed by partner notification makes the mandatory application of this public health tool to persons infected with HIV unreasonable. Partner notification is only one of a number of prevention devices available to the state, and when looking at the empirical success of notification systems, it can hardly be heralded as necessary, when compared to vaccination efforts to control the smallpox epidemic in early twentieth century Cambridge. Moreover, the evidence that mandatory partner notification may deter people from getting tested for HIV in the first place shows that this necessity may actually be more of a liability in the state's effort to protect the health of its citizenry.

Need, however, may no longer be the standard for determining the constitutionality of intrusive public health measures, especially measures that release private medical information. In 1977 the United States Supreme Court decided *Whalen v. Roe*,[175] holding that a statute mandating the reporting of all prescriptions for controlled substances to the Department of Health, along with the name of the prescribing doctor, dispensing pharmacy, and patient receiving the drug, was constitutional.[176] The state's purpose in enacting this legislation was to discourage and contain the distribution of prescribed controlled substances beyond the intended recipient of the prescription.[177] This statute supplemented already existing criminal statutes prohibiting the sale or distribution of controlled substances without a prescription or medical license.[178] When the respondent challenged the statute as an unnecessary infringement of his privacy rights, in light of the already existing criminal statute, the Court held that "state legislation which has some effect on individual liberty or privacy may not be held unconstitutional simply because a court finds it *unnecessary*."[179] This alters the *Jacobson* analysis of measuring the infringement of personal liberties against the necessity of the situation that calls for the infringement, at least regarding the privacy of medical information. The *Whalen* court effectively ignored the *Jacobson* analysis by substituting the prerogative of the states to experiment with possible solutions to matters of vital local concern, leaving the legislature to correct any mistakes.[180]

Although *Whalen v. Roe* discusses the police powers of the state, it is cited more for the establishment of a constitutional right to informational privacy. The Court recognized two privacy interests alleged by the respondents: the individual interest in avoiding disclosure of personal matters, and the interest in independence in making certain important decisions.[181] The Court held that the New York statute instituted sufficient safeguards against disclosure of this information so that these privacy interests were not unconstitutionally infringed by the statute.[182] Although the Court did not go so far as to hold these privacy

174. Gostin, *supra* note 47, at 59-60.
175. 429 U.S. 589 (1977).
176. *Id.* at 603-04.
177. *Id.* at 591-92.
178. *Id.* at 591-93.
179. *Id.* at 597(emphasis added).
180. 429 U.S. 589, 597-98 (1977).
181. *Id.* at 599-600.
182. *Id.* at 600-02.

interests fundamental, subjecting the challenged statute to strict scrutiny, it did seem to balance the risk of disclosure of information and the type of personal information at risk against the interests of the state.[183]

The *Whalen* balancing test was further refined in *Nixon v. Administrator of General Services*.[184] In *Nixon*, the president argued that his right to informational privacy was violated by the Presidential Recordings and Material Preservation Act, which mandated an archival screening of tapes and documents made during his presidency to screen out personal conversations and documents from those to be retained and released to the public.[185] Nixon argued that he had a privacy interest in those personal conversations and documents guaranteed by the First, Fourth, and Fifth Amendments, and that these interests were violated by the Act's screening process.[186] In *Nixon*, the Court first determined whether there was a legitimate expectation of privacy in the materials at issue,[187] and then weighed any intrusion into that expectation against the public interest in such information.[188] The Court held that the archival screening process was not a violation of Mr. Nixon's privacy interests, because the intrusion into Mr. Nixon's private affairs was minimal, there was an important national interest in the material, and the archival screening process was the least intrusive way of extricating the private conversations and documents.[189] Although the Court in *Whalen* refused to speculate at the consequences of a disclosure of personal information, it held that when collecting personal data, the state typically has a "concomitant statutory or regulatory duty to *avoid unwarranted disclosures*."[190]

It is interesting to note that the Supreme Court cases discussed above are facial challenges to statutes in which personal information was only disclosed to governmental entities. The *Whalen* duty to avoid unwarranted disclosures is thought provoking when speculating about the outcome of a constitutional challenge to a mandatory partner notification statute, because the purpose of such statutes is to disclose information about the HIV positive index patient. In such a case, the state's argument would probably be that the possibility of slowing or arresting HIV transmission within the population, and improving the health of infected partners who are ignorant of their infection, is enough to warrant the limited disclosure of the index patient's HIV status, especially if his name is not attached to the disclosure. The opposing argument would be that the risk and consequences of inadvertent disclosure of a person's HIV status, combined with the expense and low success rate of many partner notification programs, is unwarranted because current or former partners are probably already infected. If a current partner is not infected, transmission of the virus can be controlled through other existing prevention tools, such as education, free anonymous testing, and counseling, which are more cost effective, and, in most

183. *Id.*
184. 433 U.S. 425 (1977).
185. *Id.* at 429.
186. *Id.* at 455.
187. *Id.* at 458. This test was taken from the expectation of privacy derived from the Fourth Amendment's protection against unreasonable government searches and seizures. *See* Katz v. United States, 389 U.S. 347, 351-53 (1967).
188. 433 U.S. at 458.
189. *Id.* at 465.
190. 429 U.S. at 605 (emphasis added).

situations, can prevent HIV transmission to future partners. In addition, the threat to physical safety for those involved in relationships with domestic violence, and the discrimination that might result from a breach in confidentiality make mandatory HIV partner notification an unwarranted public health measure.[191]

The federal circuit courts have interpreted the privacy rights of *Whalen* and *Nixon* differently. For instance, the D.C. Circuit questions whether *Whalen* actually establishes a constitutional right to privacy in the nondisclosure of personal information.[192] However, many other circuit courts have accepted the right to privacy in the nondisclosure of personal information as constitutionally based.[193] In *United States v. Westinghouse Electric Corp.*, the Third Circuit held medical information to a higher standard then other relevant information, as evidenced by the higher burden in the Federal Rules of Civil Procedure for discovery of reports of the physical or mental condition of parties.[194] The *Westinghouse* court then balanced the following factors to determine whether the intrusion into the individual's privacy was justified: the type of record requested, the information it does or might contain, the potential for harm in any subsequent nonconsensual disclosure, the injury from disclosure to the relationship through which the record was generated, the adequacy of safeguards to prevent unauthorized disclosure, the degree of need for access, and whether there is an express statutory mandate, articulated public policy, or other recognizable public interest militating access.[195] These differing interpretations by the circuit courts of the constitutional protection for personal and medical information indicate a possibly more liberal interpretation of these rights in the future, leaving room for a constitutional challenge to a mandatory HIV partner notification statute. This would be particularly true if there is an aggrieved plaintiff who can demonstrate that the intrusion of a partner notification statute was unwarranted under his specific circumstances.

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191. In all the articles that discuss HIV partner notification, *see supra* note 13, any mention of legal challenges to partner notification statutes on constitutional grounds concludes that the statute will probably be upheld in light of the deference courts pay to state public health matters. Only Roger Doughty's article concludes that a constitutional challenge to a state public health provision involving the disclosure or dissemination of HIV-related information may be successful on privacy grounds if the state program demonstrates a lack of capacity to meet public health goals (a category in which Doughty does not place partner notification provisions). *See* Doughty, *supra* note 13, at 153-54. Doughty's analysis, however, does not take into account the dicta in Whalen v. Roe which allows for states to experiment with solutions to public health problems, therefore potentially making effectiveness unnecessary to a facial challenge to public health legislation.

192. *See* American Fed'n of Gov't Employees, AFL-CIO v. Department of H.U.D., 118 F.3d 786, 791 (D.C. Cir. 1997) ("We begin our analysis by expressing our grave doubts as to the existence of a constitutional right of privacy in the nondisclosure of personal information.").

193. *See, e.g.*, Walls v. City of Petersburg, 895 F.2d. 188, 192 (4th Cir. 1990) (holding that there is a reasonable expectation of confidentiality protected by one's constitutional right to privacy in withholding personal information from an employer, and the more personal the information, the more justified the expectation that it will not be subject to public scrutiny); Barry v. City of New York, 712 F.2d 1554, 1559 (2nd Cir. 1983) (applying an intermediate standard of review to uphold a financial disclosure requirement); United States v. Westinghouse Elec. Corp., 638 F.2d 570, 577-80 (3d Cir. 1980) (holding that there is a constitutional right to privacy of medical records kept by an employer).

194. *Westinghouse*, 638 F.2d at 577.

195. *Id.* at 578.

Another theory through which an individual could contest a mandatory HIV partner notification statute is that it deprived him of his liberty interest without due process of law under the Fifth and Fourteenth Amendments. The United States Supreme Court has held that "where a person's good name, reputation, honor, or integrity is at stake because of what the government is doing to him, notice and an opportunity to be heard are essential."[196] Damaging a person's good name, whether the released information is true or untrue has been found to deprive a person of liberty by imposing a stigma on the person's character, thus implicating due process protections.[197] However, in *Paul v. Davis*,[198] the United States Supreme Court limited stigma as a deprivation of due process by holding that a person's liberty interest could only be invaded by the imposition of a stigma plus some other change in status.[199] The Court has used discharge from a job[200] or losing the right to buy alcoholic beverages[201] to demonstrate what would satisfy the "stigma plus" test for deprivation of liberty.

HIV partner notification is an excellent example of possible deprivation of liberty through the stigma plus test. Being publicly labeled as HIV positive cannot only damage a person's character through association with certain sexual and drug-using practices, but it also can lead to the deprivation of major or fundamental interests, such as employment, housing, and familial rights.[202] Although there are efforts to limit discrimination through legal protections for HIV positive persons and people with AIDS,[203] these protections may be eroding.[204]

The Supreme Court has held that once a liberty interest is established, notice and opportunity to be heard must be provided to satisfy due process; these protections must be meaningful and can be flexible to suit the demands of each particular situation.[205] For persons subject to mandatory HIV partner notification, the timing of informing the person about the notification process and the timing of the hearing become crucial. For notice to be meaningful to

196. Wisconsin v. Constantineau, 400 U.S. 433, 434 (1971).

197. *Id.* at 436-37. *See also* Board of Regents v. Roth, 408 U.S. 564 (1972) (holding in dicta that if the state, when discharging the respondent as a professor, made any charges against him that might seriously damage his standing and associations in the community, it might have deprived him of his due process rights).

198. 424 U.S. 693 (1976).

199. *Id.* at 711-712.

200. 408 U.S. 564; *see also* Doe v. Univ. of Md. Med. Sys. Corp., 50 F.3d 1261, 1262-63 (4th Cir. 1995).

201. 400 U.S. 433

202. *See* 50 F.3d at 1262; Downtown Hosp. v. Sarris, 588 S.2d 748, 751-52 (N.Y. Cir. Ct. 1992); Stewart v. Stewart, 521 N.E.2d 956, 958 (Ind. Ct. App. 1988); *see supra* text accompanying notes 97-99.

203. *See, e.g.*, Section 504 of the Rehabilitation Act, 29 U.S.C.A. § 794 (West Supp. 1994), prohibits exclusion of persons with disabilities otherwise qualified solely by reason of his disability from participation in any program or activity receiving Federal funding.

204. Runnebaum v. Nationsbank of Maryland, 123 F.3d 156 (4th Cir. 1997) (holding that the Americans with Disabilities Act does not protect discrimination of HIV positive persons that are asymptomatic); *see also* Catherine Hanssens, *HIV Reporting May Deter Some From Testing*, N. Y. TIMES, Jan. 20, 1998, at A22. *But cf. Disability Act Umbrella Covers Asymptomatic HIV*, 12 AIDS ALERT 52 (1997) (citing a New Hampshire case where an asymptomatic HIV woman won damages under the Americans with Disabilities Act from discriminatory treatment by a dentist).

205. Matthews v. Eldridge, 424 U.S. 319, 333 (1976).

people in a situation where partner notification would be compromising or even dangerous, it must be provided before the person gets tested for HIV. Once a person with HIV gets tested, his liberty will be deprived if the subsequent partner notification is mandatory. States that have passed mandatory HIV partner notification laws could comport with this meaningful notice requirement by mandating pretest counseling at all testing sites. This pretest counseling must inform the person being tested that if their test results are positive, all known sex and needle sharing partners will be notified that they have been exposed to HIV. However, if people are told that their partners will be notified, they may decide not to get tested. This decision would counteract the primary purpose of HIV prevention, which is to inform people of their HIV status through testing so they can change any risk taking behavior and receive early treatment to limit the possible damage caused by the virus.

For hearings to comport with due process protections, their timing must meet the balancing test established by the Supreme Court in *Matthews v. Eldridge*.[206] The four factors to be balanced in the *Matthews* test are: the private interest that will be affected by the public action; the risk of erroneous deprivation of that interest through current procedures, and the probable value of additional procedural safeguards, and the government's interest, including the fiscal or administrative burdens imposed by additional procedures.[207]

The result of this balancing test, if applied to a mandatory partner notification statute, would depend on the actions the court is able and willing to take as a result of the evidence heard. If the court is confined to only determining whether the person actually has HIV, then the result would probably be in favor of a post-determination hearing.[208] In *Matthews*, a case about terminating disability benefits, the Court held, after balancing the above factors, that a post-determination hearing was adequate to protect the disability recipient's due process rights.[209] The Court in *Matthews* was persuaded by the fact that the evidence used by the Social Security Administration prior to termination was largely medical, and, therefore, could be independently evaluated and challenged without a hearing.[210] If a court is only allowed to consider medical evidence that a person tested HIV positive, when determining whether the partners of an HIV positive person should be notified of possible exposure, then an outcome similar to *Matthews* is likely.

Courts, however, might also have to interpret statutes that give doctors or public health officials some discretion in determining whether the partners of an HIV-infected person should be notified of possible exposure. In New York, for example, physicians and public health officials may only notify the partner of an infected person if the notification is medically appropriate and if there is a

206. *Id.* at 319.

207. *Id.* at 335.

208. This could be true if in the challenged statute all persons tested for HIV could be subject to partner notification regardless of their circumstances. *See, e.g.*, MICH. COMP. LAWS ANN. § 333.5131(5)(b) (West 1992) (holding physicians to an affirmative duty to disclose information of possible HIV infection to any individual known to the physician to have been exposed through contact with their patient).

209. 424 U.S. at 349.

210. *Id.* at 337-340.

significant risk of infection to the contact.[211] Therefore, in New York, if partner notification would put an infected person at a significant risk of domestic violence, a judge may determine that notification is medically inappropriate. In addition, if a person can prove that he was practicing safe sex with certain partners, then a New York judge might determine that there is not a significant risk of infection that justifies that partner's notification. In cases where a state's legislature has provided factors that depend on individual circumstances to determine whether or not partner notification should occur, a post-determination hearing might not adequately protect an individual's due process rights.

The *Matthews v. Eldridge* test should be applied to both mandatory and discretionary partner notification statutes to determine whether a pre-determination hearing is required. The first factor, the private interest at stake, is very high. It is the interest in not having the state impose a stigma that might result in an additional detrimental change in status. Since there are no statutory provisions in place at this time to protect against the loss of this liberty, the risk of erroneous deprivation could be high. Additional procedural safeguards, therefore, are needed to lower that risk. If contesting the statute on its face, there may be an argument, similar to that made in *Nixon v. Administrator of General Services*, that the number of persons for which a liberty interest is really at risk is very small in proportion to all persons requiring partner notification.[212] However, for such an argument to be successful, it would have to be statistically proved one way or the other.

The governmental interest in avoiding a hearing before performing partner notification is twofold. A hearing could hinder efforts to combat the spread of HIV, and it could be burdensome. Although both of these state interests seem compelling at first, a closer look shows that their significance can be easily mitigated. The state could decrease the number of hearings it conducts by offering them only to people who request them. Not every person who tests positive has reason to fear that his partners will be notified of possible exposure, and many prefer to notify their partners. Also, epidemiological studies show that partner notification may not always be effective against the spread of HIV. In situations where AIDS education is high, many people are already aware of the risks they take with HIV transmission and do not need to be told by the state that they have possibly been exposed. Lastly, many who do not want certain partners to be notified will simply not put down the names of those partners, rather then go through the more lengthy procedure of having a hearing held. When considering these factors, the number of hearings that will probably be held are few, and they will probably be held for the individuals who need due process

211. N.Y. PUB. HEALTH LAW § 2782(4)(a) (McKinney 1998).

212. In Nixon, when deciding whether Mr. Nixon's fundamental privacy interests were violated by the Presidential Recordings and Materials Preservation Act, which gave public access to a large amount of tapes and documents made during his presidency, the Court found particularly relevant the small amount of personal material claimed in comparison to the vast amount of material made while Mr. Nixon was acting in his official capacity. There was no way to screen out the personal conversations without listening to the tapes. The large amount of relevant information was subject to public access, and only an extremely small amount of personal recordings was alleged to be contained on the tapes, so the court held that Mr. Nixon's informational privacy interest in the material was outweighed by the public interest in access the material made while acting as President. 433 U.S. at 456-60.

protections the most, such as persons in relationships involving domestic violence. Therefore, since the governmental interest is arguably much lower than the private interest at stake or the risk of erroneous deprivation, a pre-determination hearing should be afforded.

Moreover, a post-determination hearing in a situation involving a deprivation of liberty due to stigma does not make sense logically. Once information about someone's HIV status has entered a community, it cannot subsequently be extracted. At this point, the damage to the individual's reputation has already happened and cannot be erased. Only the subsequent information of a false test could possibly eradicate any such stigma, and unfortunately such information is usually not forthcoming.[213] Therefore, for states with mandatory HIV partner notification laws to fully comport with the due process requirement of a meaningful opportunity to be heard, they must provide all people who test HIV positive with an opportunity to request a hearing to determine whether partner notification is appropriate under the circumstances.

Although the courts have traditionally upheld state public health statutes as legitimate exercises of a state's police power,[214] litigation may be an effective strategy to challenge mandatory HIV partner notification statutes. The leading United States Supreme Court case, *Whalen v. Roe*, was a facial challenge to a public health law that required disclosure of medical information on prescriptions to the state. Contesting partner notification statutes on privacy grounds with an actual party aggrieved by the state law may bring about a different result,[215] particularly because challenges to the disclosure of personal medical information have been successful in lower courts.[216] Furthermore, no decisions to date contain challenges to public health laws as a violation of an aggrieved party's procedural due process rights.

VII. Conclusion

The previous analysis of theoretical, epidemiological, and legal issues shows that mandatory HIV partner notification will not be as effective as voluntary efforts. HIV partner notification differs from traditional contact tracing efforts because it depends on a behavior change from the notified partner to be effective. If a partner is unwilling or unable to change his behavior, is already aware that he was possibly exposed, or is already HIV infected, subsequent notification of possible exposure will not lessen the possibility of transmission. HIV partner notification is really only effective in slowing transmission in situations where the notified partner is unaware that the behavior

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213. The chances of a false positive test are very slim. The FDA reports that 1 out of every 144,000 test comes back incorrectly false, with some fluctuation due to medical conditions, sample qualities, and lab work quality. Dolores Kong, *One 'False Positive' Points Up Pitfalls of AIDS Screening*, BOSTON GLOBE, Dec. 30, 1991, at 1. Another Minnesota study showed that only 1 out of 290,000 tests were falsely positive. Rob Stein, *AIDS Screening Tests Highly Accurate, Study Says*, UNITED PRESS INTERNATIONAL, Apr. 14, 1989.

214. *See* Gostin, *supra* note 47, at 60.

215. *See generally* 429 U.S. 589 (1977).

216. *See supra* note 195, plus accompanying text.

he has been engaging is risky, and is willing to discontinue that behavior.

From a theoretical perspective, mandatory HIV partner notification weighs the value of public health over the individual personal liberties of HIV infected persons. It puts at risk the confidentiality of medical information of people who test HIV positive, but only benefits partners who are notified, tested positive, and subsequently change their behavior. As many people who are involved in the AIDS epidemic have already seen, this behavioral change is very difficult.[217] If the notified partners who test positive do not change their behavior, then their future partners do not benefit and transmission of HIV through society is not slowed. Moreover, the very institution of mandatory HIV partner notification may deter people who are afraid of governmental intervention from getting tested for HIV, thereby separating them from medical treatment that could prolong their lives.

Epidemiological studies show that partner notification is more successful with people who are not readily exposed to other forms of HIV prevention, like HIV education and counseling. In these studies, HIV partner notification was most successful in rural communities where there were no large gay and intravenous drug using populations, and, therefore, no large HIV prevention efforts, and heterosexual communities where persons were aware of the dangers of HIV transmission but did not consider themselves at risk. In studies of other communities, HIV partner notification was shown to be less effective because of the non-cooperation of the participants, the massive cost of running the programs, the knowledge about HIV participants had already obtained through other means, and participants' fear of government intervention.

Mandatory HIV partner notification legally compromises infected individuals' privacy rights to avoid disclosure of personal medical information and their procedural due process right to notice and an opportunity to be heard before deprivation of any liberty interest. Although previous public health measures have withstood similar challenges in the interest of public health, mandatory HIV partner notification might have a more difficult time sustaining a legal challenge. A partner notification statute would be particularly vulnerable if the aggrieved plaintiff or plaintiffs suffered domestic violence or discrimination, especially, since in many situations, HIV partner notification is not as effective as other prevention measures in combating the spread of HIV. Furthermore, there are currently no provisions for due process protections in partner notification statutes.

Despite the evidence and arguments against its institution, mandatory HIV partner notification might well soon be a reality on a national scale. The current political climate is frustrated with the lack of control it has over HIV prevention measures. Not only are states proposing mandatory HIV partner notification, many are suddenly considering, seventeen years into the epidemic, instituting the reporting of all people with HIV to their public health departments.[218] There is even a bill in the New York legislature that would make

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217. *In the Company of Men*, OUT, Oct. 1997, at 89, 149-49.

218. Along with the debate about whether people with HIV should be reported to state health departments, is the question of how they should be reported. Some AIDS advocates believe that a system using unique identifiers instead of names would insure the confidentiality of people with HIV, while others feel that disclosing names is the most effective way to track the disease. *See*

it a crime for an HIV positive person to have sex with someone without informing the sex partner first of his status.[219] This is possible due to a strong conservative political lobby that believes that traditional public health measures will control the spread of the virus, and a lack of alternative HIV prevention measures proposed by opposing political camps.[220]

If mandatory HIV partner notification is not to be included in the struggle to control HIV transmission, policy makers need to seriously consider other programs that should be instituted. Most existing HIV prevention programs have been active for many years, yet the rate of HIV infection is still rising.[221] Some think the next step in HIV prevention should be to focus on the social factors that affect the transmission of HIV; people should be provided with an environment where they can remain healthy by ensuring them food, shelter, medical attention, and minimal education.[222] Some see the sharp rise in substance abuse as a co-factor of transmission that must be addressed and changed before the spread of infection will significantly diminish.[223] Still others see the sexual transmission of HIV as a function of sexual ecology; until people change their sexual behavior to make their sexual environment less conducive to the transmission of HIV and other STDs, HIV will continue its unabated march through our society.[224] These theories are all based on the need to change society on a large scale, something that harm reduction strategies, such as condom use and needle exchange, will not achieve. Perhaps it is time that our government and society look at HIV, as well as other problems such as drug

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Across the USA: Alaska, USA TODAY, Jan. 28, 1998 at A11; Lisa Krieger, *City Urged to Require Doctors to Report HIV*, SAN FRANCISCO EXAMINER ONLINE (Jan. 26, 1998); Katie Szymanski, *Panel on HIV Reporting Raises More Questions*, N.Y. BLADE NEWS, Jan. 23, 1998, at 1.

219. Christine Dinsmore, *Trio of Bills Worry State AIDS Activists*, N.Y. BLADE NEWS, Jan. 30, 1998, at 9.

220. There are some possible HIV prevention programs that might prove very effective yet are not widely institutionalized because of other ethical considerations, notably needle exchange programs and HIV education in schools. *See generally* Stryker, *supra* note 85: Lurie, *supra* note 87.

221. There are some who think that we are in the middle of a "second wave" of HIV infection due to the development of newer treatments and the public misconception that the AIDS epidemic is over from the fall in the rate of fatalities. *See* Rotello, *supra* note 36, at 118-134.

222. In his essay *Human Rights and AIDS: The Future of the Pandemic*, Dr. Jonathan M. Mann eloquently advocates the application of the United Nations General Assembly's Universal Declaration of Human Rights which provides a list of societal conditions considered essential for well-being, peace, and health as the key to assist societies in empowering their citizens to believe in the possibility of change and stopping the spread of HIV. *See* Jonathan M. Mann, *Human Rights and AIDS: The Future of the Pandemic*, 30 J. MARSHALL L. REV. 195 (1996); *Universal Declaration of Human Rights*, G.A. Res. 71, U.N. GAOR, 3d Sess., U.N. Doc A/810 (1948).

223. Grant Lukenbill cites studies from the University of Michigan, Columbia University, and the New York State Psychiatric Institute showing a dramatic increase in substance abuse in young adults, particularly gay and lesbian youth, as a probable cause of unsafe sex and drug practices in those communities. He quotes Richard Elovich, director of HIV Prevention at Gay Men's Health Crisis as saying that the "4% (rise annually of HIV infection in young gay men) may sound low to you, but at that rate one half of the gay men who are now 18 years old will be infected by the time they turn thirty." *See* Grant Lukenbill, *Sex Panics Unplugged!*, LESBIAN & GAY NEW YORK, Jan. 5, 1998, at 14.

224. *See generally* Rotello, *supra* note 36.

abuse, crime, and poverty, as symptoms of larger societal issues which must be addressed before the current HIV epidemic can be ended, and before more such epidemics emerge.