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ADVOCATING FOR A CHANGE IN THE MASSACHUSETTS HIV STATUTE: PUTTING AN END TO PHYSICIAN UNCERTAINTY

I. INTRODUCTION

Historically there have been many conflicts between individual rights and the state's interest in protecting public health.¹ Such conflicts determine whether personal liberties outweigh the need to safeguard public health.² As we gauge this war amongst ourselves, one thing must not be forgotten - individual privacy is paramount but human life is sacred.

Human Immunodeficiency Virus (HIV), the virus known to cause Acquired Immune Deficiency Syndrome (AIDS), has perpetuated this conflict, spawning more lawsuits than any other disease.³ As is common with any new area of law, the issues are not yet settled, as a result, jurisdictions differ substantially in their application of the legal principles. Currently, the medical and legal duties confronting physicians who treat HIV-infected patients are inconsistent among the jurisdictions and, in some areas, inconsistent with established law.⁴ In almost all states, a physician is required to report cases of communicable

¹ See, e.g., *Whalen v. Roe*, 429 U.S. 589, 602, 97 S. Ct. 869, 878 (1976) (favoring public safety concerns over policy of confidentiality); *Tarasoff v. Regents of Univ. of Cal.*, 118 Cal. Rptr. 129, 137, 529 P.2d 553, 561 (1974) (finding disclosure to state health officials not an impermissible invasion of privacy per se); *Simonsen v. Swenson*, 104 Neb. 224, 225, 177 N.W. 831, 832 (1920) (finding no common law physician-patient privilege to protect disclosure).

² See cases cited *supra* note 1.

³ Francis & Chin, *The Prevention of Acquired Immunodeficiency Syndrome in the United States: An Objective Strategy for Medicine, Public Health, Business and the Community*, 257 JAMA 1357, 1357 (1987); *Human Immunodeficiency Virus Infection in the United States*, 36 MORBIDITY & MORTALITY WKLY REP. 801, 801 (1987). HIV was previously referred to as the human T-cell lymphotropic virus type III/lymphadenopathy associated virus (HTLV-III/LAV). Francis & Chin, *supra*, at 1357.

⁴ See, e.g., CAL. [HEALTH & SAFETY] CODE § 121015 (West 1996) (authorizing disclosure to spouse of patient, needle sharing contacts, and known sexual partners); COLO. REV. STAT. § 25-4-1402 (1989 Replacement Vol. & Supp. 1995) (requiring physician to report HIV status); TEX. [HEALTH & SAFETY] CODE ANN. § 81.041 (West 1992) (listing HIV as a reportable disease).

diseases to public health officials.⁵ In the context of HIV, however, which is not only contagious but fatal, physicians are prohibited from doing so.⁶

The duty of confidentiality imposed upon health care providers conflicts with the duty to warn. Since 1986, Massachusetts has statutorily prohibited physicians from disclosing a patient's HIV status without first obtaining the patient's written informed consent.⁷ Despite this mandate of confidentiality, a 1985 case decided by the Supreme Judicial Court (SJC), *Alberts v. Devine*,⁸ imposed upon physicians a duty to warn in situations where their patient poses a serious danger to third parties.⁹ This leaves physicians facing a no-win situation. On one hand, they face potential liability to the patient for unauthorized disclosure of confidential information. On the other hand, they face potential liability to the endangered third party for not disclosing the diagnosis. Massachusetts law should be restructured to provide physicians with a definite legal course of action.

This article advocates retaining the duty to warn in a limited context and thus proposes that more needs to be done to protect the public health. It outlines the changes in the law which are not only justified, but are essential to moderate the rate of HIV infections which have left a trail of human tragedy in their wake. A narrowly tailored response directed at protecting society from an incurable, fatal disease, while shielding the patient to the extent possible and protecting physicians from uncertain liability, is appropriate.

II. HISTORY

A. The Physician-Patient Privilege and the Duty of Confidentiality

Unauthorized disclosure of a patient's test results or other medical records is now prohibited by statute in most states.¹⁰ This is frequently referred to as the

⁵ See, e.g., FLA. STAT. ANN. § 381.0031 (West 1993) (requiring medical professionals to report confirmed or suspected cases of infectious disease); N.J. STAT. ANN. § 26:4-15 (West 1986 & Supp. 1988) (requiring listed communicable diseases to be reported within 12 hours to state health department); TEX. [HEALTH & SAFETY] CODE ANN. § 81.041 (West 1992) (including HIV and AIDS as reportable diseases).

⁶ See MASS. GEN. L. ch. 111, § 70F (1994) (requiring informed consent for both testing and disclosure).

⁷ *Id.*

⁸ 395 Mass. 59, 479 N.E.2d 113 (1985).

⁹ *Id.* at 75, 479 N.E.2d at 124.

¹⁰ See, e.g., CAL. [HEALTH & SAFETY] CODE § 121015 (West Supp. 1996) (prohibiting HIV disclosures without following stated procedure for disclosure and selected notification); IDAHO CODE § 39-610 (1988) (promulgating procedures for collecting and disclosing confidential public health records); KY. REV. STAT. ANN. §214-420(2)

physician-patient privilege, violation of which provides for a remedy sounding in tort.¹¹ This privilege, however, is not recognized at common law.¹² The physician-patient privilege is a statutory response to the need for patients to fully disclose to their physician all information needed for appropriate treatment.¹³ Although there is no such statutory privilege in Massachusetts, the courts of the Commonwealth acknowledge that patients have a legitimate interest in having their communications with their physicians, as well as their medical records, withheld from public scrutiny.¹⁴ The American Medical Association supports the duty of confidentiality which has been an ethical constraint in the medical profession for many years as evidenced by the physician's Hippocratic Oath.¹⁵

(Michie/Bobbs-Merrill 1986) (limiting access to sexually-transmitted disease records).

¹¹ *Alberts*, 395 Mass. at 69, 479 N.E.2d at 120. There are at least five states which do not recognize the physician-patient privilege: Florida, Illinois, Maryland, Massachusetts, and Rhode Island. Dina Khajezadeh, *Patient Confidentiality Statutes in Medicare & Medicaid Fraud Investigations*, 13 AM. J. L. & MED. 105, 114 n.56 (1987).

¹² 8 J. WIGMORE, EVIDENCE § 2380, nn.3, 5, & 6, §§ 2388-2391 (McNaughton rev. ed. 1961).

¹³ *Cf. Alberts*, 395 Mass. at 66, 479 N.E.2d at 118 (emphasizing the importance of complete disclosure by patients). The justifications for the states' enactment of a physician-patient privilege have been to promote public health and ensure the individual's statutory right to privacy. Khajezadeh, *supra* note 11, at 114-15.

¹⁴ *See Bratt v. International Business Machs. Corp.*, 392 Mass. 508, 522-23, 467 N.E.2d 126, 136-37 (1984) (recognizing confidentiality as an essential component of the physician-patient relationship). Massachusetts does recognize the psychotherapist-patient privilege as codified by Massachusetts General Laws, chapter 233, section 20B. *See Alberts*, 395 Mass. at 67-68, 479 N.E.2d at 119 (discussing confidentiality of medical facts).

¹⁵ *See Bernard Friedland, HIV Confidentiality and the Right to Warn - The Health Care Providers Dilemma*, 80 MASS. L. REV. 3, 4 (1995) (discussing ethical considerations in confidentiality). The AMA has expressed that physicians "shall respect the rights of patients . . . and shall safeguard patient confidences within the constraints of the law." *Id.* (citing American Medical Association, *Principles of Medical Ethics IV* (rev. ed. 1981)). A former president of the AMA stated, however, with respect to HIV, "the physician has a responsibility to inform the spouse. This is more than an option. This is a professional responsibility." *Id.* (citation omitted).

One version of the Hippocratic Oath states "[w]hat I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself holding such things shameful to be spoken about." *Id.* at 3 (citation omitted). There are many versions of the Hippocratic Oath taken by physicians. *Id.* The different versions are a result of various translations from the original Greek oath. *Id.* at 3-4 n.4.

Courts acknowledge that the duty of confidentiality is not absolute.¹⁶ The benefits of a strict confidentiality policy are weighed against the states' interest in protecting public health.¹⁷ Disclosure is allowed when strict confidentiality prevents the furtherance of the "supervening interest of society."¹⁸ The physician therefore possesses a qualified privilege to disclose otherwise confidential information when necessary to prevent the spread of disease.¹⁹

In Massachusetts, however, there exists a specific mandate of confidentiality with respect to HIV test results.²⁰ This statute, enacted in 1986, provides that a physician may not test any person for HIV nor disclose the results of such test to any person other than the patient without first obtaining the patient's written informed consent.²¹ It further provides that whoever violates this section is subject to a private cause of action.²²

In opposition to the statute, Massachusetts case law authorizes a physician to warn third parties to whom their patient presents a "serious danger."²³ *Alberts* was the first Massachusetts case to enunciate the requirement of a physician warning, as well as the first reported time the SJC expressly adopted the physician-patient privilege.²⁴ The court held that a duty of confidentiality did arise from the relationship, violation of which gives rise to a cause of action against the physician absent a serious danger to the patient or others.²⁵ The court, however, failed to assert what constitutes a "serious danger."

¹⁶ See, e.g., *Whalen v. Roe*, 429 U.S. 589, 602, 97 S. Ct. 869, 878 (1976) (noting disclosure is not automatically an impermissible invasion of privacy); *Horne v. Patton*, 291 Ala. 701, 706, 287 So. 2d 824, 827 (1973) (stating patient enjoys only a limited right); *Berry v. Moench*, 8 Utah 2d 191, 196, 331 P.2d 814, 817 (1958) (holding one may have conditional privilege to reveal confidential information).

¹⁷ *Hague v. Williams*, 37 N.J. 328, 336, 181 A.2d 345, 349 (1962).

¹⁸ *Id.*

¹⁹ See *Simonsen v. Swenson*, 104 Neb. 224, 225, 177 N.W. 831, 832 (1920) (holding that there is no common law physician-patient privilege to prevent disclosure).

²⁰ MASS. GEN. L. ch. 111, § 70F (1994).

²¹ *Id.*

²² *Id.*

²³ *Alberts v. Devine*, 395 Mass. 59, 75, 479 N.E.2d 113, 124 (1985).

²⁴ *Id.* at 75, 479 N.E.2d at 124. The *Alberts* decision is the first time the SJC acknowledged that a physician's disclosure of confidential information without the patient's consent gives rise to a civil cause of action. *Id.* at 65, 479 N.E.2d at 118.

²⁵ *Id.* at 75, 479 N.E.2d at 124.

B. The Duty to Warn

Case law in several states requires physicians to warn third parties who are endangered by their patients even if it means breaching their duty of confidentiality.²⁶ The common law, however, does not require that a person warn one who is endangered by a third person's conduct.²⁷ The principal case concerning the duty to warn is *Tarasoff v. Regents of University of California*²⁸ in which the Supreme Court of California held that "a doctor . . . treating a physical illness, bears a duty to use reasonable care to give threatened persons such warnings as are essential to avert foreseeable danger arising from his patient's condition or treatment."²⁹ The court noted that the interest in safeguarding confidential information must be weighed against the public's interest in safety. It concluded that the policy favoring confidentiality must

²⁶ See, e.g., *Horne v. Patton*, 291 Ala. 701, 706, 287 So. 2d 824, 831 (1973) (finding disclosure of patient information to employer constituted invasion of privacy); *Simonsen v. Swenson*, 104 Neb. 224, 225, 177 N.W. 831, 832 (1920) (finding no common law privilege); *Alberts*, 395 Mass. at 75, 479 N.E.2d at 124 (holding that physician owes duty of confidentiality "absent . . . a serious danger . . . to others").

²⁷ See *Lipari v. Sears, Roebuck & Co.*, 497 F. Supp. 185, 188 (D. Neb. 1980) (adopting the Restatement approach to find a sufficient basis for a psychotherapist duty to warn); *Tarasoff v. Regents of Univ. of Cal.*, 118 Cal. Rptr. 129, 133, 529 P.2d 553, 557 (1974) (restating common law rule and noting those exceptions that impose a duty to warn). The *Tarasoff* court adopted the Restatement (Second) of Torts §315 as an exception to the common law rule. *Tarasoff*, 118 Cal. Rptr. at 133, 529 P.2d at 557. According to the Restatement, a person is required to control a third person's conduct, or warn those endangered by it if: (1) he has a special relationship with the third person or with the person who is endangered, or (2) he can reasonably foresee the danger. See *id.* (citing Restatement 2d Torts §§ 315-20); accord *Lipari*, 497 F. Supp. at 191 (adopting Restatement §315 as special exception); see also J. David Butts, Ph. D., *HIV/AIDS-Related Information and the Rule of Confidentiality: Can We Accept Exceptions?*, 40 MED. TRIAL TECH. Q. 1, 29 (1994) (noting the special relationship exception).

²⁸ 118 Cal. Rptr. 129, 529 P.2d 553 (1974).

²⁹ *Id.* at 135, 529 P.2d at 559. In *Tarasoff*, a patient communicated to his therapist his intention to kill a person whom the therapist identified as the girl the patient was infatuated with (the victim). *Id.* at 132, 529 P.2d at 556. The patient was subsequently released from the university hospital, where the therapist was employed, and proceeded to murder the victim. *Id.* The victim's parents brought suit against the therapist for negligent failure to warn. *Id.* The court held the therapist liable notwithstanding the lack of a special relationship with the victim. *Tarasoff*, 118 Cal. Rptr. at 131, 529 P.2d at 555. The court noted that "[w]hen a doctor or a psychotherapist, in the exercise of his professional skill and knowledge, determines, or should determine, that a warning is essential to avert danger arising from the medical or psychological condition of his patient, he incurs a legal obligation to give that warning." *Id.*

succumb to a policy of disclosure when necessary to prevent danger to others.³⁰

In *Simonsen v. Swenson*,³¹ the Nebraska Supreme Court justified disclosure, stating, "[n]o patient can expect, that, if his malady is found to be of a dangerously contagious nature, he can still require it to be kept secret from those to whom, if there was no disclosure, such disease would be transmitted."³² Massachusetts has already adopted the *Tarasoff* rationale in part.³³ Courts following *Tarasoff* would admittedly acknowledge a duty to warn known individuals who have had sexual contacts with an infected patient of the possibility of transmission.³⁴

Several courts have adopted the *Tarasoff* duty to warn in some form.³⁵ For example, in *Lipari v. Sears, Roebuck & Co.*,³⁶ the United States District Court for the District of Nebraska held that the therapist-patient relationship "gives rise to an affirmative duty for the benefit of third persons."³⁷ This duty, the court explained, mandates the physician to protect potential third party victims from the patient and arises when the physician is aware, or should be aware, of the risk of harm to others.³⁸ Following the principle enunciated in *Tarasoff*, the SJC held that a physician owes a duty not to disclose confidential medical information without the patient's consent *except* to meet a serious danger to the patient or others.³⁹

³⁰ *Id.* at 137, 529 P.2d at 560.

³¹ 104 Neb. 224, 177 N.W. 831 (1920).

³² *Id.* at 225, 177 N.W. at 832.

³³ *Alberts v. Devine*, 395 Mass. 59, 67-68, 479 N.E.2d 113, 119 (1985). The Supreme Judicial Court adopted the *Tarasoff* rationale by creating an exception to the physician's duty of confidentiality which is applicable when their patient poses a serious harm to themselves or others. *Id.* This was the basis for liability in the *Tarasoff* decision. See *Tarasoff*, 118 Cal. Rptr. at 135, 529 P.2d at 559 (imposing duty to warn of foreseeable dangers).

³⁴ Joseph D. Piorkowski, Jr., *Between a Rock and a Hard Place: AIDS and the Conflicting Physician's Duties of Preventing Disease Transmission and Safeguarding Confidentiality*, 76 GEO. L.J. 169, 182 (1987).

³⁵ See, e.g., *Alberts*, 395 Mass. at 69, 479 N.E.2d at 120 (mandating physician to disclose information when required to "meet a serious danger to the patient or to others"); *McIntosh v. Milano*, 168 N.J. Super. 466, 489, 403 A.2d 500, 511 (1979) (holding psychiatrist has duty to warn third parties when possibility of danger presented by patient); *MacDonald v. Clinger*, 446 N.Y.S.2d 801, 805, 84 A.D.2d 482, 487 (1982) (requiring physician to disclose when patient presents danger to others).

³⁶ 497 F. Supp. 185 (D. Neb. 1980).

³⁷ *Id.* at 193.

³⁸ *Id.*

³⁹ *Alberts v. Devine*, 395 Mass. 59, 75, 479 N.E.2d 113, 124 (1985).

With respect to HIV, jurisdictions are not in conformity concerning the duty to warn. Some states mandate that physicians report the patient's HIV status to public health authorities or persons known to be at risk, thus imposing a "duty to protect."⁴⁰ Other states have *authorized* disclosure when necessary to prevent foreseeable danger, thus merely recognizing an exception to the duty of confidentiality.⁴¹ Still others prohibit disclosure altogether.⁴² All states, however, mandate the reporting of AIDS, as well as all other communicable diseases, to public health officials.⁴³

Consistent with the policy justifications, a duty to warn is systematically imposed on physicians in cases involving communicable diseases. As a general rule, physicians are obligated to warn others of exposure to communicable and infectious diseases. To protect public health and curtail the spread of disease, most states enacted statutes requiring physicians to report all such diseases to local health officials.⁴⁴ The physician is placed in a position where it becomes his duty to exercise ordinary care to protect others from injury or danger, and is liable for failure to do so.⁴⁵ Thus, a physician who treats a patient for a communicable disease is under a duty to warn those who, by reason of family ties or otherwise, are reasonably likely to come into contact with the patient. This duty has been consistently upheld by state courts and affirmed by the United States Supreme Court, which concluded that disclosure is an essential part of modern medicine and neither deprives the patient of a constitutional right

⁴⁰ See COLO. REV. STAT. § 25-4-1402 (1989 Replacement Vol. & Supp. 1995) (requiring any attendant physician to report known cases within 24 hours).

⁴¹ See CAL. [HEALTH & SAFETY] CODE § 121015(b) (West 1996) (permitting disclosure to partners after attempt to get consent from patient fails).

⁴² See MASS. GEN. L. ch. 111, § 70F (1994) (requiring consent before any disclosure).

⁴³ See, e.g., MASS. REGS. CODE TIT. 105, § 300.140 (1987) (listing diseases reportable to public health department); N.C. GEN. STAT. §§ 130A - 135 (1987) (mandating reporting of communicable diseases by physicians); O.R. REV. STAT. § 433.045 (1988) (prohibiting disclosure except as per rules); see also Donald H. J. Hermann & Rosalind D. Gagliano, *AIDS, Therapeutic Confidentiality, and Warning Third Parties*, 48 MD. L. REV. 55, 56 (1989) (stating that legislation in every state mandates the reporting of AIDS).

⁴⁴ See, e.g., FLA. STAT. ANN. § 381.0031 (West 1993) (mandating reporting of diseases of "public health significance"); MASS. REGS. CODE TIT. 105, § 300.140 (1987) (requiring disclosure to public health department); TEX. HEALTH & SAFETY CODE ANN. § 81.041 (West 1992) (specifying HIV and AIDS as reportable diseases).

⁴⁵ See Michael L. Closen & Scott H. Isaacman, *The Duty to Notify Private Third Parties of the Risks of HIV Infection*, 21 J. HEALTH & HOSP. L. 295, 297 (1988) (discussing liability in the wake of *Tarasoff*).

nor violates the patient's privacy.⁴⁶

To date, no court has specifically ruled on the existence, or non-existence, physician's duty to warn third parties of the risk of exposure to HIV. Recently, however, the Supreme Court of Alaska in *Chizmar v. Mackie*⁴⁷ held that "when a physician diagnoses a patient with a fatal, sexually transmitted disease such as AIDS, the physician's disclosure of this diagnosis to the patient's spouse is privileged as a matter of law."⁴⁸

Consistent with the policies supporting the duty to warn, many states have implemented contact tracing.⁴⁹ Contact tracing is a system of notification designed to prevent further transmission of communicable diseases by alerting those who have been exposed to an infected person.⁵⁰ It is used in conjunction with reporting procedures and is carried out by public health officials.⁵¹ Practiced in the United States since the 1930's, contact tracing continues as a form of medical surveillance and public health protection in several states.⁵²

C. The Statutory Right to Privacy

There is yet another barrier which may prevent physicians from warning persons at risk of contracting HIV from their patients. A physician who discloses a patient's test results without his express consent may be held liable for an invasion of the patient's privacy.⁵³ The Massachusetts "privacy statute"

⁴⁶ See, e.g., *Davis v. Rodman*, 147 Ark. 385, 227 S.W. 612 (1921) (holding failure to warn nurses and attendants that patient had typhoid fever was negligent); *Skillings v. Allen*, 143 Minn. 323, 173 N.W. 663 (1919) (finding that failure to warn of infectious nature of scarlet fever was not negligent); *Jones v. Stanko*, 118 Ohio St. 147, 160 N.E. 456 (1928) (holding physician treating patient with small pox has duty to notify those in dangerous proximity to patient). The *Davis* court specified that physicians have a duty to warn "regardless of the rules and regulations of the State Board of Health." *Davis*, 147 Ark. at 387, 27 S.W. at 614; see also *Whalen v. Roe*, 429 U.S. 589, 602, 97 S. Ct. 869, 878 (1976) (requiring reporting "even when the disclosure may reflect unfavorably on the character of the patient").

⁴⁷ 896 P.2d 196 (Alaska 1995).

⁴⁸ *Id.* at 208.

⁴⁹ Karen H. Rothenberg, *The AIDS Project: Creating a Public Health Policy - Rights and Obligations of Health Care Workers*, 48 MD. L. REV. 93, 180-82 (1989).

⁵⁰ *Id.* at 180.

⁵¹ *Id.* at 181.

⁵² *Id.* at 180-81.

⁵³ See, e.g., *Horne v. Patton*, 291 Ala. 701, 709, 287 So. 2d 824, 830 (1973) (recognizing action for invasion of privacy rights by unwarranted publication by physician); *Barber v. Time*, 348 Mo. 1199, 1207-08, 159 S.W.2d 291, 295 (1942) (holding right to privacy includes right to have information given to a physician kept confidential); *Doe v.*

states that "[a] person shall have a right against unreasonable, substantial or serious interference with his privacy."⁵⁴ The SJC interprets this statute as "proscrib[ing] the required disclosure of facts about an individual that are of a highly personal or intimate nature when there exists no legitimate countervailing interest."⁵⁵ Whether preserving public health in the face of the AIDS epidemic constitutes a "legitimate countervailing interest" is an issue on which this article advocates for an affirmative response.

An individual's right to privacy accedes to the maintenance of public health.⁵⁶ Thus, the state has a "fundamental right to enact laws which promote public health, welfare and safety, even though such laws may invade the [individual's] right of privacy."⁵⁷ Following this basic tenet, the United States Supreme Court held that although the constitutional right to privacy encompasses a patient's interest in preserving the confidentiality of personal information, this right is not absolute.⁵⁸

III. ANALYSIS AND ARGUMENT

Massachusetts law currently mandates disclosure of AIDS and other sexually transmitted diseases to the Department of Public Health within twenty four hours after diagnosis. Yet the law concurrently prohibits disclosure of HIV, the virus which causes AIDS.⁵⁹ There seems to be no justification for this contradiction. The policy behind the reporting statutes is to protect public health by preventing the spread of disease.⁶⁰ The Commonwealth can limit

Roe, 400 N.Y.S.2d 668, 676, 93 A.D.2d 201, 213 (1977) (approving cause of action for invasion of patient's privacy rights).

⁵⁴ MASS. GEN. L. ch. 214, § 1B (1995). Prior to the enactment of this statute, Massachusetts courts did not recognize a common law action for invasion of privacy. *Cefalu v. Globe Newspaper Co.*, 8 Mass. App. Ct. 71, 77, 391 N.E.2d 935, 939 (1979).

⁵⁵ *Bratt v. International Business Machs. Corp.*, 392 Mass. 508, 518, 467 N.E.2d 126, 133-34 (1984); *see also* *Tower v. Hirschhorn*, 397 Mass. 581, 588, 492 N.E.2d 728, 733 (1986) (holding defendant liable for unreasonable interference of privacy).

⁵⁶ *See Kathleen K. v. Robert B.*, 198 Cal. Rptr. 273, 276, 150 Cal. App. 3d 992, 996 (1985) (noting right to privacy not absolute). The *Kathleen* court cited examples of such laws where the state's fundamental right to protect its citizens outweighs the right of privacy. *Id.* The examples given included penal laws concerning forcible and consensual sex acts, registration of convicted sex offenders, and paternity laws. *Id.*

⁵⁷ *Id.*

⁵⁸ *Whalen v. Roe*, 429 U.S. 589, 602 (1976).

⁵⁹ MASS. REGS. CODE tit. 105, § 300.140 (1987); MASS. GEN. L. ch. 111, § 70F (1994).

⁶⁰ *Rothenberg, supra* note 49, at 175.

transmission of HIV from the start, by including HIV in the list of reportable diseases, rather than waiting until a diagnosis of AIDS, by which time the disease has most likely spread.

Unnecessary transmission to even one innocent person is simply unjustified when the means to prevent it are within reach. Continuing to focus on AIDS, as opposed to HIV, is ineffectual.⁶¹ Additionally, the duty of confidentiality enunciated in the HIV statute conflicts with the duty to warn imposed by the *Alberts* decision. The need for clear standards is indisputable. State law must provide consistency and relieve physicians of the anguishing decision between liability to the patient or to the person infected by the patient. Commentators have noted that "[t]oo much in the law itself compels, justifies, and excuses disclosure"⁶² Mandated reporting in certain situations and limited contact tracing are ways to achieve such imperative objectives.

Reporting statutes are held to be constitutional and not violative of any duty owed by the physician.⁶³ Imposing a legal requirement to report HIV seropositivity to public health officials appears constitutional under the doctrine articulated by the United States Supreme Court in *Whalen v. Roe*,⁶⁴ provided that "(1) the information were reasonably related to a valid public health purpose; (2) the information were limited to public health departments; and (3) there were adequate statutory confidentiality protections in place."⁶⁵ Adding HIV to the list of reportable diseases is consistent with the purposes of existing reporting procedures to protect public health by preventing further transmission of a dangerous, communicable disease.⁶⁶ It is also consistent with

⁶¹ Closen & Isaacman, *supra* note 45, at 298.

⁶² Bernard M. Dickens, *Legal Limits of AIDS Confidentiality*, 259 JAMA 3449, 3451 (1988).

⁶³ *Whalen*, 429 U.S. 589, 603-04, 87 S. Ct. 877 (1976).

⁶⁴ 429 U.S. 589, 97 S. Ct. 869 (1976).

⁶⁵ Dickens, *supra* note 62, at 3451. In *Whalen*, the Supreme Court of the United States addressed the conflict between the government's interest in public health and the individual's interest in privacy. *Whalen*, 429 U.S. at 598-604, 97 S. Ct. at 875-79. It held that a New York statute that required physicians who prescribe schedule II drugs, which include opium, cocaine, methadone, and amphetamines, to send a copy of the prescription containing the patient's name, address, and age, to the state health department did not violate constitutionally protected rights of privacy. *Id.* at 603-04, 97 S. Ct. at 879. Under the minimum rationality test applied by the Court, collection of HIV information by state health departments would be permissible because the state has a reasonable public health interest in tracking and collecting information about the disease. *Id.* at 602, 97 S. Ct. at 878.

⁶⁶ See Hermann & Gagliano, *supra* note 43, at 71 (citing the potential for transmission as the principal argument in favor of reporting).

Massachusetts case law in that the SJC has stipulated that physicians must warn third parties who face a "serious danger" posed by their patients.⁶⁷ There can be no question that HIV constitutes a serious harm because it is a fatal disease for which there is no known cure.

Contact tracing used in conjunction with the reporting procedure for HIV best facilitates the protection of identifiable victims. Adopting a system similar to those in Texas, Colorado, or California, for example, would authorize physicians and/or public health officials to notify the patient's spouse or known sexual partner of the risk of infection.⁶⁸ This policy would restrict notification to those persons readily identifiable as required by the *Tarasoff* holding and subsequent cases.⁶⁹ It would also help stifle the rapid transmission rate among spouses.⁷⁰ The duty to notify should be strictly limited to the public health department because it has traditionally been the authority for disease prevention.⁷¹ The physician's primary responsibility and ultimate loyalty is, and should remain, to the patient. Physicians are not trained counselors and cannot reasonably be expected to shoulder the responsibility of contact notification. Public health officials are far better equipped to handle notification with discretion and expertise.⁷²

Contact tracing is not without its detractors. Some authorities contend that contact tracing violates the duty of confidentiality owed by the physician to the patient.⁷³ It is held, however, that such a system does not force physicians to breach any duty owed to the patient because the duty of confidentiality is not absolute and information may be disclosed "to such persons as is necessary to prevent the spread of the disease."⁷⁴ Further, the above argument is not

⁶⁷ *Alberts v. Devine*, 395 Mass. 59, 75, 479 N.E.2d 113, 124.

⁶⁸ See CAL. [HEALTH & SAFETY] CODE § 121015 (West 1996) (authorizing disclosure to spouse of patient, needle sharing contacts, and known sexual partners); COLO. REV. STAT. § 25-4-1402 (1989 Replacement Vol. & Supp. 1995) (requiring physician to report HIV status); TEX. [HEALTH & SAFETY] CODE ANN. § 81.041 (West 1992) (listing HIV as a reportable disease).

⁶⁹ *Tarasoff v. Regents of Univ. of Cal.*, 118 Cal. Rptr. 129, 135, 529 P.2d 553, 559 (1974); see also *Mavroudis v. Superior Court*, 162 Cal. Rptr. 724, 730, 102 Cal. App. 3d 594, 600 (1980) (finding duty owed only to readily identifiable third parties).

⁷⁰ See *Piorkowski*, *supra* note 34, at 173 (noting 12 of 14 spouses who had regular sexual relations with their HIV-infected spouse, who used condoms intermittently or not at all, contracted the disease) (citations omitted).

⁷¹ *Rothenberg*, *supra* note 49, at 181.

⁷² *Rothenberg*, *supra* note 49, at 181.

⁷³ *Rothenberg*, *supra* note 49, at 181.

⁷⁴ *Simonsen v. Swenson*, 104 Neb. 224, 225, 177 N.W. 831, 832 (1920).

compelling when we consider existing laws which require the reporting of other communicable diseases such as genital herpes which, like HIV, is sexually transmittable, incurable and has a long latency period.⁷⁵

The Commonwealth has a legitimate interest in protecting the health of its citizens.⁷⁶ The policies behind reporting statutes and contact tracing programs reflect this fundamental goal of preserving public health. Massachusetts, as well as other states, should further this interest by modifying the existing statute to mandate physicians to report HIV status to the department of public health. In turn, the department of public health should implement a limited contact tracing program notifying specific individuals, known to be at risk of infection.⁷⁷ To achieve the dual goals of safeguarding public health and protecting the patient's confidentiality to the extent possible, the contact is notified of exposure, offered testing and counseling, but the name of the patient is not disclosed.

Another argument in opposition to the reporting of HIV and associated contact tracing programs is that these programs deter some individuals from being tested and seeking medical treatment, thus defeating the state's legitimate interest in controlling the transmission of the disease.⁷⁸ While this is certainly a possibility, the advantages to such programs far outweigh the possible deterrent effect. HIV reporting allows the government to trace the epidemiology of the disease and provides a mechanism for follow-up behavior modification and research. More importantly, reporting and contact tracing serve to notify spouses, and other known contacts, effectively saving lives. Notification is especially important in cases where the spouse is pregnant. With treatments available to prevent prenatal transmission, the possibility of saving a newborn substantially outweighs the possibility of a slight drop in the number of individuals tested.⁷⁹

⁷⁵ William Sundbeck, *It Takes Two to Tango: Rethinking Negligence Liability for the Sexual Transmission of Aids*, 5 HEALTH MATRIX 397, 407 (1995).

⁷⁶ Butts, *supra* note 27, at 20.

⁷⁷ See Rothenberg, *supra* note 49, at 181. A contact tracing program would also include the notification of spouses of HIV infected persons as already undertaken in California. CAL. [HEALTH & SAFETY] CODE § 121015 (West 1996).

⁷⁸ See Rothenberg, *supra* note 49, at 181 (discussing contact tracing as a viable method of preserving confidentiality while controlling transmission).

⁷⁹ The relative number of cases of HIV among children has been steadily increasing. KURT J. ISSELBACHER ET. AL., HARRISON'S PRINCIPLES OF INTERNAL MEDICINE at 1572 (13th ed. 1994). By June 1, 1993, 4615 children in the United States under the age of thirteen were infected with HIV and greater than fifty percent have died. *Id.* Ninety four percent of the pediatric cases were attributed to perinatal transmission. BERNARD N. FIELDS ET. AL., FIELD'S VIROLOGY 1966 (3d ed. 1996). This is simply too grave a risk to take when given the alternative of relinquishing a small portion of an individual's privacy. There are

Other authorities claim that HIV infection commands special protection due to the stigma and societal discrimination which may result from disclosure.⁸⁰ Again, this argument simply does not warrant a policy that undermines public health concerns nor justifies a physician's failure to warn. *Tarasoff* teaches us that the moderately inconsequential discrimination suffered by an infected patient must be weighed against the grave risk that an uninfected person will become infected.⁸¹ Although a person suffering at the hands of AIDS discrimination may bring an action to redress the harm done, the now infected person faces certain death for which no legal action can compensate.⁸² The American Medical Association lent support to this argument by stating that it is "of critical importance" that "individuals who are not infected with the AIDS virus must have every opportunity to avoid transmission of the disease to them."⁸³

Although some worthy arguments have been advanced in opposition to reporting and tracing procedures, they are substantially outweighed by the exacting harm which results from the absence of such procedures. The mortal fate awaiting unsuspecting spouses and their unborn children cannot be justified by a policy calculated to preserve the confidentiality and privacy of the individual who is infected. The focus must be on the sanctity of human life.

IV. PRACTITIONER'S NOTES

The legal responses to the HIV virus are causing permutations of traditional legal policies. They are extremely controversial and far reaching in their implications. Although these responses are sharply divided by jurisdiction, there are a number of actions available. Massachusetts practitioners should be aware of the possible defenses which may be raised when confronted with a charge that a physician violated the HIV or privacy statute, breached the duty of confidentiality, or failed to warn a third party.⁸⁴ Although the legislature did not

a number of treatments that exist, the most prevalent being administration of AZT, which significantly reduce the transmission of the virus to newborns. *Id.* at 1966.

⁸⁰ Piorkowski, *supra* note 34, at 183.

⁸¹ Piorkowski, *supra* note 34, at 183.

⁸² Piorkowski, *supra* note 34, at 183.

⁸³ Butts, *supra* note 27, at 25 (citations omitted).

⁸⁴ See, e.g., Butts, *supra* note 27, at 35 (illustrating common law doctrine of necessity); Friedland, *supra* note 15, at 7-20 (explaining common law defenses available); Judy E. Zelin, Annotation, *Physician's Tort Liability For Unauthorized Disclosure of Confidential Information About Patient*, 48 A.L.R. 4th 668, 703-13 (1995) (citing the available defenses to a charge of violating practitioner duties).

specifically incorporate defenses to a statutory violation of the HIV and privacy statutes, the weight of authority suggests that common law defenses continue to apply.⁸⁵

A. The HIV Statute

The HIV statute expressly provides for a private cause of action.⁸⁶ To date, however, the SJC has not addressed the scope of the statute's protection.⁸⁷ In *Attorney General v. Bodimetric Profiles*,⁸⁸ the court addressed the issue of testing for HIV without consent but did not elaborate on the boundaries of the statute because the conduct in question was prohibited on the face of the statute.⁸⁹ The plain meaning of the statute, however, reveals the precarious liability a physician may face if he or she discloses a patient's HIV test results to a third party.⁹⁰

One possible defense, based on the wording of the statute, may be available in situations where the physician notified a third person known to be at risk based on a purely clinical diagnosis of the patient.⁹¹ There are no test results to reveal because such a diagnosis is symptomatic. In support of this argument, the practitioner could conceivably cite the *Alberts* decision and the assumption that HIV poses a "serious danger."⁹²

Common law defenses which may be asserted against a charge of a statutory violation may also provide some degree of hope. The common law "defense of others justification" and the "doctrine of necessity" are two such defenses. Although the SJC has had little opportunity to elaborate on the elements of the "defense of others justification," it has asserted that:

[a]n actor is justified in using force against another to protect a third person

⁸⁵ See sources cited *supra* note 84.

⁸⁶ MASS. GEN. L. ch. 111, § 70F (1994).

⁸⁷ Friedland, *supra* note 15, at 13.

⁸⁸ 404 Mass. 152, 533 N.E.2d 1364 (1989).

⁸⁹ *Id.* at 155-56, 533 N.E.2d at 1366.

⁹⁰ See MASS. GEN. L. ch. 111, § 70F (1994).

⁹¹ Friedland, *supra* note 15, at 9-10.

⁹² *Alberts v. Devine*, 395 Mass. 59, 75, 479 N.E.2d 113, 124 (1985). Although the *Alberts* decision did not specify how certain the physician must be of the danger, the *Tarasoff* court lends support in this area. Friedland, *supra* note 15, at 12-13. The *Tarasoff* court indicated that virtual certainty was not a prerequisite to disclosure. See *Tarasoff v. Regents of Univ. of Cal.*, 118 Cal. Rptr. 129, 136, 529 P.2d 553, 560 (1974) (discussing standard to apply to therapist). The therapist is to exercise that degree of skill and care which is ordinarily possessed by members of the psychiatric profession under similar circumstances. *Id.*

when (a) a reasonable person in the actor's position would believe his intervention to be necessary for the protection of the third person, and (b) in the circumstances as that reasonable person would believe them to be, the third person would be justified in using such force to protect himself.⁹³

The foreseeable problem with this defense, when used in the HIV context, concerns the possibility that the third person is unaware of the risk of harm and thus, unaware that they are justified in protecting themselves.⁹⁴ However, the defense only mandates that the third person be justified, not that they be aware of the risk of harm.⁹⁵

The doctrine of necessity may also offer a safeguard against liability. This defense, as used in criminal law, provides a safe harbor for those who violate the law intending to preserve human life.⁹⁶ Given the modern scientific knowledge regarding HIV transmission, a willful violation of the HIV statute committed to prevent an individual from becoming infected with the disease is a credible attempt to preserve human life.⁹⁷ As noted, "[c]ourts may . . . find that a defendant's sense of necessity to save life invokes pervasive values that the legislation does not intend to displace because they concern not just the transitory preference of public health policy but also the enduring sentiments of the people concerning the sanctity of life."⁹⁸

B. The Privacy Statute

Given the available case law, a violation of the privacy statute affords the practitioner greater leeway in constructing a defense. The Massachusetts privacy statute provides, in relevant part, that "[a] person shall have a right against unreasonable, substantial or serious interference with his privacy."⁹⁹ The SJC has interpreted this statute to proscribe disclosure of facts which are highly personal in nature "when there exists no legitimate countervailing interest."¹⁰⁰

⁹³ See Friedland, *supra* note 15, at 15 (quoting *Commonwealth v. Martin*, 369 Mass. 640, 649, 341 N.E.2d 885, 891 (1976)).

⁹⁴ Friedland, *supra* note 15, at 15.

⁹⁵ Friedland, *supra* note 15, at 15.

⁹⁶ Dickens, *supra* note 62, at 3450.

⁹⁷ Dickens, *supra* note 62, at 3450.

⁹⁸ Dickens, *supra* note 62, at 3450.

⁹⁹ MASS. GEN. L. ch. 214, § 1B (1995).

¹⁰⁰ *Bratt v. International Business Machs. Corp.*, 392 Mass. 508, 518, 467 N.E.2d 126, 133-34. The court in *Bratt* held that disclosure of medical information to the patient's employer without consent was not a violation of the privacy statute because it was reasonably necessary to serve a substantial and valid interest. *Id.* at 524, 467 N.E.2d at 137.

Disclosure of HIV status is unquestionably personal in nature. Therefore, the issues of whether the interference is reasonable and whether there exists a legitimate countervailing interest are the focal points of the determination of liability.

There is scant judicial authority on the issue of when a disclosure is reasonable under the statute. It can be argued, however, that if disclosure is motivated by the propensity to protect human life, it is certainly reasonable. Additionally, several authorities have implied that the preservation of life and public health also constitutes a legitimate countervailing interest sufficient to warrant breach of the patient's right to privacy.¹⁰¹

C. Breach of Confidentiality

A physician's duty of confidentiality generally stems from the fiduciary nature of the physician-patient relationship and is recognized by statute or case law in almost every state.¹⁰² When representing a physician charged with breaching this duty, the practitioner should first determine whether the patient has waived the physician-patient privilege because this supplies a full defense to the charge.¹⁰³

Several states have recognized an exception to the duty of confidentiality where disclosure is necessary to protect the health, welfare, or safety of

¹⁰¹ See *Whalen v. Roe*, 429 U.S. 589, 602, 97 S. Ct. 869, 878 (1976) (holding that the duty of confidentiality is not absolute); *Tarasoff v. Regents of Univ. of Cal.*, 118 Cal. Rptr. 129, 137, 529 P.2d 553, 561 (noting that confidentiality must yield to need to protect others); *Alberts v. Devine*, 395 Mass. 59, 75, 479 N.E.2d 113, 124 (1985) (noting confidentiality is required absent "serious danger"); *Skilling v. Allen*, 143 Minn. 323, 324, 173 N.W. 663, 663 (1919) (examining relationship between physician and patient); *Simonsen v. Swenson*, 104 Neb. 224, 225, 177 N.W. 831, 832 (1920) (discussing the duty to report absent legislative protection); *Berry v. Moench*, 8 Utah 2d 191, 197, 331 P.2d 814, 817-18 (1958) (finding existence of a duty due to threat to public health); see also *Dickens*, *supra* note 62, at 3451 (commenting on legal consequences of disclosure); *Closen & Isaacman*, *supra* note 45, at 301 (emphasizing need to prevent HIV transmission is paramount).

¹⁰² There are a few jurisdictions which have refused to recognize a cause of action against a physician for unauthorized disclosure of confidential information. *Zelin*, *supra* note 84, at 691-92. These jurisdictions continue to follow the common law rule, which does not recognize the physician-patient privilege, and have not enacted statutes providing for such a privilege. *Zelin*, *supra* note 84, at 691-92; see also *Mikel v. Abrams*, 541 F. Supp. 591, 598 (W.D. Mo. 1982) (stating no case in jurisdiction recognizing such a cause of action); *Collins v. Howard*, 156 F. Supp. 322, 324 (S.D. Ga. 1957) (holding no confidential relationship between physician and patient).

¹⁰³ *Zelin*, *supra* note 84, at 677.

society.¹⁰⁴ Other states have allowed disclosure of confidential medical information to the patient's spouse based on the marital relationship.¹⁰⁵ Under these circumstances, it can be argued that the physician has a qualified privilege to disclose HIV status.

D. Failure to Warn

A cause of action may arise against a physician for failure to warn. A common scenario is that of a spouse infected with HIV who asserts that transmission could have been prevented had the physician warned her/him about the patient's seropositivity. It is unclear whether the Commonwealth courts would recognize this cause of action. Considering that a failure to warn action lies in tort, the most sound defense concerns the requisite causation factor. To prevail, the plaintiff must establish by a preponderance of the evidence that the physician's failure to warn indeed caused the illness. Even if other possible channels of transmission, for example contaminated blood or dirty needles, are ruled out, problems of proof endure. HIV may remain dormant in an infected person leaving the individual asymptomatic for years. It is therefore, an onerous task to determine how long a plaintiff has been infected. Consequently, a plaintiff may have a difficult time proving he/she was infected after the physician diagnosed the individual's condition.

V. CONCLUSION

Physicians should not continue to face the indeterminate legal consequences exacted upon them by present Massachusetts law. The inimitable response is for

¹⁰⁴ See *Horne v. Patton*, 291 Ala. 701, 709, 287 So. 2d 824, 830 (1973) (recognizing exception to duty where supervening interests of society or private interest of patient intervene); *Alberts*, 395 Mass. at 68, 479 N.E.2d at 119 (permitting disclosure when necessary to "meet a serious danger to the patient or to others"); *Simonsen*, 104 Neb. at 225, 177 N.W. at 832 (1920) (allowing disclosure when necessary to prevent the spread of disease); *Hague v. Williams*, 37 N.J. 328, 336, 181 A.2d 345, 349 (1962) (holding where public interest demands, disclosure allowed to person with legitimate interest in patient's health); *MacDonald v. Clinger*, 446 N.Y.S.2d 801, 805, 84 A.D.2d 482, 487 (1982) (noting that confidentiality must yield to countervailing public interests when, for example, a patient poses danger to self or others); *Berry*, 8 Utah 2d at 196, 331 P.2d at 817 (1958) (recognizing conditional privilege to disclose as is reasonably necessary to protect a sufficiently important interest).

¹⁰⁵ See, e.g., *Chizmar v. Mackie*, 896 P.2d 196, 208 (Alaska 1995) (holding disclosure of AIDS or related disease to spouse is privileged as a matter of law); *Pennison v. Provident Life & Accident Ins. Co.*, 154 So. 2d 617, 618 (La. Ct. App.), *cert. denied*, 244 La. 1019, 156 So. 2d 226 (1963); *Curry v. Corn*, 277 N.Y.S.2d 470, 471, 52 Misc. 2d 1035, 1037 (1966) (recognizing spouse has right to know existence of disease).

the legislature to modify the current HIV statute to mandate reporting of HIV, as all other contagious diseases, to the department of public health. Such an undertaking would relieve physicians of the haphazard liability and present ethical quandary, while controlling HIV transmission. The history of the law and the continued health of our citizens demand this response.

The proposals set forth above are designed to thwart the rampant transmission of a fatal communicable disease. HIV is an illness which is caused by infection with a human retrovirus, not by homosexuality, drug abuse or promiscuity. As education concerning this disease progresses, ignorance will continue to decline. With sufficient anti-discrimination legislation in place, the proposed means justify the end. An individual's privacy is paramount, but human life is sacred.

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