HIV Name Reporting and Partner Notification in New York State

Sonia Bhatnager*
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Abstract

This Article focuses on a 1998 New York law that required physicians and other health officials to report individuals who test positive for HIV, AIDS, or other HIV-related illnesses to the municipal health commissioner. As New York has the highest rate of reported AIDS cases, the Article notes that the state’s decision to enact this law could have significant influence on other states. It begins by describing the partner notification system laws in the United States, and then presents arguments for and against partner notification. The Article ultimately argues for a modified version of the New York law. This refined system would call for a unique identifier system that would focus on valuable factors such as risk behavior, instead of name reporting, with the ultimate goal of effective implementation and patient privacy.

KEYWORDS: HIV/AIDS, name reporting, privacy
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Introduction

The World Health Organization estimates that new cases of full-blown Acquired Immunodeficiency Syndrome ("AIDS") increase by almost twenty percent worldwide each year, and that at the end of 1996, 1.64 million people worldwide were suffering from AIDS. It also estimates that only one-fifth of the actual number of cases is reported. The nature of the disease is changing as well: advancements in drug therapy and treatment are enabling infected individuals to remain asymptomatic for years.

Calls for epidemiological data that enable scientists to study the disease and treat people with HIV infection have led to HIV name reporting in some states. Other states have instituted partner notification programs in hopes of apprising contacts of their exposure.

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1. A case of AIDS was first defined as "illness in a person who 1) has either biopsy-proven KS [Kaposi's Sarcoma] or biopsy- or culture-proven, life-threatening opportunistic infection, 2) is under age 60, and 3) has no history of either immunosuppressive underlying illness or immunosuppressive therapy." U.S. Department of Health and Human Services, Updates on Kaposi's Sarcoma and Opportunistic Infections in Previously Healthy Persons - United States, 31 Morbidity & Mortality Wkly. Rep. 294 (1982). The definition was expanded in 1985 to include diseases such as disseminated histoplasmosis, chronic isosporiasis and certain non-Hodgkin's lymphomas. In 1987, another expansion occurred to the definition, which resulted in diseases such as extrapulmonary tuberculosis, HIV encephalopathy and HIV wasting syndrome being added. The latest revision takes effect as of January 1, 1993, which "includes all HIV-infected adults and adolescents who have less than [sic] 200 CD4+ T-lymphocytes/µL or a CD4+ T-lymphocyte percent of total lymphocytes less than 14, or who have been diagnosed with pulmonary tuberculosis, invasive cervical cancer, or recurrent pneumonia." Centers for Disease Control and Prevention, AIDS Surveillance in the United States (visited Mar. 12, 1999) <http://www.cdc.gov> [hereinafter CDC, AIDS Surveillance].


3. See id.

4. See infra note 99 and accompanying text.

5. See The Association of the Bar of the City of New York (Committees on AIDS, Civil Rights, Health Law, Legal Issues Affecting People with Disabilities and
to the virus and breaking the chain of transmission.\textsuperscript{6} Thirty-three states and U.S. Territories provide for some form of partner notification by statute.\textsuperscript{7} Although, as of June 30, 1998, thirty-one states collect the names of HIV-infected people,\textsuperscript{8} these names only account for a small percent of those suffering from AIDS nationally.\textsuperscript{9} New York, on the other hand, has the nation's highest rate of reported AIDS cases.\textsuperscript{10} Thus, New York's decision to enact a name reporting and partner notification law may significantly influence other states with high seroprevalence levels to follow its lead,\textsuperscript{11} or alternatively, to determine that the process does not work in those areas.

On July 7, 1998, the New York State Senate enacted a name reporting and partner notification law that amended Article 21 of the Sex and Law), Name Reporting of HIV Cases 1, 1 (1998) [hereinafter NYC Bar, Name Reporting].

\textsuperscript{6} See infra note 15 and accompanying text; see also Lawrence O. Gostin & James G. Hodge, Piercing the Veil of Secrecy in HIV/AIDS and Other Sexually Transmitted Diseases: Theories of Privacy and Disclosure in Partner Notification, 5 DUKE J. GENDER L. & POL'y 9, 14 (1998) (claiming that the goal of contact tracing is to "reduce disease transmission by locating and containing the spread of a given STD within a certain population") [hereinafter Gostin & Hodge, Piercing the Veil].

\textsuperscript{7} See The Association of the Bar of the City of New York (Committees on AIDS, Civil Rights, Health Law, Mental Health, Legal Issues Affecting People with Disabilities and Sex and Law), Partner Notification and HIV 1, 3 (1998) [herinafter NYC Bar, Partner Notification].

\textsuperscript{8} See Centers for Disease Control and Prevention, 10 HIV/AIDS SURVEILLANCE REP. 1 (1998). Connecticut and Texas required name reporting of children less than thirteen years old, and Oregon required reporting for children less than six years of age. The remaining twenty-eight states that have laws requiring confidential reporting by name of all persons infected with HIV are Alabama, Arizona, Arkansas, Colorado, Florida, Idaho, Indiana, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Utah, Virginia, West Virginia, Wisconsin and Wyoming. See id. at 7. Texas disposed of its unique identifier system and adopted name reporting for all HIV positive individuals as of January 1, 1999. See infra note 126 and accompanying text. New York also has adopted name reporting for HIV as of July 1998. See infra notes 12-13 and accompanying text.

\textsuperscript{9} See NYC Bar, Name Reporting, supra note 5, at 1-2.

\textsuperscript{10} See Centers for Disease Control and Prevention, supra note 8, at 1. In a survey conducted from July 1997 to June 1998 of Metropolitan areas in the U.S., New York City had the highest AIDS annual rate per 100,000 population with a rate of 101.2. No other city had a rate over 100.0 per 100,000. Jersey City, New Jersey came the closest with a rate of 72.2 per 100,000. See id. at 8. More importantly, however, is the fact that out of the 665,357 AIDS cases reported to the CDC through June 1998, New York State contributed to about 124,793 of them. See id. at 6. The CDC does not have HIV infection rates for New York. See id. at 5.

\textsuperscript{11} See Lynda Richardson, AIDS Groups Stunned by Vote for Partner Notification, N.Y. TIMES, June 20, 1998, at B3.
Public Health Law by adding a new Title III. The new law requires physicians and other health officials to report individuals who test positive for HIV, AIDS or other HIV-related illnesses to the municipal health commissioner. The law also mandates notification of contacts by the infected individual or physician. This Note explores the consequences and benefits of partner notification for HIV, focusing on its likely impact on New York State. Part I details the meaning and history of partner notification in the United States. Part II presents arguments for and against partner notification. Part III analyzes the New York law and argues that a unique identifier system in lieu of name reporting would assuage fears of privacy, encouraging a more effective implementation of a partner notification system. This Note concludes that HIV is a public health problem that cannot be ignored and must be combated aggressively, in a manner that simultaneously promotes testing and stunts transmission.

I. Name Reporting and Partner Notification in the United States and New York

Every state has implemented a policy of name reporting for AIDS. The information collected by state health departments includes “demographics, diagnostic facility, patient risk history, laboratory analysis, clinical status, and treatment/service referrals.” At the national level, patient and provider identifiers are deleted from the data so that reporting is done without the disclosure of infected individuals’ names. The national system of AIDS reporting had developed almost from the inception of the epidemic.

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12. See N.Y. PUB. HEALTH LAW § 2130 (McKinney 1999).
13. See id. § 2130(1).
14. See id. § 2133(1).
15. See CDC, AIDS Surveillance, supra note 1 (describing that data is collected from all fifty states, the District of Columbia, U.S. dependencies and possessions and independent nations in free association with the United States (Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, the Republic of Palau, the Republic of the Marshall Islands, the Commonwealth of the Northern Mariana Islands and the Federated States of Micronesia).
16. See id. ("[B]y 1985 all states had regulations requiring physicians and other health care providers to report AIDS cases directly to the local or health department," which in turn, share their data with the CDC.); see also Lawrence O. Gostin & James G. Hodge, The "Names Debate": The Case for National HIV Reporting in the United States, 61 ALB. L. REV. 679, 705 (1998) [hereinafter Gostin & Hodge, The "Names Debate"].
18. See id. at 706.
19. See id. at 696.
and caused little uproar. Early on in the epidemic, those identified as AIDS' carriers often were on the brink of death already, thus privacy issues were of little concern. However, this claim is not true today for HIV-positive individuals, especially those who are asymptomatic and may remain so for years. Accordingly, it is no surprise that the trend towards expanding the name reporting system to HIV infected individuals has resulted in conflicted emotions, despite the benefits of gathering epidemiological data about the epidemic.

The current push for partner notification, especially in New York, can most likely be attributed to advances in effective drug therapy and recent reports of individuals putting others at risk of contracting the virus. In New York, a name reporting and partner notification bill, introduced by Senator Velella and Assembly Member Nettie Mayersohn, was enacted on July 7, 1998.

A. Meaning and History of Partner Notification in the United States

Partner notification can be viewed as a combination of three concepts that sometimes overlap: "(1) contact tracing; (2) the duty of the infected persons to disclose their infection to a sexual partner; and (3) the duty of health care providers to warn of sexual and other risks to the partners of their infected patients."  

1. Contact Tracing

The practice of contact tracing generally enlists the help of public health authorities who interview infected individuals (referred to as "index" patients) to assemble a list of their contacts that may have been exposed to HIV. With this information, the authorities...
attempt to trace the contacts and notify them of their potential infection. The name of the index patient is not disclosed but may be deduced under certain circumstances, such as where the notified individual has only had one contact. This process then continues with any identified contact who likewise tests positive for HIV.

The first contact tracing program dates back to the syphilis epidemic of the early sixteenth century. Once syphilis was recognized as a sexually transmitted disease, individuals infected with the disease were banished from communities, quarantined in special hospitals and/or banned from public places. Prostitutes, who were viewed as the carriers of sexual contagion, such as syphilis, were subjected to government-sponsored medical inspection known as regimentation throughout Europe and the United States. The Illinois Board of Health even had the authority to hospitalize women on mere suspicion of infection and to place signs on their doors warning "suspected VD."

Thomas Parran, the newly-appointed Surgeon General during Franklin Delano Roosevelt's presidency, decreed his goal to be the eradication of the syphilis epidemic. With the assistance of federal funding, Parran began a national contact tracing program, which included contact notification. This effort "marked the first time in the United States that formal case finding and contact tracing were applied to a sexually transmitted disease on a national scale." However, the advent of penicillin in 1943 and its promise to cure syphilis stymied the role that contact tracing would play in reducing infection rates. Penicillin diminished the urgency for notification, leaving the success of contact tracing undetermined.

Although contact tracing is mainly the responsibility of state health departments, the Centers for Disease Control and Preven-

28. See id.
29. See id.
30. See id.
31. See id. at 16.
32. See id. 16-17.
33. See id. at 17-19.
34. See id. at 19 (quoting Marvin S. Amstey, The Political History of Syphilis and Its Application to the AIDS Epidemic, 4 Women's Health Issues 16, 17 (1994)).
35. See id. at 21.
36. See id. at 21-22.
37. Id. at 22.
38. See id. at 22-23.
tion ("CDC"), as part of the federal Department of Health and Human Services, provide funding to these state offices.40 The CDC, in turn, requires state health departments to implement partner notification programs according to certain guidelines.41 The guidelines include models denominated "patient referral," "provider referral" or the hybrid "conditional referral."42

The patient referral model enlists the aid of the index patient, who is asked to disclose her seropositive status to her sexual contacts and/or to injection drug users ("IDUs") with whom she has shared syringes.43 The index patient is assisted by the public health authorities to the extent that she is provided with medical information, which she may pass on to her contacts.44 These programs do not guarantee notification of contacts and do not provide for confidentiality of the index patient, as she personally notifies her contacts of the exposure to HIV.45

Provider referral programs, on the other hand, place the responsibility of contact tracing in the hands of public health officials once an index patient has disclosed a list of her contacts.46 Counseling is provided to the contact, preferably face to face, by the official.47 The anonymity of the patient is maintained because her name is not revealed to contacts.48 Obviously, however, the contact may deduce the name in certain circumstances.49 Although provider referral programs generally are more costly because of the heightened involvement of health authorities, they tend to ensure the transmission of high quality information.50 They also typically result in a higher rate of notification. In a study conducted in North Carolina, which assigned participants to either a patient referral group or a provider referral group, seventy-eight of 157 partners were successfully notified in the latter group whereas only ten out of 153 were notified by the patient referral model group.51

40. See Gostin & Hodge, Piercing the Veil, supra note 6, at 25-26.
41. See id. at 26.
42. Id.
44. See id.
45. See id.
46. See id.
47. See Gostin & Hodge, Piercing the Veil, supra note 6, at 27.
49. See Gostin & Hodge, Piercing the Veil, supra note 6, at 27.
50. See Dimas & Richland, supra note 43, at 206.
The third model, conditional referral, is a hybrid of the patient and provider referral models. In this model, the index patient is granted a limited period of time in which she may notify her contacts before the health authority intervenes. As with the provider referral model, the official does not disclose the identity of the index patient.

2. Duty to Disclose

Partner notification sometimes denotes the "duty to disclose," whereby a duty exists to disclose one’s sexually transmitted disease to his/her sexual partner. Since the turn of the century, persons aware of their infections have been responsible for disclosing contagious conditions, such as whooping cough and tuberculosis, to others with whom they were in contact. Today, in the context of HIV/AIDS, the duty to disclose has been significantly extended. In fact, the failure to disclose one’s positive serostatus can result in criminal prosecution for putting others at risk for infection. Nushawn Williams, the man accused of having unprotected sex with a teenage girl months after learning he was HIV-positive, was charged with reckless endangerment in New York City. By the end of 1991, more than three hundred people had been prosecuted for exposing others to HIV, and approximately fifty of those cases resulted in conviction.

3. Duty to Warn

The third component of partner notification, a physician’s duty to warn foreseeable third parties who may be endangered by the patient, is based on the principle articulated in Tarasoff v. Regents.

52. See Gostin & Hodge, Piercing the Veil, supra note 6, at 27.
53. See id.
54. See id.
55. See id. at 14-15.
56. See id. at 36-37.
57. See, e.g., IND. CODE ANN. § 16-41-7-1(d) (West 1998):
Carriers who know of their status as a carrier of a dangerous communicable disease described in subsection (a) [includes AIDS and HIV] have a duty to warn or cause to be warned by a third party a person at risk of the following:
(1) The carrier’s disease status.
(2) The need to seek health care such as counseling and testing.
58. See Lynda Richardson, Man Faces Felony Charge of Exposing Girl to H.I.V., N.Y. TIMES, Aug. 20, 1998, at B4 (noting that Williams also was suspected of infecting more than a dozen women and girls in upstate New York).
The California Supreme Court determined that physician-patient confidentiality must yield to the interests of third parties in similar situations where a special relationship exists between the patient and the individual responsible for warning. As of 1996, twenty-three states had adopted a Tarasoff-type duty by way of either judicial decision, legislative enactment or both.

This duty to warn was extended to HIV/AIDS cases in Reisner v. Regents of the Univ. of California. In this case, the California Court of Appeals determined that a physician, who failed to inform his patient that she had received a tainted blood transfusion and thus was infected with HIV, was liable to the patient's sexual partner who later contracted the virus from the patient. Like Tarasoff, a special relationship existed between physician and patient in Reisner, and the physician's responsibility did not stop at just treating his patient, but extended to informing her of her contagion.

Physician liability also has been found where a third party, with whom the physician has established no physician-patient relationship, was injured by the physician's patient. In DiMarco v. Lynch Homes – Chester County, Inc., the Supreme Court of Pennsylvania found two physicians liable to a third party who had been harmed as a direct result of the doctors' erroneous medical advice to their patient. The court determined that a physician's duty required informing her patients of their disease or condition, not in-

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60. 551 P.2d 334 (Ca. 1976). In Tarasoff, a California court imposed such a duty on psychotherapists whose patient expressed an intent to kill his victim. Because the patient was mentally unstable and had expressed a desire to kill a readily identifiable individual, the physicians should have alerted the victim that she was in danger. See id.

61. See id. at 343 (finding that a "special relationship" exists between a patient and his/her doctor or psychotherapist such that affirmative duties for the benefit of third persons may arise).


64. See id.

65. 583 A.2d 422 (Pa. 1990). The physicians had given erroneous medical advice to their patient concerning the contagious nature of her illness, which resulted in injury to the third-party plaintiff. The physicians only were required to give correct medical advice to their patient concerning the transmission of the hepatitis virus that she may have contracted; they were not required to inform third persons, foreseeable or not. See id.

66. See id.
forming every possible third-party plaintiff. This scenario would suggest that the physicians' duty is to inform, rather than to warn. As long as the physician correctly informs her HIV-diagnosed patient concerning the modes of transmission, she should be free from professional liability. Reisner emphasizes this duty to inform by finding the physician liable to an injured third party for failure to warn his patient, not for failure to warn the third party directly. The reasoning in Reisner would not seem to require partner notification; rather, it serves as a reminder to physicians about their pre-existing duty to fully inform patients about their disease.

Although courts have laid down a tradition that requires physicians to warn family members and others in close proximity to the patient of the contagious nature of the patient's disease, these cases are "generally characterized by the inability of the patient either to adapt his conduct so as to avoid or minimize the risk of infection or to communicate adequately to third parties the nature of the risk."

Moreover, these duty-to-warn cases generally involved minor children or seriously debilitated people. It thus follows that opponents of partner notification likely would respond that this tradition does not apply to HIV because the index patient is informed of her condition and the ways to control transmission to others when she is diagnosed.

Furthermore, the foundation upon which the duty to warn has been erected is factually distinguishable from that in the HIV situation. In Tarasoff, the physician was a psychotherapist and the patient a mentally deranged individual who had made explicit comments about his intent to murder a readily identifiable woman. However, in reality, the physician who diagnoses an index

67. See id.
68. See Reisner, 31 Cal. App. 4th at 1195 (finding physician liability in an action by a man who had contracted HIV through his girlfriend due to physician's failure to inform his patient that she had received tainted blood in a transfusion and was HIV positive).
70. See Price, supra note 39, at 449 (citing Davis v. Rodman, 227 S.W. 612 (Ark. 1921); Jones v. Stanko, 160 N.E. 456 (Ohio 1928); Wojcik v. Aluminum, 183 N.Y.S.2d 351 (1959); Simonsen v. Swenson, 177 N.W. 831 (Neb. 1920)).
71. Id. at 450.
72. See id. at 449 (citing Davis, 227 S.W. at 612; Jones, 160 N.E. at 456; Wojcik, 183 N.Y.S.2d at 351 (1959); Simonsen, 177 N.W. at 831).
73. See, e.g., N.Y. PUB. HEALTH LAW § 2781(3) (McKinney 1999) (requiring health officials testing patients to inform them of the nature of the disease, the possibility of discrimination, and ways to curb transmission).
patient with HIV is generally not a psychotherapist, nor is the index patient generally insane. More likely, the physician is a medical doctor who can explain the known routes of HIV transmission and the ways to prevent it. The patient, through behavior modification, can stop the chain of transmission, as can his/her contact via protective measures. An individual who desires to kill another, whether it be with a physical weapon or with a virus, differs greatly from one who is infected with a virus and will take the necessary precautions to prevent its transmission. Additionally, the duty to warn applies to future harm that may occur to an individual from the intended acts of another.75 Partner notification, however, attempts to retrospectively warn those potentially infected by the virus, which in its own way may make a stronger case for partner notification – the harm, e.g., exposure, has already occurred and is no longer speculative.

Although many of the duty-to-warn cases do involve contagious diseases such as hepatitis, HIV/AIDS can be distinguished from those infectious diseases. Not surprisingly, the stigma associated with HIV/AIDS is far greater than that associated with any other infectious disease.76 "The privacy interest in one's exposure to the AIDS virus is even greater than one's privacy interest in ordinary medical records ... The potential for harm in the event of a non-consensual disclosure is substantial."77 Additionally, HIV/AIDS is different in kind from diseases such as tuberculosis because of the determinate role that behavior modification plays in transmission of the former. Adhering to certain precautions can prevent the spread of HIV, whereas tuberculosis is air-borne.78 While incurable,79 Hepatitis B also is different from HIV because vaccines ex-

75. See id. at 340.
76. See NYC Bar, Partner Notification, supra note 7, at 8; see also Herek & Capitiano, infra note 77 and accompanying text.
78. See Gostin & Hodge, Piercing the Veil, supra note 6, at 686.
79. See Marc Kaufman, Hepatitis B Vaccine Effort Draws Fire; Critics Cite Reports of Adverse Effects in Opposing Mandatory Inoculations of Children, WASH. POST, Feb. 2, 1999, at Z11. The hepatitis B virus infects about 200,000 Americans annually. At least 36 states, however, require the vaccine, which consists of a series of three shots, before a child can register for school. See id.
ist for Hepatitis B, capable of preventing its spread for at least fifteen years. However, both diseases are spread through blood and other bodily fluids, and are found most frequently among IDUs and people engaging in high-risk sexual activities in the United States. Still, Hepatitis B, while more readily transmissible, is less likely to be fatal.

**B. Name Reporting and Partner Notification in New York**

The new law enacted by New York in the summer of 1998 mandates that physicians and others authorized to order diagnostic tests, as well as laboratories performing these tests, must report any person testing positive for HIV, AIDS or HIV-related illness to the municipal health commissioner. This commissioner must then forward the information, which contains the identifying information of the index patient and any contacts, to the municipal health commissioner of the municipality where the disease occurred. Although name reporting of HIV would serve certain epidemiological benefits such as “facilitat[ing] the study of the course of the disease and allow[ing] better targeting of resources and prevention efforts,” many assert that it is a great deterrent to testing.

New York legislation continues to state that, in the case of contacts residing outside of the municipality, the commissioner will send the report to the particular contact’s municipality, whose commissioner will make a good faith effort to notify the contact. The commissioner will accompany notification with information relating to HIV treatment and prevention, ensuring, at the very least, that accurate information is disclosed. During the notification process, the commissioner or authorized official is not permitted to divulge the identity of the index patient or the identity of any other contact.

81. See Kaufman, supra note 79, at Z11.
82. See Stenger, *supra* note 62, at 488; see also Ron Geraci, *supra* note 80 (stating that most cases of Hepatitis B resolve themselves but almost 15% become chronic and can cause cirrhosis or liver cancer).
84. See id. §§ 2130(2)-(3).
85. NYC Bar, *Name Reporting*, supra note 5, at 1.
86. See *supra* notes 168-169 and accompanying text.
88. See id. § 2133(2).
89. See Dimas & Richland, *supra* note 43, at 206.
The law also stipulates that no criminal or civil liability will result for any index patient's failure to cooperate in contact tracing, and adds a safety provision for index patients threatened by domestic violence. Other safety precautions are the ones given to health officials who must report or notify partners: "Good faith reporting or disclosure pursuant to this title shall not constitute libel or slander or a violation of the right of privacy or privileged communication." Furthermore, immunity from civil and criminal liability is granted for good faith attempts at reporting. The physician also is given the alternative of notifying contacts if she has notified the patient of her intent and given the patient an opportunity to express a preference as to notification.

Finally, the option of anonymous testing still is retained by the new law. Section 2138 emphasizes that: "Nothing in this article shall be interpreted to eliminate the anonymous testing option provided for in section twenty seven hundred eighty-one of this chapter." Unlike other infectious diseases, anonymous testing has been available for HIV at publicly-funded sites in the United States since 1985. In confidential testing, a person's name is linked to the specimen, and the result of the test is recorded in the medical chart with a name. Anonymous testing, on the other hand, uses a unique identifier, rather than the patient's name, to link the specimen with the test result, and the results are not recorded in the medical chart.

II. The Debate Over Name Reporting and Partner Notification: The Ramifications of Disclosure

It is no secret that name reporting and partner notification are controversial and emotionally-charged issues. At the heart of the debate, the welfare of unknowingly HIV-infected individuals is directly pitted against the privacy interest one has in her own serostatus. It is difficult, if not impossible, to draw clear lines between

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91. See id. §§ 2136(3), 2137.
92. Id. § 2136(1).
93. See id. § 2136(2).
94. See id. § 2782(4)(a)(4).
95. Id. § 2138.
96. See A. B. Bindman et al., Multistate Evaluation of Anonymous HIV Testing and Access to Medical Care, 280 JAMA 1416 (1998) (stating that as of October 1998, forty states have publicly funded anonymous testing sites for HIV, and all fifty states have publicly funded confidential testing sites).
97. See id.
98. See id.
right and wrong. The following are arguments posited by proponents and opponents of name reporting and partner notification.

A. The Benefits of Name Reporting and Partner Notification

Proponents of name reporting and partner notification ground their argument in the changing face of the disease: once found primarily in male homosexuals and IDUs, HIV has evolved. "[T]he epidemic American society now faces is no longer a plague of unstoppable, deadly disease among predominantly gay persons, but a potentially controllable chronic condition with increasing effects on heterosexuals, women, and children."\(^9\) As HIV has affected more of the American population, the push to decrease the spread of HIV infection has increased considerably. The need for epidemiological data to understand and control HIV is crucial, especially considering the benefits that recent advances have already shown: "From a public health and epidemiological perspective, the advantages of tracking and profiling HIV are significant, as HIV marks the beginning of the disease process rather than the end. In contrast, AIDS surveillance is triggered by events marking the late-stage progression of disease."\(^\text{100}\)

1. Advances in Drug Therapy

The practices of name reporting and partner notification are further justified by the recent success of drug therapies. Encouraging trends in AIDS cases in the United States have been attributed primarily to the effect of antiretroviral therapies on HIV-positive individuals.\(^\text{101}\) AIDS deaths declined twenty-three percent in 1996 compared to 1995, indicating that the therapies are having a significant impact on the rate of HIV progression.\(^\text{102}\) In addition, recent studies varying antiretroviral regimens have shown significant improvements in mortality and AIDS-free survival for men and wo-


\(^\text{102}\) See USHHS, Update, supra note 101 ("From 1995 to 1996, deaths declined in all four geographic regions . . . ; among men and women; among all racial/ethnic groups; and in all risk/exposure categories. . . ").
Individuals free of AIDS who took the less effective regimen were nearly three times more likely to progress to AIDS or die than those in the other group. Antiretroviral agents also have been known to reduce viral loads in individuals for periods of months to years, reflecting the strides medicine has made since the beginnings of the epidemic.

Furthermore, recent reports indicate that a triple therapy regimen without protease inhibitors can effectively suppress HIV. A study was conducted in 173 drug-naive HIV-positive individuals in which eighty-seven received triple-drug therapy while eighty-six received two-drug therapy. The results showed that triple-drug therapy resulted in undetectable levels of the virus in eighty-six percent of patients after sixteen weeks, while two-drug therapy only resulted in undetectable levels of the virus in forty-three percent of patients after the same week period. Thus, it has been asserted that “HIV has become a potentially manageable disease on a multiple decade timetable.”

Advancements in medical research have even created optimism about the development of a vaccine.

Treatment with zidovudine also has reduced the rate of perinatal transmission of HIV. Perinatal transmission accounts for virtue-

103. See Robert S. Hogg et al., Improved Survival among HIV-infected Individuals Following Initiation of Antiretroviral Therapy, 279 JAMA 450 (1998) (attributing improvement of HIV-infected individuals to new antiretroviral therapy strategies that included separating patients into two therapy regimens: ERA-I included zidovudine-, didanosine-, or zalcitabine-based therapy and ERA-II included lamivudine or stavudine).

104. See id. (noting that the ERA-II group showed marked improvements).


107. See id. (stating the two-drug therapy group received lamivudine and zidovudine only).

108. See id.


ally all new HIV infections in children.\textsuperscript{112} "As of September 30, 1997, perinatal transmission of HIV accounted for 7310 (one percent) of the 626,334 total AIDS cases in adults and children reported to the CDC by state and territorial health departments."\textsuperscript{113} New York State alone comprised twenty-seven percent of the perinatally transmitted infections.\textsuperscript{114} A 1996 study showed that the HIV transmission rate for infants receiving a placebo was 22.6\%, as compared with a 7.6\% rate for infants receiving zidovudine.\textsuperscript{115} These differences amounted to a sixty-six percent reduction in the risk of transmission.\textsuperscript{116} The Institute of Medicine has recommended that HIV testing be universal and added to the standard battery of prenatal tests.\textsuperscript{117} Partner notification may apprise pregnant women of their exposure to HIV and potentially prevent their children from contracting the disease.

Partner notification may help HIV-positive individuals make better use of available drugs by informing them that they have been exposed to the disease in hopes of getting them into treatment before any symptoms of infection occur. "Early detection of the virus is considered increasingly important since a new class of AIDS drugs called protease inhibitors has proven effective in treating the disease in many people."\textsuperscript{118} Research has indicated that these new drug therapies are more effective if begun soon after infection.\textsuperscript{119} Name reporting may help to develop even more effective treatments or improve those already available.

\section{2. Cost Efficiency of Partner Notification}

Proponents of partner notification also argue that money spent on implementing such programs is money well spent. Colorado


\textsuperscript{113} Id.

\textsuperscript{114} See id.

\textsuperscript{115} See id.

\textsuperscript{116} See id.

\textsuperscript{117} See Centers for Disease Control and Prevention, \textit{Status of Perinatal HIV Prevention in the United States: CDC Statement Following the Release of the Institute of Medicine Report} (Oct. 14, 1998) <http://www.cdc.gov> (stating that the CDC has recommended since 1994 that all pregnant women be offered HIV testing as part of prenatal care, and if infected, be offered an AZT regimen).


health officials calculated that every dollar spent on HIV partner notification saves $7.20 in clinical care costs for AIDS patients.\textsuperscript{120} This figure assumes that each partner who elects to be tested as a result of notification will transmit HIV to one less partner and fifty percent of those tested would develop AIDS.\textsuperscript{121}

Another way to understand the cost-efficiency of partner notification is to analyze the increasing costs associated with HIV/AIDS drug therapy and the subsequent economic benefits derived from halting transmission to others. Several years ago, basic HIV therapy amounted to an annual cost of $3000, whereas basic therapy in 1998, which currently involves four or five drugs, has risen to more than $12,000 annually.\textsuperscript{122}

3. No Effective Alternatives

Many proponents of name reporting rally against non-name reporting systems, such as the unique identifier system used in several states, which they view as ineffective in collecting data to study the disease. Maryland’s unique identifier system, in effect since June 1, 1994, is a twelve digit number consisting of the last four digits of an individual’s Social Security number, date of birth, race/ethnicity and gender.\textsuperscript{123} An evaluation of Maryland’s system from July 1994 through December 1996 found that twenty-nine percent of 9971 laboratory reports entered into the system were missing a portion of the unique identifier, usually the social security number.\textsuperscript{124} The Maryland system was also plagued by a fifty percent rate of completeness, a large number of duplicate reports and lack of HIV risk information.\textsuperscript{125}

Texas also instituted a unique identifier system in March 1994, but recently abandoned it in favor of HIV reporting by name,

\textsuperscript{120} See Dimas & Richland, \textit{supra} note 43, at 207.
\textsuperscript{121} See id.
\textsuperscript{122} See David N. Rose, \textit{AIDS Drug Regimens that are Worth Their Costs}, 279 JAMA 160 (1998).
\textsuperscript{125} See id.
which will be effective January 1, 1999. However, this change will not affect the availability of anonymous HIV testing. ‘Texas’ decision to stop using the unique identifier system stems from incomplete codes collected throughout the years: from a pool of 20,000 reports in the last three years, only forty-nine percent have been complete.

### 4. Name Reporting is not a Deterrent to Testing

Studies have shown that name reporting and partner notification are not significant deterrents to testing. One study conducted last year revealed that there were no significant declines in the total number of HIV tests provided at counseling and testing sites in the months immediately after implementation of HIV reporting occurred in any of the six states studied, other than those expected from previous trends. In fact, the study found increases in Nebraska (15.8%), Nevada (48.8%), New Jersey (21.3%) and Tennessee (62.8%). Predicted decreases occurred in Louisiana and Michigan (10.5% and 2.0%, respectively). All six states showed increases in testing of at-risk heterosexuals. Only two states showed minimal declines for men who have sex with men. Three states had declines for IDUs.

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127. See id.

128. See Texas to Switch from Codes to Names to Track HIV Cases, AIDS Pol’y & Law, Feb. 20, 1998, at 1, 11.

129. See A. K. Nakashima et al., Effect of HIV Reporting by Name on Use of HIV Testing in Publicly Funded Counseling and Testing Programs, 280 JAMA 234 (1998) (explaining studies that found name reporting and partner notification to be deterrents were flawed either because they targeted people seeking anonymous testing, who were naturally more likely to be concerned about confidentiality than the average person, or conducted their studies before highly effective antiretroviral therapies were available, or both).

130. See id.

131. See id.

132. See id.

133. See id. (chronicling increases for heterosexuals were as follows: Louisiana, 10.5%; Michigan, 225.1%; Nebraska, 5.7%; Nevada, 303.3%; New Jersey, 462.9%; Tennessee, 603.8%).

134. See id. (“Declines in testing occurred among men who have sex with men in Louisiana (4.3%) and Tennessee (4.1%) after HIV reporting; testing increased for this group in Michigan (5.3%), Nebraska (19.6%), Nevada (12.5%), and New Jersey (22.4%).”)

135. See id. (“Among injection drug users, testing declined in Louisiana (15%), Michigan (34.3%), and New Jersey (0.6%) and increased in Nebraska (1.7%), Nevada (18.9%), and Tennessee (16.6%).”)

The Texas Department of Health ("TDH") conducted a study in 1996 and 1997 in which HIV prevention workers interviewed 615 Texans in three risk categories for HIV (men who have sex with men, IDUs and high risk heterosexuals).\textsuperscript{136} Eighty-five percent of those interviewed said that they were likely to test for HIV in the next year.\textsuperscript{137} Seventeen percent expressed some concern about named reporting of HIV test results, but only two percent cited concerns over confidentiality or reporting as the most important reason for delaying or avoiding testing.\textsuperscript{138}

Moreover, from a survey of 399 patients who had not been tested for HIV, only eighteen cited discrimination and confidentiality concerns as factors in their decision, showing that despite widespread misconceptions about partner notification, the deterrence to testing is small.\textsuperscript{139} This survey also showed that ninety-one percent of respondents believed that HIV-positive index patients should apprise their sexual partners of their possible exposure to HIV.\textsuperscript{140}

5. \textit{Allocating and Improving Scarce Resources}

After abandoning its unique identifier system, TDH argued that HIV reporting by name was necessary to "make sure that resources get to the communities that need them most."\textsuperscript{141} TDH uses AIDS case numbers to allocate HIV treatment resources, but these numbers do not accurately reflect the people infected with HIV.\textsuperscript{142} Thus, communities with large numbers of asymptomatic HIV individuals do not get the resources they need.\textsuperscript{143} Additionally, TDH has argued that it cannot get a reliable estimate on the number of HIV infected individuals in Texas without HIV reporting.\textsuperscript{144} Without this number, improving HIV prevention and services programs is difficult, especially considering the increasing time lag between HIV infections and AIDS.\textsuperscript{145} The subtle trends in in-


\textsuperscript{137} See id.

\textsuperscript{138} See id.

\textsuperscript{139} See Dimas & Richland, \textit{supra} note 43, at 206.

\textsuperscript{140} See \textit{id.} at 208.


\textsuperscript{142} See \textit{id.}

\textsuperscript{143} See \textit{id.}

\textsuperscript{144} See \textit{id.}

\textsuperscript{145} See \textit{id.}
fection rates among different groups cannot be gauged without data on HIV.\textsuperscript{146}

B. Arguments Against Name Reporting and Partner Notification

1. Threats to Confidentiality

Perhaps the most basic argument against name reporting and partner notification is the potential breach of patient confidentiality and the degeneration of the doctor-patient relationship: "Named reporting also by its nature requires a breach of the therapeutic relationship, because the physician, by law, must report confidential information to the health department."\textsuperscript{147} Partner notification results in a similar breach, because although the physician does not disclose the name of the index patient, she still must inform contacts of the index patient, not unreasonably resulting in the index patient's fear of discovery.

In states requiring partner notification, the contours of what would be the inner-sanctum of the doctor-patient relationship are mandated by statute. Some states impose penalties on HIV positive individuals who fail to notify contacts,\textsuperscript{148} and others authorize physicians and public health officials to notify contacts, even without the patient's consent.\textsuperscript{149}

The creation of databases containing the names of infected individuals and their contacts increases the possibility of further breaches in confidentiality. There already have been such breaches, including the theft of a computer containing the names of people with AIDS from a public health office in Sacramento, California.\textsuperscript{150} State experts reviewing a backup computer tape found a list of names and characteristics of about sixty AIDS patients that

\textsuperscript{146} See id.
\textsuperscript{147} See Gostin & Hodge, The "Names Debate," supra note 16, at 684.
\textsuperscript{148} See, e.g., IND. CODE ANN. § 35-50-3-3 (West 1994).
\textsuperscript{149} See, e.g., CONN. GEN. STAT. ANN. § 19a-584 (West 1997):
A public health officer may inform or warn partners of an individual that they may have been exposed to the HIV virus under the following conditions: (1) The public health officer reasonably believes there is a significant risk of transmission to the partner; (2) the public health officer has counseled the protected individual regarding the need to notify the partner and the public health officer reasonably believes the protected individual will not inform the partner; (3) the public health officer has informed the protected individual of his intent to make such disclosure.
\textsuperscript{150} See Richard C. Paddock, Thieves Steal Computer Containing Confidential List of 60 AIDS Victims, L.A. T\textsc{imes}, July 9, 1987, at 3.
dated back more than a year and should have been erased earlier.\textsuperscript{151}

There have also been leaks of information on computer discs from the Pinellas County Health Unit in Florida, which may have contained the names of approximately 4000 individuals infected with HIV.\textsuperscript{152} The database contained telephone numbers, addresses, dates of birth and the manner by which individuals contracted AIDS.\textsuperscript{153} Investigation into this incident revealed the practice of Florida’s employees visiting hospitals and doctors carrying laptops and discs containing the entire list of HIV-positive individuals for the county in which they worked.\textsuperscript{154} Opponents of HIV partner notification fear that health officials privy to the HIV serostatus of so many individuals will continue to compromise confidentiality by leaking the information.

Disclosure of one’s serostatus to others may also lead to domestic violence. One study showed that forty-five percent of health care providers serving HIV-positive women reported that they have patients who feared domestic violence as a result of partner notification.\textsuperscript{155} One-quarter of these providers had patients who actually had been assaulted by their partners upon notification.\textsuperscript{156}

Additional breaches in confidentiality may come from the contact who is notified by the physician or public health authority. Although statutory requirements prohibit disclosure to non-privileged sources,\textsuperscript{157} the name of an index patient whose identity is deducible by the contact may be leaked by that contact.\textsuperscript{158} In certain situations, it could be virtually impossible to determine where a breach occurred, especially if it was perpetrated by an angered

\begin{itemize}
\item \textsuperscript{151} See id.
\item \textsuperscript{152} See Sue Landry, \textit{AIDS List is Out}, \textit{St. Petersburg Times}, Sept. 20, 1996, at 1A.
\item \textsuperscript{153} See id.
\item \textsuperscript{154} See Sue Landry & Tim Roche, \textit{Lawsuit Filed Over AIDS List}, \textit{St. Petersburg Times}, Sept. 24, 1996, at 1A.
\item \textsuperscript{155} See ACLU, \textit{Why Coercion Won't Work}, \textit{supra} note 119, at 9 (citing Karen H. Rothberg et al., \textit{Domestic Violence and Partner Notification: Implications for Treatment and Counseling of Women with HIV}, 50 JAMWA 3:87 (1995)).
\item \textsuperscript{156} See id. (citing Karen H. Rothberg et al., \textit{Domestic Violence and Partner Notification: Implications for Treatment and Counseling of Women with HIV}, 50 JAMWA 3:87 (1995)).
\item \textsuperscript{157} See, e.g., \textit{N.Y. Pub. Health Law} § 2135 (McKinney 1999) ("All reports or information secured by the department, municipal health commissioner or district health officer . . . shall be confidential except in so far as is necessary to carry out the provisions of this title.").
\item \textsuperscript{158} See Price, \textit{supra} note 39, at 469.
\end{itemize}
contact. Not surprisingly, it would be difficult to enforce laws prohibiting disclosure by contacts.

Opponents of name reporting and partner notification have rallied behind programs such as anonymous testing and unique identifier systems. Another system that would not breach confidentiality but may pose other problems is the use of a unique identifier that is not comprised of the last four digits of a patient's social security number. An example of this identifier is a word or phrase that the patient chooses herself, similar to e-mail addresses used on the internet. This identifier need not in any way be linked to the patient, assuring perfect confidentiality. However, this system relies completely on the patient's cooperation, making the collection of a comprehensive pool of data in comparison with a name reporting system more difficult.

2. Stigma and the Inadequacy of Legal Protections

Mandatory name reporting and partner notification may be more palatable to the general populace if the stigma surrounding HIV/AIDS was not so strong. In a study conducted by Gregory M. Herek, Ph.D. and John P. Capitanio, Ph.D. at the University of California at Davis, it was demonstrated that the stigma of AIDS is still alive and strong. The study examined attitudes towards people with AIDS ("PWA") in the second decade of the disease. It found that between one-third and one-fifth of the general public holds negative feelings towards PWA, believes that they deserve their illness, or even supports punitive measures to be taken against them. The study further revealed that many misconceptions around transmissibility of the disease still exist.

Legal protections are necessary to stop discrimination against PWA. Unfortunately, current protections are inadequate in accomplishing this goal. As illustrated by the Americans with Disabilities Act ("ADA"), although a law may be able to prohibit discrimination in theory, it cannot always control it in practice. For

160. See id.
161. See Herek & Capitanio, supra note 77.
162. See id.
163. See id.
164. See id. Of the 538 surveyed, roughly half thought transmission of HIV was likely when two uninfected homosexual men had intercourse without condoms, when a person shared a drinking glass with an HIV-positive person, was coughed or sneezed on by a infected individual, or was bitten by an insect. See id. at tbl. 2.
example, in *Bragdon v. Abbott*\(^{165}\) the Supreme Court recently determined that asymptomatic HIV infection is a disability for ADA purposes, thereby prohibiting employment discrimination against HIV-positive individuals.\(^{166}\) Still, the Court cannot eliminate the obvious social stigma attached to the disease. Even the ADA working at full capacity cannot prevent a seropositive individual from suffering discrimination in social situations and by loved ones.\(^{167}\)

3. **Name Reporting and Partner Notification Deter Testing**

A common argument against name reporting and partner notification programs is that they will deter people from voluntary HIV testing. According to some, “while the goal of increased tracking of HIV infection is to bring those with HIV into the public health system and to obtain more accurate epidemiological data, name reporting will likely have the opposite effect.”\(^{168}\) Studies suggest that a significant number of individuals tested anonymously for HIV would not have undergone testing if their names would have been reported to public health authorities.\(^{169}\)

Moreover, if the ultimate goal is to get people tested, treated and engaged in less risky behavior as quickly as possible, then name reporting and partner notification may have a deleterious effect.\(^{170}\) Research indicates that when anonymous testing is available, the average amount of time spent deciding to be tested can be reduced by more than one half, from a mean of twelve months to a mean of five months.\(^{171}\) Moreover, more individuals return for their results at anonymous testing centers than at centers that prac-

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166. See id.
168. See id.
169. See id. (citing Susan M. Kegeles et al., *Many People Who Seek Anonymous HIV-Antibody Testing Would Avoid it Under Other Circumstances*, 4 AIDS 585, 586 (1990) (observing that over sixty percent of individuals tested anonymously would not have tested if their names were reported to public health officials); see also Gostin & Hodge, *Piercing the Veil*, supra note 6, at 33 (citing Centers for Disease Control & Prevention, U.S. Dep't of Health & Human Servs., *Partner Notification and Confidentiality of the Index Patient: Its Role in Preventing HIV*, 17 SEXUALLY TRANSMITTED DISEASES 113, 113-14 (1990)).
171. See id.
HIV NAME REPORTING

The number of individuals failing to return likely would increase where testing entailed not only name disclosure to authorities, but also was followed by partner notification. Additionally, fears of discrimination and stigmatization are so strong that many travel across state lines to obtain anonymous testing. Performed in conjunction with name reporting, partner notification appears to add barriers to an already emotionally-charged situation. Partner notification is self-defeating if it acts as a deterrent to testing. Fewer contacts will be notified if fewer people are willing to be tested.

4. The Failure of Partner Notification to Eradicate the Spread of Syphilis

Although sexually-transmitted, HIV/AIDS is different in degree from other STDs. HIV/AIDS cannot be rendered non-infectious like syphilis and gonorrhea, meaning that any partner notification program for HIV/AIDS-infected individuals would have to continue throughout the person’s existence, making it considerably more expensive than those employed for other STDs. Despite the central role partner notification played in syphilis treatment programs in the 1940s, it is unclear whether it had an effect on reducing transmission. In fact, both syphilis and gonorrhea infections have increased in the past twenty years, leading many to question the effectiveness of partner notification measures. Even the CDC recognized this dilemma, attributing partner notification’s failure to control syphilis to the fact that syphilis affects a large number of illegal drug users, rendering notification of contacts difficult and sometimes impossible. HIV infection also is largely related to IDUs: The demographics of HIV are changing from largely gay and bisexual men in the first decade of the epidemic to people of color and IDUs in the second decade.

172. See id. A study conducted in North Carolina showed that 30.3% of people undergoing confidential testing did not return, as compared to only 8.2% of anonymously tested individuals. See id. (citing Irva Hertz Picciotto et al., HIV Test-Seeking Before and After the Restriction of Anonymous Testing in North Carolina, 86 Am. J. Pub. Health 1446, 1448 (1996)).
173. See id.
174. See NYC Bar, Partner Notification, supra note 7, at 3, 8.
175. See id. at 3.
176. See id.
178. See id. at 2.
In addition, the various risk factors that have been attributed to the failure of partner notification efforts in controlling recent outbreaks of syphilis - drug dependency, anonymous sex, needle-sharing partners, and the exchange of sex for drugs or money - are all present among the fastest growing population at risk for contracting HIV.179

The circumstances surrounding HIV and syphilis are similar, suggesting that partner notification may not effectively combat the spread of HIV either.

III. Improving the New York Name Reporting and Partner Notification Law

Many obstacles must be overcome before the New York Name Reporting and Partner Notification Statute can be applied effectively. Between the statute itself and the proposed regulations, a definitive plan for instituting the law remains muddied and impractical. The following section analyzes the new law, suggesting various changes to it while also supporting the implementation of a unique identifier system in conjunction with partner notification.

A. Cost Efficiency of Partner Notification

Even if one assumes that the costs and resources associated with partner notification are reasonable considering the results,180 one cannot help but wonder whether available resources may be better spent on medical research and providing access to health care.181 "The CDC estimated in April 1987 that the cost of identifying, locating, counseling, and testing partners was $98 per HIV-infected partner and $91 per HIV-seronegative partner."182 New York, however, is not just any state. One must recognize the many obsta-

179. Id. at 8.
180. See generally Andrew T. Pavia, M.D. et al., Partner Notification for Control of HIV: Results after 2 Years of a Statewide Program in Utah, 83 AM. J. PUB. HEALTH 1418, 1422-23 (1993) ("The benefits of partner notification for HIV exposure thus appear to outweigh the potential risks and costs, but its precise role remains to be determined.").
181. See ACLU, Why Coercion Won't Work, supra note 119, at 12 (Data from test sites in Florida and New Jersey show that it cost $281,964 to locate 1035 partners (of 8633 that had been named), and 122 of those notified tested positive for HIV) (citing Thomas A. Peterman, et al., HIV Partner Notification: Cost and Effectiveness Data from a Multicenter Randomized Controlled Trial, XI INT. CONF. AIDS, Abstract #Th.C.4626 (1996)).
182. Dimas & Richland, supra note 43, at 206-07 (stating that the difference in cost stemmed from the need for additional post-test counseling for HIV-positive individuals).
cles in reporting infected individuals and notifying their partners in urban areas with such high seroprevalence levels such as New York City.  

Still, New York has posited that after several thousands of dollars spent on updating laboratory materials and facilities to accommodate the increase in HIV reporting, the additional costs associated with reporting and notification will be nominal: $5.00 per report for a health care provider to fill out the form, $8.00 per interview with HIV positive individual, post-test counseling that may be eligible for Medicaid reimbursement at an average rate of $72.00 per session, and an estimated $100.00 for one hour of time per partner notified by a physician. These numbers then have to be multiplied by the additional 11,000 newly diagnosed cases of HIV that the state expects to report annually (9000 in New York City and 2000 in the rest of the state). Also added to these costs must be the number of contacts notified. Another factor that must be taken into account for New York City in particular is the difficulty in locating partners of IDUs and other marginalized groups, such as people without places of permanent residence. “[T]he fastest expansion [of HIV cases in New York] is among the state’s most disenfranchised: the poor, intravenous-drug users, people of color, gay teenagers and runaway children.” These people, if attempted to be notified, will surely increase the costs per notification.

The state must recognize that partner notification in New York will necessarily be more expensive and less successful than in other states, so that a basic weighing and evaluation of each tested individual should be done. If it appears that the contacts named by the index patient are not able to be located without undue costs, or the information concerning their whereabouts is not forthcoming, a health official may not want to incur the unexpected, additional costs. This evaluation should be done on a case-by-case analysis so that much needed funds that could be used for treatment are not wasted on hopeless cases.

183. See Price, supra note 39, at 478; see also Centers for Disease Control and Prevention, supra note 8 and accompanying text.


185. See id. at 6.

186. See supra notes 177-179 and accompanying text.

187. Laurie Garrett, Hidden HIV / The Search is on for People Who Don't Know They Carry the Virus that Causes AIDS, NEWSDAY, Aug. 18, 1998, at C6.
B. A Unique Identifier System

New York could achieve its twin goals of data collection and partner notification without discouraging testing by instituting a unique identifier system and eliminating name reporting. As noted earlier, this system has been instituted in Maryland, and until recently, Texas. Although Maryland recognizes its problems with incomplete reports, it notes that the percentage of complete reports has been steadily increasing. A pilot program, whereby staff members are trained in the unique identifier system, has resulted in a markedly improved 96.6% completeness rate. Therefore, New York should ensure that health department employees creating unique identifier numbers undergo training programs when the system is initiated.

A unique identifier system’s success is measured by more than the completeness of the numbers reported. Its “ability to match the [unique identifiers] of persons listed in the UI Registry with the UI’s of persons listed in the state’s AIDS Registry and consequently to be able to distinguish new cases of HIV infection from previously reported AIDS cases” also mark a system’s value. Maryland’s match rate was 76.5%, while that of Alabama and Arizona, two states using HIV name reporting, had match rates of seventy-nine to ninety percent. The seroprevalence rate of Maryland, however, is approximately three times higher than that of Alabama and Arizona, suggesting a higher case load; may have been responsible for lower match levels. Because New York has one of the highest seroprevalence rates in the U.S., a unique identifier system is feasible within the state only with better training, adequate staffing, and more resources proportionate to its seroprevalence rate. If New York can lead the way in instituting an efficient and effective unique identifier system, it should not be difficult for other states to follow.

After a series of public meetings revealed great opposition to a name-based reporting system, Washington authorized a pilot pro-

\[188. \text{See N.Y. PUB. HEALTH LAW } \S 2130 \text{ (McKinney 1999).} \]
\[189. \text{See TDH, HIV Reporting by Name, supra note 126.} \]
\[190. \text{See ACLU, The Maryland Lesson, supra note 123 ("While only 61% of UI's reported in the first six months of the program were complete, approximately 77% of the UI's reported in the last six months of 1996 were complete.").} \]
\[191. \text{See id.} \]
\[192. \text{Id.} \]
\[193. \text{See id.} \]
\[194. \text{See id.} \]
\[195. \text{See supra note 10 and accompanying text.} \]
gram using a non-name unique identifier system. The Washington system differs slightly from those used in Texas and Maryland and promises to eliminate incomplete reports and assure confidentiality by destroying records linking the individual to her identifier. In this new system, the individual’s name and related information would be sent to the health department, who would then create the coded number and delete the individual’s name from the database, rather than requiring the entity who does the testing to complete these tasks. If the Washington system does lead to more complete reports, New York also should tailor its program similarly. By shifting the onus of creating coded numbers onto the health department, the state does not need to rely on the cooperation of private facilities, especially if cooperation is not forthcoming.

Rather than employing the twelve digit number used in Maryland, New York should expand its system to include important information such as risk behavior. This goal can be accomplished by encoding different behaviors and adding more digits to the system. The addition of risk behavior and other information may assist in locating trends among certain at-risk populations or identifying other populations that are increasingly affected by the epidemic, so as to maximize the infusion of resources where they are needed most.

C. Non-cooperation by the Index Patient

As required by the New York Bill, the report sent to the commissioner at the state health department will contain information identifying both the index patient and any contacts. The first obvious problem with this law and other partner notification statutes is the hurdle posed by an index patient’s refusal to cooperate with the authorities. Although the index patient may be forced to reveal her own name to obtain insurance reimbursement, she

197. See id.
198. See id.
199. See supra note 123 and accompanying text.
200. See generally CDC, Evaluation of HIV Case Surveillance, supra note 124, at 1254 (noting the importance of including HIV risk information for an effective surveillance system).
201. See N.Y. PUB. HEALTH LAW § 2130(3) (McKinney 1999).
cannot be forced to reveal the name of her sexual and/or needle-sharing contacts. The law stipulates that no criminal or civil liability will result for any index patient's failure to cooperate in contact tracing.\textsuperscript{203}

This non-cooperation obstacle suggests that the process of partner notification, at its essence, is voluntary or contingent on index patient cooperation. That is not to say that coercive notification may not occur. An individual ignorant of her rights under the law may be unwillingly duped into cooperation. Even worse, she may lie about her sexual history and characteristics, resulting in inaccurate data. Thus, written informed consent\textsuperscript{204} is the key to managing non-cooperation. Informed consent for HIV testing here means that the patient who is to be tested must first be given pre-test counseling, which includes explanations regarding the nature of the disease and current treatment options, the possibility of discrimination, and ways to prevent transmission.\textsuperscript{205} Most importantly, however, pre-test counseling includes notice of name reporting and partner notification, and the availability of anonymous testing sites.\textsuperscript{206}

In addition to these elements of informed consent, health officials and physicians should be required to inform patients of their right not to disclose contacts, while always emphasizing the importance of contacting partners. This \textit{Miranda}-like\textsuperscript{207} warning should be built into the informed consent definition such that a failure to give it to the individual about to undergo testing may result in professional liability for the physician or center offering the test.

opposed to anonymous testing is required."). The reporting regulations apply to people receiving confidential HIV-related information.

203. \textit{See} N.Y. PUB. HEALTH LAW \S\ 2136(3) (McKinney 1999).

204. \textit{See id.} \S\ 2780(5). “Capacity to consent” is defined as:

an individual’s ability, determined without regard to the individual’s age, to understand and appreciate the nature and consequences of a proposed health care service, treatment, or procedure, or of a proposed disclosure of confidential HIV-related information, as the case may be, and to make an informed decision concerning the service, treatment, procedure or disclosure.

\textit{Id.}

205. \textit{See id.} \S\ 2781(3).

206. \textit{See id.} \S\ 2781(4).

207. In \textit{Miranda v. Arizona}, 384 U.S. 436 (1966), the Supreme Court held that statements that were obtained from defendants during incommunicado interrogation in a police-dominated atmosphere, without full warning of constitutional rights, were inadmissible as having been obtained in violation of the Fifth Amendment privilege against self-incrimination.
D. Defining “Contacts”

This problem of non-cooperation, in turn, creates another one: the problem of defining the term “contact.” The amendments to section 2780(10) attempt to elaborate on the definition of “contact”:

identified spouse or sex partner of the protected individual, a person identified as having shared hypodermic needles or syringes with the protected individual or a person who the protected individual may have exposed to HIV under circumstances that present a risk of transmission of HIV, as determined by the commissioner.\(^{208}\)

This definition is neither exhaustive nor realistic. It does not take into account the existence of sexually-inactive spouses or estranged spouses, nor does it clearly delineate how far back the contact tracing process must venture. It also does not set limits on the extent of probing a health official or physician must undertake, such as whether she must investigate claims of sexual inactivity by the index patient. The law’s over-broad reach may extend into the realm of marital privacy, an area upon which the Supreme Court has declined to tread.\(^{209}\) Infringement on the privacy rights of one’s sexual partners also is prohibited.\(^{210}\)

E. Notification of Contacts

“[T]he municipal health commissioner or the department’s contact notification assistance program staff . . . [must make a] determination that the reported case or any other case merits contact notification in order to protect the public health . . . .”\(^{211}\) Factors to be considered in this determination are the awareness of known contacts and situations involving newly-diagnosed persons with HIV.\(^{212}\) The first factor is obviously spawned out of convenience; limited or no investigation is required prior to notification. The second factor, on the other hand, does not seem grounded in any logic. What the health official may think is a “new diagnosis” may actually be a “newly discovered” one because of the difficulty in

\(^{208}\) N.Y. PUB. HEALTH LAW § 2780(10) (McKinney 1999).
\(^{212}\) See id. § 63.8(b).
predicting with certainty when a person first contracted the disease. Also, it would seem more efficacious to notify partners of someone who has been HIV positive for a longer period because there has been a longer period in which the person has been infectious.

The New York law also requires health officials to notify the contact in person unless circumstances prevent this method. While the great expense of carrying out this requirement exhausts money and resources that could be used in finding a cure or better treatments, the in-person notification may be well worth the expense in such an emotionally-charged situation. Moreover, providing the contact with an opportunity to receive detailed advice on the importance of getting tested and reducing risk behavior from an individual trained to share accurate information is critical. After all, partner notification serves little purpose in breaking the chain of transmission if the notified individual does not then herself get tested.

Many opponents of the law understandably fear health officials knocking on a contact's door while neighbors look on or leaving a message that the contact should get in touch with the local health department. Thus, the state should consider a policy of notifying contacts in neutral places, such as the physician's office or the local health department. If telephone contact must be made, the health official should never leave a message with a party other than the named contact.

F. Special Cases Where Immunity Should be Granted

During the notification process, the commissioner or authorized official is not permitted to divulge the identity of the index patient or the identity of any other contact. In reality, the identity protection offered by the plan is a façade in some circumstances where the index patient's identity easily can be deduced. For example, if the contact of an index patient only has engaged in sexual relations with the index patient and has never injected drugs, the identity of the index patient may be obvious to the contact. Under these cir-

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214. See supra notes 182-155 and accompanying text.
215. See N.Y. Pub. Health Law § 2133(3) (McKinney 1999); see also Notice of Proposed Rule Making, Amendment of N.Y. Comp. Codes R. & Regs., tit. 10, § 63.1 (1999) (proposed regulations, on file with the Fordham Urban Law Journal) ("In all cases of contact tracing authorized in this Part, the name or other identifying information regarding the protected person shall not be disclosed to contacts and the name of contacts shall not be disclosed to other contacts.")
cumstances, the statute should have an immunity provision, which weighs the degree of exposure to the contact against the need for confidentiality to the index patient on a case-by-case basis. Unless the degree of risk is substantially likely to transmit the virus, immunity should be granted to the index for nondisclosure. Of course, the index patient should always be strongly encouraged to notify on her own, despite the risk of discovery.

Another difficult scenario for partner notification proceedings is where domestic violence plays a role. Physicians and other persons required to report must indicate whether they have conducted a domestic violence screen on each case.\textsuperscript{216} Statistics show that domestic violence in relationships is prevalent,\textsuperscript{217} and partner notification to an abusive spouse may aggravate the situation. As part of the aforementioned HIV "Miranda" warning, the health authority should initiate the inquiry into whether there exists a threat of domestic violence for the individual being tested, rather than waiting for the patient to offer the evidence him/herself. The health official also should clearly explain that the threat of domestic violence may excuse the patient from partner notification.\textsuperscript{218}

Additionally, considering the difficulty in detecting domestic violence and the secrecy usually maintained around it by victims, the state may want to defer domestic violence judgments to those professionally-trained in such matters, rather than give just any physician or authorized testing facility such important discretionary power. In the alternative, the state should train health officials in domestic violence screening, and then defer to their discretionary power.

G. The Physician's Role

Another problem associated with New York's law is the unwarranted emphasis it places on the doctor-patient relationship, presuming that there exists something inherently special between


\textsuperscript{217} See supra notes 155-156 and accompanying text.

\textsuperscript{218} See Notice of Proposed Rule Making, Amendment of N.Y. COMP. CODES R. & REGS., tit. 10, § 63.8(c) (1999) (proposed regulations, on file with the Fordham Urban Law Journal) ("Where partner notification is otherwise merited, "if an indication of risk of domestic violence has been identified, the health official must be satisfied in his/her professional judgment that reasonable arrangements and referrals to address safety of affected persons have been made if and when the notification is to proceed.").
provider and patient to warrant disclosure by that particular provider, as opposed to any other. By assigning such highly personal responsibilities to physicians, the state may be relying upon a misperception of the status of the professional relationship as it exists currently. In today's managed care system, it is not uncommon for an individual to lack a close relationship with her physician. In fact, with the relatively recent advent of health care maintenance organizations and preferred provider organizations, a patient may see a different healthcare provider with every visit. The days of the family doctor that cared for the patient from birth on is no longer a reality for most individuals.

Also, the law does not explore the ramifications of disclosure from the contact's perspective. Although the index patient may have established a relationship with the physician, it is unlikely that the contact also would know the physician. Mandating that the index patient disclose her risk practices with others, the law also reveals risk practices of the contact, including sexual and/or drug-related activity that the contact may want to keep confidential. Despite confidentiality requirements, partner notification may infringe on the contact's right to privacy and confidentiality.

The law addresses the issue of possible liability incurred by the reporting individual or agency: "Good faith reporting or disclosure pursuant to this title shall not constitute libel or slander or a violation of the right of privacy or privileged communication." Furthermore, immunity from civil and criminal liability is granted for good faith attempts at reporting. This provision is essential to eliminating any kind of fear a physician might feel concerning legal action.

The amendment also changes section 2782(4) of the Public Health Law, concerning the physician's authorization to notify contacts: "A physician may disclose confidential HIV related information . . . [if] the physician has counseled the protected individual [about notification] . . . and . . . the physician has informed the protected individual of his or her intent to make such disclosure to a contact . . . ." In this instance, the physician must give the

219. See BARRY R. FURROW ET AL., HEALTH LAW ch. 3.III, at 800 (3d ed. 1997) (arguing that "[b]ecause subscribing to an HMO usually means being treated by an HMO-affiliated doctor, HMOs are less likely to attract persons with chronic illnesses already attached to a doctor").
220. See supra notes 147-149 and accompanying text.
221. N.Y. PUB. HEALTH LAW § 2136(1) (McKinney 1999).
222. See id. § 2136(2).
index patient an opportunity to express a preference as to the process of disclosure.224

In the patient referral model, it may be difficult for health authorities to ensure that contacts have been notified. Also, fewer partners may be notified in this model in comparison to the physician referral model.225 Unfortunately, if the goal of partner notification is to actually notify contacts, New York’s provision giving index patients an option over whether to personally inform contacts or assign that responsibility to a health authority may be self-defeating. Thus, it is important that the law requires public health officers to take reasonable steps to inform contacts if notification by the physician cannot be verified.226 In a unique identifier system, however, the contact may even use a code name for herself that has been prearranged, and/or refer to the index patient through her unique identifier number.

H. Anonymous Testing Sites

Despite the enactment of the new law, anonymous testing sites still are alternatives to confidential testing, which will be accompanied by name reporting.227 Currently, the availability of anonymous testing is important because even with a system of non-named reporting in place, some individuals will fear confidentiality breaches. Although anonymous testing may create some initial data errors,228 it may be the only way to encourage certain groups to be tested and possibly conduct partner notification.

A multistate survey found benefits to anonymous testing, such as a shorter time span between being tested anonymously and seeking treatment than that of testing confidentially and entering the healthcare system: “The mean time from learning they were HIV positive to the diagnosis of AIDS was almost a year and a half longer (529 days) for those tested anonymously than for those

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224. See id. § 2782(a)(4).
225. See supra note 51 and accompanying text.
227. See N.Y. PUB. HEALTH LAW § 2138 (McKinney 1999). The option of anonymous testing may be more mirage than real under the revised law since a patient must be tested confidentially in order to receive insurance reimbursement for HIV medical treatment. See supra note 202 and accompanying text.
228. See Bindman et al., supra note 96, at 1416 (“Because people who test HIV positive anonymously cannot be individually identified, reporting systems that rely on the results of anonymous testing are prone to measurement error. It can be difficult to detect repeat tests, and the potential exists for duplicate reporting.”).
tested confidentially . . . ."\textsuperscript{229} Earlier testing allowed patients to receive the benefits of a longer period of medical treatment for HIV.\textsuperscript{230} The same survey also showed that almost a quarter of HIV-positive persons who had been tested voluntarily before being diagnosed with AIDS had sought anonymous testing.\textsuperscript{231} Thus, at least for the present, the option of anonymous testing is crucial in New York because it may alleviate many of the fears associated with HIV testing.

Eventually, however, anonymous testing should be phased-out to prevent data errors, which threaten to be substantial: "Anonymous testing appears to be on the upswing in New York. In 1992, nearly 190,000 New Yorkers had an HIV test in a publicly funded facility. In 1996, that number was less than 40,000."\textsuperscript{232} These statistics can only mean either New Yorkers have switched to private, anonymous testing or there has been a seventy-nine percent decrease in HIV testing.\textsuperscript{233} Once people are made to understand the privacy protections of a unique identifier system, the elimination of anonymous testing should not be so frightening. The unique identifier system would alleviate most confidentiality fears while still maintaining accurate and comprehensive data.

\textbf{Conclusion}

The world soon will be entering the third decade of the HIV/AIDS epidemic. Despite great advances in treatment, there is no cure and AIDS remains an ultimately fatal disease. The New York legislature’s passage of a HIV name reporting and partner notification law marks a monumental step in the history of the disease because of the state’s high seroprevalence level.\textsuperscript{234} Despite the lofty goals set by advocates of partner notification, such as informing those who have been exposed to HIV with the hope that they will then be tested and motivated into less risky behavior,\textsuperscript{235} drawbacks still exist. The fear of stigmatization is still strong, as is the possibility of discrimination.\textsuperscript{236} There is no doubt that some people, whether few or many, will be deterred from being tested.\textsuperscript{237}

\textsuperscript{229} Id. at 1418.
\textsuperscript{230} See id.
\textsuperscript{231} See id.
\textsuperscript{232} Garrett, supra note 187, at C6.
\textsuperscript{233} See id.
\textsuperscript{234} See supra note 10 and accompanying text.
\textsuperscript{235} See supra note 168 and accompanying text.
\textsuperscript{236} See supra notes 161-167 and accompanying text.
\textsuperscript{237} See supra notes 168-169 and accompanying text.
In order to achieve the twin goals of the collection of epidemiological data for research purposes and the notification of partners exposed to risk, the New York law needs to be modified. By replacing name reporting with a more refined system of unique identifiers, which include valuable factors like risk behavior, the first goal may be achieved and patient security ensured. Modifying the New York statute to include immunity provisions for certain patients and opt-out provisions for providers may also further these goals. In the end, it appears that a unique identifier system in conjunction with a compassionate system of partner notification may be the best route for New York to take in its fight against AIDS.