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# A Proposed Exception to the AIDS Confidentiality Laws for Psychiatric Patients

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**ABSTRACT:** The authors offer psychotherapists a proposed exception to strict acquired immune deficiency syndrome (AIDS)-related confidentiality laws. The proposal is based on previously established exceptions to the psychotherapist-patient privilege. The recommended breach of confidentiality applies only to cases that meet all of the following criteria: (1) A patient knows that he or she has a human immunodeficiency virus (HIV) positive blood test and has been informed of AIDS-related safety precautions, (2) the HIV-positive patient has a mental disorder, and (3) it is reasonable to believe that the mental disorder has significantly impaired or may significantly impair the patient's ability and behavior to follow AIDS-related safety precautions.

**KEYWORDS:** psychiatry, acquired immune deficiency syndrome (AIDS), doctor-patient priviledge

Acquired immune deficiency syndrome (AIDS) was first identified in 1980. This contagious and fatal disease has been spreading at such an alarming rate that it has been declared "the public health threat of the century" [*1*]. Its catastrophic effects are perceived as so great that a statutory proposal [*2*] was offered to limit its spread by holding criminally liable any person with AIDS/AIDS-related complex (ARC) or positive antibodies to the virus who "purposely, knowingly, or recklessly transfers or attempts to transfer any of his bodily fluid to another person" [*2*, p. 101]. In Arizona, a bisexual soldier who knew he had AIDS was court-marshaled for having sex with unsuspecting male and female soldiers [*3*]. More recently, a person with a psychiatric history and AIDS was charged with attempted murder for knowingly selling his contaminated blood to a donation center [*4,5*]. Effective in 1989, it is now a felony in California for any person to donate blood, body organs, other tissue, semen, or breast milk when he or she knows they have AIDS or have tested positive [*6*].

We are now faced with an AIDS population that is growing and spreading exponentially across socioeconomic, racial, age, and sexual groups. Curran et al. stated that, "In most cases of AIDS in the United States, the virus appears to have been transmitted through

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one or more of four routes; sexual contact, intravenous drug administration with contaminated needles, administration of blood and blood products, and passage of the virus from infected mothers to their newborns" [7, p. 1355]. There is an urgency in research efforts to understand more fully the risk factors, susceptibility, contagion, prevention, and treatment of the disease. The need for accurate information is essential and confidentiality has played a vital role in providing research data in this area.

Just as confidentiality has been assured to promote data collection and research, it is also the underlying principle used to encourage the evaluation and treatment of the human immunodeficiency virus (HIV) positive patient. Strict confidentiality is partly based on the assumption that more persons would be willing to seek out evaluation and treatment as well as receive treatment if guaranteed confidentiality. Presumably, if there were no confidentiality, people frightened of stigmatization and discrimination would possibly go underground and not pursue evaluation and treatment for the disease. People with HIV-positive serology have suffered discrimination in employment, housing, education, insurance, interpersonal relationships, and medical treatment [8,9]. In 1986, the American Hospital Association issued a report which recognized that a balance should exist between the need to prevent the spread of the disease and the special care needed to preserve the dignity and confidentiality of the patient with AIDS or human T-lymphocyte virus Type III (HTLV-III) infection [10].

## Compelling State Interests Versus Fundamental Individual Rights

The principle of "police power" permits the state to use its authority to protect the public health and the public safety. One area where such authority has been declared constitutional is that of controlling and preventing the spread of contagious disease. While the rights of the individual might be subordinated to the state's rights, the state must not abuse its "police power." In 1905, the U.S. Supreme Court found constitutional a Massachusetts statute on mandatory vaccination [11]. The Court wrote that although liberty interests were important and should be recognized, such interests must yield to the state's right "to secure the general comfort, health, and prosperity" as long as the state did not act "arbitrarily and oppressively" [11, pp. 26,28].

The states have attempted to halt the spread of communicable diseases through mandatory reporting laws. Consequently, pursuant to the reporting laws, doctor-patient confidentiality is breached when this medical information is disclosed to the state department of health. The AIDS virus is considered a communicable disease, and thus, all states have identified AIDS as a reportable disease to a state agency; in addition, some states have included HIV-positive status as reportable to a state agency [12]. The required disclosure to public health authorities, which is an exception to confidentiality, illustrates the significant conflict experienced today by professionals identifying or treating, or both, HIV-positive patients. This conflict between reporting and confidentiality may become even more intense if close contacts, who have been or may be exposed to the HIV-positive patient, are *not* warned of the patient's potentially fatal disease. Only a handful of states have permitted disclosure to either the spouse or those who have been exposed to HIV-positive patients [12].

In 1986, a position paper on "Acquired Immune Deficiency Syndrome" was published by a committee from the American College of Physicians and the Infectious Disease Society of America, in which the issue of confidentiality and the duty to warn were addressed [13]. It stated, "revealing the identity of persons with AIDS to their prior sexual contacts, to those with whom they have shared intravenous needles, or to any others who are likely to have had contact with their bodily fluids may be appropriate to curtail the spread of infection" [13, p. 579]. The position offered by this committee later extended the exception to confidentiality to include confirmed HIV-positive persons,

whether asymptomatic or not [*14*]. They wrote, "the duty to warn becomes a major and significant obligation and under some circumstances outweighs the obligation of confidentiality" [*14*, p. 467].

In 1987, Gostin and Curran [*15*] acknowledged the physician's duty to protect others exposed to the AIDS virus and commented about the lack of clear guidelines in discharging this duty. They proposed that the duty should at least include an advisement to the patient to warn his or her close contacts of his or her infection and to behave safely. They concluded that, "When there are strong clinical grounds for believing that a specific contact has not been informed who is in serious danger from exposure to HIV, then the prudent course for the physician is to notify the contact of the positive serological status of the patient" [*15*, p. 364].

Similarly, Acheson [*16*] stated, "In seropositive cases the doctor will advise the patient how to avoid transmitting the infection to others and also recommend that the sexual partner or partners should be told. The doctor has discretion to inform a third party to prevent the spread of infection" [*16*, p. 665]. The American Psychiatric Association (APA) has also acknowledged the dilemma regarding the AIDS epidemic and the confidentiality of the HIV-positive patient. In 1988, the APA published an AIDS policy that encouraged physicians to help patients stop their infectious behavior or notify those who may be exposed [*17*]. The policy further stated, "If a patient refuses to agree to change behavior or to notify the person(s) at risk, or the physician has good reason to believe that the patient has failed to or is unable to comply with this agreement, it is ethically permissible for the physician to notify an identifiable person who the physician believes is in danger of contracting the virus" [*17*, p. 27].

In a review article, Matthews and Neslund [*18*] concluded that it is unclear at this time how courts will handle the issues of liability and duty to warn in cases where professional parties know that the patient is infected with the AIDS virus, but do not notify a potentially uninformed sex partner of the patient's infected status. They cite a Pennsylvania case of a family who is suing a Pittsburgh hospital, several physicians, the blood bank, and six pharmaceutical companies for $44 million. The family had alleged failure to diagnose and warn in an apparent situation in which the husband-patient acquired the AIDS virus through a blood transfusion, then sexually transmitted the AIDS virus to his wife, who in turn gave birth to an infant, who contracted AIDS prenatally.

## A Proposed Exception to Confidentiality Regarding HIV-Positive Patients

To strike a balance between society's interest to control the spread of the AIDS virus and that of encouraging people to seek evaluation and treatment for the AIDS/ARC syndrome by maintaining confidentiality, we propose an exception to the strict confidentiality laws that exist in the majority of states. The proposed exception must include all of the following criteria: (1) a patient knows that he or she has a HIV-positive test and has been informed about medical recommendations concerning AIDS-related safety precautions (for example, "safe sex," no needle-sharing); (2) the HIV-positive patient has a mental disorder; and (3) it is reasonable to believe that the mental disorder has significantly impaired or may significantly impair the patient's ability and behavior to follow the AIDS-related medical safety recommendations. Under these circumstances, there is a significant likelihood for potential danger to others.

Our recommendations for breaching confidentiality in these limited circumstances have been previously established through statutory and case law regarding psychiatric patients and their dangerousness. We are not endorsing a carte blanche policy of disclosing a patient's HIV serology or AIDS/ARC diagnosis to others. The disclosures proposed are applicable only if there is reasonable belief that the patient's mental illness has impaired or may impair his or her ability and behavior to remain medically safe with others. Under

these conditions, the exceptions to confidentiality might occur for warning *readily identifiable* others who have been exposed to the patient in the past or those who may be exposed to the patient in the foreseeable future, for purposes of civil commitment, or for both reasons.

In general, civil commitment for persons who are dangerous to others as a result of mental disorder requires a limited waiver of the psychotherapist-patient privilege in order to hospitalize the patient for purposes of psychiatric treatment as well as to serve a protective function to society. Specifically, civil commitment proceedings for the mentally disordered HIV-positive patient would require a disclosure of that information which is necessary to support involuntary psychiatric hospitalization; that is, the patient's mental disorder and how it impairs the patient's ability and behavior to follow AIDS-related safety precautions, thus resulting in the patient's potential dangerousness to others.

Another proposed breach of confidentiality is warning others who have been exposed or may be exposed to the patient. We believe that this exception to confidentiality is similar to reporting requirements outlined in "child-abuse" laws and "Tarasoff"-like situations. All states have laws which waive confidentiality in the psychotherapist-patient relationship when the psychotherapist knows or reasonably suspects that child abuse has taken place. In such cases, the psychotherapist has a duty to report the abuse to the appropriate protective agency. In addition, a number of civil suits have arisen in cases where psychotherapists failed to warn identifiable others of a patient's potential threat of harm to them. Some states have enacted laws requiring psychotherapists to breach confidentiality and warn readily identifiable potential victims of a patient's threat of danger. The main principle guiding both "child-abuse-reporting laws" and "Tarasoff"-like situations is the protection of children from abuse in the former and protection of people from threatened harm in the latter. Note that child-abuse-reporting laws focus on *past* dangerous behavior in an effort to stop current or future abuse. "Tarasoff"-like cases, however, focus only on potential dangerous behavior in the foreseeable *future*. In justifying the breach of the psychotherapist-patient privilege, the Tarasoff court [*19*] stated, "the protective privilege ends where the public peril begins" (p. 347).

Both the courts and ethical standards of the psychiatric and psychological associations have stated that mental-health professionals have an obligation to disclose confidential information if it is necessary to protect the patient or community from imminent danger. Similarly, if an HIV-positive patient's mental disorder significantly impairs his or her ability and behavior to follow recommended safety precautions, we believe the psychotherapist should be permitted to breach confidentiality in order to protect others. We believe that the protection of others in these cases would include warning potential victims. The psychotherapist should be permitted to warn (1) readily identifiable persons (for example, spouse, sex partner, needle-sharing drug partner) who were previously exposed to the patient's AIDS virus (analogous to child-abuse-reporting laws) and (2) readily identifiable persons (for example, spouse, sex partner, needle-sharing drug partner) who have a high likelihood of being exposed to the patient's AIDS virus in the foreseeable future (analogous to "Tarasoff"-like cases). The psychotherapist's breach of confidentiality should be limited to disclosure of that information which would be necessary to protect readily identifiable others (for example, the patient's identity, patient's AIDS/ARC diagnosis or HIV-positive serology, mode of viral transmission by the patient, and potential effects of exposure to the virus).

The following case vignettes are examples in which the proposed exceptions to confidentiality of the psychotherapist-patient privilege would apply.

*Case 1*

This is a 32-year-old male with a recent diagnosis of ARC following a contaminated blood transfusion. He has been married for the past five years. For the last several

months, he has been seen as an outpatient for treatment of depression since finding out he has ARC. His depression has been getting worse as his mental condition deteriorates. Presently, he is feeling more depressed, with crying spells; he has feelings of helplessness and is negative toward any interventions. His depression has impaired his judgment concerning "safe-sex" practices related to AIDS patients. During the last psychotherapy session, he admitted that out of fear of his wife leaving him, he has not informed her of his ARC condition and has continued with unprotected sexual intercourse. He adamantly stated that he will not change his behavior.

One therapeutic approach is to attempt, if possible, to continue to treat the patient as an outpatient with increased frequency of his sessions. The therapist should assess the severity of the patient's depression as it relates to his thoughts and behavior regarding unsafe sexual practices. Also, the therapist should immediately recommend conjoint sessions with the patient's wife and have the patient realize the need for him to inform his wife fully regarding his ARC diagnosis. In these sessions, the therapist would be available to offer both support and guidance to the couple regarding the ramifications of the disease and to recommend appropriate medical evaluation for the wife, in addition to the patient.

If the patient's mental state was sufficiently fragile or he refused to abstain from further engaging in unprotected sexual intercourse with his wife, his psychiatric hospitalization as a voluntary or involuntary patient would be required. The same recommendations for conjoint sessions, having the patient fully inform his wife of his ARC diagnosis, and the appropriate medical evaluations should be followed.

We believe that the therapist should be permitted to warn in this case. The rationale for warning can arise from either a past history of failure to follow recommended safety precautions because of a mental disorder or the possibility of future unsafe behavior because of mental disorder. In this case example, the patient's past history and future conduct regarding unsafe sexual behavior and its potential effects must be addressed, irrespective of whether he is treated on an inpatient or outpatient basis. If the patient informed his wife of his ARC diagnosis, past history of unsafe sexual behavior, and its potential effect on her, the therapist would not have to warn her. However, if the patient refused to do so, even if his psychological condition improved to the point that he would agree to and abstain from future unsafe sexual practices, we believe the therapist should be permitted to warn because of the patient's past unsafe sexual conduct. The therapist's warning would include informing the wife of her husband's ARC diagnosis, his past unsafe sexual practices with her, and the potential consequences of her exposure to the virus.

*Case 2*

A 30-year-old female heroin addict was referred to the psychiatric consultant by the emergency-room physician for possible psychiatric hospitalization after a serious overdose of heroin in an intentional suicide attempt secondary to depression. She was very agitated and depressed as a result of being informed earlier that day of having AIDS, which she probably contracted through intravenous needle-sharing with her live-in boyfriend. The patient is quite depressed and self-destructive, which makes her have little concern about the effects of future needle-sharing and "safe" sexual intercourse with her boyfriend.

We would recommend an involuntary hospitalization for this patient on the basis of a "danger to self" (suicide attempt) and a "danger to others" (future spread of AIDS through intravenous needle-sharing and unprotected sexual practice) as a result of her mental disorder (depression). With respect to breaching confidentiality by warning others, we view this scenario as an example of *future* dangerousness. That is, in addition to the treatment of the patient's depression and heroin addiction, the therapist must assess the patient's willingness to inform significant others fully of her AIDS diagnosis as well as

her ability to abstain from unsafe practices (needle-sharing, unprotected sexual intercourse) in the future.

As stated earlier, the therapist should recommend conjoint sessions with the patient's live-in boyfriend. If the patient fully informs him (that is, of her AIDS diagnosis, likely means of transmission, and its potential consequences for him), there would be no need to warn on the part of the therapist. If the patient refuses to inform him fully of her AIDS condition but recovers from her mental disorder to the point that she is able to abstain from future unsafe AIDS-related behavior, there again would be no need to warn. However, if the patient does not fully inform her boyfriend of her AIDS condition and her mental disorder continues to impair her ability to abstain from *future* unsafe conduct, the therapist should be allowed to warn. This would include telling him of her AIDS diagnosis, the likely means of transmission, and its potential effects on him.

We do not believe that this case meets our proposal's exception to the confidentiality rule based upon the patient's *past* unsafe AIDS-related behavior. When the patient was previously engaging in needle-sharing and unprotected sexual intercourse, she did not know she had AIDS nor was she informed about medical safety precautions. Thus, she did not meet our first proposed necessary criterion, and a breach of confidentiality would not be recommended based solely on *past* unsafe conduct.

*Case 3*

This is a 40-year-old homosexual male with a 10-year history of bipolar affective disorder who was referred to the psychiatric emergency room after becoming psychotic with increased hypersexuality. He has had a positive HIV serology for the past 6 months. For the first 5 months subsequent to the positive HIV serology, he was following his physician's advice by engaging only in "safe-sex" practices. During the last month, as he has decompensated into a psychotic state, he has denied his HIV infection, and has been promiscuous and noncompliant with the recommended "safe-sex" practices.

This case clearly illustrates the causal connection between the patient's mental disorder and his resultant dangerousness. Before the onset of his psychosis, the patient was accepting of his HIV-positive serology and compliant with "safe-sex" practices. However, following his psychotic decompensation, the patient denied having HIV-positive serology, was promiscuous, and refused to follow "safe-sex" practices. Civil commitment appears indicated on the basis of "danger to others" as a result of his mental disorder. We do not believe that the therapist can warn because there are no readily identifiable victims at the present time. One focus of treatment would be on the reduction of the patient's psychotic denial of his HIV-positive serology which leads to his promiscuity and noncompliance with "safe-sex" practices. It is likely that his degree of dangerousness to others would be reduced as his psychosis goes into remission, based on his history of accepting his HIV infection and following medical recommendations.

## Conclusions

Current medical and social circumstances have rendered the treatment of the HIV-positive patient as one of the most challenging issues confronting the health-care practitioner. Our focus is not on the HIV-positive patient who behaves in an unsafe manner and is handled through public-health mechanisms; rather, our interest is on the patient who has a dual diagnosis of HIV-positive serology and mental disorder (which includes personality disorders, such as antisocial personality). Specifically, we are concerned with the HIV-positive patient who suffers from a mental disorder which is causally related to the patient's failure to exercise reasonable caution in preventing the spread of the AIDS viral infection. Our proposal is not meant to advocate the use of psychiatric hospitals as

a place of quarantine for HIV-positive patients; rather, the psychiatric hospital is used when it is appropriate for the treatment of mental patients who have HIV-positive blood tests.

As the AIDS virus rapidly progresses across the country with its devasting cost to both the individual and society, a reexamination of confidentiality laws related to AIDS patients and HIV-positive patients will have to be conducted. Legislators will have to remain sensitive to the discrimination that AIDS patients and HIV-positive patients may experience when confidentiality is compromised; however, they will also have to remain aware of society's interest to be protected from the AIDS virus.

California law has been undergoing a recent evolution in relaxing some of the stringent confidentiality requirements related to HIV-positive patients. The law was amended in 1988, allowing physicians to disclose the results of a positive AIDS antibody test to the patient's spouse. Later, effective in 1989, the law was further amended to allow physicians to disclose the patient's confirmed positive test results to persons reasonably believed to be the patient's sexual partner or persons with whom the patient has shared hypodermic needles [*20*].

Recognizing that other states have strict confidentiality laws related to the HIV-positive patient, we have proposed a modification to these laws based on established exceptions to the psychotherapist-patient privilege (for example, involuntary civil commitment, child-abuse-reporting laws, and duty to warn identifiable others). We understand that many mental health professionals may be reluctant to act as social control agents. Therefore, we are not proposing another law mandating protection of others. Rather, we are recommending that psychotherapists who are treating HIV-positive patients and are experiencing an ethical or legal dilemma, or both, related to the protection of others, be *permitted* to do so under certain circumstances.

Our proposal states that all of the following criteria must be included: (1) A patient knows that he or she has a HIV-positive test and has been informed about medical recommendations concerning AIDS-related safety precautions; (2) the HIV-positive patient has a mental disorder; and (3) it is reasonable to believe that the mental disorder has significantly impaired or may significantly impair the patient's ability and behavior to follow the AIDS-related medical safety recommendations. We hope that the exceptions we propose to confidentiality will help to decrease some of the dilemmas experienced by the psychotherapist who treats the mentally ill HIV-positive patient.

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