An Examination of Partner Notification Laws:
What does Partner Notification
Mean for HIV/AIDS in the African-American Community?

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Abstract

The AIDS epidemic presents challenges in regulation, especially when examined in the African-American community context. However the African-American community desperately needs effective legislation to combat HIV/AIDS because forty-seven percent of persons infected with the disease are African American. Partner notification laws exemplify a legislative attempt at combating HIV/AIDS. Partner notification laws, for purposes of this article, include efforts made at identifying partners at risk of exposure to HIV/AIDS by using information gathered from an infected person. Partner notification efforts are defended by public health officials partially because of their successful use during the syphilis epidemic. On the other hand, partner notification laws threaten individual privacy rights and have faced great opposition from various groups over the years. Additionally, the federal courts do not all agree on whether a right to privacy exists with respect to the dissemination of information contained in medical records. Federal courts that do recognize this right consider HIV/AIDS-infected persons to be deserving of constitutional protection from unauthorized disclosure of their infected status. Finally, “stigma” within the African-American community potentially decreases the efficacy of partner notification laws in this population. In order to be effective, partner notification laws must incorporate culturally sensitive interventions by officials.
who understand the African-American community and the special challenges that arise in battling HIV/AIDS.

Introduction

Since its discovery in 1981, HIV/AIDS has challenged public health officials and lawmakers alike, while simultaneously causing deaths and avoiding eradication. Originally, HIV/AIDS was characterized as a disease affecting homosexual men, but now its prevalence is especially high within the African-American community. The Center for Disease Control (CDC) states that African Americans are one of the groups most impacted by HIV. Estimates from CDC research concluded that in 2006 African Americans made up forty-nine percent, almost half, of the HIV/AIDS diagnoses while making up only thirteen percent of the surveyed population. Thus, there is a great need within the African-American community for effective HIV prevention programs that encourage testing and the adoption of risk-reducing behaviors.

This article examines legislation aimed at HIV/AIDS prevention known as partner notification laws. Part I of this article defines partner notification laws, as well as provides the common law rationale behind different partner notification models. Part II gives a brief description of a state’s authority to enact partner notification laws. Then, Part III explores a legal debate that has been around since the discovery of HIV/AIDS—the debate between an infected person’s right to privacy, and the public health interest in combating the disease. These opposing interests create challenges in implementing legislation that effectively combats HIV/AIDS, while still respecting individual privacy rights. Public health concerns, which are explored in Part IV, are the primary justifications for the continued use of partner notification laws. Part V gives a brief background of HIV/AIDS in the African-American community and presents stigma as one of the greatest barriers to the effectiveness of partner

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2 See id.
notification laws in this community. Part V also mentions other factors that may contribute to high HIV/AIDS infection rates among African Americans that partner notification laws may, or may not, directly impact. Finally, Part VI of this article advocates combining culturally-sensitive interventions with partner notification efforts in the African-American community.

I. Partner Notification Laws Defined

Partner notification laws developed from a practice used to combat the transmission of sexually transmitted diseases (STDs), known as “sexual contact tracing.” Under this practice, when an individual tested positive for an STD (called the “infected person”), sexual partners of the infected person were notified of their risk of exposure to the disease. Sexual contact tracing was a popular tool used during the Syphilis epidemic. In fact, success in controlling Syphilis was attributed, at least in part, to the use of contact tracing. Thus, with the discovery of HIV/AIDS, sexual contact tracing became an option for controlling the disease.

The use of contact tracing to battle HIV/AIDS was met with opposition, especially from gay advocacy organizations and civil liberty groups. Because the disease was first discovered in homosexual men, HIV/AIDS was associated with homosexuals, a group that was already marginalized in society. Since non-infected individuals feared contracting the disease, becoming an infected person resulted in further discrimination. Thus, the gay community insisted upon privacy, as well as measures to avoid targeting of gay men for testing. For example, the National Gay Task Force and Lambda Legal Defense and Education Fund demanded a legal guarantee that the first test for HIV detection would not be used to

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5 *Id.* at 11.

6 *Id.* at 16.


8 *Id.* at 123.
target homosexual men.\textsuperscript{9} Further, due to rumors that the test would be used to identify and fire gay teachers, these organizations pressured the Food and Drug Administration (FDA) and CDC not to use the test to screen and identify people for HIV. The FDA agreed, determining that the test would only be used to screen blood in blood banks.\textsuperscript{10}

As a result of the FDA’s agreement, public health procedures that threatened individual privacy were substituted with voluntary, confidential procedures.\textsuperscript{11} In fact, confidentiality and HIV/AIDS prevention were soon viewed as complementary—one not able to occur without the other.\textsuperscript{12} Since HIV was a disease new to public health officials, infected persons’ cooperation was needed to control and understand it.\textsuperscript{13} The price for that cooperation was confidentiality. The traditional invasive tools of public health officials, including routine testing and names reporting, were no longer realistic options. Rather, public health officials employed a new approach that emphasized individual responsibility and patient accountability for preventing HIV/AIDS transmission.\textsuperscript{14} Individual responsibility entailed educating patients about HIV/AIDS and persuading them to cooperate with prevention efforts.\textsuperscript{15} The emphasis on individual responsibility resulted in the infrequent use of routine testing and names reporting and ineffective, or nonexistent, contact tracing efforts.\textsuperscript{16}

Initially, patient privacy rights seemed to take priority over HIV/AIDS prevention efforts. This priority was reflected by public health officials replacing invasive tools with tools that were less offensive to patient confidentiality. However, as time progressed, public health advocates spoke out against preserving confidentiality at the expense of HIV/AIDS prevention. Advocates argued for a return of the aggressive public health measures traditionally used by public

\textsuperscript{10} \textit{Id.} at 59.
\textsuperscript{11} \textit{Id.}
\textsuperscript{12} \textit{See id.}
\textsuperscript{13} \textit{Id.}
\textsuperscript{14} \textit{See} Burr, \textit{supra} note 9.
\textsuperscript{15} \textit{Id.} at 59.
\textsuperscript{16} \textit{Id.}
The familiar debate between honoring individual privacy rights and protecting the public health continued.

More recently, efforts made at controlling the spread of HIV/AIDS have included states enacting legislation focused less on individual responsibility and more on the role of health care providers. For example, all states have implemented name-based confidential reporting systems\(^\text{18}\) for patients who test positive for HIV or AIDS.\(^\text{19}\) The reporting system is useful to public health officials in tracking HIV/AIDS prevalence. Some states have also implemented partner notification laws, modeled after the old practice of sexual contact tracing.

Partner notification laws, for purposes of this article, are efforts made at identifying partners at risk of HIV/AIDS exposure by using information gathered from an infected person. Once a person tests positive for HIV/AIDS — becoming the infected person — states with partner notification laws have the goal of ensuring that the partners of infected persons are notified of their risk of exposure.\(^\text{20}\) A partner is defined as “a person who engages in any type of sexual activity or needle-sharing activity with the infected person.”\(^\text{21}\) The CDC has created several partner notification models, which are generally referred to as “Partner Contact and Referral Services”

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\(^\text{17}\) Doughty, supra note 7.

\(^\text{18}\) See, e.g., 18 V.S.A. § 1001 (“When a physician, health care provider, nurse practitioner, nurse, physician’s assistant, or school health official has reason to believe that a person is sick or has died of a diagnosed or suspected disease, identified by the department of health, as a reportable disease and dangerous to the public health or if a laboratory director has evidence of such sickness or disease, he or she shall transmit within 24 hours a report thereof and identify the name and address of the patient and the name of the patient's physician to the commissioner of health or designee. In the case of the human immunodeficiency virus (HIV), “reason to believe” shall mean personal knowledge of a positive HIV test result.”).\(^\text{19}\) Ctrs. for Disease Control and Prevention, HIV Infection Reporting, http://www.cdc.gov/hiv/topics/surveillance/ reporting.htm (last updated Aug. 26, 2008).

\(^\text{20}\) Id.

When a person tests positive for HIV or AIDS, the health care provider offers to create a PCRS plan with the infected person. One of the goals of the PCRS plan is to contact the infected person’s partners. For purposes of this article, the term “partner notification” will encompass PCRS. Partner notification laws may be broken down into four basic models: patient referral, provider referral, dual referral, and contract referral.

A. Patient Referral

The patient referral system reflects an individual responsibility approach by leaving the infected person with the obligation of contacting partners. The health care provider asks the infected person to notify partners of their possible risk of HIV/AIDS exposure and to refer them for testing. The health care provider is required to provide the infected person with counseling about the proper way to inform and refer partners. The counseling typically involves four areas: when to notify partners, where to notify partners, how to notify partners, and responding to partners’ reactions. The health care provider encourages the infected person to notify all partners promptly and in a private location. When being coached on “how” to tell partners, the health care provider advises the infected person to avoid placing blame on anyone and to focus on referring the partner to examination and treatment. The health care provider also gathers information about partners’ likely reactions. Then, the health care provider advises the infected person on managing the different reactions and any potential problems that may arise.
Patient referral is rooted in the common law duty to warn. A “duty” is a general standard of conduct owed to another person.\(^{29}\) A duty is imposed when it is reasonably foreseeable that a person’s conduct will cause harm to another.\(^{30}\) An example would be an infected person engaging in unprotected sex. When an infected person has knowledge of his or her HIV-positive status and has knowledge about methods of transmission, such as engaging in unprotected sex, harm to a sexual partner is “reasonably foreseeable.” When circumstances are such that a duty is imposed upon an individual, that individual must take “due care” to avoid behavior that will cause harm to another.\(^{31}\) Under this rationale, “due care” requires an infected person to notify partners, or modify behaviors, to avoid placing partners at risk of contracting HIV.\(^{32}\) Complying with the requirements of a patient referral model would likely satisfy this duty.

The patient referral model, when effective, results in a partner receiving a timely notification and referral to treatment. It also saves resources by requiring less staff participation. On the other hand, since there is no assurance that the infected person actually notifies partners, the effectiveness of this approach is uncertain.\(^{33}\) This problem is exacerbated at anonymous testing sites. The fact that the infected person chooses anonymous testing, rather than confidential, indicates the infected person’s desire to remain unidentified. The health care provider may never even learn the infected person’s actual name. The infected person is likely to be more resistant to providing the health care provider with information that would be needed for proper counseling or follow-up.\(^{34}\) On the other hand, when the health care provider does have the infected person’s contact information, the health care provider should make every attempt to follow up with the infected person,\(^{35}\) thus increasing patient referral efficacy.

The partner referral model creates additional problems. Health care providers have no way to guarantee what information the

\(^{29}\) Restatement (Second) of Torts § 4 (1965).
\(^{30}\) Id.
\(^{31}\) Id.
\(^{32}\) See B.N. v. K.K., 312 Md. 135, 142 (1988).
\(^{33}\) Ctrs. for Disease Control and Prevention, supra note 23.
\(^{34}\) Ctrs. for Disease Control and Prevention, supra note 21.
\(^{35}\) Id.
infected person conveys to partners.\textsuperscript{36} Despite counseling, the infected person may not be prepared to handle the partner’s reaction or to clearly direct the partner to testing. Also, when the infected person notifies his or her partners, the infected person’s right to confidentiality and anonymity has essentially been forfeited.\textsuperscript{37}

**B. Provider Referral**

A provider referral system requires the health care provider to contact the infected person’s partners about their risk of HIV exposure, thus relieving the infected person of this responsibility.\textsuperscript{38} The health care provider collects the names and contact information of the infected person’s partners.\textsuperscript{39} In addition to providing contact information, the infected person should provide the health care provider with information such as the best way to inform partners, method of approaching partners, prediction on the psychosocial impact on the partner, and how to handle partners’ reactions.\textsuperscript{40} The health care provider then notifies partners that they may have been exposed to HIV without revealing the exposure source.\textsuperscript{41} Health care providers must also report the names of any patients who test positive for HIV or AIDS to a national confidential name-based registry.\textsuperscript{42}

Provider referral is premised on the duty to warn imposed upon the health care provider. The health care provider’s duty was defined in *Tarasoff v. Regents of California*.\textsuperscript{43} The Supreme Court of California held that when a psychologist recognizes that a patient poses a serious risk to a third person, the psychologist has the duty to take “reasonable care to protect the foreseeable victim of that danger.”\textsuperscript{44} The court noted the impact its holding would have on the patient’s confidentiality, but reasoned that public safety was a more

\textsuperscript{36} Id.
\textsuperscript{37} Id.
\textsuperscript{38} Id.
\textsuperscript{39} Id.
\textsuperscript{40} Id.
\textsuperscript{41} Id.
\textsuperscript{42} Id. (This is a recent change to state laws. Previously some states allowed notification to public health departments to be made through unique identifiers, such as birthdates, rather than by name.); See Sharron Salmon, *The Name Game: Issues Surrounding New York State's HIV Partner Notification Law*, 16 N.Y.L. SCH. J. HUM. RTS. 959, 967 (2000).
\textsuperscript{43} Tarasoff v. Regents of Univ. of Cal., 17 Cal. 3d 425, 438 (1976).
\textsuperscript{44} Id.
important interest.\footnote{Id. at 441.} In jurisdictions that follow \textit{Tarasoff}, health care providers may be liable for negligence to a third party who is infected with HIV, due to the health care provider’s failure to warn the third party.\footnote{Gostin & Hodge, \textit{supra} note 4, at 42, 45.} However, this requirement does not necessarily mean that the health care provider must personally contact all partners at risk of contracting HIV.\footnote{\textit{Gostin & Hodge, supra} note 4.} The \textit{Tarasoff} court noted that the provider’s duty is to warn the endangered party or those “reasonably expected” to notify the endangered person.\footnote{\textit{See Carrie Gene Pottker-Fishel, R.N., Note, Improper Bedside Manner: Why State Partner Notification Laws Are Ineffective in Controlling the Proliferation of HIV, 17 \textit{Health Matrix} 147, 159 (2007) (commenting that under the \textit{Tarasoff} rationale, all pertinent parties should be contacted, which would include the state health officials who could then contact infected person’s contacts).} Thus, the health care provider’s duty may be satisfied by giving the infected person’s name to the public health department,\footnote{\textit{Tarasoff, 17 Cal. 3d at 443.}} which all states now require through use of the nationwide name-based HIV/AIDS registry. The public health department should then contact the infected person. However, the \textit{Tarasoff} court also seemed to indicate that the duty required depends upon the circumstances\footnote{Pottker-Fishel, \textit{supra} note 47.} so that if there is no way to identify a person at risk, there may not be a duty. If an infected person refuses to name any partners or to participate with partner notification efforts, the health care provider or public health department should be absolved of a duty to warn. Alternatively, states can create legislation limiting liability for health care providers who fail to warn.\footnote{\textit{Gostin & Hodge, supra} note 4.}

The provider referral approach has several pros and cons. Provider referral programs are costly and require extra staff due to the dependence on health care providers to contact partners.\footnote{\textit{Ctrs. for Disease Control and Prevention, supra} note 21.} However, the health care provider is properly trained on how to notify partners
of their risk and can provide partners with information about testing.\textsuperscript{53} The probability that partners will actually be informed is greater than it is with use of the patient referral model.\textsuperscript{54} In theory, confidentiality is maintained because the health care provider does not reveal the infected person’s name to the partner.\textsuperscript{55} However, a partner could determine the infected person’s identity through deduction, especially in cases of marriage, or long-term relationships where the partner has only been sexually active with the infected person. Further, this model’s efficacy depends greatly on the infected person being honest and forthcoming with the health care provider. When the infected person and health care provider have an ongoing relationship, the provider referral approach is more likely to be effective because the health care provider has had time to establish trust. However, when an infected person meets the health care provider for the limited purpose of testing, establishing a trusting relationship is difficult. Finally, even if the infected person does provide his or her partners’ contact information, the health care provider may experience difficulty in locating partners.\textsuperscript{56} For example, the health care provider may be unfamiliar with a partner’s location or face other cultural or language barriers.

C. Dual Referral and Contract Referral

Dual referral and contract referral each represent a combined approach of partner and provider referral models. Under the dual referral approach, the health care provider and infected person inform partners together.\textsuperscript{57} Deciding whether the health care provider, or the infected person, will speak to the partner is determined during a counseling session between the infected person and the health care provider.\textsuperscript{58} This approach is especially helpful for infected persons who fear repercussion from partners. Further, the health care provider is immediately available to answer the partner’s questions and refer the partner to testing.\textsuperscript{59} The health care provider is also able to track the informed partners and learn of other at-risk persons.\textsuperscript{60} Naturally,

\textsuperscript{53} Id.
\textsuperscript{54} Id.
\textsuperscript{55} Id.
\textsuperscript{56} Id.
\textsuperscript{57} Ctrs. for Disease Control and Prevention, supra note 21.
\textsuperscript{58} Id.
\textsuperscript{59} Id.
\textsuperscript{60} Ctrs. for Disease Control and Prevention, supra note 19.
confidentiality is still forfeited, so the infected person must be prepared for any consequences associated with revealing his or her infected status. The health care provider is still responsible for counseling the infected person about possible consequences.\textsuperscript{61}

Under a contract referral program, the infected person is given a deadline by which the infected person must locate and notify partners of their risk of HIV/AIDS exposure.\textsuperscript{62} The names and contact information of the infected person’s partners are still collected by the health care provider, as under the provider referral approach.\textsuperscript{63} If the infected person does not contact the partners within the specified time frame, then the health care provider contacts the partners.\textsuperscript{64} The health care provider and infected person negotiate a method by which the infected person confirms when partners have been notified.\textsuperscript{65} If possible, the health care provider should negotiate a method where the partner also confirms notification, for example by setting an appointment for testing with the same health care provider who tested the infected person.\textsuperscript{66} Under this model, time is of the essence. If the infected person does not notify his or her partners, the health care provider cannot do so until the deadline passes.\textsuperscript{67} Consequently, a partner continues to be unknowledgeable about the risk of exposure until that deadline.

Under any partner notification model, the infected person’s participation is voluntary. Theoretically, infected persons are “willing” to participate with one of the partner notification models when they fully understand the benefits to themselves and partners.\textsuperscript{68} However, the model most frequently chosen is the patient referral model which, coincidentally or not, happens to be the least effective.\textsuperscript{69} Further, much of the responsibility lies with the health care provider to convince the infected person to willingly participate with partner notification efforts. This may require sorting through an infected

\textsuperscript{61} Id.
\textsuperscript{62} Id.
\textsuperscript{63} Id.
\textsuperscript{64} Id.
\textsuperscript{65} Id.
\textsuperscript{66} Id.
\textsuperscript{67} Id.
\textsuperscript{68} Id.
\textsuperscript{69} Id.
person’s difficult issues, such as suicidal thoughts or fear of partner reprisal.\textsuperscript{70}

\section*{II. State’s authority to protect the Public Health}

Partner notification laws are created and enacted by the individual states under the state’s police power. The police power has been defined as an “inherent right [left to the states] to govern.”\textsuperscript{71} States have the authority to subject individuals to reasonable legislation when the legislation is created for the general welfare.\textsuperscript{72} The legislation, however, must not violate the Constitution or any protections it guarantees.\textsuperscript{73} In \textit{Jacobson v. Massachusetts},\textsuperscript{74} the United States Supreme Court examined the police power in the context of a statute created in furtherance of public health. The Court in \textit{Jacobson} upheld a statute giving public health officials the authority to order vaccinations of all inhabitants of a city or town. The public health officials had the discretion to determine whether the vaccinations were necessary to protect the public health or inhabitant’s safety.\textsuperscript{75} The Court held that the statute fell within the state’s authority under the police power.\textsuperscript{76} Legislation enacted under the police power should not be arbitrary, but should be “justified by the necessities of the case.”\textsuperscript{77} Further, the Court emphasized the importance of protecting a majority of healthy individuals, rather than only a few who are sick.\textsuperscript{78} While the statute at issue in \textit{Jacobson} was not identical to a partner notification law, it did involve coercion of individuals for the benefit of the public health. In light of \textit{Jacobson}, states are likely to be within their authority under the police power when creating and enacting partner notification laws.

\section*{III. Constitutional Debate: Right to Privacy vs. Right to be Informed}

\textsuperscript{70} Ctrs. for Disease Control and Prevention, \textit{supra} note 19.
\textsuperscript{71} In re Quinn, 110 Cal. Rptr. 881 (Cal. App. 5th Dist. 1973).
\textsuperscript{72} \textit{See id.}
\textsuperscript{73} Jacobson v. Massachusetts, 197 U.S. 11, 25 (1905).
\textsuperscript{74} \textit{Id.} at 11.
\textsuperscript{75} \textit{Id.} at 11.
\textsuperscript{76} \textit{Id.} at 24-25.
\textsuperscript{77} \textit{Id.} at 29.
\textsuperscript{78} \textit{Jacobson}, 197 U.S. at 29.
In at least some jurisdictions, infected individuals are entitled to constitutional protection regarding disclosure of their HIV-positive status. However, the infected person’s right to privacy must always be balanced against a partner’s right to have knowledge of an impending risk and the government’s interest in preserving public health. Furthermore, the parameters of a general right to privacy have not been clearly defined. The right is even more uncertain when the privacy interest is disclosure of one’s HIV-positive status. Nonetheless, examining the relevant court decisions is helpful in understanding what is at stake when implementing laws that require HIV status disclosure such as partner notification laws.

No explicit right to privacy is guaranteed by the Constitution. In *Griswold v. Connecticut*, the United States Supreme Court recognized a right to privacy, created from the penumbra of the Constitution and protected by the Fourteenth Amendment. The parameters of the right to privacy were not clearly defined in *Griswold*, but courts have generally recognized that the right to privacy is implicated in cases involving medical records disclosure. For example, in *Whalen v. Roe*, the United States Supreme Court examined a statute requiring doctors to give state health representatives the names of patients who received a prescription. The Court held that the release of this information to state health officials did not amount to an “impermissible invasion of privacy,” noting that such disclosures were often necessary to ensure public health. The Court acknowledged two interests—the individual interest in avoiding disclosure of personal matters and the interest in making decisions without government interference. These interests may be referred to as the right to confidentiality and the right to autonomy. The *Whalen* court also noted other concerns implicated by its holding. The Court recognized that some individuals would be deterred from seeking medical attention due to privacy and stigma concerns. Thus, the Court limited its holding to the statute at issue, noting that it was not ruling on unauthorized disclosures or on statutes

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81 Id. at 602.
82 Id. at 599-600.
83 Id. at 602.
that lacked comparable securities against unauthorized disclosures.\textsuperscript{84}\n
Recognizing the confidentiality and autonomy interests in \textit{Whalen} provided the foundation for other courts to shape the right to privacy applicable to disclosures of information in medical records.

The United States Court of Appeals in \textit{United States v. Westinghouse Electric Corp.} was faced with deciding whether workers’ medical records could be disclosed to officials for the purpose of improving occupational safety.\textsuperscript{85} The \textit{Westinghouse} court identified factors relevant to determining whether the public interest weighed more heavily than the individual’s right to keep medical records private. The court found the following factors relevant:

\begin{itemize}
  \item The type of record requested, the information it does or might contain, the potential for harm in any subsequent nonconsensual disclosure,
  \item the injury from disclosure to the relationship in which the record was generated, the adequacy of safeguards to prevent unauthorized disclosure, the degree of need for access, and whether there is an express statutory mandate, articulated public policy, or other recognizable public interest militating toward access.\textsuperscript{86}
\end{itemize}

The court recognized that the public interest — ensuring occupational safety — warranted disclosure of medical information that is usually considered private.\textsuperscript{87} The court also noted that inquiry into the workers’ records was relevant to furthering occupational safety and that the workers made no showing that the information contained in their records could be regarded as “sensitive” information.\textsuperscript{88} Finally, the court noted that appropriate safeguards were taken against unauthorized disclosure of information.\textsuperscript{89} The court held that the strong public interest in improving occupational

\begin{itemize}
  \item\textsuperscript{84} \textit{Id.} at 605-06.
  \item\textsuperscript{85} \textit{United States v. Westinghouse Electric Corp.}, 638 F.2d 570, 572 (3d Cir. 1980).
  \item\textsuperscript{86} \textit{Id.} at 578.
  \item\textsuperscript{87} \textit{Id.} at 579.
  \item\textsuperscript{88} \textit{Id.}
  \item\textsuperscript{89} \textit{Id.} at 580.
\end{itemize}
safety outweighed the “minimal” intrusion on the workers’ privacy, and held the statute constitutional.\textsuperscript{90}

Then, in \textit{Doe v. Barrington},\textsuperscript{91} the United States District Court for the District of New Jersey held that a police officer disclosing the plaintiff’s AIDS status was a violation of the plaintiff’s right to privacy, as well as that of his family.\textsuperscript{92} The court recognized the right to privacy in medical records established in \textit{Westinghouse}.\textsuperscript{93} The court further noted that AIDS status is sensitive information falling within the zone of privacy, due to the stigma associated with the disease.\textsuperscript{94} Disclosing that an individual is infected with AIDS leaves the individual subject to harassment and discrimination. The court observed that not only is the infected individual placed at risk of discrimination but those closest to the individual, such as family members, are also at risk.\textsuperscript{95} As such, the government was required to show a compelling interest and establish that the disclosure was made in furtherance of that interest as set forth in \textit{Westinghouse}. The court decided that the disclosure to the plaintiff’s neighbor was not made in furtherance of the government interest in preserving public health.\textsuperscript{96} The plaintiff posed no risk of transmitting the virus to his neighbors through casual contact, thus disclosure to the neighbor was a violation of the plaintiff’s right to privacy.\textsuperscript{97}

By contrast, in \textit{Doe v. Wigginton}, the United States Court of Appeals for the Sixth Circuit refused to recognize a prisoner’s right to privacy concerning the prisoner’s HIV-positive status.\textsuperscript{98} The court commented that the right to nondisclosure of medical records was a “vague concept” not explicitly guaranteed by the Constitution.\textsuperscript{99} However, in \textit{Doe v. Delie}, the United States Court of Appeals for the Third Circuit recognized the constitutional right to privacy in medical

\begin{footnotes}
\item[90] \textit{Westinghouse}, 638 F.2d at 580.
\item[92] \textit{Id.} at 385.
\item[93] \textit{Id.} at 382.
\item[94] \textit{Id.} at 384.
\item[95] \textit{Id.} at 384-85.
\item[96] \textit{Barrington}, 729 F. Supp. at 385.
\item[97] \textit{Id.}
\item[98] \textit{Doe v. Wigginton}, 21 F.3d 733, 740 (6th Cir. 1994).
\item[99] \textit{Id.}
\end{footnotes}
information and recognized that the right exists in prisons.\(^\text{100}\) The court also emphasized the sensitive nature of HIV status, making it the type of interest falling within the protected zone of privacy.\(^\text{101}\)

The Federal Circuits do not all agree on the parameters of the right to privacy in nondisclosure of medical records or even recognize that such a right exists.\(^\text{102}\) For circuits that have recognized this right, HIV status is information that is sensitive enough to protect from unauthorized disclosures.\(^\text{103}\) On the other hand, a government showing of a compelling interest, and disclosure in furtherance of that compelling interest, can often overcome this right to protection.\(^\text{104}\) Partner notification laws are created for the purpose of furthering the compelling government interest of preserving public health. Thus, in any given case of an unauthorized HIV/AIDS status disclosure, determining whether the disclosure was made in furtherance of that legitimate government interest would be the issue. Further, a court may find the *Westinghouse* factors relevant in determining whether the disclosure was constitutional.

### IV. Public Health Concerns

Public health officials have used partner notification efforts, in some form, since the syphilis epidemic. Thus, public health officials have developed several justifications in support of partner notification laws to battle HIV/AIDS.

Partner notification laws are premised on the theory that partners are entitled to knowledge. The theory poses that “(1) knowledge empowers individuals to avoid continuing risks; (2) knowledge of infection allows for early treatment; and (3) knowledgeable partners can adapt their behavior to prevent further transmission of infection to others.”\(^\text{105}\) Studies have concluded that people are less likely to have unprotected sex once they are aware of

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\(^{100}\) Doe v. Delie, 257 F.3d 309 (3d Cir. 2001) (noting that, while the right to nondisclosure in medical records exists in prison, a prisoner’s right to nondisclosure is not protected to the same extent that a free citizen’s right to nondisclosure is).

\(^{101}\) *Id.*

\(^{102}\) See *id.*; Wigginton, 21 F.3d at 740.

\(^{103}\) See *Westinghouse*, 638 F.2d 570.

\(^{104}\) *Id.*

\(^{105}\) Gostin & Hodge, *supra* note 4, at 65.
their HIV status. Additionally, equipping public health officials with knowledge is important because it assists them in identifying high-risk populations and offering HIV testing. The knowledge theory is based upon individuals taking responsibility for their own health by deciding to get tested and deciding to adopt risk-reducing behaviors. If barriers prevent the individual from seeking testing or cooperating with public health officials, then the knowledge component of this theory is never met and the power of partner notification laws is tapered.

Another justification for partner notification laws in the battle against HIV/AIDS is based upon the historical success of mandatory reporting and notification laws during the syphilis epidemic. Given the success seen in reducing syphilis infection rates, using partner notification efforts to combat HIV/AIDS should produce similar results. This argument is based on the premise that syphilis and HIV/AIDS are similar diseases. For example, both communicable diseases are associated with risky behavior, such as drug use and unprotected sex, and both invoke feelings of fear and carry a stigma in society.

However, the similarities seem to end there. Public health officials gained control over the syphilis epidemic due, partially, to the discovery of penicillin as a cure. No comparable cure for HIV/AIDS exists. The goal of contact tracing efforts during the

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107 Matthew Hogben et al., The effectiveness of HIV partner counseling and referral services in increasing identification of HIV-positive individuals: a systematic review, 33 AM. J. PREVENTIVE MED. § 89, § 90 (2007).
108 Gostin & Hodge, supra note 4, at 11-13.
109 Id.
110 Id. at 24.
111 Id. at 22-23.
112 See Donald G. McNeil, Rare Treatment is Reported to Cure AIDS Patient, N.Y. TIMES, November 14, 2008, at A12. (However a man with AIDS was reported cured of AIDS through a stem cell transplant from a person naturally resistant to the virus. Doctors generally believe that this treatment is unrealistic as a cure for the majority of people infected with AIDS.)
syphilis epidemic was to cure the disease. However, since no widely accepted cure exists for HIV/AIDS, the goal is simply modifying behavior. Infected persons and partners are referred to behavior modification services, required to disclose names of sexual partners, and have their name reported to the state name-based registry. These actions take the power away from the individual, which may result in feelings of government domination, resulting in an unwillingness to cooperate with treatment.

Finally, public health officials claim that early intervention in HIV cases justifies the use of partner notification laws. Previously, opponents argued that partner notification laws were not worth the financial investment because there was no cure for AIDS. Without a cure, the benefit of early intervention is arguably not worth the financial burden. Medical advances in understanding HIV progression have revealed that HIV-1 replicates actively in the body early, often before infected individuals exhibit symptoms. Individuals who are identified early can benefit from slowing the progression of their HIV into full-blown AIDS, thus reducing AIDS infection rates overall and increasing the lifespan of HIV infected persons. From a legal standpoint, effective treatment is relevant in determining whether HIV notification should be an exception to a patient’s right to confidentiality. Arguably, the benefit of partner notification laws in increasing early intervention warrants the invasion of privacy that results from notifying partners of infected persons.

114 Id.
115 Doughty, supra note 7, at 167.
117 Id.
120 See Bradshaw v. Daniel, 854 S.W.2d 865, 867 (Tenn. 1993).
121 Notes, supra note 116.
V. Barriers in the African American Community

A. Background

The first AIDS cases among African Americans were discovered in the early 1980s.\(^{122}\) Initially, AIDS was primarily identified in African-American homosexual men and intravenous drug users.\(^{123}\) In 1983, the first AIDS infection in an African-American woman was documented,\(^ {124}\) after which time the number of African Americans with AIDS began to grow. The main obstacle in battling AIDS among African Americans during the early years of the epidemic was the belief that AIDS was a white gay man’s disease.\(^ {125}\) Many African Americans believed that they were not at serious risk of transmitting the disease. In response to rising AIDS infection rates, AIDS awareness groups became active in the African-American community, raising awareness about the risk that HIV/AIDS posed. For example, the group Black and White Men Together (BWMT) gave rise to the National Task Force for AIDS Prevention.\(^ {126}\) Additionally, a BWMT member named Reggie Williams worked to raise awareness of HIV/AIDS in the gay black community.\(^ {127}\) His work lead to the first CDC grant that targeted HIV prevention in the gay black community in 1988.\(^ {128}\)

HIV awareness among African Americans was furthered by the death of well-known figures in the African American community. The deaths of the first nationally recognized black anchorman Max Robinson, tennis player Arthur Ashe, and rapper “Eazy-E” all helped to raise awareness.\(^ {129}\) Similarly, black basketball player, Ervin “Magic” Johnson revealed his HIV-positive status and Reverend Jessie Jackson publicly took an oral HIV test to make the point that

\(^{123}\) Id.
\(^{124}\) Id.
\(^{125}\) Id.
\(^{126}\) Id.
\(^{127}\) DE BOER, supra note 122.
\(^{128}\) Id.
\(^{129}\) Id.
AIDS was more than just a “gay disease” and, in the words of “Magic” Johnson, “could happen to anyone.”

Despite these early efforts, African Americans are still being diagnosed with HIV/AIDS at an alarming rate. African Americans consistently make up a large portion of infected persons. The most recently published study by the CDC on HIV incidence rates estimates the rate of HIV incidence for Blacks is eight times what it is for Whites. Further, African-American men have the highest rate of HIV infection, which is seven times the rate of White males. African-American women are also disproportionately affected, with a rate nineteen times the rate of White women. Additionally, African Americans have higher numbers of infected persons, with shorter survival rates, and experience more deaths from HIV/AIDS than other races. These numbers suggest that effective HIV/AIDS prevention efforts in the African-American community are urgently needed. These numbers further suggest that efforts currently in place are not particularly effective at reducing HIV/AIDS transmission among African Americans. This portion of the article discusses stigma as a barrier to partner notification laws’ effectiveness. Other factors that may contribute to HIV infection rates among African Americans are also mentioned.

B. Layers of Stigma

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130 Id.
131 “Incidence rate” refers to the number of individuals with HIV. This number is not necessarily the number of individuals actually infected with HIV in 2006. Rather, ‘incidence rate’ includes individuals who already had HIV, but were not detected by medical officials until 2006.
132 The Center for Disease Control that compiled this data only collects from states that have had confidential HIV reporting for at least 4 years to ensure “vitality” of the data. There were 33 states that qualified for the study.
134 Id.
135 Id.
Stigma is defined as “a mark of shame or discredit” and has surrounded HIV/AIDS since its discovery. The HIV/AIDS stigma presents challenges when attempting to use partner notification laws effectively in the African American community. The fear of stigma has a deterring effect, creating a disincentive for individuals to get tested or to cooperate with public health officials after testing. In the case of African Americans, being HIV-positive creates a double layer of stigma—being a member of a marginalized group and carrying an incurable disease. For African Americans and infected persons alike, negative consequences result from being the carrier of a stigma source.

The stigma surrounding HIV/AIDS most commonly results in discrimination. Discrimination is often unwarranted since HIV cannot be transmitted through casual contact, which is all that is required in many settings where discrimination occurs. One should consider the example of employment discrimination and the problems it poses. An infected person may be fired from work due to an employer’s fears about transmission. However, as the court in *Barrington* pointed out, HIV cannot be transmitted through casual contact; thus, in most employment settings, there is no threat of transmission. Further, an infected person cannot simply quit a job where discrimination or harassment is occurring. If an infected person quits a job and seeks new employment, then HIV may be classified as a pre-existing condition for medical insurance purposes. Without adequate medical coverage, an infected person will face financial burdens in acquiring treatment.

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138 See N.Y. State Soc’y of Surgeons v. Axelrod, 77 N.Y.2d 677 (N.Y. 1991) (holding that the decision of the New York Dept. of Health Commissioner not to classify HIV or AIDS as a sexually transmitted or communicable disease under N.Y. Pub. Health Law 225(5)(h) and 2231 was not arbitrary and capricious because the designation would subject persons suspected of having HIV to mandatory testing and contact tracing, discouraging cooperation of affected individuals, and would lead to the loss of confidentiality for infected persons, and therefore was contrary to the public health).
139 See Gostin & Hodge, supra note 4, at 59.
141 Id.
Discrimination in the workplace is not the only result of stigma surrounding HIV/AIDS. Discrimination also occurs in housing, social welfare, and medical services. An infected person is likely to be dependent on services from these areas for survival. Additionally, when the infected person attempts to contact partners, or when notification is done on his or her behalf by a health care provider, the infected person may become the victim of physical violence, isolation from the community, or loss of personal relationships. In fact, an infected person faces a lifetime of stigma even if he or she exhibits no symptoms and is able to live a long life due to effective medical treatment.

The discrimination resulting from the stigma surrounding HIV is very similar to the discrimination faced by African Americans who are victims of racism. African Americans face discrimination in the job market, housing market, and in receiving social services. Thus, when African Americans are faced with a possible HIV infection, they are faced with becoming a target for additional discrimination.

Stigma most likely plays a role in African Americans’ decision-making when deciding whether to get tested, or to cooperate with public health officials in partner notification efforts. Members of marginalized groups often search for ways to hide additional stigma-producing factors. Race is a factor that cannot be hidden; however, HIV is different. Partner notification laws threaten the ability to hide HIV-positive status by requiring notification to partners. No one can guarantee that a notified partner will not disclose the infected person’s status to others in the community or that legal recourse may be sought, but this does not prevent the actual disclosure by the partner and by the time a judgment is rendered, the damage will likely already have occurred to the infected person.
accidental disclosures by health care providers will not occur. To avoid the risk of exposure and the chance of becoming a victim of HIV associated stigma, one option is to not take a HIV test at all.\textsuperscript{148} Another option, under the patient referral system, is never to notify partners of their exposure risk. With either option, partner notification laws are not effective and HIV continues to spread, silently and undetected, throughout the African-American community.

C. The Problem with Homosexuality

Historically, homosexuality was considered non-Afrocentric and a practice “forced upon the African-American community.”\textsuperscript{149} Openly gay African-American men are, at times, labeled as “race traitors.”\textsuperscript{150} Bisexuality is viewed in a similar manner because accepting bisexuality means acknowledging homosexual activity.\textsuperscript{151} As a result, homosexuality within the African-American community has been driven underground and a large portion of African-American men who have sex with other men do not self-identify as homosexual or bisexual.\textsuperscript{152} Some African-American men who have sex with men fear community rejection so strongly that they adopt the belief that although their behavior is homosexual, their identity is heterosexual and their behavior as irrelevant.\textsuperscript{153} This perspective poses problems for partner notification laws. The fear of adding yet another layer of stigma reemerges in the sexuality context. This fear is compounded by the fact that the African-American man does not self-identify as homosexual. Revealing an HIV infection would involve not only revealing his homosexuality to the community, but to himself. As such, partner notification laws that threaten privacy create a huge incentive for African American men who have sex with men to resist HIV testing, thus preventing the risk of having to expose homosexual or bisexual activity.

D. Other Factors

\textsuperscript{148} Burris, supra note 143, at 871.
\textsuperscript{150} Id. at 31.
\textsuperscript{151} Id. at 30.
\textsuperscript{152} Id.
Several other factors contribute to high rates of HIV/AIDS infection among African Americans. For example, African Americans generally distrust medical officials due to historical discriminatory treatment.\footnote{See generally Vanessa Northington Gamble, Under the Shadow of Tuskegee: African Americans and Health Care, 87 AM. J. PUB. HEALTH 1773 (1997) (discussing a history of abuse that lead the African American community to distrusting health care officials).} This distrust may result in African Americans doubting that health care providers will make a sincere effort to keep their HIV status confidential. Also, the ratio of men to women within the African American community actually discourages HIV/AIDS risk-reducing behavior.\footnote{See Airhihenbuwa et al, supra note 149.} Fewer African-American men than women are available, or desirable, in African-American communities due to incarceration, racism, violence, and poverty.\footnote{Id.} Frequently, African-American women end up possessing less power in relationships.\footnote{See id. at 33.} Thus, she is less likely to insist upon taking HIV/AIDS risk-reducing measures during the relationship.\footnote{Id.} When African-American women are dependent financially upon their male partner and do not want to risk losing financial support, the same problem occurs.\footnote{Id.} Finally, African Americans face socioeconomic barriers, such as poverty, which make access to health care difficult.\footnote{Ctrs. for Disease Control and Prevention, Fact Sheet: HIV/AIDS among African Americans, http://www.cdc.gov/ hiv/topics/aa/resources/factsheets/aa.htm (last updated Aug. 3, 2008).} Without access to adequate health care, HIV/AIDS testing and treatment are impossible. Attacking HIV/AIDS in the African-American community requires also attacking other factors that decrease the probability, or ability, of African Americans to protect themselves.

VI. Conclusion: Can Partner Notification Laws Work?

Creating effective state law to combat HIV/AIDS in the African-American community is a difficult task given the barriers of stigma and other cultural or socioeconomic factors. This task is further complicated by privacy issues and the need for public health preservation. Despite these challenges, applying partner notification
models in the African-American community can be effective if cultural factors are considered. Health care providers play a key role in this respect. Health care providers’ role must include fostering relationships based on trust and cooperation. Encouraging trust and cooperation with African-American patients requires community outreach by staff members who understand the impact of stigma and African American culture in partner notification efforts. Collaboration with community leaders is also essential. For example, Metropolitan Interdenominational Church Technical Assistance Network (MICTAN) provides training for community churches interested in reducing the number of HIV/AIDS infected persons in their African-American community. MICTAN collaborates with community leaders who act as change agents within their community. MICTAN’s goal is that the change initiated by community leaders will create a ripple effect by producing individual change in community members. MICTAN’s goal is enhanced by working through churches in the African-American community. These churches play a large role in African-American culture and frequently have the community’s trust. However, African-American churches have traditionally held anti-homosexual beliefs which can alienate infected persons. MICTAN aims to assist churches in reaching out to alienated community members. The goal is not to change religious beliefs, but to encourage the church’s community to work towards reducing HIV/AIDS; this requires reaching out to as many community members as possible.

Additionally, encouraging community members to communicate openly about HIV/AIDS is an important part of combating stigma by incorporating culture. Again, MICTAN is a good example. MICTAN places great emphasis on dialogue. Dialogue with infected persons is encouraged and facilitated through the community establishments. MICTAN’s goal is that infected persons

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162 See id.
164 Id.
165 Id.
in the community who have been afraid to come forward will feel more comfortable publicly discussing their disease once they realize that they are not alone.\textsuperscript{166} Open dialogue encourages understanding and decreases the likelihood that infected persons will be marginalized because of their disease. MICTAN’s strategies would likely increase partner notification efficacy by decreasing the fear of stigma that African Americans experience when deciding to get tested or after receiving positive test results.

To further increase partner notification efficacy, public health officials should consider how culture is implicated when certain language is used in relation to HIV/AIDS. For example, risk factors for HIV/AIDS should use terminology that African Americans will recognize and identify with. Since African-American men who have sex with men do not self-identify as homosexual, using the term “homosexuality” as a risk factor will not attract this population to testing.\textsuperscript{167} This term forces the African-American man to either self-identify as homosexual or to ignore the HIV/AIDS risk by refusing to identify as a member of a high risk group. Using language that takes the perception of homosexuality in the African-American community into consideration may encourage more to seek out testing.

On a positive note, HIV/AIDS prevention workers have recently begun to realize the importance of understanding culture in battling HIV/AIDS in the African-American community. Several programs have been implemented to research and better understand what it means to apply a cultural approach.\textsuperscript{168} These techniques, used in combination with partner notification efforts, have the potential to increase the impact partner notification laws have in the African American community. In the mean time, the statistics about HIV/AIDS and African Americans reveal a community that is dying from a disease. If partner notification laws are to play any role in reducing these numbers, the focus must be not on forced disclosure but on maintaining confidentiality and building trust with patients. Naturally, the stigma surrounding HIV/AIDS has been around since the discovery of the disease and will not disappear immediately. As

\begin{footnotes}
\item[166] Id.
\item[167] See generally Airhihenbuwa et al, supra note 149.
\item[168] See generally Ctrs. for Disease Control and Prevention, supra note 160.
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such, neither will the privacy issues that arise in connection with partner notification laws disappear accordingly. However, progress can be made if public health officials battle, not against privacy rights, but, against the stigma that motivates infected individuals to demand privacy.