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NOTES

TO DISCLOSE OR NOT TO DISCLOSE THE PRESENCE OF AIDS: RESOLVING THE CONFIDENTIALITY CONCERNS OF PATIENTS, PHYSICIANS, AND THIRD PARTIES

I. INTRODUCTION

The ethics of the medical profession have, for centuries, regarded the confidence between physicians and patients as sacred and secret.¹ Accordingly, physicians have an ethical duty to keep medical information confidential.² In addition to their ethical duty, physicians have a common law duty of nondisclosure of patients' medical information.³ The importance of the physicians' duty to keep inviolate the intimate knowledge of their patients is evidenced by the legal relief afforded to a patient whose confidential information is disclosed to unauthorized parties.⁴

Although physicians may face legal action for disclosure of confidential information, maintenance of confidentiality can also lead to a lawsuit. Health care providers have been held liable for not disclosing patient information to third parties who are later harmed by the nondisclosure. In general, the duty to maintain confidentiality exists if disclosure could harm the patient, while at the same time, a duty to disclose exists if confidentiality could cause harm to a third party. Traditionally, these duties rarely overlapped. A recent development, however, has the potential of changing this tradition. This development is Acquired Immune Deficiency Syndrome—

1. C. DEWITT, PRIVILEGED COMMUNICATIONS BETWEEN PHYSICIAN AND PATIENT 15-16 (1958); *Selections from the Hippocratic Corpus*, ETHICS IN MEDICINE 5,8 (S. Reiser, A. Dyck, and W. Curran eds. (1977)); *See infra* notes 59-65 and accompanying text.

2. C. COPPENS, MORAL PRINCIPLES AND MEDICAL PRACTICE 138-39 (1905); C. DEWITT, *supra* note 1.

3. *See infra* notes 95-119 and accompanying text.

4. *See generally* Note, *Extrajudicial Truthful Disclosure of Medical Confidences: A Physician's Civil Liability*, 44 DEN. L.J. 463 (1967) (examination of physicians' civil liability for truthful disclosure of medical confidences). *See also infra* notes 95-119 and accompanying text.

AIDS.

Physicians treating a patient with AIDS must choose between the Scylla and Charybdis of the confidentiality issue. Because victims of AIDS face extreme discrimination, there is a duty to keep an AIDS patient's diagnosis confidential. On the other hand, AIDS is a contagious disease and once contracted is almost certainly fatal. Thus, there is an opposing duty to disclose information concerning AIDS patients. These duties are in direct conflict, and a breach of either may result in a lawsuit.

This note explores the confidential relationship between physicians and their patients and the effects AIDS may have on this relationship. Section II first provides background information on the characteristics and epidemiology of AIDS, and then discusses the problems that AIDS victims face as a result of the social response to the disease. Section III surveys the issue of confidentiality in the physician-patient relationship and focuses on the doctor's liability for breach of confidentiality and concludes with a discussion of exceptions to physician-patient confidentiality.

Section IV introduces the conflict between the confidentiality interests of AIDS patients and the interests third parties may have in receiving confidential AIDS information. This note concludes by proposing legislative regulation by the adoption of a statute aimed at protecting physicians from legal action for the disclosure or nondisclosure of information that identifies AIDS patients to certain third parties.

II. THE AIDS CRISIS

A. History and Characteristics of the Disease

Although isolated cases may have occurred earlier,⁵ the medical community was first alerted to the development of a severe immuno-depressant disease in June of 1981.⁶ By June 1982, the Center for Disease Control⁷

5. Selik, Haverko & Cunnann, *Acquired Immune Deficiency Syndrome (AIDS) Trends in the United States*, 76 AM. J. MED. 493 (1984).

6. *Update: Acquired Immunodeficiency Syndrome (AIDS)—United States*, 32 CENTERS FOR DISEASE CONTROL: MORBIDITY & MORTALITY WEEKLY REP. 49 (Jan. 6, 1984). In mid 1981, the Center for Disease Control received reports of several outbreaks of *Pneumocystis Carinii* and Kaposi's Sarcoma in previously healthy young male homosexuals. Previously, those diseases were essentially seen only in persons with severely compromised immunologic defenses such as may result from immunosuppressive treatments for organ transplant. INSTITUTE FOR MEDICINE, NATIONAL ACADEMY OF SCIENCES, CONFRONTING AIDS 37 (1986) [hereinafter CONFRONTING AIDS].

7. The Center for Disease Control (CDC) was established as an operating health agency within the Public Health Service by the Secretary of Health, Education, and Welfare on July 1, 1973. The Center is the federal agency charged with protecting the public health of the Nation by providing leadership and direction in the prevention and control of diseases and other preventable conditions, and responding to public health emergencies. THE UNITED

(CDC) had received over 350 reports of serious opportunistic infections,⁸ primarily affecting homosexuals and bisexuals, but also affecting intravenous drug users, Haitians, and hemophiliacs.⁹ Recognizing the common symptom of depressed immunity as a characteristic of a new disease, the CDC, in September of 1982, gave the disease a descriptive name—Acquired Immune Deficiency Syndrome.¹⁰ The spread of AIDS has not been exclusively limited to the previously mentioned high risk groups. Although the AIDS epidemic is often associated with homosexual men, the disease has proven to be nondiscriminatory—it affects heterosexuals as well, including men, women, adults, children, Caucasians, and minorities.¹¹

B. Epidemiology of the Disease

AIDS is caused by an infectious agent called Human Immunodeficiency Virus (HIV).¹² HIV has been isolated from blood, semen, vaginal fluids, saliva, tears, and breast milk.¹³ This virus is transmitted through the

STATES GOVERNMENT MANUAL 1987/88, at 298 (June 2, 1987).

8. Opportunistic infections are infections caused by a microorganism that rarely causes disease in persons with normal defense mechanisms. CONFRONTING AIDS *supra* note 6, at 356.

9. *Update on Kaposi's Sarcoma and Opportunistic Infections in Previously Healthy Persons—United States*, 31 CENTERS FOR DISEASE CONTROL: MORBIDITY & MORTALITY WEEKLY REP. 29 (June 11, 1982).

10. *Update on Acquired Immunodeficiency Syndrome (AIDS)—United States*, 31 CENTERS FOR DISEASE CONTROL: MORBIDITY & MORTALITY WEEKLY REP. 17 (Sept. 24, 1982). The CDC established a surveillance definition to monitor AIDS. Under this definition, AIDS is "a reliably diagnosed disease process that is at least moderately predictive of a defect in cell-mediated immunity occurring in a person with no known cause for diminished resistance." The Case Definition of Aids Used by CDC for National Reporting, Doc. #0312S, Aug. 1, 1985.

11. *Acquired Immunodeficiency Syndrome (AIDS) Update—United States*, 32 CENTERS FOR DISEASE CONTROL: MORBIDITY & MORTALITY WEEKLY REP. 37 (June 24, 1983).

12. A. Macher, *The Medical Background*, in AIDS AND THE LAW 6 (W. Dornette ed. 1987). HIV is the causative agent of the immune deficiency. HIV is transmissible; the syndrome resulting from HIV infection—AIDS—is not. *Id.* at 7. Furthermore, mere infection by HIV does not necessarily mean a person has AIDS. Rather, in order to say that someone has AIDS the infection must become "full blown," which means that the victim is afflicted with one or more of the opportunistic diseases which attack the infected person's immune system. *Update: Acquired Immunodeficiency Syndrome—United States*, 35 CENTERS FOR DISEASE CONTROL: MORBIDITY & MORTALITY WEEKLY REP. 141 (Jan. 17, 1986). However, a person who tests positive for HIV must be assumed to be contagious even if the person fails to develop AIDS. See Handsfield, *Screening for HTLV-III Antibody*, 313 NEW ENG. J. MED. 888 (1985) (correspondence stating that although persons who have tested positive for HIV infection must be assumed to be infectious, despite the person's failure to develop AIDS).

13. *Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/Lymphadenopathy—Associated Virus in the Workplace*, 34 CENTERS FOR DISEASE CONTROL: MORBIDITY & MORTALITY WEEKLY REP. 128 (Nov. 15, 1985).

exchange of various body fluids, which occurs via intimate sexual contact, sharing contaminated needles, transfusion of whole blood or clotting factor concentrates, and from infected mothers to their children at birth.¹⁴ While the virus has been isolated from blood, semen, vaginal fluids, saliva, tears, and breast milk, studies have shown that only blood and semen effectively transmit the disease.¹⁵ Evidence indicates that casual contact, such as hugging an infected individual, sharing the same eating utensils as an infected individual,¹⁶ or using the same toilet as an infected individual, does not transmit HIV.¹⁷ No cases have been reported of HIV being transmitted through food, water, or air.¹⁸

C. Social Ramifications of the Disease

Despite the limited means by which the AIDS virus is transmitted,¹⁹ the public is terrified that the disease will spread to the general population.²⁰ This fear has had disturbing effects both on society and its treatment

14. A. Macher, *The Medical Background*, in AIDS AND THE LAW, *supra* note 12, at 7; CONFRONTING AIDS, *supra* note 6, at 52.

15. *Provisional Public Health Service Inter-Agency Recommendations for Screening Donated Blood and Plasma for Antibody to the Virus Causing Acquired Immunodeficiency Syndrome*, 34 CENTERS FOR DISEASE CONTROL: MORBIDITY & MORTALITY WEEKLY REP. 75 (Jan. 11, 1985); A. FETTER & W. CHECK, *THE TRUTH ABOUT AIDS* 90 (rev. ed. 1985) (identification of anal receptive intercourse as the contact most clearly linked to transmission of human immunodeficiency virus); *California Study Confirms Virus Transmission Routes*, 2 AIDS POLICY & LAW, Feb. 11, 1987 at 7 (confirmation of the theory recognizing receptive anal intercourse as the main route of transmission for the human immunodeficiency virus in males).

16. CONFRONTING AIDS, *supra* note 6, at 50. Epidemiological data indicate that contact that does not involve sexual or parenteral exposure will not transmit HIV, despite the virus' presence in saliva and tears. *Id.* at 50-51.

17. Chicago Tribune, Oct. 14, 1987, at 8, col. 1 (quoting Surgeon General C. Everett Koop, "You don't get AIDS from shaking hands, sharing office machines or telephones, or . . . from toilet seats.").

18. CONFRONTING AIDS, *supra* note 6, at 6.

19. See *supra* notes 13-18 and accompanying text.

20. Dolgin, *AIDS: Social Meanings and Legal Ramifications*, 14 HOFSTRA L. REV. 193, 198-99 (1985) (discussion of the public fear of AIDS and the media's role in augmenting this fear).

A survey conducted by MODERN HEALTHCARE magazine indicated that:

- a) thirty-three percent of the surveyed population believed that they were in some danger of contracting AIDS;
- b) twenty-nine percent believed they could contract AIDS in a hospital in which AIDS patients were treated;
- c) thirty-one percent thought they could become infected by using a public washroom; and
- d) thirty-five percent felt AIDS could be contracted in a restaurant employing AIDS victims.

Anderson, *37% Fear Contracting AIDS in Hospitals*, MODERN HEALTHCARE, Nov. 8, 1985, at 28.

of AIDS victims.²¹ People with AIDS, and even those merely suspected of having AIDS, face a vast array of discrimination,²² including discrimination in employment,²³ housing,²⁴ insurance,²⁵ and education.²⁶ AIDS patients have also faced discrimination in certain services.²⁷ For example, people with AIDS have been removed from airline flights,²⁸ charged extra fees for dental service²⁹ and denied funeral home service.³⁰ Cities and states across the nation have responded to the discrimination faced by AIDS victims; local governments have posed various antidiscrimination statutes,³¹ and sev-

21. The hysteria surrounding AIDS has caused some churches to discontinue the sharing of the communion cup and has caused some politicians to stop shaking hands in public. AIDS: LEGAL ASPECT OF A MEDICAL CRISIS 725 (1986). *See also* D. ALTMAN, AIDS IN THE MIND OF AMERICA 16-21 (1986) (analysis of the fear, hysteria, and stigma attached to AIDS).

22. The discrimination associated with AIDS may result from a fear of infection from casual contact stemming from a misunderstanding of the modes of transmission or may be a result of prejudice against the behavior of those most at risk for AIDS or HIV infection. *See Dolgin, supra* note 20, at 197-200.

23. AIDS-related employment discrimination has manifested itself in the automatic dismissal of employees with AIDS, the conditioning of employment on the taking of an AIDS-screening test, and the refusal of employers to hire individuals suspected of belonging to a high risk group. AIDS: LEGAL ASPECTS OF A MEDICAL CRISIS 725 (1986); 2 AIDS POLICY & LAW, Apr. 22, 1987 at 8 (United Kingdom industrial tribunal upheld the firing of a gay employee over AIDS fears); 2 AIDS POLICY & LAW, Aug. 26, 1987 at 4 (Staff physician with AIDS prohibited from performing invasive procedures on patients); *See generally* 1 BIOLAW, 1986-87 Highlights §§ 3-8, at 1006-07 (1988) (examples of AIDS-related employment discrimination).

24. 1 AIDS POLICY & LAW, Dec. 3, 1986 at 3 (opportunity to purchase Co-op apartment refused to physicians who treat AIDS patients); 1 AIDS POLICY & LAW, Feb. 12, 1986 at 6 (real estate brokerage instituted policy of informing potential purchasers that property seller had AIDS). AIDS-related housing discrimination has also resulted in evictions and lock-outs of tenants with AIDS. AIDS: LEGAL ASPECTS OF MEDICAL CRISIS 727 (1986). *See also* AIDS AND THE LAW, *supra* note 14, at 78-85 (comparison of the sale of a home in which a family was murdered to the sale of a home in which a resident died of AIDS).

25. 2 AIDS POLICY & LAW, June 3, 1987 at 5 (gay rights organization alleges insurance agents refuse to consider policy applications from gays); 2 AIDS POLICY & LAW, Feb. 11, 1987 at 5 (HIV testing as part of insurance application process); 1 AIDS POLICY & LAW, Dec. 17, 1986 at 6 (AIDS victim won return of health coverage).

26. 1 AIDS POLICY & LAW, Nov. 5, 1986 at 2 (school district sued for expelling child with AIDS); 1 AIDS POLICY & LAW, Aug. 27, 1986 at 3 (Georgia school board bans students and teachers with AIDS). AIDS-related discrimination in education has resulted in teachers, students, and siblings of students with AIDS being expelled from classrooms. AIDS: LEGAL ASPECTS OF A MEDICAL CRISIS 726 (1986) [hereinafter LEGAL ASPECTS].

27. LEGAL ASPECTS, *supra* note 26, at 725-28.

28. 2 AIDS POLICY & LAW, Feb. 25, 1987 at 8 (passenger with AIDS denied transportation).

29. 1 AIDS POLICY & LAW, Dec. 31, 1986 at 2 (Oregon dentists cautioned against charging AIDS patients extra control costs because of possible violation of patients' civil rights).

30. LEGAL ASPECTS, *supra* note 26, at 726.

31. *See, e.g.*, 2 AIDS POLICY & LAW, May 20, 1987 at 3 (California cities ban AIDS

eral states have moved to prohibit AIDS-related discrimination.³² Additionally, antidiscrimination guidelines have been proposed by several civil rights groups.³³

On March 3, 1987, in the case of *School Board v. Arline*, the United States Supreme Court ruled that recipients of federal monies may not discriminate against contagious disease victims.³⁴ The Court, in a seven to two decision, held that contagious diseases are handicaps within the meaning of federal law, and thus discrimination against those suffering from a contagious disease is prohibited.³⁵ Although *Arline* involved tuberculosis rather than AIDS, the reasoning of the opinion suggests that a person suffering from any disease is protected from discrimination that results from an irrational fear of contagion.³⁶

Despite the movement toward protection against discrimination, AIDS victims still face discrimination and social isolation based on society's fear of contagion.³⁷ Because of the public's adverse reaction to AIDS, the dissemination of information regarding AIDS patients has become a legal and ethical issue. Generally, this issue involves two conflicting interests: the AIDS victims' interest in concealing their condition and the public's interest in promoting health and safety. Since physicians have both the responsibility to promote public health and the duty to maintain the confidentiality of a patient's medical information, they are in the middle of this conflict.

discrimination).

32. 1 AIDS POLICY & LAW, Sept. 10, 1986 at 4 (AIDS as a handicap under Michigan law prohibiting handicap bias); 2 AIDS POLICY & LAW, Feb. 25, 1987 at 2 (California Fair Employment and Housing Commission declared AIDS a handicap under state law).

33. 1 AIDS POLICY & LAW, April 9, 1986 at 4 (ACLU policy emphasizes that the risk of AIDS shall not be used as a pretext for discriminatory treatment).

34. 480 U.S. 273 (1987). *Arline* involved a Florida teacher who was removed from the classroom because of the fear that she would infect students with tuberculosis. This case presented the question of whether a person with a contagious disease could be considered a handicapped individual within the meaning of § 504 of the Rehabilitation Act of 1973. Section 504 prohibits a federally funded state program from discriminating against a handicapped individual because of the person's handicap. 29 U.S.C. § 794 (1973).

35. *Arline*, *supra* note 34, at 288.

36. *Id.* at 282. Justice Brennan, in a footnote, stated "this case does not present . . . the question whether a carrier of a contagious disease such as AIDS could be considered to have a physical impairment, or whether such a person could be considered, solely on basis of contagiousness, a handicapped person. . . ." *Id.* at 282, n.7. AIDS was distinguished from tuberculosis because AIDS, unlike tuberculosis, can be asymptomatic while tuberculosis produces both physical impairment and contagiousness. Nevertheless, Justice Brennan stated that the basic purpose of § 504 is to ensure "that handicapped individuals are not denied jobs or other benefits because of the prejudiced attitudes or the ignorance of others," including discrimination based on the irrational fear of a disease. *Id.* at 284.

37. See *infra* notes 159-74 and accompanying text.

III. THE CONFIDENTIALITY RELATIONSHIP BETWEEN PHYSICIANS AND PATIENTS

Both privacy and confidentiality³⁸ are significant components of medical care and treatment, specifically of the physician-patient relationship.³⁹ A patient's privacy interests encompass the right to control the information relative to the patient's conditions.⁴⁰ Unauthorized access to such information constitutes a violation of privacy.⁴¹ Once the information is divulged by the patient to the physician, however, it is no longer private;⁴² once communicated, the information becomes confidential.⁴³

Private information is often disclosed by patients to their physician because confidentiality is assured.⁴⁴ Patients disclose personal information to their doctors while being examined or receiving treatment. Thus, patients

38. Privacy and confidentiality are terms used to describe the opposite of publicity, and therefore the words are often used interchangeably. Winslade, *Confidentiality of Medical Records*, 3 J. LEGAL MED. 497, 502 (1982). Nevertheless, privacy and confidentiality are conceptually different. Privacy refers to control over personal information, while confidentiality refers to the truth given to another to preserve private information. Winslade & Ross, *Privacy, Confidentiality, and Autonomy in Psychotherapy*, 64 NEB. L. REV. 578, 594 (1985).

39. Rachels, *Why Privacy is Important*, 4 PHIL. & PUB. AFFAIRS 323, 324 (1975) (account of the value of privacy and confidentiality in establishing and maintaining various relationships); M. MACDONALD, K. MEYER & B. ESSIG, *HEALTH CARE LAW* § 19.02 (1987) (explanation of patients' right of confidentiality and the underlying policies); Adams, *Medical Research and Personal Privacy*, 30 VILL. L. REV. 1077, 1087 (1985) (discussion of confidentiality's role in the physician-patient relationship); LeBlang, *Invasion of Privacy: Medical Practice and the Tort of Intrusion*, 18 WASHBURN L.J. 205 (1979) (examination of the nature and scope of the right to privacy as it affects the medical profession).

40. See generally LeBlang, *supra* note 39, at 205-07; D. O'BRIEN, *PRIVACY, LAW, AND PUBLIC POLICY* 20-22 (1979) (discussion of the concept of privacy).

41. LeBlang, *supra* note 39, at 218. For example, a person's privacy is invaded when a physician takes a patient's photograph without authorization even if the picture is for medical purposes. *Id.* See also *DeMay v. Roberts*, 46 Mich. 160, 9 N.W. 146 (1881) (physician's liability for allowing, without consent, an assistant to aid in delivery of a child); *Inderbitzen v. Lane Hospital*, 124 Cal. App. 462, 12 P.2d 744 (1932) (teaching hospital's treatment of disrobed female patient, which included prodding and poking by ten to twelve men, was an invasion of privacy).

42. O'BRIEN, *supra* note 40, at 11; Gross, *The Concept of Privacy*, 42 N.Y.U.L. REV. 34 (1967) (discussion of the various meanings given to privacy and confidentiality); Winslade & Ross, *supra* note 38, at 519-33.

43. Winslade & Ross, *supra* note 38, at 594; Adams, *supra* note 39. "Unlike privacy, confidentiality does not refer to self-concerns at all." Winslade, *supra* note 38, at 503. "Privacy concerns control over access and disclosure in the first instance; confidentiality concerns only redisclosure of information previously disclosed." *Id.* at 503.

44. It should be noted that confidentiality does not merely flow from the disclosure of private information. Instead, confidentiality is a product of the nature of the information and the relationship between the information's discloser and its recipient. Winslade & Ross, *supra* note 38, at 503.

expect that their information will be kept confidential.⁴⁵ This expectation is a result of professional ethics, state statutes, and tort law.⁴⁶

A. Ethical Origins of the Physician's Duty Not to Disclose

Among physicians' venerable duties is the duty to keep secret and inviolate the intimate knowledge of a patient's health.⁴⁷ This duty was embodied in an oath developed by the ancient physician Hippocrates over 2,000 years ago⁴⁸ and has subsequently been adopted by the American Medical Association (AMA).⁴⁹ The AMA Revised Principles of Medical Ethics states that a physician "shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law."⁵⁰ This principle is not a law,⁵¹ but rather a standard of conduct forbidding the voluntary disclosure of medical confidences. Confidentiality promotes patient trust, which facilitates the disclosure of personal information necessary for complete health care.⁵² Because

45. Cooper, *The Physician's Dilemma: Protection of the Patient's Right to Privacy*, 22 ST. LOUIS U.L.J. 397 (1978) (examination of problems relating to physicians' disclosure of patients' medical information); Note, *Action for Breach of Medical Secrecy Outside the Courtroom*, 36 U. CIN. L. REV. 103, 109 (1967).

46. See, e.g., Cooper, *supra* note 45; Gellman, *Prescribing Privacy: The Uncertain Role of the Physician in the Protection of Patient Privacy*, 62 N.C.L. REV. 255, 266 (1984). Winslade, *supra* note 38, at 510. Sloan & Hall, *Confidentiality of Psychotherapeutic Records*, 5 J. LEGAL MED. 435 (1984).

47. DEWITT, PRIVILEGED COMMUNICATIONS BETWEEN PHYSICIAN & PATIENT 23 (1958).

48. The Hippocratic Oath, the guiding ethical code of ancient Greek physicians, is one of the most enduring traditions in Western medicine. The Oath, in its most compelling portion, states: "[W]hatsoever I shall see or hear in the course of my profession, as well as outside my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets." Hippocrates, *Selections from the Hippocratic Corpus: Oath*, in ETHICS IN MEDICINE, *supra* note 1, at 5.

49. AMERICAN MEDICAL SOCIETY, REVISED PRINCIPLES OF MEDICAL ETHICS (1980) [hereinafter AMA PRINCIPLES].

50. AMA PRINCIPLES, *supra* note 49, at § IV. It is interesting to note that prior to revision, the Principles provided that:

[A] physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary to protect the welfare of the individual or of the community.

AMERICAN MEDICAL ASSOCIATION, PRINCIPLES OF MEDICAL ETHICS, § IX (1977). The Revised Principles' limitation on disclosures—"within the constraints of the law"—is less useful in guiding physicians who must make a confidential disclosure to protect the welfare of a third party under a *Tarasoff* duty. See *infra* notes 135 to 146 and accompanying text.

51. The preamble to the Revised Principles describes the principles as "standards of conduct which define the essentials of honorable behavior for the physician." AMA PRINCIPLES, *supra* note 49.

52. Winslade, *supra* note 38, at 505; See, e.g., *Simonsen v. Swenson*, 104 Neb. 224, 177 N.W. 831 (1920). In *Simonsen*, unauthorized disclosure of confidential information by a

of the physician's standard of professional conduct which protects confidentiality, generations of patients have freely disclosed their most intimate and delicate secrets to their doctors.⁵³

B. Statutory Origins of the Duty Not to Disclose

1. Federal Bases of Liability

The ethical duty of nondisclosure embodied in the Hippocratic Oath is included in some federal statutes and provides the basis of liability for breach of confidentiality.⁵⁴ Federal statutes and regulations provide limited protection for confidentiality of patient information gathered by federal agencies or programs.⁵⁵ For example, Federal Medicare regulations establish the confidentiality of medical records of patients admitted for care in a hospital.⁵⁶ Similarly, the regulations issued pursuant to the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act⁵⁷ and the Drug Abuse Office and Treatment Act of 1972⁵⁸ provide protection of confidential patient information gathered in connection with the performance of any government alcohol or drug abuse program.⁵⁹ Although the protection of the applicable information is quite comprehensive, such regulations only apply to a limited amount of patient information.⁶⁰ Fur-

physician gave rise to civil liability. The Judge stated that, "[t]he relation of physician and patient is necessarily a highly confidential one. It is often necessary for the patient to give information about himself which would be most embarrassing or harmful to him if given general circulation." *Id.* at 226-27, 177 N.W. at 832.

53. Winslade, *supra* note 38, at 505.

54. Cooper, *supra* note 45, at 412.

55. See Winslade, *supra* note 38, at 516.

56. 42 C.F.R. § 482.24 (1986). Subchapter C—Basic Hospital Functions—of the federal regulations issued under the Health Care Financing Administration states in part that: "[A] hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital." *Id.*

The hospital must have procedures for ensuring the confidentiality of patient records. Information from or copies of records may be released only to authorized individuals, and the hospital must ensure that unauthorized individuals cannot gain access to or alter patient records. 42 C.F.R. § 482.24(b) (1987).

57. 42 U.S.C. §§ 4541-93 (1982).

58. 21 U.S.C. §§ 1101-94 (1982).

59. The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act and the Drug Abuse Office and Treatment Act of 1972 share a common set of regulations, which provide for the unauthorized disclosure of patient information only in a medical emergency, under a court order, or to qualified personnel for the purpose of conducting scientific research, management or financial audits, or program evaluations. See 42 C.F.R. §§ 2.1 to 2.67-1 (1987).

60. Gellman, *supra* note 46, at 277. Winslade, *supra* note 38, at 517. In addition to the regulations promulgated by the Department of Health, Education and Welfare, a broad category of laws prevents the government from disclosing medical information to third parties.

thermore, federal statutes that protect confidential health care information only apply to physicians who practice in federal agencies or under a federal program. Consequently, federal regulations do not provide practitioners outside the federal government with legislative guidance for determining when disclosure of confidential information is permissible.

2. State Statutory Bases of Liability

a. Direct statutory protection of confidentiality

Statutory protection of confidential information is most fully articulated at the state level. Several state legislatures have passed statutes protecting confidential medical information.⁶¹ Generally, state legislation may address the kind of information protected, to whom the information may or may not be disclosed, and the necessity of consent for disclosure.⁶² An example of such a statute is Rhode Island's comprehensive confidentiality statute.⁶³ The purpose of the Rhode Island Confidentiality of Health Care Information Act is to "establish safeguards for maintaining the integrity of confidential health care information that relates to an individual."⁶⁴ This statute prevents unauthorized disclosure of confidential health care information except in eighteen limited situations.⁶⁵ Comprehensive statutes such

Note, *Public Health Protection and the Privacy of Medical Records*, 16 HARV. C.R.-C.L. L. REV. 265, 282-85 (1981).

61. See, e.g., ALA. CODE § 26-21-8 (Supp. 1988) (to be repealed December 31, 1997) (confidentiality of abortion records); ILL. REV. STAT. ch. 111 para. 4450 (1985) (confidentiality of information disclosed at physician disciplinary hearings); CAL. BUS. & PROF. CODE § 2263 (West Supp. 1988) (stating that the willful, unauthorized violation of professional confidence constitutes unprofessional conduct).

62. Winslade, *supra* note 38, at 519.

63. R.I. GEN. LAWS § 5-37.3 (Supp. 1987).

64. *Id.*

65. The Rhode Island Confidentiality of Health Care Information Act allows for the unauthorized disclosure of confidential health care information in the following situations:

- (1) To a physician, dentist or other medical personnel who believes in good faith that such information is necessary for diagnosis or treatment of such individual in a medical or dental emergency, or
- (2) To medical peer review committees, or the board of medical review; or
- (3) To qualified personnel for the purpose of conducting scientific research, management audits, financial audits, program evaluations, actuarial, insurance underwriting, or similar studies, provided such personnel shall not identify, directly or indirectly, any individual patient in any report of such research, audit, or evaluation, or otherwise disclose patient identities in any manner; or
- (4) By a health care provider to appropriate law enforcement personnel, or to a person if the health care provider believes that person or his family to be in danger from a patient, or to appropriate law enforcement personnel if the patient has or is attempting to obtain narcotic drugs from the health care provider illegally, or to appropriate law enforcement personnel or appropriate child protective agencies if the patient is a minor child who the health care provider believes, after providing health care services to such patient, to have

as Rhode Island's protect patient information and provide guidance for physicians' disclosure of health care information consistent with the ethical considerations of the Hippocratic Oath.⁶⁶ Nevertheless, existing state statutes that directly protect confidentiality do not provide sufficient guidance to physicians who treat patients with communicable diseases.⁶⁷

Courts have consistently held that the physicians' duty of nondisclosure may be outweighed by the duty to protect third parties. However, current state statutory protection of physician-patient confidentiality fails to author-

been physically or psychologically abused or to law enforcement personnel in the case of a gunshot wound reportable under § 11-47-48; or

(5) Between or among qualified personnel and health care providers within the health care system for purposes of coordination of health care services given to the patient and for purposes of education and training within the same health care facility; or

(6) To third party health insurers for the purpose of adjudicating health insurance claims; or

(7) To a malpractice insurance carrier or lawyer if the health care provider has reason to anticipate a medical liability action; or

(8) To a court or lawyer or medical liability insurance carrier if a patient brings a medical liability action against a health care provider; or

(9) To public health authorities in order to carry out their functions . . . ; or

(10) To the state medical examiner in the event of a fatality that comes under his jurisdiction; or

(11) In relation to information that is directly related to current claim for workers' compensation benefits or to any proceeding before the workers' compensation commission or before any court proceeding related to workers' compensation; or

(12) To the attorneys for a health care provider whenever such provider considers such release of information to be necessary in order to receive adequate legal representation; or

(13) By a health care provider to appropriate school authorities of disease, health screening and/or immunization required by the school; or when a school age child transfers from one (1) school or school district to another school or school district; or

(14) To a law enforcement authority to protect the legal interests of an insurance institution agent or insurance support organization in preventing and prosecuting the perpetration of fraud upon them; or

(15) To a grand jury or to a court of competent jurisdiction pursuant to a subpoena or a subpoena *duces tecum* when said information is required for the investigation or prosecution of criminal wrongdoing by a health care provider relating to his/her/its provisions of health care services and said information is unavailable from any other source; provided however, that any information so obtained shall not be admissible in any criminal proceeding against the patient to whom said information pertains; or

(16) To the state board of elections pursuant to a subpoena or subpoena *duces tecum* when said information is required to determine the eligibility of a person to vote by mail ballot and/or the legitimacy of a certification by a physician attesting to a voter's illness or disability; or

(17) To certify . . . the nature and permanency of a person's illness or disability . . . ; or

(18) To the central cancer registry. . . .

R.I. GEN. LAWS § 5-37.3-4(b) (Supp. 1987).

66. Compare R.I. GEN. LAWS § 5-37.3-2 (1987) (purpose of the statute is to maintain the integrity of individual's confidentiality) with the Hippocratic Oath, *supra* note 48.

67. See generally Gellman, *supra* note 46, at 280 (noting that state confidentiality statutes do not always guide physicians who wish to disclose confidential information).

ize the disclosure of patient information to endangered third parties.⁶⁸ Therefore, additional legislation is needed to define when and how physicians may disclose a patient's medical information and when the duty to do so arises.

b. State licensing and privilege statutes

In addition to direct statutory protection of confidentiality, state courts have also based the physicians' duty not to disclose on testimonial privilege and licensing statutes.⁶⁹ Testimonial privilege statutes generally provide that a physician cannot testify in a court proceeding about patient information gained in the course of treatment.⁷⁰ This is a privilege exercised at the patient's discretion and is similar to the privilege recognized for confidential communications between attorney and client⁷¹ and between husband and wife.⁷² Although the privilege is a useful device for resolving some confidentiality problems faced by physicians, testimonial privilege statutes only apply when a physician is testifying in court or in court-related proceedings.⁷³ As a result, the testimonial privilege does not govern the disclosure of information outside of the courtroom. Nevertheless, some courts have relied on the public policy reflected in testimonial statutes to find liability for a physician's disclosure of patient information.⁷⁴

68. See, e.g., R.I. GEN. LAWS § 5-37.3-4(b) (1987); CAL. CIV. CODE § 56 (West 1982); MONT. CODE ANN. § 50-16-301 (1981) (repealed 1987).

69. See, e.g., *Simonsen v. Swanson*, 104 Neb. 224, 177 N.W. 831 (1920) (violation of statutory provisions governing the licensing of physicians gave rise to a cause of action for breach of confidentiality); *Horne v. Patton*, 291 Ala. 701, 287 So. 2d 824 (1973) (state licensing statute indicative of public policy requiring information obtained by a physician in the course of a doctor-patient relationship be maintained in confidence); *Berry v. Moench*, 8 Utah 2d 191, 331 P.2d 814 (1958) (reliance upon testimonial privilege statute to establish a duty of confidentiality); *Clark v. Geraci*, 29 Misc. 2d 791, 208 N.Y.S.2d 564 (Sup. Ct. 1960) (liability for unauthorized disclosure implied in state testimonial privilege statute); *Hammonds v. Aetna Casualty & Sur. Co.*, 243 F. Supp. 793 (N.D. Ohio 1965) (duty of secrecy reflected in the state privileged communication statute and in the state medical licensing statute); *Felis v. Greenberg*, 51 Misc. 2d 441, 273 N.Y.S.2d 288 (Sup. Ct. 1966) (court relied on the public policy underlying the testimonial privilege statute to find a violation of the privileged and confidential relationship of physician and patient).

70. See, e.g., CAL. EVID. CODE §§ 990-1007 (West Supp. 1988).

71. See, e.g., CAL. EVID. CODE § 952 (West 1966).

72. See, e.g., *id.* at § 980.

73. Gellman, *supra* note 46, at 272; B. FURROW, S. JOHNSON, T. JOS & R. SCHWARTZ, *HEALTH LAW* 221-22 (1987) [hereinafter *HEALTH LAW*].

74. *Berry v. Moench*, 8 Utah 2d 191, 331 P.2d 814 (1958). In *Berry*, the Supreme Court of Utah relied on policy behind the state testimonial privilege statute. The court stated that the privileged communication statute was grounded upon the necessity of full disclosure by a patient of conditions or symptoms relating to diagnosis. *Id.* at 193, 331 P.2d at 816; See also *Hammonds v. Aetna Casualty & Sur. Co.*, 243 F. Supp. 793 (N.D. Ohio 1965); *Simonsen v. Swenson*, 104 Neb. 224, 177 N.W. 831 (1920).

Testimonial privilege statutes are a public recognition of the special nature of the doctor-

In the absence of testimonial privilege statutes, courts have relied on state licensing statutes as a basis for finding a duty on the part of physicians not to disclose confidential information.⁷⁵ Like testimonial privilege statutes, physician licensing statutes also require doctors to maintain a confidential relationship with their patients.⁷⁶ Licensing statutes generally impose a duty of confidentiality as a condition on the professional practice of medicine.⁷⁷ Courts have thus interpreted licensing statutes as the basis for a legal duty upon physicians not to disclose confidential information.⁷⁸ Consequently, disclosure of patient information may give rise to liability for all damages naturally flowing from the breach.⁷⁹

Testimonial privilege and physician licensing statutes insure that patients may freely disclose personal information to their doctors without fear that the physician could, without impunity, disclose intimacies that would harm or embarrass the patient.⁸⁰ Such statutes are instrumental in protecting patients from their physicians' unauthorized disclosure of confidential information.⁸¹ However, these statutes fail to acknowledge the situations in which the need to protect third parties may outweigh the duty of nondisclosure. Consequently, physicians need additional guidance regarding the exceptions to the duty of confidentiality.⁸²

patient relationship. If public policy prohibits a physician from testifying in court as to information obtained in the course of treatment, the policy should also prohibit a doctor from publicly revealing his patient's confidences. *See Note, Extrajudicial Truthful Disclosure of Medical Confidences: A Physician's Civil Liability*, 44 DEN. L.J. 463, 472 (1967).

75. *See, e.g., Simonsen v. Swenson*, 104 Neb. at 227, 177 N.W. at 832 (licensing statute imposed a duty upon the physician not to disclose professional confidences); *Clark v. Geraci*, 29 Misc. 2d 791, 792-93, 208 N.Y.S.2d 564, 567 (state licensing regulation expresses a standard on which a patient has a right to rely).

76. *See, e.g., ILL. ANN. STAT.* ch. 111, para. 4433(4) (Smith-Hurd 1978).

77. *See, e.g., CAL. BUS. & PROF. CODE* § 2234 (West 1984); *See also Note, supra* note 45, at 112.

78. *See, e.g., Simonsen v. Swenson*, 104 Neb. 224, 177 N.W. 831 (1920). The *Simonsen* court stated:

By this [medical licensing] statute, it appears to us, a positive duty is imposed upon the physician, both for the benefit and advantage of the patient as well as in the interest of general public policy. The relation of physician and patient is necessarily a highly confidential one. . . . A wrongful breach of such confidence, and a betrayal of such trust, would give rise to a civil action for the damages naturally flowing from such wrong.

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

79. *See supra* notes 69-75 and accompanying text; *see also HEALTH LAW, supra* note 72, at 218-19.

80. *See Cooper, supra* note 45, at 412.

81. *See Mull v. String*, 448 So. 2d 952 (Ala. 1984) (absence of a state physician-patient testimonial privilege statute was evidence of a public interest in disclosure to obtain a determination of a controversy); *Quarles v. Sutherland*, 215 Tenn. 651, 389 S.W.2d 249 (1965) (absence of testimonial privilege or licensing statutes was evidence that a physician had no duty to treat a medical report as confidential).

82. *See infra* notes 187-94 and accompanying text.

C. Common Law Actions for Breach of Confidentiality

In the absence of state or federal statutes, courts have generally recognized the right of a patient to recover damages for a physician's unauthorized disclosure of medical information. Liability for a physician's breach of confidentiality has been based on breach of contract, defamation, and invasion of privacy.⁸³

1. Breach of Contract

The relationship between physician and patient is usually viewed as an implied contract,⁸⁴ and within this contract courts have found an implied covenant of secrecy.⁸⁵ This covenant of secrecy assures a patient that the disclosure of personal information to their doctor in the course of treatment or diagnosis will remain confidential.⁸⁶ Thus, a physician's breach of confidentiality is a violation of the physician's implied contractual obligation,⁸⁷

83. See *infra* notes 84-105 and accompanying text. See, e.g., *Doe v. Roe*, 93 Misc. 2d 201, 400 N.Y.S.2d 668 (Sup. Ct. 1977) (physician impliedly covenants to keep in confidence all disclosures made by a patient as well as all matters discovered during the examination and treatment); *Berry v. Moench*, 8 Utah 2d 191, 331 P.2d 814 (1958) (finding libel as a basis of liability for a physician's disclosure of derogatory information concerning a patient); *Horne v. Patton*, 291 Ala. 701, 287 So. 2d 824 (1973) (physician's release of patient information constituted an invasion of the patient's privacy).

See also *Clark v. Geraci*, 29 Misc. 2d 791, 208 N.Y.S.2d 564 (Sup. Ct. 1960). In *Clark*, a physician disclosed to his patient's employer that alcoholism was the illness causing the patient's absence from work. *Id.*, 208 N.Y.S.2d at 566. The patient subsequently sued the physician for breach of confidentiality. *Id.* *Clark* is unique because the patient alleged that the physician's disclosure was professional incompetence, and thus based the suit on medical malpractice. The *Clark* court suggested that breach of confidentiality was unprofessional conduct, but nonetheless held that the patient waived his right to confidentiality, and thus held for the physician. *Id.* at 793, 208 N.Y.S.2d at 568.

84. HEALTH CARE, *supra* note 69, at 195.

An implied contract is usually the basis of the relationship between a doctor and a patient. When a patient goes to a doctor's office with a particular problem, he is offering to enter into a contract with the doctor. When the doctor examines the patient, she accepts the offer and an implied contract is created. *Id.* at 194; See also Note, *supra* note 57, at 104-06.

85. See Note, *supra* note 45, at 104; see, e.g., *Hammonds v. Aetna Casualty & Sur. Co.*, 243 F. Supp. 793, 801 (N.D. Ohio 1965) (implied condition of contract is that any confidential information gained through the doctor-patient relationship will not be released without the patient's permission); *Quarles v. Southerland*, 215 Tenn. 651, 389 S.W.2d 249 (1965) (reference to the contractual relationship between physicians and their patients in relation to a breach of secrecy).

86. *MacDonald v. Clinger*, 84 A.D.2d 482, 483, 446 N.Y.S.2d 801 (1982) (finding an implied covenant that requires doctors to keep in confidence all disclosures necessary to diagnosis and treatment of the patient's mental or physical condition); *Doe v. Roe*, 93 Misc. 2d at 210, 400 N.Y.S.2d at 674 (Sup. Ct. 1977).

87. See *Geisberger v. Willuhn*, 72 Ill. App. 3d 435, 438, 390 N.E.2d 945, 948 (1979) ("for all practical purposes, the breach of a confidential relationship and the breach of contract

for which an injured patient can recover.⁸⁸

Although the implied contractual relationship between physician and patient is generally accepted, courts have frequently applied other theories⁸⁹ to establish a basis of liability for breach of confidentiality.⁹⁰ Traditionally, awards for breach of contract have been limited to reliance damages and compensatory or restitution damages.⁹¹ The difficulty in applying contract damages to an injury arising out of disclosure of confidential information may explain the limited use of contract theory as a basis for liability in breach of confidentiality cases.⁹²

2. Defamation

Courts frequently consider defamation⁹³ in their analysis of liability for unauthorized disclosure of confidential information.⁹⁴ Although no court has held a physician liable for unauthorized disclosure based solely on defamation, defamation has been acknowledged as a basis for liability.⁹⁵ Courts that have considered defamation as a potential basis of liability have ex-

are probably co-extensive").

88. See *Horne v. Patton*, 291 Ala. 701, 708, 287 So. 2d 824, 829-30.

89. See *infra* notes 93-105 and accompanying text.

90. See, e.g., *Horne v. Patton*, 291 Ala. at 710, 287 So. 2d at 831-32 (citing opinions from other jurisdictions to establish contract theory of liability between doctor and patient).

91. J. CALAMARI & J. PERILLO, *THE LAW OF CONTRACTS* 590-93 (3d ed. 1987). The objective of contract damages is to place the aggrieved party in the same economic position he would have been in had the contract been performed. Thus, contract damages are limited to those which were reasonably contemplated by both parties at the time the contract was made. *Id.*

92. For an example of the difficulty courts face in applying contract damages to medical injuries see *Sullivan v. O'Connor*, 363 Mass. 579, 296 N.E.2d 183 (1973). See also Miller, *The Contractual Liability of Physicians and Surgeons*, 1953 WASH. L.Q. 413, 416-23.

Limiting recovery to breach of contract generally limits a person to economic loss flowing directly from the breach. In such a situation, the injured party would be precluded from recovering for mental distress, loss of employment, or deterioration of marriage. See *MacDonald v. Clinger*, 84 A.D.2d 482, 486, 446 N.Y.S.2d 801, 804 (1982). Since the primary injuries in breach of confidentiality cases are emotional injuries, contract law provides a problematic basis of liability. Furthermore, punitive damages are generally not available for breach of contract. See *Doe v. Roe*, 93 Misc. 2d 201, 400 N.Y.S.2d 668 (Sup. Ct. 1977) (discussion of whether punitive damages could be awarded for breach of implied contract).

93. The tort of defamation arises in two forms: libel, the publication of defamatory matters, and slander, the conveyance of defamatory matter through oral communication. W. PROSSER & W. KEETON, *THE LAW OF TORTS* 785 (5th ed. 1984).

94. See, e.g., *Simonsen v. Swenson*, 104 Neb. 224, 177 N.W. 831 (1920); *Berry v. Moench*, 8 Utah 2d 191, 331 P.2d 814 (1958); *France v. St. Claire's Hosp.*, 82 A.D.2d 1, 441 N.Y.S.2d 79 (1981) (libel suit alleging hospital's disclosure to third party falsely stated plaintiff was afflicted with venereal disease).

95. See, e.g., *Simonsen v. Swenson*, 104 Neb. at 229, 177 N.W. at 832 (court indicated that disclosure of a patient's communicable disease to an unauthorized party should be governed by the tort of defamation).

pressed concern over the need to protect patients from physicians' unauthorized disclosure of private information. Courts also see the tort of defamation as one manner in which a patient's private information can be protected.⁹⁶ Defamation, therefore, is a useful tool for imposing liability on physicians for the disclosure of a patient's confidential information.⁹⁷

3. Breach of Privacy

Prior to 1890, no court had considered granting relief expressly based on a breach of privacy; however in 1890, an influential law review article introduced the concept of the right to privacy.⁹⁸ Since the introduction of privacy rights, invasion of privacy has steadily evolved as a tort.⁹⁹ In general, the specific tort for breach of privacy is composed of the intrusion or interference with private affairs, the appropriation of a name or likeness, the creation of a false light in the public eye, and the public disclosure, even if truthful, of private facts.¹⁰⁰ A physician's disclosure of confidential information thus falls within the tort of breach of privacy.¹⁰¹

Courts have frequently applied the tort of breach of privacy to physicians' unauthorized disclosure of patient information.¹⁰² In general, courts

96. See *Simonsen v. Swenson*, 104 Neb. 224, 229, 177 N.W. 831, 832 (1920); *Berry v. Moench*, 8 Utah 2d 191, 331 P.2d 814 (1958).

97. *Berry v. Moench*, 8 Utah 2d at 196, 331 P.2d at 817 (finding libel as a basis of liability for any injury suffered by a patient as a result of a physician's disclosure of derogatory confidential information).

98. W. PROSSER & W. KEETON, *supra* note 93, at 849. In 1890 Samuel D. Warren and Louis D. Brandeis published in the Harvard Law Review their now famous article on privacy. The article reviewed a number of cases which concerned either defamation, invasion of property rights, breach of implied contract, or breach of confidence, and concluded that relief in each case was actually provided based upon a common principle, which was the right to privacy. Warren & Brandeis, *The Right to Privacy*, 4 HARV. L. REV. 193 (1890).

99. See W. PROSSER & W. KEETON, *supra* note 93, at 849 (discussion of the expansion of privacy actions into the realm traditionally held by the tort of defamation). Privacy rights have also extended into the realm of constitutional law. In *Griswold v. Connecticut*, 381 U.S. 479 (1965), the Supreme Court found that a Connecticut law forbidding the use of contraceptives unconstitutionally invaded the privacy rights of married couples.

100. Breach of privacy is generally limited to the appropriation of a name or likeness, the unreasonable intrusion upon the seclusion of another, the public disclosure of private facts, or the creation of a false light in the public eye. See W. PROSSER & W. KEETON, *supra* note 93, at 851-65.

101. See Note, *supra* note 45, at 107.

102. *Horne v. Patton*, 289 Ala. 701, 287 So. 2d 824 (1973) (disclosure of information acquired in the course of the physician-patient relationship constituted an invasion of the patient's privacy); *Doe v. Roe*, 93 Misc. 2d 201, 400 N.Y.S.2d 668 (1977) (psychiatrist who extensively reported a disclosure made by a former patient had invaded the patient's privacy); *Hammonds v. Aetna Casualty & Sur. Co.*, 243 F. Supp. 793 (N.D. Ohio 1965) (physician's unauthorized disclosure of a patient's confidential communications held to violate the privacy of the patient).

that recognize a patient's right to recover for breach of privacy have consistently based their decisions on the confidential nature of the information disclosed.¹⁰³ As with breach of contract and defamation, a patient's recovery for breach of privacy stems from the realization that, for effective medical care, a patient must disclose to his or her physician information that may be embarrassing, disgraceful, or incriminating.¹⁰⁴ Courts have held that patients intend the disclosure of personal information to be private; consequently, a physician's revelation of a patient's confidence would effect an invasion of that patient's privacy.¹⁰⁵

The existing common law actions for breach of confidentiality would be sufficient guidance for physicians' disclosure of confidential information if the physicians only duty was to protect patient confidences.¹⁰⁶ However, physicians' duties are not so one-sided. On the contrary, physicians may have an equal duty to disclose patient information to third parties.¹⁰⁷ Therefore, physicians need further guidance to avoid liability for the disclosure or nondisclosure of confidential information.

D. Exceptions to Confidentiality—The Duty to Disclose

There are several legal exceptions to the confidentiality of doctor-patient communications.¹⁰⁸ Perhaps the most obvious of these exceptions is waiver of confidentiality in the physician-patient relationship.¹⁰⁹ Statutory

103. See *Vassiliades v. Garfinckel's, Brooks Bros., Miller & Rhoades, Inc.*, 492 A.2d 580 (D.C. App. 1985) (plastic surgeon's public display of "before" and "after" photographs of a former patient invaded the privacy of the patient based upon the patient's expectations that the photographs would not be publicized without consent); *Valencia v. Duval Corp.*, 132 Ariz. 348, 645 P.2d 1262 (1982) (company physician's disclosure of employee's medical records did not constitute invasion of privacy since no confidential medical facts were disclosed; the information disclosed already appeared in the employee's employment record).

104. *Hammonds v. Aetna Casualty & Sur. Co.*, 243 F. Supp. 793 (N.D. Ohio 1965); *Horne v. Patton*, 291 Ala. 701, 287 So. 2d 824 (1973).

105. *Id.*; *Valencia v. Duval Corp.*, 132 Ariz. 348, 645 P.2d 1262 (1982); *Doe v. Roe*, 93 Misc. 2d 201, 400 N.Y.S.2d 668 (1977).

106. *Tarasoff v. Bd. of Regents*, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976) (physician's maintenance of a patient's confidentiality was insufficient for the physician to escape liability for not disclosing a patient's intent to commit violence). See *infra* notes 108-56 and accompanying text.

107. See *infra* notes 108-56 and accompanying text.

108. See *infra* notes 110-56 and accompanying text.

109. See *Quarles v. Sutherland*, 215 Tenn. 651, 389 S.W.2d 249 (1965) (patient's claim based on a physician's unauthorized disclosure of information to the attorney of a potential defendant was dismissed because the information would be discoverable if the patient sued the potential defendant); *Acosta v. Casy*, 365 So. 2d 4 (La. Ct. App. 1978) (employee claiming workers' compensation for a work-connected injury waived his right to privacy with respect to all information relevant to the claim); *Jordan v. Kelly*, 728 F.2d 1 (1st Cir. 1984) (plaintiff's failure to object to allegedly privileged testimony constitutes waiver of that privilege, thus plaintiff could not recover for damages arising from the testimony).

compulsion is another exception to a physician's general duty of nondisclosure. Statutory exceptions to physician-patient confidentiality generally mandate the disclosure of specific diseases or injuries to state authorities.¹¹⁰ For example, physicians may have a statutory duty to report gunshot wounds,¹¹¹ injuries which indicate child abuse,¹¹² or communicable diseases to the proper state agencies. Such statutes, however, do not govern the disclosure of AIDS information to parties other than state authorities.¹¹³ Nevertheless, courts have held that such statutes imply the existence of a physician's duty to alert third parties about a patient's malady.¹¹⁴ An implicit duty to alert, however, only serves to intensify the disclosure conflict especially when the information to be disclosed is AIDS related.¹¹⁵ Consequently, reporting statutes inadequately regulate physician-patient confidentiality unless they are equipped with express provisions that detail the prevention or authorization of physicians' disclosure.

Pursuant to state reporting statutes, a physician is required to reveal patient medical information to state authorities.¹¹⁶ In addition, a physician is generally allowed to reveal patient information in instances in which the welfare of others may be adversely affected.¹¹⁷ This exception to the confidentiality duty is included in the physician's professional code of ethics¹¹⁸ and has been set forth by various state courts.¹¹⁹ Unlike a statutory duty to disclose patient information, the permissive authority granted to physicians by their ethical code and by case law is discretionary.¹²⁰

110. See Cooper, *supra* note 42, at 403.

111. See, e.g., CAL. PENAL CODE §§ 11160-61 (West 1982).

112. *Id.*, §§ 11165-74 (West 1982 & Supp. 1985).

113. See, e.g., CAL. HEALTH & SAFETY CODE § 3125 (West 1979).

114. All jurisdictions require the reporting of AIDS cases to state or local health departments. Arizona, Colorado, Kentucky, Montana, Nevada, South Carolina, and Wisconsin require positive tests for HIV to be reported. AIDS AND THE LAW, *supra* note 12, at 349-50; see, e.g., IND. CODE ANN. § 16-1-9.5-2(b)(1) (West 1987).

115. See, e.g., Peck v. Counseling Serv. of Addison Co., 499 A.2d 422 (Vt. 1985), McIntosh v. Milano, 168 N.J. Super. 466, 403 A.2d 500 (1978); but see Gammill v. United States, 727 F.2d 950 (10th Cir. 1984) (holding that a state reporting statute does not impose a duty on physicians to warn third parties unless the physician is aware of the specific risks to the specific parties).

116. See *infra* notes 157-86 and accompanying text.

117. See, e.g., MICH. COMP. LAWS § 333.5213 (1980) (requiring physicians to report every case of a hazardous communicable disease to agencies designated by the state department of health).

118. "A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless it becomes necessary in order to protect the welfare of the individual or community." AMA PRINCIPLES OF MEDICAL ETHICS, CURRENT OPINIONS OF THE JUDICIAL COUNSEL, § 9 (1984). Cf. WORLD MEDICAL ASSOCIATION, DECLARATION OF GENEVA, which merely states "I will respect the secrets which are confided in me."

119. See *infra* notes 122-56 and accompanying text.

120. See *infra* notes 123-56 and accompanying text.

In certain situations, however, a physician's discretionary right to override the duty of confidentiality becomes a legal duty to inform third parties of confidential information.¹²¹ Based on this duty to third parties, a physician who treats a patient for a communicable disease may be liable for failing to relay the diagnosis of the disease's infectious nature to family members and health care workers who are likely to come in contact with the patient.¹²² The duty imposed on physicians who treat patients with communicable diseases, however, does not interfere with doctor-patient confidentiality.¹²³ In cases addressing this subject, the third parties to whom the physician owed the duty were those who, as a result of their relationship with the patient, were aware of the patient's medical status.¹²⁴ Thus, a physician who treats a patient with typhoid fever may be liable for failing to inform the patient's family and hospital employees of the dangers associated with exposure to the disease.¹²⁵ Similar liability has been found in

121. See Cooper, *supra* note 45, at 411-12. A physician's permissive authority to disclose patient information is based on the recognition that the patient's interests in confidentiality must be balanced against the societal interests in disclosure. Accordingly, physicians bear the burden of balancing these interests. Not surprisingly, the lack of specific statutory language either prohibiting or permitting the disclosure of confidential medical information increases a physician's burden. *Id.* at 411. Furthermore, when the disclosure involves AIDS information, the burden of balancing societal and patient interests becomes even more troublesome. Consequently, physicians need specific statutory guidance for the disclosure of AIDS information. See *infra* notes 156-94 and accompanying text.

122. See, e.g., Davis v. Rodman, 147 Ark. 385, 227 S.W. 612 (1921) (the court recognized the physician's duty to inform the family of the patient about the patient's medical condition and the infectious nature of the patient's disease). The *Rodman* court stated that

It is a sound rule of law that one who by reason of his professional relation is placed in a position where it becomes his duty to exercise ordinary care to protect others from injury or danger is liable in damages to those who are injured by reason of his failure to exercise such care.

Id. at 388, 227 S.W. at 614.

123. *Id.*

124. See, e.g., Hofmann v. Blackmon, 241 So. 2d 752 (Fla. Dist. Ct. App. 1970) (holding that the information to be disclosed by a physician was the nature of the contagious disease and the precautionary steps to be taken to prevent the patient from contracting such disease) *cert. denied*, 245 So. 2d 257 (Fla. 1971).

125. See Davis v. Rodman, 147 Ark. 385, 227 S.W. 612 (1921) (duty owed to parents of patients); Skillings v. Allen, 143 Minn. 323, 173 N.W. 663 (1919) (duty owed to father of patient); Hofmann v. Blackmon, 241 So. 2d 752 (Fla. Dist. Ct. App. 1970) (duty owed to minor child of patient); Edwards v. Lamb, 69 N.H. 599, 45 A. 480 (1899) (duty owed to wife of patient); Jones v. Stanko, 118 Ohio St. 147, 160 N.E. 456 (1928) (duty owed to patient's neighbor who aided the patient prior to death and performed certain services in preparation for the patient's burial after death).

In most situations, medical information can be shared with patient's relatives. However, if the patient objects to the release of information, the information should not be shared with members of his family. In general, the appropriateness of disclosure to family members depends upon the purpose of the disclosure. An acceptable purpose is to warn family members of the patient's contagious disease. M. MACDONALD, K. MEYER & B. ESSIG, *supra* note 39, at § 19.03[3].

cases dealing with septic poison,¹²⁶ scarlet fever,¹²⁷ smallpox,¹²⁸ and tuberculosis.¹²⁹ In each of these cases, however, the doctors were only required to inform third parties of the diseases' communicable nature.¹³⁰ Such information is not confidential.¹³¹ Recently, however, legal scholars have expressed concern about the possible expansion of the duty to inform about communicable diseases.¹³² Such an expansion has already occurred in the area of psychiatric care.¹³³

In *Tarasoff v. Board of Regents*¹³⁴ the Supreme Court of California found a psychotherapist liable for the wrongful death of a patient's former girlfriend.¹³⁵ In reaching its decision, the *Tarasoff* court relied on cases in which doctors had been held liable to third persons for failure to warn

126. *Davis v. Rodman*, 147 Ark. 385, 227 S.W. 612 (1921).

127. *Edwards v. Lamb*, 69 N.H. 599, 45 A. 480 (1899).

128. *Skillings v. Allen*, 143 Minn. 323, 173 N.W. 663 (1919).

129. *Jones v. Stanko*, 118 Ohio St. 147, 160 N.E. 456 (1928).

130. *Hofmann v. Blackmon*, 241 So. 2d 752 (Fla. Dist. Ct. App. 1970), *cert. denied*, 245 So. 2d 257 (Fla. 1971).

131. *See, e.g., Hofmann v. Blackmon*, 241 So. 2d at 753. The *Hofmann* court stated that

a physician owes a duty to a minor child who is a member of the immediate family and living with a patient suffering from a contagious disease to inform those charged with the minor's well being of the nature of the contagious disease and the precautionary steps to be taken to prevent the child from contracting such disease. . . .

Id.

In addition to informing those likely to come in contact with an infectious patient, a physician is also duty-bound not to indicate to third parties that contact with an infectious patient entails no risks. *See Edwards v. Lamb*, 69 N.H. 599, 45 A. 480 (1899) (physician liable for negligently informing the plaintiff that there was no danger of infection from her contagious husband).

The infectious nature of a patient's disease cannot be considered confidential information since it is a medical fact independent of the physician-patient relationship. However, while a disease's infectious nature is not confidential, the fact that a patient is diseased can be. *See generally Simonsen v. Swenson*, 104 Neb. at 224, 177 N.W. 831, 832 (1920), which recognized that information, such as infection with disease, is confidential information conveyed in reliance on the confidential doctor-patient relationship. The *Simonsen* court, however, found that although information given to a physician by his patient is confidential, if the patient's disease is found to be dangerous and highly contagious, the physician is privileged to disclose information necessary to prevent the spread of the disease. *Id.*

132. *See* 15 HEALTH LAWYERS NEWS REP., Aug. 1987, at 7 (noting that some legal scholars have indicated that health care professionals have a duty to warn the sexual partners of an AIDS carrier if the carrier poses a predictable risk to the partner).

133. *See Note, The Duty to Warn Third Parties: A Retrospective on Tarasoff*, 18 RUTGERS L.J. 145 (1986).

134. 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976).

135. In *Tarasoff*, a patient confided to his university psychologist his intentions to kill Tatiana Tarasoff. The psychologist had the patient briefly incarcerated by campus police, but failed to warn Tarasoff of the patient's intentions. Two months later the patient killed Tarasoff. *Id.*

members of the patient's family about the patient's contagious disease.¹³⁶ The court held that when a therapist determines, or should determine that his patient presents a serious danger of violence to another, the therapist has a duty to use reasonable care to protect the intended victim against such danger.¹³⁷ In *Tarasoff*, the court suggested that the duty to protect the victim could have been fulfilled by warning the victim, or those persons likely to apprise the victim, of the danger.¹³⁸

Critics have vigorously attacked the duty established in *Tarasoff*.¹³⁹ Nevertheless, several jurisdictions have adopted and extended the duty to warn.¹⁴⁰ In 1980, the Supreme Court of California further defined the scope of the duty owed to third parties.¹⁴¹ In *Thompson v. County of Alameda*,¹⁴² a county psychiatric patient killed the plaintiff's young son.¹⁴³ In *Thompson*, the plaintiff alleged that the county's mental health employee had a duty to inform the victim's parents, local police, or parents in the victim's community about the patient's violence toward young children.¹⁴⁴ In clarifying the *Tarasoff* duty, the *Thompson* court found no general duty to warn.¹⁴⁵ Instead, the court found that a psychotherapist has a duty to warn identifiable third parties of foreseeable harm that a patient may cause.¹⁴⁶

136. *Tarasoff*, 17 Cal. 3d at 339-40, 551 P.2d at 343-44, 131 Cal. Rptr. at 25-26.

137. *Id.* at 442, 551 P.2d at 345-46, 131 Cal. Rptr. at 27.

138. *Id.* at 440, 551 P.2d at 346, 131 Cal. Rptr. at 26.

139. See, e.g., Comment, *The Psychiatric Duty to Warn: Walking a Tightrope of Uncertainty*, 56 U. CIN. L. REV. 269 (1987) (courts' failure to define crucial elements of the duty to warn); George, Korin, Quattrone & Mandel, *The Therapist's Duty to Protect Third Parties: A Guide for the Perplexed*, 14 RUTGERS L.J. 637 (1983) (duty to warn interferes with effective psychotherapy); Karasu, *The Ethics of Psychotherapy*, 137 AM. J. PSYCHIATRY 1502 (1980) (confidential relationship between psychotherapist and patient destroyed due to duty to warn); Rath & Meisel, *Dangerousness, Confidentiality, and the Duty to Warn*, 134 AM. J. PSYCHIATRY 508 (1977) (duty to warn undercuts confidentiality of the therapeutic relationship); Stone, *The Tarasoff Decisions: Suing Psychotherapists to Safeguard Society*, 90 HARV. L. REV. 358 (1976) (duty to warn reduces the utility of psychotherapy); Note, *Imposing a Duty to Warn on Psychiatrists—A Judicial Threat to Psychiatric Profession*, 48 U. COLO. L. REV. 283 (1977) (patients' rights could be destroyed by duty to warn).

140. See *Lipari v. Sears, Roebuck & Co.*, 497 F. Supp. 185 (D. Neb. 1980) (duty to warn extended to all persons foreseeably in danger of being injured by a patient's conduct); *Petersen v. State*, 100 Wash. 2d 421, 671 P.2d 230 (1983) (state hospital liable for failure to confine mental patient who injured another); *Jablonski v. United States*, 712 F.2d 391 (9th Cir. 1983) (psychotherapist has duty to protect a potential victim even though no actual threats were made); *Peck v. Counseling Serv. of Addison Co., Inc.*, 146 Vt. 61, 499 A.2d 422 (1985) (mental health professional has duty to protect third party from physical harm or property damage caused by a patient).

141. *Thompson v. County of Alameda*, 27 Cal. 3d 741, 614 P.2d 728, 167 Cal. Rptr. 70 (1980).

142. *Id.*

143. *Id.* at 746, 614 P.2d at 730, 167 Cal. Rptr. at 72.

144. *Id.* at 746, 614 P.2d at 730, 167 Cal. Rptr. at 72.

145. *Id.* at 752, 614 P.2d at 734, 167 Cal. Rptr. at 76.

146. *Id.* at 759, 614 P.2d at 735, 197 Cal. Rptr. at 77. The *Thompson* court concluded

This holding continues to be the standard for determining a psychotherapist's duty to warn third parties in California¹⁴⁷ as well as in other jurisdictions across the country.¹⁴⁸

Although a duty to warn identifiable third parties has primarily affected the mental health profession,¹⁴⁹ the duty closely parallels the physician's duty to inform certain third parties of the infectious nature of a patient's disease.¹⁵⁰ Both psychotherapist-patient and physician-patient relationships involve confidentiality, and in both relationships the confidentiality must yield to the extent that disclosure is essential for the protection of third parties.¹⁵¹ Accordingly, physicians who treat AIDS patients may have a duty to warn a patient's family members¹⁵² or sexual partners based on a *Tarasoff* duty to warn. The requirement of an identifiable third party who is foreseeably endangered by a patient's actions can be fulfilled in AIDS cases since exposure to HIV may lead to infection and since family members and sexual partners may be identifiable victims.¹⁵³ Thus, a physician who believes a third party is in danger of contracting AIDS via a pa-

that no duty to warn was owed to a segment of the general population where there were no specific threats toward any specific victim.

147. See *Jablonski v. United States*, 712 F.2d 391 (9th Cir. 1983) (The *Jablonski* court found that a psychiatrist owed a duty to warn a patient's girlfriend since the girlfriend was a foreseeable victim of the patient's violence. The court found this duty despite the lack of specific threats concerning any specific individuals. However, the court concluded that the patient's medical history placed the psychiatrist on notice of the patient's violent propensity toward women who were very close to him. Thus, the patient's girlfriend was an identifiable foreseeable victim, although not specifically identified by the patient).

148. See *supra* note 140 and accompanying text.

149. But see *Mangeris v. Gordon*, 94 Nev. 400, 580 P.2d 481 (1981) (*Tarasoff*-like analysis applied to a massage parlor operator who failed to warn a taxicab driver that a patron had a criminal history and was a fugitive of the law); Leblang, *The Duty to Warn Third Parties Threatened by a Patient*, 10 LEGAL ASPECTS OF MED. PRACT., Sept. 1982, 5 (detail of judicial interpretations of the *Tarasoff* doctrine in jurisdictions other than California); Milne, "Bless Me Father, for I Am About to Sin . . .": Should Clergy Counselors Have a Duty to Protect Third Parties?, 22 TULSA L.J. 139 (1986) (application of *Tarasoff* to clergy); Sands, *The Attorney's Affirmative Duty to Warn Foreseeable Victims of a Client's Intended Violent Assault*, 21 TORT & INS. L.J. 355 (1986) (discussion of the application of the *Tarasoff* duty to warn to attorneys).

150. See *supra* notes 123-33 and accompanying text.

151. See *supra* notes 123-33 and accompanying text.

152. See, e.g., *Tarasoff v. Board of Regents*, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976); *Berry v. Moench*, 8 Utah 2d 191, 331 P.2d 814 (1958) (doctor who warned patient's fiancée of his syphilis was successful in defending against patient's claim of breach of confidence).

153. Some AIDS patients may develop AIDS-related psychiatric disorders, which may cause a patient to become disorganized, agitated, confused, belligerent, impulsive, hypersexual, violent, or assaultive. A patient suffering from an AIDS-related psychiatric disorder may be unable to abide by infection-control guidelines, and thus, in certain cases, a family member may be a foreseeable victim. See Navia & Price, *Dementia Complicating AIDS*, 16 PSYCHIATRIC ANNALS 158 (1986).

tient must make a decision: inform the third party and face potential liability for breach of confidentiality,¹⁵⁴ or maintain confidentiality and face potential liability for failure to satisfy a *Tarasoff*-like duty to warn.¹⁵⁵ The possible repercussions of the disclosure of confidential AIDS information aggravate this quandary.

IV. AIDS AND CONFIDENTIALITY—CONFLICTING CONCERN

Medical ethics, statutes, and common law generally guide a physician's disclosure of a patient's medical information. Physicians who treat AIDS patients, like psychotherapists or physicians who treat typhoid, must follow the appropriate professional guidelines.¹⁵⁶ AIDS, however, is a unique disease, and the standards that physicians have previously applied to determine the appropriateness of the disclosure of patient information are no longer suitable. The disclosure of information pertaining to an AIDS patient requires a rebalancing of the private and public interests involved and a redrafting of the parameters of liability surrounding the disclosure of patient information.¹⁵⁷

A. *The Concerns of AIDS Victims and Their Physicians*

The object of allowing recovery for a breach of confidentiality is to compensate for the resulting injuries.¹⁵⁸ The injuries suffered by patients whose medical records are improperly disclosed by their physicians may include harm to reputation, interference with personal privacy, personal humiliation, loss of employment, and emotional distress.¹⁵⁹ These injuries have commonly been suffered by AIDS victims upon publicity of their plight.¹⁶⁰

154. Belitsky & Solomon, *Doctors and Patients: Responsibilities in a Confidential Relationship*, in AIDS AND THE LAW: A GUIDE FOR THE PUBLIC 201 (H. Dalton & S. Burris eds. 1987).

155. See *supra* notes 83-107 and accompanying text.

156. See *supra* notes 119-149 and accompanying text.

157. Murphy, *Evolution of the Duty of Care: Some Thoughts*, 30 DE PAUL L. REV. 147 (1980).

158. See Note, *Public Health Protection and the Privacy of Medical Records*, 16 HARV. C.R.-C.L. L. REV. 265, 303 (1983) (concluding that the problem of secondary disclosures to private third parties demands a response, be it common law development, regulatory schemes, or legislative acts).

159. See *Hammonds v. Aetna Casualty & Sur. Co.*, 243 F. Supp. 793, 802 (N.D. Ohio 1965) (approval of action for damages directly caused by breach of confidence); *Simonsen v. Swenson*, 104 Neb. 224, 227, 177 N.W. 831, 832 (1920) (breach of confidentiality would give rise to a civil action for the damages naturally flowing from such wrong); *Berry v. Moench*, 8 Utah 2d 191, 193, 331 P.2d 814, 817 (1958) (finding an action would lie for any injury suffered as a result of a breach of confidence).

160. See Winslade, *supra* note 38, at 505.

Since the disease can be transmitted from one person to another,¹⁶¹ and because the future for a person who develops AIDS is almost certainly death,¹⁶² individuals diagnosed as having AIDS face discrimination and social ostracism based upon the fear of contagion.¹⁶³ Although a person afflicted with AIDS may be able to recover damages from the party from whom the disease was contracted,¹⁶⁴ a physician who improperly discloses information regarding a patient's affliction with AIDS also becomes a potential source of recovery.¹⁶⁵ As a result, physicians should be extremely cautious in handling and discussing the medical records of AIDS victims. The near certainty of harm that AIDS patients suffer upon public disclosure of their illness, and the severity of that harm, creates a potential for economic loss and professional damage to an unwary physician.¹⁶⁶

Despite the potentially damaging consequences of public disclosure of an AIDS victim's condition, persons afflicted with AIDS should not be afforded absolute confidentiality. Consequently, a physician may have a duty to disclose certain information to a third party.¹⁶⁷ In addition to protecting AIDS patient's from being injured by unauthorized disclosures, confidentiality also may help curb the spread of AIDS.¹⁶⁸ The testing and counseling

161. See *supra* notes 19-37 and accompanying text.

162. See *Update: Acquired Immunodeficiency Syndrome (AIDS)—United States*, 35 CENTERS FOR DISEASE CONTROL: MORBIDITY & MORTALITY WEEKLY REP. 757 (1986).

163. M. MACDONALD, K. MEYER & B. ESSIG, *supra* note 39, at § 19.05[4].

164. See generally *id.*; Comment, *Running From Fear Itself: Analyzing Employment Discrimination Against Persons With AIDS and Other Communicable Diseases Under Section 504 of the Rehabilitation Act of 1973*, 23 WILLAMETTE L. REV. 857, 861 (1987) ("[P]ublic fear of AIDS has remained high since its first documentation by the Center For Disease Control (CDC) in 1981 because the disease in its final stage is at present incurable and frequently fatal. . . .") (quoting Leonard, *Employment Discrimination Against Persons With AIDS*, 10 U. DAYTON L. REV. 681, 696 (1985)).

165. See 2 AIDS POLICY & LAW, Feb. 25, 1987 at 6 (woman filed suit against former fiancée claiming he exposed her to the HIV virus); AIDS AND THE LAW, *supra* note 12, at 150-54.

166. 2 AIDS POLICY & LAW, Feb. 25, 1987 at 6. On Feb. 5, 1987, a California man filed a suit against his physician charging a violation of California's AIDS Testing Confidentiality Act (CAL. HEALTH & SAFETY CODE § 199.21 (West 1982)). The California man claimed that his HIV positive status was being used to prevent his collection of compensation for an unrelated head injury suffered two years ago.

167. See generally Peter & Sanchez, *The Therapist's Duty to Disclose Communicable Diseases*, 14 W. ST. U.L. REV. 465, 472-73 (1987) (discussing the duty of confidentiality with respect to communicable diseases).

168. A reflection of this duty can be observed in contact-tracing and partner-notification plans. Under these plans, a state department of health could contact an HIV-infected person's sexual or needle-sharing partners for testing and counseling. See IDAHO CODE § 39-601 (1987). These plans require physicians to disclose a patient's AIDS information to the respective health department and then allow the health department to disclose information regarding a patient's AIDS status to third parties. Such plans, nevertheless, fail to relieve physicians of their potential liability to third parties or their potential liability for breach of confidentiality if a third party is notified of a patient's infection. Consequently, even though a state may provide

of those who might be exposed to HIV are the principle measures available for the reduction of the transmission of AIDS.¹⁶⁹ To motivate the individuals at risk to be counseled and tested, physicians must ensure confidentiality.¹⁷⁰

Although medical ethics and most state laws permit breaching patient confidentiality in certain situations, disclosure that a patient tested positive for AIDS may not be such a situation. Unlike a positive test for typhoid,¹⁷¹ or a psychotherapy patient's confession of an intent to kill,¹⁷² a positive test for HIV infection does not clearly indicate a foreseeable harm to an identifiable individual.¹⁷³ Thus, given the uncertainty involved with warning a patient's associates, a physician must speculate whether any warning would be worth the harm the individual could suffer through embarrassment and discrimination.

B. The Concerns of Third Parties and Physicians

AIDS is a communicable disease which poses a predictable risk to other persons.¹⁷⁴ If a physician can identify a person who may become infected by a patient, the physician likely has a duty to warn the other person.¹⁷⁵ In general, a physician has a duty to keep a patient's medical history and condition confidential.¹⁷⁶ This duty, however, is not absolute.¹⁷⁷ The

legislation that notifies parties at risk of being infected, such legislation is not sufficient to indicate what physicians' duties and liabilities are with respect to the disclosure of AIDS information.

169. 2 AIDS POLICY & LAW, May 6, 1987 at 2 (reporting that the U.S. Surgeon General and other public health experts endorse the guarantee of confidentiality, saying that efforts to stem the spread of AIDS cannot succeed without the assurance of confidentiality).

170. See 1 AIDS POLICY & LAW, Jul. 2, 1986, at 7 (confidentiality is crucial to insure that individuals at high risk for AIDS are motivated to be counseled and tested); 1 AIDS POLICY & LAW, Nov. 5, 1986, at 8 (mandatory disclosure of patients' positive tests for AIDS would discourage AIDS victims from seeking help).

171. See *Davis v. Rodman*, 147 Ark. 385, 227 S.W. 612 (1921).

172. See *Tarasoff v. Board of Regents*, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976).

173. *CONFRONTING AIDS*, *supra* note 6, at 189-91; *AIDS AND THE LAW*, *supra* note 12, at 158.

174. *CONFRONTING AIDS*, *supra* note 6, at 57-73.

175. See *AIDS AND THE LAW*, *supra* note 12, at 252. The means by which AIDS is transmitted, however, and the severe discrimination which accompanies its diagnosis, have raised several arguments in opposition to the duty to warn. See generally Dolgin, *supra* note 20.

176. See Note, *Breach of Confidence: An Emerging Tort*, 82 COLUM. L. REV. 1426, 1455 (1982) (recognizing tortious breach of confidence as a distinct basis of liability).

177. See, e.g., notes 108-53 and accompanying text; CAL. CIV. CODE § 56.10(b) (West 1982) (listing of seven circumstances under which a physician must disclose medical information regarding a patient); *Lipari v. Sears, Roebuck & Co.*, 497 F. Supp. 185 (D. Neb. 1980)

physician's duty of confidentiality is limited by the *Tarasoff* duty to warn identifiable third parties who foreseeably might be harmed by a patient's conduct.¹⁷⁸ Because AIDS is contagious, a sexual partner's or intravenous needle-sharer's ignorance of an AIDS patient's condition could be fatal.¹⁷⁹ Furthermore, because of neuropsychiatric complications, an AIDS patient may not be able to abide by reasonable infection-control guidelines; thus, a family member's ignorance of a patient's AIDS condition may be dangerous.¹⁸⁰ Consequently, a physician may have a duty to inform sexual partners, intravenous needle-sharers, and family members that a patient has AIDS.¹⁸¹ However, the mere fact that a patient has AIDS does not necessarily indicate that the patient is a danger to third parties.¹⁸² Furthermore, not all AIDS patients develop neuropsychiatric complications; thus, not all patients will pose a risk to family members.¹⁸³ Consequently, without explicit statutory provisions that allow a physician to disclose to those identifiable third parties who are in danger of being infected or harmed by an AIDS patient, the physician must also consider the possible liability for breach of confidentiality.

A physician's decision to disclose AIDS information to a third party must be determined by resolving two conflicting policy concerns. The first concern is the need to protect third parties from infection or other injury by the patient through appropriate disclosure of relevant medical information.¹⁸⁴ The second is the need to administer health care in a manner that will encourage those who have been exposed to AIDS to seek testing and treatment.¹⁸⁵ Since confidentiality competes with the duty toward third parties, physicians are in need of guidelines through which they will be protected from liability for their decision to disclose or not to disclose the information that a patient has AIDS.

(holding a physician must disclose confidential patient information to persons foreseeably endangered by the patient's condition).

178. *Tarasoff v. Board of Regents*, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976).

179. See Felberbaum, *Epidemiology and Risk Factors Associated with AIDS*, 9 TOPICS EMERGENCY MEDICINE 1, 9 (1987).

180. Belitsky & Solomon, *Doctors and Patients: Responsibilities in a Confidential Relationship*, in AIDS AND THE LAW: A GUIDE FOR THE PUBLIC 201, 208 (H. Dalton & S. Burris eds. 1987).

181. *Id.* at 207-08.

182. Since AIDS is primarily spread through high risk activities, abstinence from these risk activities will prevent the spread of AIDS. See United States Department of Health and Human Services Public Health Service, *AIDS Information Bulletin: the Public Health Service Response to AIDS* (1985).

183. See Rundell, Wise & Ursano, *Three Cases of AIDS-Related Psychiatric Disorders*, 143 AM. J. PSYCH. 777 (1986).

184. See Mills, Wofsy & Mills, *The Acquired Immunodeficiency Syndrome: Infection Control and Public Health Law*, 314 NEW ENG. J. MED. 931-33 (1986).

185. 1 AIDS POLICY & LAW, July 2, 1986 at 7.

C. *Legislative Action as a Cure to Physicians' Dilemma*

The problem facing physicians who treat or diagnose AIDS patients is a lack of guidance as to whom a patient's confidential information can be disclosed. Physicians receive a modicum of guidance through state reporting statutes, which mandate disclosure to state officials or agencies,¹⁸⁶ and confidentiality statutes, which require physicians to keep patient information confidential.¹⁸⁷ Despite the existence of reporting and confidentiality statutes, however, states presently lack legislation that explicitly governs physicians' disclosure of confidential AIDS information to non-official third parties.¹⁸⁸ An effective solution to physicians' lack of governance would be a definitive statute that indicates to whom, under what conditions, and how AIDS information could be disclosed. Such a statute could solve the physicians' predicament of determining whether the risk of failing to warn a third party is greater than the risk of breaching confidentiality, and thus could free doctors from potential litigation.

A recently enacted North Carolina law requires the physician of a person infected with AIDS to provide a state health official with the name of the patient's spouse.¹⁸⁹ Upon receiving the spouse's name, North Carolina provides a "trained, compassionate counselor" to counsel the spouse.¹⁹⁰ Statutes like North Carolina's may accomplish the goal of protecting third parties from possibly contracting AIDS.¹⁹¹ Such statutes, however, do not relieve a physician from the potential liability for failure to warn third parties and thus are not a complete solution to the physician's dilemma.

In proposing statutory guidelines for physicians, the two competing policy concerns surrounding confidentiality must be considered.¹⁹² The goal of protecting third parties from infection can be achieved by carefully defining the situations in which the potential harm is severe enough to require disclosure and by defining the manner in which the information would be disclosed. To achieve the second goal, the administration of health care in a

186. See *supra* notes 110-16 and accompanying text.

187. See *supra* notes 61-82 and accompanying text.

188. See, e.g., CAL. CIV. CODE § 56.10(c) (West 1982). California, having spawned the *Tarasoff* doctrine, and having one of the most comprehensive statutes regulating physician's disclosure of confidential information, does not have any provisions for the disclosure of medical information when a physician believes a patient poses a danger to a third party.

189. N.C. GEN. STAT. § 130A-147 (1987).

190. See 2 AIDS POLICY & LAW, Jan. 13, 1988 at 7 (quoting Chris Hoke, Chief of the Office of Legal Assistance in the North Carolina Department of Human Resources' Division of Health Services).

191. *Id.*

192. See generally Peter & Sanchez, *The Therapist's Duty to Disclose Communicable Diseases*, 14 W. ST. U.L. REV. 465, 477 (1987) (discussing the conflicting interests of therapists, patients, and society in the disclosure of the fact that a patient has a disease).

manner promoting testing and treatment, the legislation must provide a reasonable alternative to a physician's disclosure. In addition, limitations upon the type of information to be disclosed should be included. This note proposes legislation to accommodate both policy concerns. A statute designed to accommodate these concerns should be phrased as follows:

AIDS PREVENTION THROUGH NOTIFICATION ACT

Section 1. Purpose. In response to increasing public and health care concerns regarding Acquired Immune Deficiency Syndrome (AIDS), this Act allows health care providers who treat or diagnose patients with AIDS to disclose that the patient is an Human Immunodeficiency Virus (HIV) carrier to third parties who foreseeably may contract AIDS from or be harmed by the patient. Compliance with this statute safeguards health care providers who wish to disclose patient AIDS information from liability for breach of confidentiality, while maintaining the integrity of the professional-patient confidentiality.

Section 2. Definitions.

1) "Acquired Immune Deficiency Syndrome" (AIDS) is a severe manifestation of infection with the Human Immunodeficiency Virus (HIV) characterized by

a) one or more opportunistic diseases that are indicative of an underlying immunity disorder,

b) an absence of all other causes of immunodeficiency other than HIV, and

c) the absence of all other causes of reduced resistance associated with one or more of the opportunistic infections.

2) "Health Care Provider" means any person duly licensed by this State to provide health care services. Such persons shall include, but not be limited to, physicians, nurses, psychiatrists, or psychologists.

3) "Patient" is any natural person who received health care services from a health care provider and to whom the medical information pertains.

4) "Endangered Individual" is a person whose identity can be reasonably determined from information expressly or implicitly provided by the patient, and who is one or more of the following:

a) spouse of patient; or

b) sexual partner of patient; or

c) immediate family members of patient; or

d) other person likely to share an intravenous needle with the patient.

Section 3. Confidentiality. Except as outlined in Section 4, no part of this

statute shall be construed as an authorization to physicians to breach their ethical or statutory duty of confidentiality. Any physician who discloses or fails to protect a patient's confidential medical information in contravention of Section 4 of this Act shall be liable to that patient for all harm caused by such disclosure.

Section 4. Disclosure. A health care provider engaged in the treatment or diagnosis of AIDS patients must disclose to an endangered individual the medical status of the patient with AIDS if such disclosure may prevent the individual from contracting AIDS or from being harmed as a result of the patient's affliction with AIDS. Since, pursuant to this Act, the disclosure of confidential information is mandatory, any information so disclosed must be disclosed as defined in Section 5 of this statute.

Section 5. Implementation.

1) A health care provider shall make a disclosure of a patient's confidential AIDS information to an endangered third party in the following manner:

a) First, upon the determination of the need for disclosure a health care provider shall attempt to persuade the infected patient to voluntarily disclose to the endangered individual that the patient is a carrier of AIDS. If the patient refuses, or the health care provider has reason to believe the patient will not comply with the requested voluntary disclosure, then

b) the health care provider shall inform the patient of the intended disclosure and shall attempt to secure the patient's consent to reveal to the endangered individual that the patient has AIDS. Once the health care provider has informed the patient of the intended disclosure, the provider shall disclose to the endangered individual that the patient is infected with AIDS.

2) A health care provider who in good faith discloses confidential AIDS information to an endangered individual in the manner described in subsection 1) of Section 5 shall be immune from any civil liability which may arise from a disclosure made in compliance with this Act.

V. CONCLUSION

The epidemic of AIDS and the judicial expansion of the *Tarasoff* duty to warn have intensified the conflict between patient confidentiality and a physician's duty to warn third parties. The present-day stigma attached to AIDS and the discrimination suffered by AIDS carriers enhance a physician's duty to maintain patient confidences. However, the severity of AIDS and the predictable means by which it is transmitted intensify the physician's duty to warn third parties whom the physician identifies as being endangered by the AIDS patient. Current judicially imposed parameters of liability provide insufficient guidance to physicians who wish to protect their

patients from disclosure of confidential information, third parties from contracting AIDS, and themselves from possible lawsuits for breach of confidentiality or failure to warn. Legislative adoption of a definitive statute that specifies a physician's discretionary right to disclose AIDS information is needed. Carefully drawn legislative regulations that govern a physician's disclosure to endangered third parties of a patient's confidential AIDS information and provide an accompanying grant of civil immunity to the physician for good faith disclosures are the most appropriate means of protecting patients and their physicians in the midst of the AIDS crisis.

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