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I. INTRODUCTION

The constitutional rights of privacy and liberty are closely related and seem inseparable at times.[1] In the era of HIV/AIDS disease,[2] the concepts of individual privacy and liberty as they re-

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1. Courts sometimes rely upon both concepts to decide a single issue. *See, e.g., In re* A.C., 573 A.2d 1235, 1248 (D.C. 1990) (referring to a woman's "liberty and privacy interests and bodily integrity" on the issue of whether a court should order the caesarean delivery of a terminally ill patient's baby); *see also* Johnson, *The Creation of Fetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy and Equal Protection*, 95 YALE L.J. 599 (1986). The constitutional analysis in the right-to-die cases had rested principally upon the right to privacy, until recently when the Supreme Court proclaimed that a liberty analysis was more appropriate. "Although many state courts have held that a right to refuse treatment is encompassed by a generalized constitutional right of privacy, we have never so held. We believe this issue is more properly analyzed in terms of a Fourteenth Amendment liberty interest." Cruzan v. Director, Mo. Dep't of Health, 110 S. Ct. 2841, 2851 n.7 (1990) (citing Bowers v. Hardwick, 478 U.S. 186, 194-95 (1986)).

2. The abbreviation HIV/AIDS stands for Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome. This designation is preferred over reference to AIDS alone because the focus upon AIDS is not representative of the full course of the disease, which starts with HIV infection and the gradual erosion and suppression of the immune system. After becoming infected with HIV, people may remain in an asymptomatic state for up to nine years or longer. Once people with HIV develop symptoms and are diagnosed as having AIDS Related Complex (ARC) (a label that seems to be falling out of favor) or AIDS, those persons may live with the disease for several years (possibly as long as eight to ten years). Hence, HIV/AIDS can appropriately be considered a chronic disease condition. *See* REPORT OF THE PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC 8, 15 (1988) [hereinafter PRESIDENTIAL COMMISSION REPORT], U.S. DEP'T OF HEALTH AND HUMAN SERVS., SURGEON GENERAL'S REPORT ON ACQUIRED IMMUNE DEFICIENCY SYNDROME 11-12, 20 (1986) [hereinafter SURGEON GENERAL'S REPORT]; R. JARVIS, M. CLOSEN, D. HERMANN &

late to HIV blood test[3] results have two distinct applications. First, an individual may have a privacy or liberty concern about the disclosure to others of medical information identifying the individual's HIV/AIDS condition. This subject seems to come to mind first for almost everyone confronted with an inquiry about confidentiality, disclosure, or self-determination. Confidentiality of the HIV test results has been extensively treated in the statutes and the literature.[4] Additionally, courts have begun to confront allegations of unlawful dissemination of the highly sensitive and personal information about a plaintiff's HIV/AIDS status.[5] That particular privacy concern is not the subject of this Article.

Instead, this Article focuses upon an almost completely overlooked concern of many individuals under present HIV testing statutes—the right not to be informed of their HIV status. Most of these statutes require that the individual tested be informed of the

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A. LEONARD, AIDS LAW IN A NUTSHELL 22-23 (1990) [hereinafter R. JARVIS & M. CLOSEN, AIDS NUTSHELL].

> The term "AIDS" is obsolete. "HIV infection" more correctly defines the problem. The medical, public health, political, and community leadership must focus on the full course of HIV infection rather than concentrating on later stages of the disease (ARC and AIDS). Continual focus on AIDS rather than the entire spectrum of HIV disease has left our nation unable to deal adequately with the epidemic.

Id. PRESIDENTIAL COMMISSION REPORT at xvii.

3. A serologic test for antibodies to HIV (formerly HTLV-III or LAV) was developed, licensed, and placed into widespread use in this country in the spring of 1985. Importantly, it does not test directly for the virus, but only for antibodies that are produced in reaction to infection with the virus. The full HIV test protocol should consist of two important steps. First, an enzyme-linked immunozorbent assay (ELISA) test is administered as a preliminary screening device to identify those blood samples that may be HIV-infected. Any blood specimen that tests repeatedly seropositive for HIV on ELISA testing should then be submitted to a second level of testing, the Western blot test. The Western blot serves as a confirmatory test to ascertain the presence of HIV antibodies or to disprove the existence of HIV antibodies in particular blood samples that have shown positive at the ELISA testing level. *See* PRESIDENTIAL COMMISSION REPORT, *supra* note 2, at 198, 201; M. CLOSEN, D. HERMANN, P. HORNE, S. ISAACMAN, R. JARVIS, A. LEONARD, R. RIVERA, M. SCHERZER, G. SCHULTZ & M. WOJCIK, AIDS: CASES AND MATERIALS 148-49 (1989) [hereinafter M. CLOSEN, AIDS CASES]; R. JARVIS & M. CLOSEN, AIDS NUTSHELL, *supra* note 2, at 17-18.

4. *See generally* Closen, Connor, Kaufman & Wojcik, *AIDS: Testing Democracy—Irrational Responses to the Public Health Crisis and the Need for Privacy in Serologic Testing*, 19 J. MARSHALL L. REV. 835 (1986) [hereinafter Closen, *Testing Democracy*]; Closen & Isaacman, *The Duty to Notify Private Third Parties of the Risks of HIV Infection*, 21 J. HEALTH & HOSP. L. 295 (1988) [hereinafter Closen, *Duty to Notify*]; Closen & Power, *AIDS In the Workplace*, COMPLEAT LAWYER, Summer 1988, at 14 [hereinafter Closen, *Workplace AIDS*]; Comment, *HIV/AIDS Confidentiality: Are Computerized Medical Records Making Confidentiality Impossible?*, 4 SOFTWARE L.J. 93 (1990).

5. *See, e.g.*, Harris v. Thigpen, 727 F. Supp. 1564 (M.D. Ala. 1990); McCune v. Neitzel, 235 Neb. 754, 457 N.W. 2d 803 (1990).

test result, especially if the result is positive (indicating infection with HIV).[6] The tested individual is afforded no choice in the matter. Thus, for example, when applicants for life or health insurance,[7] blood, semen, or organ donors,[8] prisoners,[9] or medical and mental patients[10] are tested for HIV, statutes provide that those individuals must be told of their results. Moreover, many of these statutes require that the individual be counseled, particularly if the individual tests seropositive.[11]

This author strenuously disapproves not only of almost all HIV testing conducted without the informed consent of the individual

6. *See* statutes cited *infra* notes 34-42 and accompanying text.

7. *See, e.g.*, FLA. STAT. ANN. § 627.429(4)(c) (West Supp. 1990); N.Y. PUB. HEALTH LAW §§ 2781(5), 2782(1)(a),(j) (Consol. 1990); N.C. GEN. STAT. § 130A-148(g) (1989); *see also* sample standard consent form for life and health insurance (on file with author).

8. *See, e.g.*, ARIZ. REV. STAT. ANN. § 32-1483 (1989) (blood donors are to be notified of positive HIV test results); CAL. HEALTH & SAFETY CODE § 1603.3(a) (West 1990); LA. REV. STAT. ANN. §§ 1062.1(c), 1299.142(B)(1) (West 1990); MD. HEALTH-GEN. CODE ANN. § 18-334(b),(c) (1990) (requires notification to a donor when there is a positive test result); N.Y. PUB. HEALTH LAW §§ 2781(6), 2782(1)(a) (Consol. 1990); WIS. STAT. ANN. § 146.023(1) (West 1990); *see also* N.C. GEN. STAT. § 130A-148(g) (1989); N.D. CENT. CODE § 23-07.5-05(1)(d),(e) (Supp. 1989).

9. *See, e.g*, MD. HEALTH-GEN. CODE ANN. § 18-338(b),(d),(f) (1990) (allows testing without consent of prisoner if there is a possible exposure of a correctional employee to HIV; and requires counseling if test result is positive); MO. ANN. STAT. §§ 191.653(3), .656(2)(1)(e), .659 (Vernon Supp. 1991); N.Y. PUB. HEALTH LAW §§ 2781(5), 2782(1)(l)-(o) (Consol. 1990); N.C. GEN. STAT. § 130A-148(g) (1989); *see also* S.C. CODE ANN. §§ 44-29-100, -110 (Law. Co-op. 1989) (allows testing of prisoners for HIV and denies discharge of those who test positive until release is recommended by health department).

10. *See, e.g.*, MO. ANN. STAT. §§ 191.653(3), .656(2)(1)(e), .662 (Vernon Supp. 1991) (testing and disclosure to individuals in drug treatment programs and mental health patients); N.H. REV. STAT. ANN. § 141-F:7(II) (1988) (testing of and disclosure to medical patients); WIS. STAT. ANN. § 146.025(3) (West Supp. 1990) (testing of and disclosure to mental patients who pose risk of transmission of HIV to other patients); *see also*, CAL. HEALTH & SAFETY CODE § 199.25b (West 1990); N.C. GEN. STAT. § 130A-148(g) (1989); S.C. CODE ANN. § 44-29-230 (Law. Co-op. 1989) (if possible accidental HIV transmission from patient to health care worker, patient can be tested with consent and must be told of result).

11. *See, e.g.*, FLA. STAT. ANN. § 627.429(4)(c) (West Supp. 1990); ILL. REV. STAT. ch. 111 1/2, para. 7307(b),(c) (1989) (appropriate counseling to be provided when an individual tests positive and when informed consent to test was not required due to a statutory exception); MD. HEALTH-GEN. CODE ANN. § 18-334(c)(2) (1990) (providing that a semen, blood, or tissue donor who tests positive be informed of the availability of counseling); N.M. STAT. ANN. § 24-2B-4 (Supp. 1990); TEX. REV. CIV. STAT. ANN. art. 4419b-4, § 1.028 (Vernon 1990) (posttest counseling provided following a positive HIV test); *see also* N.H. REV. STAT. ANN. § 141-F:7(III) (1988) (providing for notification and counseling of parent or legal guardian of minor or mentally incompetent person who tests seropositive); WASH. REV. CODE ANN. § 70.24.330 (1988) (requiring counseling for insurance applicants who test positive).

tested,[12] but also of statutes which require that people be told the results of their HIV tests. Each individual should have the right to decide in advance whether he or she will be told of the HIV test result. The constitutional rights of liberty and privacy mandate that citizens be permitted to decline forced disclosure of this information. Moreover, allowing people to choose is better public policy than forcing their HIV test results upon them.

This Article begins with a review of various state legislative provisions on test result disclosure. The Article then explores the absence of medical or legal justifications for compelled disclosure of HIV results to the persons tested and the reasons why an individual rightly might not want to know his or her HIV status. It then briefly discusses statutorily mandated counseling for those who test positive. The Article concludes with a short commentary on the tort and criminal law implications of mandatory disclosure to and counseling of those who test seropositive for HIV.

II. STATUTES ON MANDATORY HIV TEST RESULT DISCLOSURE

As might be anticipated, the statutes on HIV test result disclosure vary markedly from state to state. However, among the numerous variations in specific language and terms, four basic categories can be discerned. First, many states require that individuals who are tested for HIV must be informed of their test results.[13] Other states give state officials or agents the discretion to advise individuals of their HIV results.[14] Some states do not address the subject at all.[15] Finally, a few states permit some tested individuals to elect whether they receive their HIV test results.[16]

Several points common to many of the HIV testing statutes and applicable to all four categories discussed below should be noted. First, the statutes sometimes do not require that HIV testing include a confirmatory procedure.[17] In other words, statutes often

12. *See* Closen, *Testing Democracy*, *supra* note 4; Closen, *Duty to Notify*, *supra* note 4; Closen, *Workplace AIDS*, *supra* note 4. *But see* Closen, *A Call For Mandatory HIV Testing and Restriction of Certain Health Care Professionals*, 9 ST. LOUIS U. PUB. L. REV. 421 (1990) [hereinafter Closen, *Call for HIV Testing*]. The author's position is not altered by the inclusion of mandatory counseling provisions in the mandatory disclosure statutes.

13. *See* statutes cited *infra* notes 34-39 and accompanying text.

14. *See* statutes cited *infra* notes 40-42 and accompanying text.

15. *See* statutes cited *infra* note 43 and accompanying text.

16. *See* statutes cited *infra* note 44 and accompanying text.

17. For example, many statutes make no reference to the need to confirm a positive HIV test. *See, e.g.*, MD. HEALTH-GEN. CODE ANN. §§ 18-333-339 (1990); N.J. STAT.

establish no protocol to insure the accuracy of HIV testing, such as a procedure demanding that any repeatedly reactive results on an ELISA test[18] be confirmed by the more accurate Western blot test.[19] The ELISA test is intended merely as a less expensive and overly sensitive initial screening test when massive numbers of blood samples are to be processed. The Western blot is a more expensive and less sensitive test thought to be more than 99 percent accurate when used as part of a full testing protocol.[20] Thus, many more samples will test seropositive for HIV if submitted only to ELISA testing, than if also submitted to the Western blot analysis. Therefore, if people were informed of test results based solely upon ELISA processing, many of them would be erroneously advised that they are infected with HIV.[21]

Second, although many HIV testing statutes generally require informed consent before testing, such provisions do not serve to

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ANN. §§ 26:5C-5 to -14 (West Supp. 1990); N.Y. PUB. HEALTH LAW § 2780 (Consol. 1990); N.D. CENT. CODE §§ 23-07.4-01 to -07.5-08 (Supp. 1989); R.I. GEN. LAWS § 23-6-10 (1989); S.C. CODE ANN. § 44-29-20 (Law. Co-op. 1989). Illinois does not expressly provide for confirmation of statutory HIV testing, but does have an odd requirement that the test subject be informed about the availability of confirmatory testing. ILL. REV. STAT. ch. 111 1/2, para. 7305 (1989); *see also* TEX. REV. CIV. STAT. ANN. art. 4419b-4, § 1.02(7) (Vernon 1990) (refers to informing the test subject of "the potential need for confirmatory testing," without further explanation). Several statutes do include a general reference to some sort of confirmatory testing without any description of specific protocol. *See, e.g.*, GA. CODE ANN. § 31-22-9.1(a)(5) (Supp.1990) (a "confirmed positive HIV test" requires at least two separate types of HIV tests to be administered); IOWA CODE ANN. § 141.22(6) (West 1990) (referring to "confirmation according to prevailing medical technology of a positive HIV-related test"); KAN. STAT. ANN. § 65-6001(c) (Supp. 1989) (referring to a confirmatory AIDS test); KY. REV. STAT. ANN. §§ 214.454(1), 214.458(7), and 214.464(2) (Michie/Bobbs-Merrill Supp. 1988) (referring to confirmatory positive test for HIV); MO. ANN. STAT. § 191.653(3) (Vernon Supp. 1991) (referring to "confirmed" test result, with no further explanation of protocol); N.C. GEN. STAT. § 130A-148(a) (1989) (referring to confirmatory testing); OHIO REV. CODE ANN. § 3701.24.1(B)(1) (Anderson Supp. 1989) (requires state director of health to define the phrase "confirmed positive test result"); WIS. STAT. ANN. § 146.025(1)(g) (West Supp. 1990) (defining a "validated test result" as an HIV test that meets the validation requirements deemed necessary by the state epidemiologist). For statutes that set out a testing protocol, see LA. REV. STAT. ANN. § 1299.141(1), (5) (West 1990) (referring to the Western blot); MONT. CODE ANN. § 50-16-1003(6) (1989) (referring to both an ELISA and a Western blot test).

18. *See supra* note 3 and accompanying text; *see also* Closen, *Testing Democracy*, *supra* note 4, at 872-73.

19. *See supra* note 3 and accompanying text; *see also* Closen, *Testing Democracy*, *supra* note 4, at 873.

20. *See supra* note 3 and accompanying text; *see also* Closen, *Testing Democracy*, *supra* note 4, at 873.

21. *See* R. JARVIS & M. CLOSEN, AIDS NUTSHELL, *supra* note 2, at 17-18; *see also* Benenson, Peddecord, Hofherr, Ascher, Taylor & Hearn, *Reporting the Results of Human Immunodeficiency Virus Testing*, 262 J. A.M.A. 3435 (1990) (details erroneous and confusing laboratory reporting of HIV results).

dispel the objections raised in this Article about mandatory HIV result disclosure to the individuals tested. Although refusal to consent certainly prevents the administration of an HIV test and the generation of an HIV test result, so many statutes include so many exceptions that the exceptions appear to be swallowing up the field. Hence, there are exceptions that allow testing without consent of prison inmates,[22] medical and mental patients,[23] defendants arrested for certain criminal offenses,[24] donors of organs, blood, semen, and other human tissue,[25] and so on.

Furthermore, many situations are not conducive to true consent. Military personnel and recruits,[26] applicants for life and health insurance,[27] immigrants,[28] Job Corps applicants,[29] and certain for-

22. *See, e.g.*, Dunn v. White, 880 F.2d 1188 (10th Cir. 1989), *cert. denied*, 110 S. Ct. 871 (1990) (upholding mandatory HIV testing of prison inmate); Harris v. Thigpen, 727 F. Supp. 1564 (M.D. Ala. 1990) (upholding HIV testing of prison inmates); MD. HEALTH-GEN. CODE ANN. § 18-338(b) (1990) (no informed consent required if possible exposure of a correctional employee to HIV has occurred); MO. ANN. STAT. § 191.659 (Vernon Supp. 1991); OHIO REV. CODE ANN. § 3701.24.2(E)(4) (Anderson Supp. 1989).

23. Medical patients can be tested without their informed consent. *See, e.g.*, ILL. REV. STAT. ch 111 1/2, para. 7308(b) (1989) (when physician determines that it is medically indicated that patient should be tested); OHIO REV. CODE ANN. § 3701.24.2(E)(1),(5),(6) (Anderson Supp. 1989) (in medical emergency, when necessary for diagnosis and treatment, or in the case of possible accidental exposure to HIV); OR. REV. STAT. § 433.080 (Supp. 1990) (upon court order without consent of test subject if there may have been an accidental exposure to HIV); R.I. GEN. LAWS § 23-6-14(a),(e) (1989) (allowing health care providers to test infants under one year of age and to test patients if there has been a possible accidental transmission of HIV to a health care provider). Certainly, numerous statutes permit disclosure of positive HIV results to the treating physician(s) of the test subject. *See, e.g.*, KY. REV. STAT. ANN. § 214.420(3)(a) (Michie/Bobbs-Merrill Supp. 1988). Some statutes permit the testing of mental patients. *See, e.g.*, WIS. STAT. ANN. § 146.025(2)(b) (West Supp. 1990) (if mental patient "poses a significant risk of transmitting HIV to another resident or patient"); *see also* IOWA CODE ANN. § 141.63(d)(2) (West Supp. 1990) (requiring disclosure to person who tests positive for HIV if physician determines that there is imminent danger of transmission to a third party); KY. REV. STAT. ANN. § 214.464(2) (Michie/Bobbs-Merrill 1990) (requiring disclosure to emergency blood transfusion recipient of the results of a positive HIV test on the blood received by the donee).

24. *See, e.g.*, Haywood County v. Hudson, 740 S.W.2d 718 (Tenn. 1987) (upholding forced HIV testing of felony arrestee who told police he suffered from AIDS); ARK. STAT. ANN. § 16-82-101(b)(1) (Supp. 1989) (allowing HIV testing of arrestees charged with criminal sexual offenses); *see also* GA. CODE ANN. § 31-17A-2 (Supp. 1990) (permitting court-ordered testing without consent when test subject presents health threat to others); MO. ANN. STAT. § 191.674(1) (Vernon Supp. 1991) (same); W. VA. CODE § 16-3C-2(f)(2),(4) (1991) (mandatory testing for persons convicted of certain sexual offenses and for persons who may be a danger to the public health).

25. *See, e.g.*, N.H. REV. STAT. ANN. § 141-F:5(I) (Supp. 1989).

26. *See* Wilers, *Putting AIDS to the Test: Tough Questions About the Merits of Mass Screening*, TIME, Mar. 2, 1987, at 60 (noting that by the end of 1987, the military would have screened three million members of the armed forces).

27. *See* MO. ANN. STAT. § 191.671 (Vernon Supp. 1991) (allowing life and health

eign service employees[30] might refuse HIV testing, but such refusals may have serious adverse consequences including loss, denial, or restriction of employment, denial of entry into the country, or denial of life and health insurance. Moreover, some health care professionals may soon face reprisals for failure to submit to HIV testing.[31] In any event, the informed consent opportunity does not ordinarily extend to the later decision to decline to learn of one's HIV test result. As noted above, some HIV testing statutes do not even mandate informed consent for the testing itself.

As a practical matter, some subjects of HIV testing may successfully dodge the efforts of government agents to communicate the results of their HIV tests. An HIV test result, under present technology, is not available until a few days after the blood sample is obtained.[32] Hence, unless the test subject is confined involuntarily in a hospital, jail, or other facility, the subject may simply walk away and not return to receive the mandatory HIV disclosure.[33] However, we should not encourage that kind of situation. People

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insurance companies to test for HIV upon informed consent of applicant); OR. REV. STAT. § 433.045(7) (Supp. 1990) (same); R.I. GEN. LAWS § 23-6-24(a),(b) (1989) (allowing life and health insurance companies to test for HIV upon informed consent of applicant); Schatz, *The AIDS Insurance Crisis—Underwriting or Overreaching*, 100 HARV. L. REV. 1782 (1987); *see also* statutes cited *supra* note 7 and accompanying text.

28. *See* 42 C.F.R. § 34.4(a)(1)(i) (1990) (serologic testing for HIV required of all applicants for immigrant visas); S. SONTAG, AIDS AND ITS METAPHORS 33 (1989) (noting that "testing positive now makes one ineligible to immigrate everywhere").

29. *See* Wilers, *supra* note 26, at 60 (noting plans to test some 60,000 Job Corps applicants).

30. *See, e.g.*, Local 1812, Am. Fed'n of Gov't Employees v. United States, 662 F. Supp. 50 (D.D.C. 1987).

31. *See* Leckelt v. Board of Comm'rs of Hosp. Dist. No. 1, 909 F.2d 820 (5th Cir. 1990) (nurse who refuses to submit to HIV test may be discharged by employer); Closen, *Call for HIV Testing*, *supra* note 12; *Woman with AIDS Tied to Her Dentist Will Get $1 Million*, N.Y. Times, Jan. 24, 1991, at A13, col. 1 [hereinafter *Woman With AIDS*] (reporting that the insurance carrier for a Florida dentist with AIDS settled a claim by a former patient who asserted that she contracted HIV from the dentist, after the Centers for Disease Control confirmed the probability of the transmission in this case); *see also* R.I. GEN. LAWS § 23-6-14(d)(ii) (1989) (requiring that a person, such as a health care professional, who may have been occupationally exposed to an accidental transmission of HIV must submit to an HIV test and must test negative in order to obtain an HIV test of another without that person's informed consent). *But see*, Glover v. Eastern Neb. Community Office of Retardation, 867 F.2d 461 (8th Cir.), *cert. denied*, 110 S. Ct. 321 (1989) (risk of HIV transmission to mentally retarded patients too minimal to justify mandatory HIV testing of agency employees).

32. Blood samples must be sent to outside laboratories for testing and analysis, and the results must then be returned. R. JARVIS & M. CLOSEN, AIDS NUTSHELL, *supra* note 2, at 17.

33. *See* FLA. STAT. ANN. § 381.609(3)(c) (West Supp. 1990) ("the person ordering the test shall schedule a return visit with the test subject for the purpose of disclosing the test results and conducting post test counseling").

should not have to hide from government agents or avoid answering their telephones or collecting their mail for fear of receiving the HIV test results.

The first category of mandatory HIV testing statutes consists of the large group of laws that require individuals to be told of their HIV test results.[34] For example, in New Hampshire, a public health provision on HIV testing provides that "[t]est results shall be disclosed by the physician or the person authorized by the physician to the person who was tested."[35] Similarly, Minnesota's law on testing for HIV in the context of possible exposure of emergency medical services personnel to the virus reads: "The facility that receives the patient shall inform the patient . . . of test results for all tests conducted under this chapter."[36] Other laws, such as North Carolina's, provide very simply that "[p]ersons tested for AIDS virus infection shall be notified of test results."[37] Occasionally, these statutes provide for disclosure to the test subject only if the result is positive.[38] For example, the Florida insurance code states that "[a]n applicant shall be notified of a positive test result by a physician designated by the applicant."[39]

The second category of laws authorizes government officials and their agents to tell a person of his or her HIV status, but do not expressly state that the individual must be told of the test result.[40] The West Virginia statute is typical. It states that "[n]o person may disclose . . . the results of [an HIV-related test] . . . except to

34. LA. REV. STAT. ANN. §§ 40:1062.1(C), 40:1299.142(B)(1) (West 1990); MONT. CODE ANN. § 50-16-1007(1),(4) (1989) (requiring informed consent for testing and requiring that the test subject be told of the results); WIS. STAT. ANN. § 146.025(2)(b)3b (West Supp. 1990); *see also* MO. ANN. STAT. §§ 191.653(3), 191.656(2)(1)(e) (Vernon Supp. 1991) (apparently mandating test result disclosure to the test subject).

35. N.H. REV. STAT. ANN. § 141-F:7(II) (Supp. 1989).

36. MINN. STAT. ANN. § 144.767(2) (West Supp. 1991).

37. N.C. GEN. STAT. § 130A-148(g) (1989).

38. *See, e.g.*, ARIZ. REV. STAT. ANN. § 32-1483 (1989); *see also* IOWA CODE ANN. § 141.6(3)(d)(2) (West Supp. 1990) (requiring disclosure of a positive HIV test to the person tested if a physician determines that there is imminent danger of HIV transmission to a third party); KY. REV. STAT. ANN. § 214.464(2) (Michie/Bobbs-Merrill 1990) (requiring disclosure to emergency blood transfusion recipient of positive HIV test on blood received by the donee.)

39. FLA. STAT. ANN. § 627.429(4)(c) (West Supp. 1990).

40. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 199.24(a) (West 1990); ILL. REV. STAT. ch. 111 1/2, para. 7309(a) (1989); N.Y. PUB. HEALTH LAW §§ 2781(5), 2782(1) (Consol. 1990) (fairly presumed that the test subject will be informed of results); N.D. CENT. CODE § 23-07.5-05 (Supp. 1989); OHIO REV. CODE ANN. § 3701.24.3(B)(1)(a) (Anderson Supp. 1989) (authorizing disclosure to legal guardian, spouse, or any sexual partner); VA. CODE ANN. § 32.1-36.1 (A)(1) (1991); W. VA. CODE § 16-3C-3(a)(1) (Supp. 1990); WASH. REV. CODE § 70.24.105(2)(a) (1988).

the following persons: (1) the subject of the test."[41] These statutes give unlimited authority to government agents to tell a person of his or her HIV result; they ordinarily impose no restrictions on that broad discretion. Only occasionally do these laws include any prerequisites for disclosure to the subject of the test. For instance, the Texas statute provides that "[a] test result indicating the presence of HIV infection may not be revealed to the person tested without giving that person the immediate opportunity for individual, face-to-face posttest counseling."[42] As discussed below, one suspects that individuals tested are routinely being told of their test results under this type of provision.

A third category of state enactments makes no reference to who is required, or even entitled, to be informed of the HIV test results.[43] In all likelihood, people who are tested for HIV in these states routinely are told of the test results because the statutes do not prohibit disclosure. Moreover, those administering or supervising HIV tests might automatically assume that a tested person should be or must be informed of the test result (in part because the subjects of other kinds of tests are almost always told of the results). Test result disclosure is a matter of habit or standard operating procedure in the health care field.

A fourth category of statutes actually allows the individual tested the choice of whether he or she will receive the HIV results, but this kind of provision is highly unusual. The Delaware law provides a good illustration of this approach. It provides that "[a]ny person on whom an HIV-related test was performed without first having obtained informed consent . . . shall be given notice

41. W. VA. CODE § 16-3C-3(a)(1) (1991).

42. TEX. REV. CIV. STAT. ANN. art. 4419b-4, § 4.01(a) (Vernon Supp. 1991).

43. For example, in Georgia, the statutory scheme implies that the test subject will be notified, although no specific provision requires such notification. *See* GA. CODE ANN. § 31-22-9.2 (c),(d) (Supp. 1990) (informed consent test subject's medical or emotional state would make disclosure of test result injurious to the subject's health; appropriate counseling required "with regard to the test results"); *see also, e.g.*, ARK. STAT. ANN. §§ 16-82-101, 20-15-901 to -904 (Supp. 1989) (allowing victim of certain sex offenses to learn result of HIV test of alleged offender, but not otherwise addressing who might get access to test results); KAN. STAT. ANN. § 65-6002 (Supp. 1989) (allowing disclosure in medical emergency only to medical personnel, and allowing Secretary of Health and Environment to provide by regulation for disclosure to others); KY. REV. STAT. ANN. § 214.420(3)(a) (Michie/Bobbs-Merrill Supp. 1988) (permits disclosure to the treating physician, but does not mention disclosure to the person tested or anyone else in the absence of informed consent); N.J. STAT. ANN. § 26:5c-8(b)(3) (West Supp. 1990) (permits disclosure to treating medical personnel, but does not mention disclosure to anyone else without informed consent); R.I. GEN. LAWS § 23-6-17 (Supp. 1990) (allowing result disclosure to a physician and very limited others, but making no reference to disclosure to the test subject).

promptly, personally and confidentially that a test sample was taken and the results of such test may be obtained upon request."[44]

III. Medical and Legal Objections to Compulsory Disclosure to the Individuals Tested

A. Compulsory Disclosure Affects Fundamental Rights

Because compulsory disclosure infringes upon every person's fundamental right to personal choice, the basic right to self-determination, we should oppose mandatory disclosure of HIV results to tested individuals. Our society and our law cherish this right as significant unto itself, regardless of the underlying subject matter involved. In the context of the abortion controversy, for instance, the overriding concern for many is a woman's right to personal choice or to preserve her autonomy in deciding whether to undergo an abortion.[45] Similarly, the right-to-die debate focuses mainly upon the right of those persons in dire health conditions to elect to refuse or withdraw extraordinary life support efforts.[46] This right derives from the right to self-determination. Finally, consider the issue of terminally ill pregnant women who refuse to undergo cesarean deliveries of their babies. Again, the woman's right of personal decision making has been the central concern.[47] Simply put, this societal and legal approach is correct, for when there is no compelling public or governmental interest, the fundamental rights of each citizen must remain paramount.

Why should we treat HIV reporting any differently than we treat nearly every other aspect of health and medicine? In other settings, we do not deprive individuals of their freedom of personal choice. We do not, for example, require women to undergo and obtain the results of mammograms; we do not mandate that adults learn their blood pressure statistics; and we do not dictate that adults submit to chest x-rays and receive their x-ray results. Yet each of these tests is associated with detection of potentially life-threatening ailments.[48] We do not even prohibit individuals from putting their lives directly in jeopardy by smoking cigarettes, be-

44. Del. Code Ann. tit. 16, § 1202(d) (Supp. 1990).

45. *See generally* Webster v. Reproductive Health Servs., 492 U.S. 490 (1989); Thornburgh v. American College of Obstetricians & Gynecologists, 476 U.S. 747 (1986); Planned Parenthood Ass'n v. Ashcroft, 462 U.S. 476 (1983); City of Akron v. Akron Center for Reproductive Health, Inc., 462 U.S. 416 (1983); Roe v. Wade, 410 U.S. 113 (1973).

46. *See, e.g.*, Cruzan v. Director, Mo. Dep't of Health, 110 S. Ct. 2841 (1990).

47. *See, e.g., In re* A.C., 573 A.2d 1235 (D.C. 1990); *see also*, Johnson, *supra* note 1.

48. *See* Funk & Wagnalls Family Medical Guide 329-32, 556-57, 561-62

coming obese, or engaging in sports such as boxing, auto racing, and sky diving.[49] In addition, with little exception, we certainly do not deprive people of the personal choice of declining to obtain health care or medical treatment.[50] We do not generally require individuals to submit to testing for syphilis, serum hepatitis, or Tay-Sachs (and, in turn, to learn the results of such testing) although those serious disease conditions can be transmitted to others through sexual, casual, and perinatal contact, respectively.[51] If all of this is so, why should the right to self-determination in regard to HIV test result disclosure be treated any differently? In short, it should not be.

Whether the freedom to decline to be informed of one's HIV result is regarded as a right based on privacy or liberty, it should certainly be characterized as fundamental. After all, the issues of death and dying are directly implicated.[52] HIV infection is the precursor of AIDS for virtually all, if not all, individuals who contract the virus,[53] and AIDS is incurable and fatal.[54] A not uncommon metaphor is that the news of one's HIV infection "amounts to a death sentence."[55]

Issues encountered in right-to-die cases seem closely analogous

(1976) [hereinafter FAMILY MEDICAL GUIDE] (describing high blood pressure test, lung cancer test and breast cancer test).

49. *See, e.g., Health Benefits of Smoking Cessation*, 39 MORBIDITY & MORTALITY WEEKLY REP. 653 (1990) (citing adverse effects of tobacco use and encouraging the reduction and prevention of those effects).

50. *See generally* Cruzan v. Director, Mo. Dep't of Health, 110 S. Ct. 2841 (1990); Lipton, *Do-Not-Resuscitate Decisions in a Community Hospital: Incidence, Implications and Outcomes*, 256 J. A.M.A. 1164 (1986); Annotation, *Patient's Right to Refuse Treatment Allegedly Necessary to Sustain Life*, 93 A.L.R.3D 67 (1979).

51. *See* M. CLOSEN, AIDS CASES, *supra* note 3, at 26-37; *see also* FAMILY MEDICAL GUIDE, *supra* note 48, at 377-78, 396-99, 542, 624 (describing tests for serum hepatitis, syphilis and Tay-Sachs).

52. As Justice Brennan observed, "[d]ying is personal. And it is profound. For many, the thought of an ignoble end, steeped in decay, is abhorrent. A quiet, proud death, bodily integrity intact; is a matter of extreme consequence." Cruzan v. Missouri Dep't of Health, 110 S. Ct. 2841, 2868 (1990) (Brennan, J., dissenting); *see also* M. CLOSEN, AIDS CASES, *supra* note 3, at 467-531; R. JARVIS & M. CLOSEN, AIDS NUTSHELL, *supra* note 2, at 1-3.

53. R. JARVIS & M. CLOSEN, AIDS NUTSHELL, *supra* note 2, at 6-7, 14-17 (explaining that HIV invades red blood cells and depresses a person's immune system, rendering that person vulnerable to infections which a healthy immune system would normally fight off); *see also* Harris v. Thigpen, 727 F. Supp. 1564, 1567 (M.D. Ala. 1990) (same); *cf.* ARK. CODE ANN. §§ 20-15-901 to -904 (Supp. 1989) (emergency clause in original act noted that AIDS ultimately causes premature death of all those infected with HIV).

54. *See Harris*, 727 F. Supp. at 1567 (characterizing AIDS as an "incurable and fatal disease"); Closen, *Testing Democracy*, *supra* note 4, at 845.

55. *See, e.g., Harris*, 727 F. Supp. at 1572 (referring to the spread of HIV in prison as a harsh punishment "that amounts to a death sentence"); Doe v. Roe, 139 Misc. 2d 209,

to those in the HIV/AIDS testing context. In right-to-die cases, courts must decide whether an individual possesses a right to refuse heroic or extraordinary life-support measures when the person has fallen into an irreversible and terminal condition progressing towards death or has fallen into a persistent vegetative state (an irreversible comatose condition).[56] In other words, do individuals have a right to decide to allow themselves to die naturally, rather than be forced by the state to suffer "life" that really amounts to a protracted, painful, demeaning, and agonizing death?

The news of HIV infection presents a similar issue. Does an individual have a right to refuse to be informed of his or her positive HIV test result, which would indicate that the person is in an incurable and terminal condition? In other words, does the state have the right to force people to "live" with the emotionally unsettling and disturbing information that they are really moving down the path of HIV disease toward a protracted, painful, demeaning, and perhaps horrifyingly disfiguring death?[57] Many rational people would prefer not to know, to live apparently healthy and emotionally happy existences until perhaps years later when they are overcome by symptoms that signal undeniably the presence of AIDS. Medical evidence shows that following HIV infection, development of symptoms of illness usually take years, possibly as

213, 526 N.Y.S.2d 718, 722 (Sup. Ct. 1988) (comparing notice of one's HIV infection "to receiving a death sentence").

56. *See, e.g.*, Cruzan v. Director, Mo. Dep't of Health, 110 S. Ct. 2841 (1990).

57. Since the first recognition of AIDS—and even before we had a name for the syndrome—one of the two most common opportunistic diseases to afflict people with HIV/AIDS has been Kaposi's sarcoma, a fairly rare form of cancer. *See Kaposi's Sarcoma and Pneumocystis Pneumonia Among Homosexual Men—New York City and California*, 30 MORBIDITY & MORTALITY WEEKLY REP. 305 (1981). This cancer can become severely disfiguring as it produces blue-black splotches or lesions on the skin (particularly about extremities such as the nose, lips, fingers, and toes, but all over the body as well). Furthermore, those with Kaposi's usually waste away from weight loss (in Africa AIDS is often referred to as "slim" disease), and those sufferers can eventually be reduced to living skeletons. For graphic photographic illustrations, *see* A. FRIEDMAN-KIEN, COLOR ATLAS OF AIDS (1989); Schneiderman & Garibaldi, *Physical Examination of HIV-Infected Patients*, 30 CONSULTANT 33 (1990). Medical science has succeeded, thus far, only in treating symptoms of HIV/AIDS and in prolonging the physiological existences of people with HIV/AIDS, with the result that they are now "falling prey to an array of other maladies." Cowley & Hager, *AIDS: The Next Ten Years*, NEWSWEEK, June 25, 1990, at 20, 22; *see also* R. JARVIS & M. CLOSEN, AIDS NUTSHELL, *supra* note 2, at 19, 22-23. Besides pneumocystis carinii pneumonia and Kaposi's sarcoma, people with HIV/AIDS also may suffer from profound fatigue, profuse night sweating, oral thrush, persistent fevers, swollen lymph nodes, digestive tract infections, loss of appetite, tuberculosis, shingles, headaches, emotional upset, dementia and other health problems. R. JARVIS & M. CLOSEN, AIDS NUTSHELL, *supra* note 2, at 14-17.

many as nine years or more.[58] That is a terribly long time to endure the death sentence of a positive HIV diagnosis, especially since medical science has succeeded thus far only in treating the symptoms of HIV/AIDS, at best in temporarily stabilizing and prolonging the death process. All of this raises the very same set of "difficult, indeed agonizing, questions" noted by Justice Scalia in the right-to-die context due to "the constantly increasing power of science to keep the human body alive for longer than any reasonable person would want to inhabit it."[59]

B. Compulsory Disclosure Fails to Serve a Valid Medical or Public Health Purpose

Is there any medical justification for compulsory HIV result disclosure to the individual tested? Compulsory disclosure could be justified if it led to behavior modification in the form of reduction of activities associated with a risk of HIV transmission. But there are important problems that diminish the persuasiveness of the argument that mandatory HIV disclosure will reduce HIV transmission.

First, with all of the media and public attention that has been directed to the HIV/AIDS epidemic generally, and to risk reduction specifically, members of the public are aware of HIV/AIDS and the routes of its transmission.[60] The Surgeon General's pam-

58. SURGEON GENERAL'S REPORT, *supra* note 2, at 12; Lemp, Payne, Rutherford, Hessol, Winkelstein, Wiley, Moss, Chaisson, Chen, Feigal, Thomas & Werdegar, *Projections of AIDS Morbidity and Mortality in San Francisco*, 263 J. A.M.A. 1497 (1990). The survival time after diagnosis with AIDS may be as long as eight to ten years or longer, so that people might have HIV/AIDS disease for 20 years. R. JARVIS & M. CLOSEN, AIDS NUTSHELL, *supra* note 2, at 22-23; *see also HIV Prevalence Estimates and AIDS Case Projections for the United States: Report Based Upon a Workshop*, 39 MORBIDITY & MORTALITY WEEKLY REP. 1, 27 (1990) [hereinafter *HIV Prevalence*] (assuming a median 10-year incubation period for life-threatening HIV infection); Lemp, Payne, Neal, Temelso, Rutherford, *Survival Trends for Patients with AIDS*, 263 J. A.M.A. 402, 403 (1990) (reporting the longest survival time for people afflicted with AIDS as 8.1 years after diagnosis).

59. Cruzan v. Director, Mo. Dep't of Health, 110 S. Ct. 2841, 2859 (1990) (Scalia, J., concurring). This artificial extension of life has also been called "the tyranny of survival." Goodman, *Choosing Death: When Life Loses Its Meaning, Is Suicide Our Right?*, Chicago Tribune, Mar. 25, 1990, § 5, at 8, col. 1; *see also* Brogdon v. State, 781 P.2d 1370 (Alaska Ct. App. 1989) (diagnosis of HIV infection due to contaminated blood transfusion caused defendant to become extremely depressed, to drive his car at speeds in excess of 100 miles per hour and to collide with another vehicle, seriously injuring its driver).

60. There is substantial evidence that most of the population is aware of HIV/AIDS and its routes of transmission. A recent study found that 82% of male and 79% of female patients at an STD clinic knew that HIV could be transmitted through vaginal and anal intercourse and the exchange of intravenous drug needles. And 97% of male and 96% of female patients knew that the regular use of condoms can reduce the risk of

phlet on HIV/AIDS was mailed to almost every household in the United States; reports about HIV/AIDS have appeared widely in newspapers and magazines, and on television and radio; and schools, churches, and places of employment frequently offer educational programs on HIV/AIDS.[61] The point is that everyone should already be avoiding activities that might risk HIV transmission. Furthermore, there is no reason to believe that those individuals who are fortuitously tested for HIV and mandatorily informed of HIV results under the various statutes do not currently practice safe habits (with the exception of persons who, in violation of criminal law, knowingly attempt to transmit HIV through sexual intercourse, sharing of intravenous drug needles, or donating blood, sperm, or organs). Why must an accidental subset of the population be tested for HIV and informed of their test results, when the rest of the citizenry are not being tested? If the extensive educational campaigns in the schools, churches, public forums, media, and elsewhere have not accomplished behavior modification in the form of risk reduction, how can we realistically believe that one more piece of information will make a difference?[62]

HIV transmission. *Heterosexual Behaviors and Factors That Influence Condom Use Among Patients Attending a Sexually Transmitted Disease Clinic—San Francisco*, 39 MORBIDITY & MORTALITY WEEKLY REP. 685, 685-86 (1990) [hereinafter *Condom Use*]. There is also evidence to suggest either ignorance of or disregard for use of steps to avoid the risk of HIV transmission. For example, in 1989, there were reports of 733,151 cases of gonorrhea and 44,540 cases of syphilis in the United States. CENTERS FOR DISEASE CONTROL, U.S. DEP'T OF HEALTH & HUMAN SERVS., SUMMARY OF NOTIFIABLE DISEASES, UNITED STATES — 1989 (Oct. 5, 1990) (special report issued by Morbidity and Mortality Weekly Report). Obviously, a large number of people are practicing unprotected, unsafe sex outside of a monogamous relationship. "American teenagers are ripe targets for AIDS: they're already experiencing 2.5 million cases of sexually transmitted disease every year, and nearly a million unintended pregnancies." Cowley & Hager, *supra* note 57, at 21; *see also* Gebbie, *AIDS and Government: Regulation of Sexual Behavior*, 57 UMKC L. REV. 251, 254 (1989) ("I have been asked often, 'Hasn't every adult learned from the evening news what is needed to stop this epidemic?' And the answer is 'no': more than 'the news' is required to teach people to eat properly, stop smoking, buckle our seat belts, and stop putting waste chemicals into our water."); *HIV Epidemic and AIDS: Trends in Knowledge—United States*, 38 MORBIDITY & MORTALITY WEEKLY REP. 353 (1989).

61. *See, e.g.*, Ware v. Valley Stream High School Dist., 150 A.D.2d 14, 545 N.Y.S.2d 316 (1989) (unsuccessful challenge to state-mandated AIDS education for primary and secondary school students); WIS. STAT. ANN. § 146.022(a)(3) (West 1990) (describing a "statewide public education campaign" about HIV/AIDS); PRESIDENTIAL COMMISSION REPORT, *supra* note 2, at 83-91 (suggesting education on prevention of the spread of AIDS); SURGEON GENERAL'S REPORT, *supra* note 2.

62. Certainly, there are those who would assert that knowledge that one is HIV-infected will influence a person more dramatically to curb activity involving the risk of HIV transmission than would mere education or warnings. *See, e.g.*, SURGEON GENERAL'S REPORT, *supra* note 2, at 29 (suggesting that high-risk groups should have blood

Perhaps, as some will argue, the message to act with care will be far more meaningful for someone who knows that he or she actually has the virus.[63] If so, then there should be widespread calls for mandatory testing and result disclosure for the entire population of the United States. But there have been almost no serious proposals to test everyone.[64] Although some call for more extensive HIV testing than is presently employed, the bureaucratic and financial barriers to massive HIV screening have dissuaded supporters from urging that everyone be tested. Yet virtually everyone could be tested. If knowing one's HIV status would save a significant number of lives, the proposal would be cost effective in the long run. Still, almost no one is advocating HIV testing for the entire population.

Further, it will not be more beneficial for some individuals to know that they actually have the virus because, unfortunately, there have been numerous documented cases of people who knew that they had HIV or AIDS and who continued to engage in high risk activities, sometimes with the sadistic desire to seek retribution and to "take others with [them]."[65] Indeed, there have been many prosecutions of people with HIV/AIDS for attempted murder and other felonies either under general criminal laws or under HIV/

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tests); 2 M. GUNDERSON, D. MAYO & F. RHAME, ETHICS IN A CHANGING WORLD—AIDS: TESTING AND PRIVACY 49 (1989).

63. SURGEON GENERAL'S REPORT, *supra* note 2, at 29; 2 M. GUNDERSON, *supra* note 62, at 49.

64. *See, e.g.*, Duncan, *Public Policy and the AIDS Epidemic*, 2 J. CONTEMP. HEALTH L. & POL'Y 169 (1986) (two-and-one-half page commentary of law professor advocating HTLV-III testing of entire population); Duncan, *Professor Defends Proposal For AIDS Testing*, NAT'L L.J., June 9, 1986, at 12, col. 2. For opposing views, see Closen, *Testing Democracy*, *supra* note 4, at 838 n.6; Leonard, *AIDS Testing Proposal Seems 'Ludicrous'*, NAT'L L.J., May 12, 1986, at 14, col. 2 (letter to the editor); Metaxas, *Professor Stirs AIDS Controversy with a Call for Universal Testing*, NAT'L L.J., May 5, 1986, at 4, col. 2 (letter to the editor).

65. Many individuals who have known of their HIV/AIDS condition have either engaged in sex with others or have bitten, scratched, or splashed blood upon others. A number of those individuals have repeatedly engaged in risk activity or have said they desired to transmit HIV/AIDS to others. For example, a Cincinnati woman is alleged to have said, "Welcome to the world of AIDS" to a man with whom she had just had sex. He alleged the statement sent him into a rage and prompted him to kill her. *Man Convicted in AIDS Killing*, Chicago Daily L. Bull., Jan. 30, 1991, at 1, col. 6; *see also, e.g.*, Brogdon v. State, 781 P.2d 1370 (Alaska Ct. App. 1989) (diagnosis of HIV infection caused defendant to become upset, drive erratically and collide with another vehicle injuring its driver); State v. Haines, 545 N.E.2d 834 (Ind. Ct. App. 1989) (HIV-infected defendant scratched, bit, and splashed others with blood, and expressed intention to infect them); M. CLOSEN, AIDS CASES, *supra* note 3, at 695-96, 715 (cases of arrests of HIV-infected male and female prostitutes; case of a man with HIV arrested for having sex with prostitutes).

AIDS-specific statutes recently enacted.[66] Often, the people involved in these incidents have expressed their intention to infect others with HIV/AIDS. Civil actions are also prevalent.[67] Most famous among them is the case of Marc Christian against the estate of Rock Hudson, in which Christian alleged, and a jury agreed, that Hudson continued to engage in sex with Christian even though Hudson knew of his HIV/AIDS condition.[68]

That compulsory testing and result disclosure alone are unlikely to affect behavior is suggested by the fact that we give the same advice to all test subjects regardless of the outcome of their testing. If you test negative, you are told, "Do not engage in risk activity" (so as not to endanger yourself by possibly contracting the virus). If you test positive, you are told, "Do not engage in risk activity" (so as not to spread the virus any further).[69] Again, if we can warn everyone, regardless of whether they are tested for HIV, not to engage in risk activity, what good does it do to force someone to know that he or she is seropositive for HIV? None.

Moreover, for the vast majority of people who test negative, there may be a danger of engendering complacency and disregard for the use of safe practices, such as the use of condoms during sexual intercourse or the use of bleach to cleanse intravenous drug needles.[70] An analogy may be drawn to the argument often heard that one reason not to routinely test hospital and surgical patients is that health care professionals may become complacent about the

66. *See, e.g.*, ILL. REV. STAT. ch. 38, para. 12-16.2 (1989). *See generally* Closen & Deutschman, *A Proposal to Repeal the Illinois HIV Transmission Statute*, 78 ILL. B.J. 592 (1990) [hereinafter Closen, *HIV Transmission*].

67. *See, e.g.*, C.A.U. v. R.L., 438 N.W.2d 441 (Minn. Ct. App. 1989); Doe v. Estate of Silva, No. CV-88-637 (Nev. Dist. Ct. 1989), *discussed in* AIDS LITIGATION REP., Jan. 27, 1989, at 2112; *Woman with AIDS*, *supra* note 31, at A13, col. 1 (reporting that the insurance carrier for a Florida dentist with AIDS settled a claim by a former patient who asserted that she contracted HIV from the dentist, after the Centers for Disease Control confirmed the probability of the transmission in this case).

68. *See, e.g.*, Christian v. Sheft, No. C574 153 (Cal. Super. Ct. 1989), *discussed in* AIDS LITIGATION REP., Feb. 24, 1989, at 2267; *$14.5 Million AIDS Verdict*, Chicago Daily L. Bull., Feb. 16, 1989, at 1, col. 5.

69. *See* Closen, *Testing Democracy*, *supra* note 4, at 876-77.

70. "It can be expected that many who *test* negatively might actually be positive due to *recent* exposure to the AIDS virus and give a false sense of security to the individual and his/her sexual partners concerning necessary protective behavior." SURGEON GENERAL'S REPORT, *supra* note 2, at 33 (emphasis in original). "The high rate [of transmission of AIDS to nonintravenous drug using heterosexuals in New Jersey] shows a lack of precautionary measures by people who mistakenly believe that they are not at risk for contracting HIV because they are not gay and do not inject drugs." *AIDS Diagnoses Grow Fastest Among Heterosexual Non-IVDUs*, 5 AIDS POL'Y & L. (BNA) No. 19, at 4 (Oct. 17, 1990) [hereinafter *AIDS Diagnoses*] (interview of Dan Bross, Executive Director, AIDS Action Council, Washington, D.C.).

use of universal or barrier precautions for procedures on persons who test negative.[71] Our guard should not be relaxed concerning persons who test seronegative for HIV. They may not truly be seronegative; the negative test result could be a false negative.[72] For example, the person tested might be in the window period between infection and the time when the body has succeeded in producing an antibody response sufficient to verify exposure to, and infection with, HIV.[73] Alternatively, the individual tested may engage in risk activity subsequent to testing and thereby contract the virus.[74]

Those who support mandatory HIV result disclosure also argue that a public health benefit may be derived by people who are HIV seropositive because they can obtain treatments (such as AZT, DDI, and others)[75] that help prolong life and preserve the quality of life.[76] That claim is unconvincing. First, this rationale appears to be more of an argument for testing everyone and forcing everyone to know their test results. Next, it disregards the wish of many people not to know and not to have "life" prolonged.[77] The definition of what constitutes a sufficient quality of life to want to prolong it is a matter open to endless debate and uncertainty, but

71. "If HCPs were falsely reassured that a patient was seronegative, they might not follow necessary infection control guidelines when working with the patient. If a patient tests negative for HIV antibodies, it would be a serious error in judgment to relax efforts to protect against accidental exposure to blood." Gostin, *Hospitals, Health Care Professionals and AIDS: The "Right to Know" the Health Status of Professionals and Patients*, 48 MD. L. REV. 12, 52 (1989).

72. Since all medical testing, including HIV testing, is conducted by humans, there is room for human error in obtaining the blood samples, labeling the samples, performing the blood tests, evaluating the results, and recording and communicating the results. *See* Closen, *Testing Democracy*, *supra* note 4, at 873-74; Benenson, *supra* note 21; R. JARVIS & M. CLOSEN, AIDS NUTSHELL, *supra* note 2, at 17-18.

73. SURGEON GENERAL'S REPORT, *supra* note 2, at 10, 33-34; *see also* LA. REV. STAT. ANN. § 40:1062.1(B) (West 1990) (requiring semen donor to test negative for HIV on a second test six months after first negative test); WIS. STAT. ANN. § 146.025(2)(a)1r (West Supp. 1990) (requiring that sperm and ova donors who initially test negative for HIV must be tested again not less than 90 days later before their donations will be used).

74. *See* LA. REV. STAT. ANN. § 40:1062.1(B) (West 1990); WIS. STAT. ANN. § 146.025(2)(a)1r (West Supp. 1990).

75. For descriptions of some of the drug therapies under investigation in the fight against HIV/AIDS, see M. CLOSEN, AIDS CASES, *supra* note 3, at 145; Cowley & Hager, *supra* note 57, at 22-25.

76. *See* M. GUNDERSON, *supra* note 62, at 23.

77. *See* the materials on the right-to-die cases and suicide, *supra* notes 46-47, 50, 56-59 and *infra* notes 79, 83, 89-92 and accompanying text. "For several generations now, the generic idea of death has been a death from cancer, and a cancer death is experienced as a generic defeat. Now the generic rebuke to life and to hope is AIDS." S. SONTAG, *supra* note 28, at 24.

remains ultimately a decision resting with each individual.[78] Medicine, religion, and law all have recognized this quandary. In fact, the uncertainty will worsen before it is reduced. As time and medical science advance, we will complicate things by improving the technology that keeps the human body functioning although the brain has ceased any of its cognitive functioning, as suggested by the remarks of Justice Scalia noted earlier.[79]

One taking the cynical view of this matter would observe that medical science has, to date, succeeded only in treating some symptoms of HIV/AIDS. Consequently, although basic physiological life is prolonged, the individuals living with AIDS will suffer more horrible fates as they struggle against more and more opportunistic infections that are given the time to attack.[80] In the earlier days of HIV/AIDS, it seemed that people usually died after a relatively short time and after being subjected to one disease, often pneumocystis carinii pneumonia.[81] Now, we can keep people alive longer, and they are subjected to more infections. As urged earlier in this Article, some people would prefer not to know that they are ill until later, when the symptoms develop to such a stage that AIDS is quite advanced and the period of suffering (especially if an individual declines treatment) is minimized.[82] Since an individual infected with HIV may look forward to several years in an asymptomatic state,[83] many people may prefer several years of

78. See the materials on the right-to-die cases and suicide *supra* notes 46-47, 50, 56-59,77 and *infra* notes 79, 83, 89-92 and accompanying text.

79. *See* Cruzan v. Director, Mo. Dep't of Health, 110 S. Ct. 2841, 2859 (1990) (Scalia, J., concurring) (quoted *supra* text accompanying note 59); *see also* Goodman, *supra* note 59. "The usefulness of self-examination for the early detection of certain common cancers, much less likely to be fatal if treated before they are very advanced, is now widely understood. Early detection of an illness thought to be inexorable and incurable cannot seem to bring any advantage." S. SONTAG, *supra* note 28, at 36.

80. *See supra* notes 57-59 and accompanying text.

81. *See* PRESIDENTIAL COMMISSION REPORT, *supra* note 2, at 200; R. JARVIS & M. CLOSEN, AIDS NUTSHELL, *supra* note 2, at 5, 19.

82. This prospect is consistent with the attitude of those individuals who would choose suicide to avoid or end their suffering from serious chronic or terminal diseases. *See supra* notes 46, 50, 56-59, 77-80 and *infra* notes 88-90, 134 and accompanying text. "[AIDS] is emerging as one of the most dreadful of human diseases. The way in which the disease recurrently savages its victims before killing them is now well known. So are the feelings of profound depression, anger, loneliness, and hopelessness so often seen in those afflicted with this miserable malady." *Caring for the Patient with AIDS*, 259 J. A.M.A. 1368 (1988); *see also* S. SONTAG, *supra* note 28, at 36.

83. *See* SURGEON GENERAL'S REPORT, *supra* note 2, at 12 (development of symptoms may take nine years); R. JARVIS & M. CLOSEN, AIDS NUTSHELL, *supra* note 2, at 22-23 ("the life span from time of infection with HIV to death due to AIDS-related infections may be twenty years").

good life without the constant torment of knowing of their sentences of death from HIV infection.

Result disclosure, early health care intervention, drug therapies, and other health care treatments do not help everyone. Some people and some communities cannot afford the high cost of these treatments.[84] For a substantial proportion of people, the toxic side effects of some drugs are intolerable.[85] Indeed, there is reason to believe that the mere knowledge that one is HIV-infected can contribute to the demise of one's mental and perhaps physical well-being.[86] These are important issues that affect people very directly and more fundamentally than any other, so we ought to allow people to choose whether to know about their HIV status.

Allowing individuals to elect in advance whether to be told of their HIV results also avoids the emotionally devastating effect of receiving the news of a seropositive result. The reasons for the substantial emotional disruption attendant to an HIV diagnosis should be obvious. A person is told that he or she is afflicted with an incurable terminal condition that people associate overwhelmingly with homosexuality and drug use — an illness often dubbed "the modern day equivalent of leprosy."[87] Consequently, just as suicide is not uncommon for people with other terminal conditions,[88] peo-

84. "In the year 1991, an estimated 145,000 patients with AIDS will need health and supportive services at a total cost of between $8 and $14 billion." SURGEON GENERAL'S REPORT, *supra* note 2, at 6; *see also*, PRESIDENTIAL COMMISSION REPORT, *supra* note 2, at 141-47 (on financing health care); *Burroughs Welcome, Lyphomed Defend Prices Against 'Excessive Cost' Charge by APHA*, 5 AIDS POL'Y & L. (BNA) No. 19, at 1 (Oct. 17, 1990); *HIV Prevalence*, *supra* note 58, at 15 (noting that minorities and intravenous drug users have a much lower level of access to drugs such as AZT).

85. *See* Cowley & Hager, *supra* note 57, at 23-24. In at least one instance, an air traffic controller with HIV declined to take AZT because the Federal Aviation Administration previously suspended without pay an air traffic controller who took AZT on the basis that the drug's side effects could impede job performance. *Air Controller Fights Removal Over Use of Anti-AIDS Drug*, N.Y. Times, Aug. 28, 1990, at A11, col. 1 [hereinafter *Anti-AIDS Drug*].

86. *See infra* note 92 and accompanying text.

87. South Fla. Blood Servs. v. Rasmussen, 467 So. 2d 798, 802 (Fla. Dist. Ct. App. 1985), *aff'd*, 500 So. 2d 533 (Fla. 1987). There have been many other comparisons of HIV/AIDS and leprosy. *See,e.g.*, D. ALTMAN, AIDS IN THE MIND OF AMERICA 21 (1983); CLOSEN, AIDS CASES, *supra* note 3, at 3-12; Comment, *Protecting the Public from AIDS: A New Challenge to Traditional Forms of Epidemic Control*, 2 J. CONTEMP. HEALTH L. & POL'Y 191, 192 (1986).

88. The suicide rate for patients with chronic renal disease undergoing dialysis is about 10 to 50 times greater than the general population; for persons with Huntington's disease, about 3 to 23 times higher; and for cancer patients, up to 4 times higher. Marzuk, *infra* note 89 at 1333; *see also* Goodman, *supra* note 59, at 8; Editorial, *AIDS and Suicide*, 259 J. A.M.A. 1369 (1988). *See generally* V. VICTOROFF, THE SUICIDAL PATIENT: RECOGNITION, INTERVENTION, MANAGEMENT (1983).

ple with HIV/AIDS are no exception. Studies report that the suicide rate for HIV-infected men between the ages of twenty to fifty-nine is about thirty-six times higher than the rate for other men of that age range and about sixty-six times higher than the suicide rate for the general population.[89] Thousands of people with HIV/AIDS have committed suicide. Others have attempted suicide and failed, occasionally with the serious disfigurement and pain that can accompany a self-inflicted injury.[90]

Even for those who do not take such a drastic step as suicide, severe depression, anxiety, and stress are commonplace.[91] Therefore, forcing people to know their HIV results will assuredly lead to stress and depression in some and to suicides and attempted suicides by others. Regrettably, some medical research also suggests that stress may itself be a factor contributing to a decline of the immune system and to the onset of symptoms of AIDS in those who are HIV-infected.[92]

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89. Marzuk, *Increased Risk of Suicide in Persons with AIDS*, 259 J. A.M.A. 1333 (1988). *But see* Perry, Jacobsberg & Fishman, *Suicidal Ideation and HIV Testing*, 263 J. A.M.A. 679 (1990); *The Risk of Suicide in Persons with AIDS*, 260 J. A.M.A. 29 (1988) (letters criticizing research of Marzuk study).

90. Some have attempted suicide and succeeded in inflicting serious injuries to themselves. *See, e.g.*, Van Straten v. Milwaukee Journal, 151 Wis. 2d 905, 447 N.W.2d 105 (Ct. App. 1989) (reporting an attempted suicide by a jail prisoner with AIDS who needed some 40 stitches and hospitalization for his injuries). In the general population, many who attempt suicide fail to kill themselves. In 1983, it was estimated that about 10 million living Americans had a history of one or more suicide attempts. And since the means used to attempt suicide include such violent instruments as guns, poisons, high voltage electricity, knives, and so forth, it can readily be imagined that considerable carnage, pain, and expense are caused. *See* V. VICTOROFF *supra* note 88, at 14, 17; *see also* DeMontiney v. Desert Manor Convalescent Center, 144 Ariz. 6, 695 P.2d 255 (1985) (en banc) (man attempted suicide, and while confined for a mental health review, hanged himself); Meier v. Ross Gen. Hosp., 69 Cal. 2d 420, 71 Cal. Rptr. 903, 445 P.2d 519 (1968) (en banc) (man attempted suicide by slashing his wrists, was hospitalized, and later killed himself by jumping head first from a second floor window); Baldwin v. Hospital Auth., 191 Ga. App. 787, 383 S.E.2d 154 (1989) (man attempted suicide twice, requiring hospitalization, and then killed his wife).

91. *See* PRESIDENTIAL COMMISSION REPORT, *supra* note 2, at 11; SURGEON GENERAL'S REPORT, *supra* note 2, at 33; Ostrow, *Psychiatric Consequences of AIDS: An Overview*, 29 INT'L J. OF NEUROSCIENCE 1 (1986); *see also* Brogdon v. State, 781 P.2d 1370 (Alaska Ct. App. 1989) (diagnosis of HIV infection due to transfusion of contaminated blood caused defendant to become extremely depressed, to drive his car at speeds in excess of 100 miles per hour, and to collide with another vehicle, seriously injuring its driver.)

92. *See, e.g.*, Antoni, Schneiderman, Fletcher, Goldstein, Ironson & Laperriere, *Psychoneuroimmunology and HIV-1*, 58 J. CONSULTATION & CLINICAL PSYCH. 38 (1990); Hassan & Douglas, *Stress-Related Neuroimmunomodulation of Monocyte-Macrophage Functions in HIV-1 Infection*, 54 CLINICAL IMMUNOLOGY & IMMUNOPATHOLOGY 220 (1990).

C. *Statutes Mandating Disclosure Are Not Rationally Related to Legitimate State Purposes*

When statutes that fall within the arena of public health and welfare legislation are challenged, they almost always are upheld because they enjoy a strong presumption of validity,[93] and because they need only be reasonably or rationally related to a legitimate public health or welfare purpose.[94] Certainly, most legislation fosters proper health and welfare goals and undertakes to achieve its ends in the least intrusive ways. Occasionally, however, a court will invalidate a health and welfare statute in which the substance of the law is not genuinely related to, or is not really appropriate to, the accomplishment of its health or welfare goal (i.e., other, less objectionable methods are just as likely to achieve the desired purpose).[95]

Legislation mandating HIV test result disclosure to the individuals tested should be challenged as violative of those general principles for several reasons. First, the legislation is haphazard. There is no attempt to be thorough and no claim that it is thorough in attempting to identify and inform people with HIV infection. Also, it is both overinclusive and underinclusive in its application to people who "should" be informed of their HIV infection. It is overinclusive because it applies to all people who are tested regardless of whether there is any particularized need for them to be informed of their HIV infection or to be counseled about the modes of transmission of HIV. The legislation is underinclusive because it does not apply to all citizens or even to all citizens with HIV, but only to those people who fortuitously are tested for HIV.

This legislation also significantly intrudes on an individual's bodily integrity because a measure that intrudes upon one's psychological or emotional state can be just as damaging as a measure that intrudes upon one's physical or physiological integrity. Less objectionable means, such as voluntary or even mandatory HIV/AIDS education programs, are readily available, and there is proof from some organized gay communities around the country that HIV/

93. *See, e.g.*, Moore v. Draper, 57 So. 2d 648 (Fla. 1952) (tuberculosis statute); Kirk v. Wyman, 83 S.C. 372, 65 S.E. 387 (1909) (leprosy regulations).

94. *Moore*, 57 So. 2d at 48; *Kirk*, 83 S.C. at 372, 65 S.E. at 387; *see also* People v. Strautz, 386 Ill. 360, 54 N.E.2d 441 (1944) (syphilis statute).

95. *See, e.g.*, Wong Wai v. Williamson, 103 F. 1 (C.C.N.D. Cal. 1900) (plague regulations); *see also* New York State Ass'n for Retarded Children v. Carey, 612 F.2d 644 (2d Cir. 1979) (school board's plan regarding children with hepatitis B); Hershberg v. City of Barbourville, 142 Ky. 60, 133 S.W. 985 (1911) (city ordinance that would have banned the smoking of cigarettes even in the smoker's own home).

AIDS education is an effective way to curb transmission of the disease.[96]

Finally, this author cannot resist another brief attack upon mandatory HIV testing in general, for mandatory testing is a predicate for mandatory test result disclosure in most statutes. There is substantial evidence that leaks in the security system for HIV test results will develop and that people will be severely impacted by these breaches of confidentiality.[97] When names or other identification data are associated with HIV test results, some of that information is going to leak out because it is too juicy, and too morbid, for human nature to allow it to be kept completely secret. After all, the real world is awfully small. Thus, news of "Robert's" or "Roberta's" HIV results may well become known and may lead to significant, and usually unwarranted, discrimination. Robert or Roberta may lose a job, a pension, a health insurance plan, a life insurance policy, a place to live, and so on. An individual may be subjected to personal ridicule, rejection, and hostility. The individual may suffer fear, shame, loneliness, depression, and anger. There would be far fewer risks of abuses in a system of predominantly voluntary, anonymous testing. Voluntary and anonymous testing is available for people who want to know their HIV results. Those people are more likely to be impressed by a positive test result than those who do not seek out testing voluntarily, but are mandatorily tested and informed that they are seropositive. We should let individuals decide for themselves whether they wish to be tested and whether they wish to know their results.

IV. MANDATED COUNSELING

Statutes about counseling of individuals who are tested for HIV vary quite substantially from state to state. Most commonly, these statutes require "counseling," "appropriate counseling," or "pretest" and "posttest" counseling.[98] Rarely, however, do the statutes define these terms or describe the intended scope of such

96. *See* R. JARVIS & M. CLOSEN, AIDS NUTSHELL, *supra* note 2, at 26; *AIDS Diagnoses*, *supra* note 70, at 4 (reporting a 185% increase in AIDS cases among non-intravenous-drug-using heterosexuals from 1986 to 1989, while the percentage of cases among homosexuals declined); Cowley & Hager, *supra* note 57, at 26 (graph showing significant reduction in new infections among gay men).

97. *See generally* Comment, *supra* note 4.

98. *See, e.g.*, ILL. REV. STAT. ch. 111 1/2, para. 7305 (physician is required to provide test subject with "information about the meaning of the test results" when an HIV test is ordered) (1989); *Id.* para. 7307(b),(c) ("appropriate counseling" defined); MINN. STAT. ANN. § 144.763 (West Supp. 1991) ("pretest" and "posttest" counseling); MONT. CODE ANN. §§ 50-16-1003(11),(12), -1007(2),(5) (1989); N.H. REV. STAT. ANN. § 141-

counseling.[99] Often, the statutes mandate counselling opportunities only for individuals who test seropositive.[100] Indeed, with some regularity, the terms of the statutes seriously diminish the extent of, or opportunity for, personal or individualized counseling. For instance, some laws refer merely to an opportunity for "consultation";[101] some permit referral to other agencies for counseling services instead of providing for counseling at the time of disclosure of test results;[102] in other cases, the presentation of a printed brochure is the only "counseling" provided;[103] other statutes either make counseling entirely discretionary with the agency

F:7(II) (1988) ("appropriate counseling"); N.C. GEN. STAT. § 130A-148(g) (1989) ("appropriate counseling"); R.I. GEN. LAWS § 23-6-11(7)(vi) (1989) ("counseling").

99. *See supra* note 98. Some laws mention quite briefly an outline of subjects to be included within such counseling. *See, e.g.*, DEL. CODE ANN. tit. 16, § 1202(e) (1988) (referring to counseling "for coping with the emotional consequences of learning the result, for understanding the interpretation of the test result, for understanding measures for preventing infection to others and to urge the voluntary notification of sexual and needle-sharing partners of the risk of infection"); FLA. STAT. ANN. § 381.609(3)(c),(e) (West 1990) (identifying the topics of the meaning of test results, possible need for additional testing, prevention of HIV transmission, availability of health care and mental health care services, and locating of third parties who may have been exposed to HIV by the test subject); N.M. STAT. ANN. § 24-2B-4 (1989) (listing similar topics to those in statutes cited above); N.Y. PUB. HEALTH LAW § 2781(2)-(3),(5) (Consol. 1990) (comprehensive list of topics to be included in pretest and post-est counseling); OHIO REV. CODE ANN. § 3701.24.2(A), (C) (Anderson Supp. 1989) (comparable listing of subjects); TEX. REV. CIV. STAT. ANN. art. 4419b-4, § 1.02(7)-(8) (Vernon 1990) (mentioning topics comparable to those listed above); VA. CODE ANN. § 32.1-37.2(B) (Supp. 1990) (comparable listing); WASH. REV. CODE ANN. § 70.24.320(1)-(2) (1988) (same); W. VA. CODE § 16-3C-2(b) (Supp. 1990) (same). *See also* GA. CODE ANN. § 31-22-9.1(a)(6) (1989) (counseling "may include all or part" of five specific topics listed).

100. *See, e.g.*, ILL. REV. STAT. ch. 111 1/2, para. 7307(b) (1989); MD. HEALTH-GEN. CODE ANN. § 18-334(c)(2) (1990) (providing that a donor of semen, blood, or tissue who tests positive is to be informed of the availability of counseling); N.M. STAT. ANN. § 24-2B-4 (Supp. 1989); TEX. REV. CIV. STAT. ANN. art. 4419b-4, § 1.02(8) (Vernon 1990) (requiring posttest counseling following positive HIV test).

101. *See, e.g.*, MO. ANN. STAT. § 191.653(3) (Vernon Supp. 1991) (no description of what is meant by "consultation").

102. *See, e.g.*, N.Y. PUB. HEALTH LAW § 2781(5) (Consol. 1990) (at the time of result disclosure, allows for immediate counseling or referral for counseling); W. VA. CODE § 16-3C-2(d) (Supp. 1990) (same); *see also* R.I. GEN. LAWS § 23-6-11(7)(vi) (1989) (provides that counseling must be offered, not that it must actually be given or accepted).

103. *See, e.g.*, GA. CODE ANN. § 31-22-9.11(a)(6) (1989) (permits counseling to be done by brochure or document, along with referral to human resources department); OHIO REV. CODE ANN. § 3701.24.2(A)(1),(A)(3),(C) (Anderson Supp. 1989) (allowing pretest and posttest counseling to be done either orally or in writing); W. VA. CODE § 16-3C-2(b),(d) (Supp. 1990) (providing that pretest counseling is to be done by printed booklet and that post test counseling or referral can be done by brochure or personally); *see also* MD. HEALTH-GEN. CODE ANN. § 18-336(e) (1990) (providing that the principal post test counseling is to be done by printed brochure); MONT. CODE ANN. § 50-16-1003(11)- (12) (1989) (providing that pretest counseling is to be done by way of written materials and that posttest counseling is to include written materials); WASH. REV. CODE

that administers the HIV testing or include no provisions at all about counseling people tested for HIV.[104] Of course, virtually no law includes penalties or sanctions for agents or agencies that fail to carry out the statutorily mandated counseling.[105]

Although the counseling provisions of these statutes undoubtedly were proposed and adopted primarily out of humanitarian motives, the brevity of these provisions stand as shallow and pathetic attempts at purposeful legislation. They seem like afterthoughts quickly inserted to make the statutes more palatable to some legislators.

These provisions raise many questions without answering them. For example, who is to undertake the counseling? After all, a health care professional, knowledgeable about infectious disease and HIV/AIDS, generally is far more capable than a nonprofessional of conveying accurate and worthwhile information and suggesting prudent health care advice. A health care professional is better able to field questions from frightened and emotional HIV test result recipients than an untrained appointee to the post of HIV counselor. Moreover, a health care professional's approach generally is more caring and compassionate than that of a nonprofessional governmental or institutional bureaucrat.[106]

Additional unanswered questions include: What is to be the substance of the counseling? What topics are to be addressed? What guidance or recommendations are to be included? How much time should be devoted to the counseling? Should counsel-

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ANN. § 70.24.325(2)(a) (1988) (providing that pretest counseling for insurance applicants is to be done by written information).

104. *See, e.g.*, ARK. STAT. ANN. §§ 16-82-101, 20-15-901 to -904, (Supp. 1989); KY. REV. STAT. ANN. § 214.400 to .990 (Michie/Bobbs-Merrill Supp. 1988); N.J. STAT. ANN. § 2-26:5c-5 to -14 (West Supp. 1990); S.C. CODE ANN. § 44-29-20 (Law. Co-op. 1989).

105. The general remedies or penalties sections of these statutes may or may not encompass failure or insufficiency of counseling. *See, e.g.*, VA. CODE ANN. § 32.1-38 (Supp. 1990); *see also* statutes cited *infra* notes 125-28 and accompanying text. *But see* OKLA. STAT. ANN. tit. 63, § 1-502.3(C)-(D) (West 1990) (remedies specifically for disclosure of confidential information or ineffective counseling); TEX. REV. CIV. STAT. ANN. art. 4419b-4, § 4.01(c)-(d) (Vernon 1990) (providing for actual damages or $1000, whichever is greater, for intentional violation of the HIV counseling section).

106. See the illustrations of careless, inaccurate, or malicious handling of information or diagnoses about HIV/AIDS by government agents such as police officials, prison administrators, military personnel, and others, *infra* notes 111-13 and accompanying text. For examples of statutes that do not identify who shall perform the counseling function, see DEL. CODE ANN. tit. 16, § 1202(e) (1988); FLA. STAT. ANN. § 381.609(3)(c),(e) (West 1990); MINN. STAT. ANN. § 144.763 (West 1990). *But see* MONT. CODE ANN. § 50-15-1007(4) (1989) (providing that the test subject is to be informed of the test result by a health care provider designated by the subject).

ing consist of a single session or multiple visits?[107] Will the counseling include both pretest and posttest sessions, as recommended by the Presidential Commission on the Human Immunodeficiency Virus Epidemic and other authorities?[108] Should anyone besides the tested individual be asked to attend (and with or without the approval of the person tested)?[109] The statutes seldom answer any of these questions.

The costs associated with testing also raise questions. For example, how much would an effective HIV counseling program cost to develop and administer each year? Who will pay that cost—government or the individuals counseled? Clearly, many individuals cannot afford extensive counseling or would be unwilling to expend the funds to pay for counseling. Therefore, government would have to support the counseling program, and it would be a very expensive undertaking.[110]

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107. No statute addresses the length of time to be devoted to the counseling. *See, e.g.*, DEL. CODE ANN. tit. 16, § 1202(e) (1988); FLA. STAT. ANN. § 381.609(3)(c),(e) (West 1990); MINN. STAT. ANN. § 144.763 (West 1990); *see also* CAL. HEALTH & SAFETY CODE § 1632(b)(3) (1990) (providing that the state will reimburse counties for "[s]hort-term information and referral sessions, of no more than one visit per person tested [for HIV] for the purpose of transmitting the person's test results").

108. PRESIDENTIAL COMMISSION REPORT, *supra* note 2, at 73-74. Some statutes do refer to both pretest and posttest counseling. *See, e.g.*, FLA. STAT. ANN. § 381.609(3)(c),(e) (West 1990); MINN. STAT. ANN. § 144.763 (West 1990).

109. Some statutes provide that notification of test results and perhaps even counseling are to be provided to third parties. *See, e.g.*, ARK. STAT. ANN. § 16-82-101(c) (Supp. 1989) (victim of sex offense may be told of test subject's HIV result and referred for appropriate counseling, although there is no provision requiring or allowing disclosure to test subject); LA. REV. STAT. ANN. § 40:1099(B)(1) (West 1990) (requiring a doctor to notify hospital or nursing home upon the admission of a patient known to be HIV-infected); MD. HEALTH-GEN. CODE ANN. § 18-337(b),(d) (1990) (describing circumstances under which a health care provider may inform sexual and needle-sharing partners of a test subject's identity and positive test result, and referral services available to such third parties); *Id.* § 18-338(f) (in case of possible exposure of correctional employee to HIV from prisoner, prisoner can be tested, and if test result is positive, both prisoner and employee are to receive appropriate counseling); MO. ANN. STAT. § 191.656(b),(d),(f), .689 (Vernon Supp. 1991) (allowing identification of HIV-infected students to superintendent of schools and other persons, and allowing disclosure of a test subject's HIV results to a spouse, parents, or legal guardian of a minor test subject, and to health care personnel); N.H. REV. STAT. ANN. § 141-F:7(III) (1988) (notification and counseling for parent or legal guardian of minor or mentally incompetent person who is seropositive); OHIO REV. CODE ANN. § 3701.24.3(B)(1)(a),(g),(B)(2) (Anderson Supp. 1989) (providing that the identity of the test subject and test results may be disclosed to the subject's legal guardian, spouse, sexual partners, and certain others); OR. REV. STAT. ANN. §§ 433.075(5), .080 (Supp. 1990) (allowing disclosure of test results to individual who may have been accidentally exposed to HIV by test subject, but no provision for counseling such individual); VA. CODE ANN. § 32.1-36.1(A)(10),(11) (1990) (allowing release of HIV results to parents of a minor test subject and to spouse of test subject).

110. PRESIDENTIAL COMMISSION REPORT, *supra* note 2, at 74 (indicating funding problems for current testing and counseling programs); *see also* ARK. STAT. ANN. § 20-

In the absence of effective counseling, episodes of callous handling of the news of HIV/AIDS diagnoses have been all too common. For instance, military officers and prison officials have sometimes delivered the message in demeaning and damning fashion.[111] Employers and co-workers have occasionally spread the sensitive and highly personal news of an employee's HIV/AIDS to other workers, customers, and the community.[112] Even doctors and other health care professionals have, once in a while, displayed indifference or malice in communicating the news of HIV/AIDS to their patients and others.[113] Typical of these anecdotal accounts is

15-901(a) (Supp. 1989) (providing for statewide free testing, but without reference to any counseling for test subjects).

111. This should not come as a surprise, because the U. S. military has openly and systematically discriminated against homosexuals more than any other employer in the last 50 years. *See* Comment, *Homosexuals in the Military: They Would Rather Fight Than Switch*, 18 J. MARSHALL L. REV. 937, 939-40 (1985). See also the account of the "harsh and cursory manner" in which one military recruit was informed and counseled in Closen, *Testing Democracy*, *supra* note 4, at 909. Military personnel who test seropositive and are removed from military service are sometimes given less than honorable discharges, and the reason for their discharges may be expressly noted on their records (with the possible consequence of creating future complications). *Id.* at 909-10; *see also* Van Straten v. Milwaukee Journal, 151 Wis. 2d 905, 447 N.W.2d 105 (Ct. App. 1989) (sheriff informed newspaper reporters that prisoner had AIDS); *Soldier Tested for AIDS Hangs Self at Walter Reed*, 7 OFFICIAL NEWSLETTER NAT'L COALITION GAY STD SERVICES 47 (1986) (reporting case of soldier who committed suicide after fellow soldiers were informed of his positive test result).

112. *See, e.g.*, Aviles v. United States, 696 F. Supp. 217 (E.D. La. 1988) (former serviceman with Coast Guard alleged that other service members disseminated news of his positive HIV results); Cronan v. New England Tel. & Tel. Co., 41 Fair Empl. Prac. Cas. (BNA) 1273 (Mass. Super. Ct. 1986) (regarding unauthorized disclosure of employee's AIDS-related medical condition); McCune v. Neitzel, 235 Neb. 754, 457 N.W. 2d 803 (1990) (successful defamation action by plaintiff about whom another person had spread the erroneous news that plaintiff had AIDS); *see also* Comment, *supra* note 4 (noting the risk of unauthorized access to patients' HIV/AIDS medical records).

113. *See, e.g.*, Doe v. Baptist Hosp., No. 88-3459 (Tenn. Ch. Dec. 22, 1988), *discussed in* 3 LAMBDA LEGAL DEF. & EDUC. FUND, AIDS UPDATE No. 5, at 11 (1989); *In re* Westchester County Medical Center, No. 88-2642 (N.Y. State Dep't of Health Dec. 9, 1988), *discussed in* 3 LAMBDA LEGAL DEF. & EDUC. FUND, AIDS UPDATE No. 5, at 3 (1989); *Hospital Sued Over Release of Patient's Test Results*, 4 AIDS POL'Y & L. (BNA) No. 6, at 9 (Apr. 5, 1989); *Missouri Physician Is Charged With Revealing Patient Status*, 5 AIDS POL'Y & L. (BNA) No. 19, at 4 (Oct. 17, 1990); *see also Antibody Positive Boy Flees Abusive Peers*, 7 OFFICIAL NEWSLETTER NAT. COALITION GAY STD SERVS. 44 (1986) (school officials learned of "confidential" blood test results); Comment, *supra* note 4 (noting the risk of unauthorized access to patients' HIV/AIDS medical records); Hilts, *Many Hospitals Found to Ignore Rights of Patients in AIDS Testing*, N.Y. Times, Feb. 17, 1990, at A1, col. 1. In addition, some health care professionals have refused to treat patients with HIV/AIDS. *See, e.g.*, Hurwitz v. New York City Comm'n on Human Rights, 142 Misc. 2d 214, 535 N.Y.S.2d 1007 (Sup. Ct. 1988) (dentist refused to treat patient with AIDS); Barton v. New York City Comm'n on Human Rights, 140 Misc. 2d 554, 531 N.Y.S.2d 979 (Sup. Ct. 1988) (sublessor-dentist would not allow sublessee-dentist to care for patients with AIDS). A Florida dentist with AIDS may have disregarded

the brevity of the only "counseling" that these people receive where they test positive for HIV.

The key point on the subject of counseling is that a *person* has tested seropositive. That *person* is deserving of thorough and compassionate counseling to minimize the psychological suffering incidental to disclosure of a terminal diagnosis. We should not require that individuals be informed of their results, but if we must do so, we must provide greater assurance that effective counseling will accompany disclosure, thereby preserving human dignity and ensuring individual privacy.[114]

V. Implications For Tort and Criminal Law

Another important set of reasons to abandon mandatory HIV disclosure and counseling provisions involves the serious implications that those statutes have on tort and criminal law.

If one knows or has constructive knowledge that he or she is HIV-infected and proceeds to engage in risk activity,[115] that person should be regarded as having committed not only an intentional tort but also a crime. This conclusion is warranted both under general law and under HIV/AIDS-specific legislation now in place in many jurisdictions.[116]

Although a full review of HIV/AIDS-specific criminal statutes is beyond the scope of this Article,[117] this author cannot resist the opportunity to opine that most of those laws are fatally flawed due to their vagueness and overbreadth.[118] Nevertheless, ambitious

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the risk of transmission to his patients by continuing to treat some 1700 people after he had contracted HIV. *See Woman with AIDS, supra* note 31; *see also* Closen, *Call for HIV Testing, supra* note 12.

114. *See* PRESIDENTIAL COMMISSION REPORT, *supra* note 2, at 11, 73-74, 119-20, 126-27.

115. "Risk activity" includes engaging in unprotected sexual intercourse, sharing of nonsterile intravenous drug syringes, or donating blood, semen, or body organs.

116. *See, e.g.*, ILL. REV. STAT. ch. 38, para. 12-16.2 (1989); statutes cited *infra* note 20; *see also* Closen, *HIV Transmission, supra* note 66; Closen & Isaacman, *Criminally Pregnant: Are AIDS-Transmission Laws Encouraging Abortion?*, A.B.A. J., Dec. 1990, at 76 [hereinafter Closen, *Criminally Pregnant*]; *Increasing Number of States Now Have Laws on AIDS Assault Cases*, Chicago Daily L. Bull., Oct. 23, 1990, at 2, col. 3 (reporting that "22 states have passed laws making it illegal to engage in conduct that could transmit . . . HIV").

117. For a detailed discussion of HIV/AIDS-specific criminal laws, see Isaacman, *Are We Outlawing Motherhood for HIV-Infected Women?*, 22 LOY. U. CHI. L.J. 479 (1991); *see also* Comment, *Combatting AIDS's Acoustic Shadow: Illinois Addresses the Problem of Criminal Transfer of AIDS*, 22 LOY. U. CHI. L.J. — (1991).

118. *See* Closen, *HIV Transmission, supra* note 66; Closen, *Criminally Pregnant, supra* note 116.

prosecutors are beginning to indict people under those laws,[119] and whether found innocent or guilty those people will be injured substantially. Even for those who are not actually prosecuted but are HIV-infected, the fear of possible prosecution and the personal guilt associated with feeling like a criminal may be present.

On the other hand, if an HIV-infected person does not know that he or she is infected, our law and our society have not gone so far as to impose tort or criminal liability for that person's participation in risk activity.[120] As noted earlier, we do not demand that people determine their own HIV status, and as will be noted later, the law does not insist that people exercise diligence in questioning their sexual or needle-sharing partners to reduce the risk of HIV transmission.[121] Therefore, statutes requiring disclosure of positive HIV results have the effect of expanding the number of people who may be subjected to tort or criminal liability. Again, an accidental subset of the citizenry is informed of their HIV infection and saddled with the risk of criminal prosecution. Since most of the general public is not really exposed to possible liability for HIV transmission under either tort or criminal law, including HIV/AIDS-specific statutes, it seems inappropriate to cast substantial numbers of others involuntarily into this legal quagmire. We should educate people to avoid HIV transmission, not test them and require them to know their test results.

After all, life in these days of HIV/AIDS is complex and diffi-

119. *See* Closen, *HIV Transmission*, *supra* note 66.

120. The statutes on criminal transmission of HIV almost always require that the offender must have known of his or her condition in order to have committed the offense. *See* Closen, *HIV Transmission*, *supra* note 66; *see also, e.g.*, ILL. REV. STAT. ch. 38, para. 12-16.2 (1989); S.C. CODE ANN. § 44-29-145 (Law. Co-op. 1989). Some civil statutes now require that individuals who know they have HIV inform certain others. *See, e.g.*, ARK. STAT. ANN. § 20-15-903 (Supp. 1989) (requires person found to have HIV to advise his or her doctor or dentist prior to receiving health care services, and makes failure to do so a Class A misdemeanor); MO. ANN. STAT. § 191.656(5) (Vernon Supp. 1991) (test subject who is HIV-positive required to inform health care professionals before receiving services); OHIO CODE ANN. § 3701.24.3(E) (Anderson Supp. 1989) (person who knows that he or she has tested positive for HIV must inform future sexual and needle-sharing partners).

121. This is the case in both the tort and the criminal arenas. In tort cases involving transmission of STDs, the failure to inquire into the health of one's sexual partners has not denied plaintiffs their entitlement to recoveries due to the defenses of assumption of risk or contributory negligence. *See* Closen, *Duty to Notify*, *supra* note 4, at 298 (citing cases). HIV criminal statutes do not require that the "victims" must have inquired into the health conditions of their sexual partners or must have employed or attempted to employ safe sex or safer sex practices. *See, e.g.*, ILL. REV. STAT. ch. 38, para. 12-16.2 (1989). Rather, the statutes establish as a defense the consent to exposure to one who is known to be infected with HIV.

cult enough already. People at risk for HIV/AIDS and those with HIV/AIDS must endure significant stress and possibly a wide array of other undesirable emotions.[122] In addition, as already noted, those individuals may suffer significant unwarranted discrimination due to the hysteria of many people toward HIV/AIDS.[123] Should we contribute further to this unfortunate situation by making these individuals feel like, and sometimes become, criminals? Why should we not instead demand that the potential "victims" of such torts and crimes refrain altogether from risk activity or engage in safer practices? They can and should avoid becoming "victims."[124]

AIDS-specific statutes that mandate counseling may open another whole range of problems involving allegations of failure to counsel or properly counsel persons who are HIV-infected. For example, the Illinois AIDS Confidentiality Act[125] requires "appropriate counseling" of certain persons who test HIV positive.[126] It also provides a right of action and recovery for violations of the statute as follows:

> (1) Against any person who negligently violates a provision of this Act or the regulations promulgated hereunder, liquidated damages of $1000 or actual damages, whichever is greater.
> (2) Against any person who intentionally or recklessly violates a provision of this Act or the regulations promulgated hereunder, liquidated damages of $5000 or actual damages, whichever is greater.
> (3) Reasonable attorney fees.
> (4) Such other relief, including an injunction, as the court may deem appropriate.[127]

A few other states have adopted similar provisions.[128] The Illinois

122. *See* PRESIDENTIAL COMMISSION REPORT, *supra* note 2, at 11; SURGEON GENERAL'S REPORT, *supra* note 2, at 33; Closen, *Testing Democracy*, *supra* note 4, at 837-45.

123. *See generally* PRESIDENTIAL COMMISSION REPORT, *supra* note 2, at 119-26; Closen, *Testing Democracy*, *supra* note 4; Closen, *Workplace AIDS*, *supra* note 4.

124. *See* SURGEON GENERAL'S REPORT, *supra* note 2, at 33; Closen, *HIV Transmission*, *supra* note 66, at 6.

125. ILL. REV. STAT. ch. 111 1/2, paras. 7301-7316 (1989).

126. *Id.* para. 7307(b),(c) ("appropriate counseling" is required, but not defined). *But see id.* para. 7305 (physician required to "mak[e] available . . . information about the meaning of the test results").

127. *Id.* para. 7313.

128. *See, e.g.*, KAN. STAT. ANN. § 65-6005 (1989) (violation of AIDS statute or regulations is a class C misdemeanor); MONT. CODE ANN. § 50-16-1013 (1989) (providing for a right of action for violation of the statute; actual damages or $1,000 for a negligent violation; actual damages or $5,000 for an intentional or reckless violation; attorney fees; and other relief, such as an injunction); N.J. STAT. ANN. § 26.5C-14 (West 1990) (viola-

law makes actionable the failure to advise an individual of a positive HIV result, the failure to counsel the individual regarding the HIV test result, and the failure to provide adequate or appropriate counseling. Those failures, of course, also are actionable under the HIV testing and mandatory disclosure statutes, although those laws do not contain provisions for liquidated damages and attorney fees.

The inclusion of liquidated damages and reasonable attorney fees provides considerable incentive to pursue cases, including test cases, to determine the meaning and reach of the statute.[129] Lawyers and clients will far more willingly litigate cases in which statutory violations have occurred, but in which actual damages did not result or would be difficult to prove. A plaintiff who can prove a technical violation of the statute will receive the liquidated sum, and the lawyer will be paid the reasonable value (probably at approximately his or her customary hourly rate)[130] of the services rendered.

Moreover, one easily can imagine cases in which substantial actual damages are sustained. Perhaps an individual who tests HIV positive and is not counseled properly will attempt suicide and incur significant physical injuries, pain, emotional distress, and medical expenses.[131] That individual will have an action for a

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tion of statute may allow recovery of actual damages, equitable relief, court costs, attorney fees, and punitive damages for wantonly reckless or intentionally malicious violation); N.D. CENT. CODE § 23-07.5-07 (1989) (violation of statute causes civil liability for actual damages, costs, and exemplary damages); *id.* § 23-07.5-08 (intentional, unauthorized disclosure of HIV results is a class C felony); *cf.* IOWA CODE ANN. § 141.24(1) (West 1990) (states merely that there shall be a "right of action for damages" for violation of the statute).

129. For an analogy to the issue of access to public education for children with HIV/AIDS, see Child v. Spillane, 866 F.2d 691 (4th Cir. 1989) (involving entitlement to attorney fees under the federal Rehabilitation Act of 1973). Some HIV/AIDS confidentiality statutes also provide for recovery of costs or provide that violations amount to criminal offenses punishable by appropriate fine, imprisonment or both. Comment, *supra* note 4, at 107.

130. *See* Closen & Tobin, *The Contingent Contingency Fee Arrangement: Compensation of the Contingency Fee Attorney Discharged by the Client*, 76 ILL. B.J. 916, 918-20 (1987).

131. *See supra* notes 87-92 and accompanying text. A counselor's unauthorized disclosure of a test subject's HIV results disclosure could constitute negligence by contributing to an attempted suicide. *See, e.g.*, Weatherly v. State, 109 Misc. 2d 1024, 441 N.Y.S.2d 319 (Ct. Cl. 1981) (negligence of professionals at psychiatric center contributed to attempted suicide of patient); *cf.* Watts v. Cumberland County Hosp. Sys., 75 N.C. App. 1, 11, 330 S.E.2d 242, 250 (1985), *rev'd in part*, 317 N.C. 321, 345 S.E.2d 201 (1986) (malpractice claim in which marital-family counselor made unauthorized disclosures of patients' confidences). That an HIV counselor might violate the confidential relationship with a test subject is not difficult to imagine in light of allegations, for instance, of breach

significant monetary judgment. Perhaps the attempt at suicide will succeed. The immediate family may assert a claim for quite a large recovery.[132] The defendants in these instances will be the people who were supposed to disclose the test results and perform the counseling and, through the doctrine of vicarious liability, their institutions, such as hospitals and medical and mental health clinics.[133]

Admittedly, there will be some problems proving that a defendant administered no counseling or inadequate counseling, or proving the causal link between the lack of adequate counseling and the suicide or attempted suicide. However, the law is now replete with plaintiffs in other settings who have asserted successfully causes of action for suicides or attempted suicides.[134] Although inadequate

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of the confidential relationship between pastor and parishioner. *See* Erickson v. Christenson, 99 Or. App. 104, 781 P.2d 383 (1989) (pastor allegedly took sexual advantage of a young parishioner). In the wake of scandals in organized religion, the stock market, federal government, and even the judiciary, the cover of Time magazine lamented: "What Ever Happened to Ethics—Assaulted by Sleaze, Scandals and Hypocrisy, America Searches for its Moral Bearings." TIME, May 25, 1987, cover.

132. *See supra* note 131 and cases cited *infra* notes 133-36; *see also* Annotation, *Liability of Hospital, Other Than Mental Institution, for Suicide of Patient*, 60 A.L.R.3D 880 The author does not intend to suggest that all suicides of those with HIV/AIDS are inappropriate and to be discouraged. Indeed, I join Professor Rhonda Rivera in the view that "suicide can be a rational act" in the HIV/AIDS context. Rivera, *Lawyers, Clients, and AIDS: Some Notes from the Trenches*, 49 OHIO ST. L.J. 883, 899-900 (1989).

133. *See generally* Reed, *Expanding Theories of Hospital Liability: A Review*, 21 J. HEALTH & HOSP. L. 217 (1988); Ring & McGuire, *Apparent Agency: Another Weapon in Suits Against Hospitals*, TRIAL, May 1988, at 16; *see also* Lucy Webb Hayes Nat'l Training School for Deaconesses and Missionaries v. Perotti, 419 F.2d 704 (D.C. Cir. 1969) (court indicated jury could find hospital negligent for failing to prevent patient's suicide, but remanded case due to error in jury instructions); Meier v. Ross Gen. Hosp., 69 Cal. 2d 420, 71 Cal. Rptr. 903, 445 P.2d 519 (1968) (en banc) (jury could have found hospital and physician liable for failing to prevent patient's suicide; new trial ordered); Annotation, *supra* note 132.

134. *See, e.g.*, cases cited *supra* notes 131, 133; *see also* DeMontiney v. Desert Manor Convalescent Center, 144 Ariz. 6, 695 P.2d 255 (1985) (en banc) (parent sued doctor, private health care center, and county for failing to prevent suicide of son after an earlier suicide attempt). Some attempts to sue institutions, doctors, and others for causing or contributing to a suicide are unsuccessful. *See, e.g.*, Rudy v. Meshorer, 146 Ariz. 467, 706 P.2d 1234 (1985); Nally v. Grace Community Church, 47 Cal. 3d 278, 253 Cal. Rptr. 97, 763 P.2d 948 (1988) (action against church and church counselors by parents whose son committed suicide); Kobeck v. Nabisco, Inc., 166 Ga. App. 652, 305 S.E.2d 183 (1983) (widow sued employer for contributing to suicide of husband caused in part by employer's release of wife's absenteeism record); Appling v. Jones, 115 Ga. App. 301, 154 S.E.2d 406 (1967) (mother sued driver who collided with her son's car, thereby allegedly contributing to his suicide some two hours later). There have been at least three unsuccessful suits against attorneys for contributing to suicides by their clients. *See* Snyder v. Baumecker, 708 F. Supp. 1451 (D.N.J. 1989); McLaughlin v. Sullivan, 123 N.H. 335, 461 A.2d 123 (1983); McPeake v. Cannon, 381 Pa. Super. 227, 553 A.2d 439 (1989); *see also*, Boruschewitz v. Kirts, 197 Ill. App. 3d 619, 554 N.E.2d 1112 (1990) (suit against psychi-

counselling will be difficult to prove, courts undoubtedly can identify a legal standard, and plaintiffs undoubtedly will be able to prove a breach of that standard.[135] Personal injury lawyers are quite capable of presenting cases of professional malpractice.[136] Thus, malpractice by HIV counselors may be the next subject of test litigation.

The possibility also exists that an individual who is not informed of his or her positive HIV result and who receives no counseling or inadequate counseling will engage in risk activity and will transmit the virus to a third party. Can the third party pursue, and prevail upon, an action against the person and institution that failed to inform or to counsel the HIV- infected individual? Successful causes of action have been brought in similar instances for contributing to the transmission of diseases, including sexually transmitted diseases.[137] Doctors have been held accountable for failing to warn others of the contagious or dangerous condition of their patients.[138] The paramour of a married person has been held liable

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atrist and mental clinic for allowing patient's mental condition to deteriorate to point where she killed two people); Baldwin v. Hospital Auth., 191 Ga. App. 787, 383 S.E.2d 154 (1989) (child sued doctor and hospitals for failing to prevent father from killing child's mother after father's second suicide attempt).

135. In law, "inappropriate or inadequate counseling" translates to the notion that the counseling did not meet the standard of reasonable accuracy and thoroughness in the HIV counseling community. *Cf.* Destefano v. Grabrian, 763 P.2d 275, 285-86 (Colo. 1988) (discussing and rejecting professional negligence claim for clergy malpractice). Proof of the malpractice will not be so difficult if the nature of the malpractice is the unauthorized disclosure of a test subject's HIV results. *See* Watts v. Cumberland County Hosp. Sys., 75 N.C. App. 1, 330 S.E.2d 242 (1985), *rev'd in part*, 317 N.C. 321, 345 S.E.2d 201 (1986) (marital-family counselor made unauthorized disclosure of patient confidences).

136. *See* Barker & Wilkinson, *Clergy Malpractice: Cloaked by the Cloth?*, TRIAL, May 1990, at 36; Annotation, *supra* note 132. The estate of an 82-year-old man, who left instructions that he not to be resuscitated, has filed a case for wrongful life because the hospital staff used electrodes to revive him. He suffered a stroke, was paralyzed, and spent almost all of his savings on medical care before he died. *First 'Wrongful Life' Suit Filed by Patient*, TRIAL, June 1990, at 83; *see also, e.g.*, Destefano v. Grabrian, 763 P.2d 275, 285-86 (Colo. 1988) (discussing and rejecting recent trend of plaintiffs to assert claims of clergy malpractice); Boruschewitz v. Kirts, 197 Ill. App. 3d 619, 554 N.E. 2d 1112 (1990) (action against psychiatrist and clinic for allowing patient's mental condition to deteriorate to point where she killed two people); Watts v. Cumberland County Hosp. Sys., 75 N.C. App. 1, 330 S.E.2d 242 (1985), *rev'd in part*, 317 N.C. 321, 345 S.E.2d 201 (1986) (allowing action for marital-family counselor malpractice for unauthorized disclosure of patient confidences and negligent counseling); Erickson v. Christenson, 99 Or. App. 104, 781 P.2d 383 (1989) (allowing action for negligence of pastor for violation of a confidential relationship due to his sexual involvement with a young parishioner); cases cited *supra* note 134.

137. *See generally* Closen, *Duty to Notify*, *supra* note 4 (citing cases).

138. *Id.* at 296-97; *see also* Boruschewitz v. Kirts, 197 Ill. App. 3d 619, 554 N.E.2d 1112 (1990) (husband sued psychiatrist and mental clinic for recovery of legal fees ex-

for transmitting a sexually transmitted disease not only to the married lover, but also to the lover's spouse.[139]

Third party "victims" will argue that if the infected individual had been advised of the infection and had been counseled about the modes of transmission, he or she either would have refrained from engaging in risk activity with the third party or would have disclosed his or her HIV status to the third party prior to engaging in risk activity.[140] Third parties may have considerably more reason to sue the people and institutions who failed to inform or counsel about HIV than the individuals who actually transmitted the virus to them. Members of the former group (often doctors and hospitals) usually have much deeper pockets than the members of the latter group (who are typically ordinary people without huge sums of money and who are dying of HIV/AIDS).[141] Furthermore, based upon analogy to other personal injury actions for transmission of sexually transmitted diseases, the law generally does not bar recovery on the theory that the plaintiff assumed the risk of infection.[142] However, courts, in awarding or reducing damages, undoubtedly will take into account the fact that the plaintiff engaged in sexual activity without inquiring about the HIV/AIDS condition of the other party and without using any barrier precautions.[143] It appears that third parties will have a cause of action under the statutes that require positive HIV test result disclosure and counseling for the infected individual when that disclosure or counseling is faulty.

VI. CONCLUSION

The issues addressed here are serious concerns. Every positive test result involves a person's life, and only the most compelling justifications should result in legislative diminution of an individual's rights of personal choice, liberty, and privacy, or as Judge Thomas Cooley first put it, "the right . . . to be left alone."[144]

Indeed, if the predictions of scientific and medical researchers

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pended to defend the criminal case against his wife, a mental clinic outpatient, on theory the doctor and clinic allowed her mental condition to deteriorate to the point where she killed two people).

139. Mussivand v. David, 45 Ohio St. 3d 314, 544 N.E.2d 265 (1989).

140. *See generally* Closen, *Duty to Notify*, *supra* note 4.

141. *Id.*

142. *Id.* at 298.

143. *Id.*

144. T. COOLEY, LAW OF TORTS 29 (2d ed. 1888). Cooley's remark often has been repeated. *See, e.g.*, Union Pacific Ry. v. Botsford, 141 U.S. 250, 251 (1890); Prosser, *Privacy*, 48 CAL. L. REV. 383, 389 (1960).

are even remotely accurate, some 1.5 to 2 million Americans are HIV-infected.[145] Hence, a significant number of citizens who are subjected to involuntary HIV testing will test positive and will be required to learn their test results. For many, these are serous concerns.

Is mandatory HIV test result disclosure to tested individuals constitutional? More importantly, is that a relevant and worthwhile inquiry? Actually, this author thinks it is not. The important question is whether such a statute constitutes good public policy, not whether it satisfies the quite minimal standard necessary to pass constitutional muster.[146] These statutes are not good public policy.

For the host of reasons set forth above, the statutes that mandate disclosure of HIV results to those who test positive and that require counseling of those persons should be amended or repealed. If amended, they should present individuals with a choice in advance of whether to be informed of their HIV results and should describe in much greater detail the appropriate counseling to be provided one who tests HIV seropositive.

If not amended, these statutes on testing, disclosure, and counseling ought to be repealed. They infringe upon individual autonomy, liberty, and privacy. They may contribute to suicides and other conduct inconsistent with public health goals. They may not in fact encourage the kinds of positive behavior modification hoped for by their advocates. They will most assuredly complicate the tort and criminal law contexts of the HIV/AIDS epidemic. If a public policy balancing test were applied, the disadvantages and dangers associated with these statutes as presently written would far outweigh their anticipated benefits.

145. PRESIDENTIAL COMMISSION REPORT, *supra* note 2, at xvii (noting estimates that 1 to 1.5 million Americans are HIV-infected); SURGEON GENERAL'S REPORT, *supra* note 2, at 12 (estimating that 1.5 million Americans are infected with HIV); R. JARVIS & M. CLOSEN, AIDS NUTSHELL, *supra* note 2, at 23-24 (up to 2 million Americans may be infected); *see also Publicly Funded HIV Counseling and Testing—United States, 1985-1989*, 263 J. A.M.A. 1901 (1990). About 74,000 people died of AIDS through June 1989. Between 390,000 and 480,000 new cases will develop between 1989 and 1993, resulting in 285,000 to 340,000 deaths. About 1 million Americans are now infected with HIV, and an additional 41,000 will become infected each year. *HIV Prevalence*, *supra* note 58, at 1, 12, 22.

146. *See* cases cited *supra* notes 93-95 and accompanying text.