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INTRODUCTION

Colorado's "model" for Acquired Immunodeficiency Syndrome ("AIDS") control has received much national attention, as well as abundant notice here in Colorado. For example, when Colorado became one of the first of two states to require the reporting of the names of persons who tested positive for AIDS-antibody,[1] an editorial comment appeared in the New York Times.[2] Several media people from newspapers, and representatives from the Department of Health and Denver's Division of Public Health were asked to appear on numerous national network programs such as Face the Nation and the McNeil-Lehrer News Hour. Initial responses to the "model" were often skeptical, but subsequent articles by *Life Magazine*, columnist Ellen Goodman, the Associated Press, the American Medical Association, and others have been very positive when commenting on the partner notification aspect of the program.

The irony of this national story is that the Colorado "model" is only the application of the well-understood traditional principles and methods of disease control to AIDS. The early disfavor, in some quarters, towards Colorado's program illustrates well the special social and political stresses created by AIDS. Criticism of traditional disease control methods—such as confidential name reporting, partner notification, and closure of public facilities which promote disease transmission—reflected the concerns of the most afflicted group, homosexual men.

The concern focused on governmental actions which, as perceived by this group, could compound their injury through greater discrimination of homosexuals. Gay activist groups were often joined by the American Civil Liberties Union ("ACLU") in those concerns. The early skepticism probably also reflects the unfamiliarity of the general public bombarded by reporters and politicians commenting on the daily activities of public health disease control programs.

Attitudes toward Colorado's programs appear to be changing to widespread reaffirmation of traditional disease control methods. Increasing numbers of states are now adopting requirements for antibody test reporting. It is perhaps a bellwether sign that in January 1988, New Jersey appropriated $800,000 for initiating a partner notification pro-

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1. 6 COLO. CODE REGS. § 1009-1 (1988) (Regulation 3, *Laboratory Reporting*).
2. *What Colorado is Doing to Control Aids*, N.Y. Times, Oct. 30, 1985, at A26, col. 4.

gram.[3] We hope and believe that as the opinion pendulum returns toward the "center" of mainstream public health activity, the strong protections for the confidentiality of public health records, as adopted by Colorado, will be part of the model. Such protections are necessary for AIDS control as well as for a democratic society.

AIDS Control Regulation and Colorado Law

Three key promulgations highlight the decisions made by Colorado's political and public health leadership to control AIDS. The first was the regulatory action by the State Board of Health (the "Board") in November 1985.[4] The Board simply added the new antibody tests for the AIDS virus to the list of fifty or more other positive disease-associated tests with patient identifiers which laboratories confidentially report to the state or local health departments. The second was also regulatory: rules adopted by the Board of Health of the Denver Department of Health and Hospitals in February 1986, which regulated the operation of bath houses and similar establishments.[5] The third key act was section 25-4-1401 to 1410[6] of the Colorado Revised Statutes, which codified the antibody test reporting requirements but, more importantly, implemented the requirement of confidentiality. Section 25-4-1401 to 1410 also substantially altered Colorado's statute on quarantine and isolation, which was originally passed in 1947.[7]

Underpinnings of Colorado's Promulgations

The Food and Drug Administration's ("FDA") approval of serologic tests for the AIDS virus antibody in March 1985, was a very significant event because of the need to screen donated bloods in blood collection centers. Little attention was given in mid-1985 to the great potential for the test in medical and public health settings to enhance disease prevention and control. An exception was Dr. Judson of Denver Health and Hospitals who wrote: " 'At this point, it seems that control measures, such as the new enzyme linked immunosanbant assay human T cell leukemia virus ("ELISA HTLV-III") antibody tests, are being directed exclusively at preventing transfusion acquired infections which represent less than 2% of all infections. Are we guilty of taking an ostrich approach . . . .' "[8]

The early dogma for use of the tests was represented by California's original legislation. All testing would be done anonymously, with spe-

3. Telephone interview with State Commissioner of Health, New Jersey (Feb. 12 1988).

4. 6 Colo. Code Regs. § 1009-1 (1988)(Regulation 3, *Laboratory Reporting*).

5. Rules and Regulations to Minimize Transmission of the HTLV-III Virus in Certain Establishments with in the City and County of Denver, Denver, Colo. Rev. Mun. Code Ch. 24, § 16 (6) (1986).

6. Colo. Rev. Stat. § 25-4-1401 to 1410 (Supp. 1987).

7. Colo. Rev. Stat. § 66-1-7 (1953), § 66-1-7 (1965), § 25-1-107 (1)(b) (1973).

8. Judson and Vernon, *The Impact of AIDS on State and Local Health Departments: Issues and a Few Answers*, 78 Am. J. Pub. Health 387, 388 (1988).

cific prohibition against informing any third parties of the results, even spouses or other partners or public health officials.[9] This represented a complete reversal of the long-standing communicable disease reporting requirements which have facilitated confidential public health activities to reduce disease transmission.

The elaborate interstate partner notification system, useful for syphilis control, was completely disregarded for AIDS. To this day, the system is prohibited in some states for locating and confidentially notifying partners potentially infected with human immunodeficiency virus ("HIV"). If a single individual with out-of-state partners was found to be infected with both syphilis and HIV, some states would comfortably carry out partner notification for syphilis but not for HIV. Colorado's statute is a sign of the pendulum swinging toward the center and a sign that this ridiculous paradox is being corrected.

Colorado departed from the early AIDS control dogma when the State Board of Health's regulation required name reporting of antibody positive persons. Section 25-4-1401 to 1410, however, was the more visible and probably the more historically important promulgation for several reasons. It was a legislative event, not simply a promulgation of a rule. It dealt broadly with confidentiality of public health records and the rights of individuals charged with being a danger to the public health by public health officials. It represented a major but unsuccessful effort for a gay activist group to eliminate name reportability and to require total anonymity in AIDS antibody testing. Section 25-4-1401 to 1410 is fascinating political history and should be a subject for a political historian of the future.

Before noting in more detail the provisions of section 25-4-1401 to 1410, the context of problems and principles in which it and the two regulatory promulgations developed in Colorado should be stated. These problems and principles represent the underpinnings of Colorado's public health policies for AIDS control:

> — Public Health must not apply a lesser standard of control to AIDS than to syphilis and other STDs [sexually transmitted disease], since AIDS was spreading far more rapidly, was far more deadly, and could only be averted through prevention.
>
> — Existing STD and general communicable disease control regulations and laws were often out of date, were overly broad (in the case of quarantine provisions), or were not clearly applicable to AIDS.
>
> — AIDS case reports are inadequate to monitor the course of the HIV epidemic. AIDS cases occurred an average of more than five years after infection and were outnumbered by undetected HIV infections by 30-50 to one. More accurate knowledge of HIV antibody prevalence with a means to correct

9. CAL. HEALTH & SAFETY CODE § 199.21 (West Supp. 1985) (as amended at *id.* at § 199.25 (West Supp. 1988)).

for multiple positive results from a single person would assist in better understanding of the epidemic.

— Approximately 10-20 percent of individuals who voluntarily are tested for HIV do not return for their test results and therefore do not receive the all-important counseling. Much benefit could come from locating such individuals, and providing counseling in the field.

— Persons at risk of HIV infection have an ethical responsibility to be tested and, if positive, to notify all unsuspecting partners. . . . When an infected individual is unwilling or unable to notify partners of exposure, the health care provider and/or public health authorities are obligated to assume this responsibility through traditional or innovative methods of partner notification.

— To achieve the full public health benefit of these principles, confidential reporting by name and locating information of all persons testing positive for HIV antibody is indicated.

— To obtain full participation of individuals at risk for HIV infection in the essential testing and counseling programs, public health records containing individual identifier data must receive near absolute legal protections against unauthorized disclosure.

— Mechanisms incorporating appeal rights and confidentiality protections must be developed to restrict the behavior of the occasional HIV-infected person who, after appropriate and intensive counseling, continues to expose others.

— Behaviors at high risk of transmitting HIV were continuing to occur in certain establishments such as bathhouses for gay men, adult bookstores, bars, and shooting galleries for intravenous drugs. Public health leaders bear responsibility for protecting the public from exposure to HIV by promoting measures which would either regulate or close such establishments.[10]

Public health leaders in Colorado are of the opinion that these principles are solidly grounded not only in tradition, but in legal precedent. It is not the purpose of this article to examine that precedent in detail, but it is helpful to note comments by Kenneth Wing in *The Law and the Public's Health*.[11]

Mr. Wing describes the "archetypal" case of *Jacobson v. Massachusetts*,[12] concerning smallpox vaccination:

> [The United States Supreme Court] . . . has distinctly recognized the authority of a State to enact . . . 'health laws of every description. . . .' According to settled principles the police power of a State must be held to embrace, at least, such reasonable regulations established directly by legislative enactment as will protect the public health and the public safety. [13]

10. Judson and Vernon, *supra* note 8, at 388.
11. *See generally* K. WING, THE LAW AND THE PUBLIC'S HEALTH (2d ed. 1985).
12. 197 U.S. 11 (1905).
13. *Id.* at 25.

Wing comments further: "At least where the state government activity is for the purpose of protecting third parties from risks created by individual conduct, virtually all courts have followed the lead of the *Jacobson* decision and quickly deferred to state legislative authority."[14]

HOUSE BILL 1177

Such were some of the origins of Colorado House Bill (H.B.) 1177. The bill was *not* introduced to make the antibody test reporting requirements statutory. The primary purpose of H.B. 1177 was to guarantee near absolute legal protection against unauthorized disclosure of those public reports. Since such protections required the reporting system to be specified in the bill, the gay community seized an opportunity to abolish the reporting requirements regulated by the Board of Health a year earlier.

Reporting, not confidentiality of reports, became the main battlefield of the legislation. A very well organized lobbying effort and testimony by the gay activists and the Colorado ACLU convinced the first House committee to abolish the confidential reporting system and to require anonymous testing. With the continued outstanding leadership of the bill's sponsor, Representative (now State Senator) Dorothy Wham, this position was resoundingly reversed on the House floor and was subsequently changed little in the Senate.

The confidentiality protections of H.B. 1177 are largely based on a suggested model derived by the Centers for Disease Control which took the best attributes of state legislation nationwide. Among other particulars, the reports to public health may not be released, shared, or made public "upon subpoena, search warrant, discovery proceedings, or otherwise. . . ."[15] Strong penalties are applied to anyone inappropriately releasing information or breaching confidentiality requirements. It should be emphasized that the protections of H.B. 1177 apply to the reports required to be made to public health agencies and to the record system created therefrom for the purpose of disease investigation and control. The confidentiality of medical records[16] continues to be well-protected in previously adopted Colorado law.[17]

House Bill 1177 also provides protections against unauthorized testings. No specimen may be tested for HIV infection "without the knowledge and consent of the patient," except in certain narrowly specified situations such as when all personal identifiers are removed from the specimens in order to conduct seroprevalence surveys or when a health worker is "immediately threatened by exposure to HIV in blood

14. K. WING, *supra* note 11, at 26.

15. COLO. REV. STAT. § 25-4-1404 (Supp. 1987).

16. A "medical record" is defined by the State Board of Health as "that clinical and laboratory information which is held by a health care professional who provides, or a facility established to provide, ongoing health care." 6 COLO. CODE REGS. § 1009-1 (1988) (Regulation 8, *Confidentiality*).

17. COLO. REV. STAT. § 18-4-412 (1973). *See also Id.* at § 25-4-1409 (2) (Supp. 1987).

or other bodily fluids."[18]

The second main purpose of the legislation was to modify the quarantine/isolation authority given to the state health department director by the legislation of 1947. The 1947 legislation read, in part: "To establish, maintain and enforce isolation and quarantine, and . . . to exercise such physical control over property and over the persons of the people within this state as the department may find necessary for the protection of the public health. . . ."[19]

In both the House and Senate, considerable time was spent debating H.B. 1177's legal safeguards for individuals, believed by public health officials to be a danger to the public health. The final compromised H.B. 1177 includes requirements that all reasonable efforts be made to obtain the voluntary cooperation of the individual. The health department has the burden of proof to show, by clear and convincing evidence, that grounds exist for measures taken. The sequence of measures directed at the recalcitrant person are applied serially and not more restrictive than necessary to protect the public health. Individuals may maintain the right of refusal to comply with any health department order and may appeal an order to a court. Court hearings and transcripts or records will be closed and confidential. Of course, an individual will have the right to have an attorney appear on the individual's behalf in any hearing.[20] These limitations on the law of 1947 are largely sensible, although the procedures are made unduly cumbersome by the convoluted compromise language which evolved from several legislative committees.

Understandable Concerns and Promising Results

Stated simply, the arguments against the Board of Health regulation and H.B. 1177, voiced predominantly by the gay activist group and the ACLU, were: (1) the confidentiality of the records could not be assured, and even greater discrimination against homosexual men would follow; (2) for fear of loss of confidentiality, homosexual men would not be tested, and the epidemic would be driven underground; and (3) having taken such risky steps, the public health agencies would demonstrate no benefit for AIDS control. In short, the argument was that benefits could not outweigh risks and that clear harm was possible.

Proponents of reportability recognized the concerns of the opponents, but were confident that the long history of confidentiality protections and efficacy in sexually transmitted disease control efforts indicated little risk and a tremendous benefit to individuals who tested positive for AIDS. Final judgment should await a longer perspective, but in all respects the results to date are promising. No breach of confidentiality has occurred from the public health records. The only threat

18. *Id.* at § 25-4-1405 (7) (Supp. 1987).
19. *Id.* at § 25-1-107 (1)(b) (1973), § 66-1-7 (1965), § 66-1-7 (1953).
20. *Id.* at § 25-4-1406 (Supp. 1987).

was a regrettable attempt by the most aggressive opponent among the gay activists to persuade a homosexual public health employee to release records "for the cause." Discrimination against homosexual and AIDS-virus infected persons unfortunately continues to occur, but no incident has resulted from the reporting requirements.

The number of people being tested at confidential test sites in Colorado remains high. In 1986, Colorado's *per capita* testing rate was the fifth highest among the states. Colorado's testing rate was twenty to forty percent above California's rate through mid-1987 despite California's statutory requirements for anonymity. Monthly variations in the two states are virtually parallel and are apparently responsive to events common to the two states, such as national media coverage, and not to the reportability of test results. Although it is likely that some gay men avoid the test solely because of reportability, the evidence suggests that those who want the test but fear the reporting system are using pseudonyms. Many of those who do use pseudonyms provide other locating information which allows field workers to reach them confidentially when necessary.

Most encouraging are the benefits now being seen. In one early study, about seventy-five percent of the antibody positive individuals, who had not returned to test sites for their results or the important counseling, were located in the field where they were counseled about virus transmission whether or not they chose to learn the results of their tests.[21]

A beneficial result affecting a small number is the follow-up counseling provided to antibody positive military recruit candidates. Reporting is provided by the military recruit stations to Colorado facilitates for follow-up counseling in a civilian environment.[22]

Colorado has made a major commitment to partner notification. A duty exists to warn unsuspecting partners, preferably by the infected individual alone, but if not with the confidential assistance of skilled disease investigators. Most citizens know little or nothing about the partner notification (or contact tracing) process, its voluntary nature, and the extraordinary confidentiality with which it is carried out. To date, a substantial number of people have already benefitted from the process in Colorado. Interviews of 282 infected persons have produced 508 names of partners in unsafe sex or intravenous drug use, of whom 414 have been located and counseled. Two- hundred-ninety-six (296) individuals have been tested for the first time with a high positivity rate of fifteen percent.

21. N. SPENCER, B. DILLON, G. WARE, J. LESLIE, *Follow-up to Ensure Counseling of HIV-Ab Positive Volunteers to HIV Test Sites*, in ABSTRACT TP 93 (1987) (III International Conference on AIDS).

22. B. Dillon, N. Spencer, *Follow-up counseling and risk behavior assessment of HIV Anitbody positive military recruits*, in ABSTRACT MP 42 (1988) (III International Conference on Aids).

The traditional disease control interventions adopted by Colorado do not constitute the entirety of an AIDS control program by any means, but its successful contribution in a milieu of scrupulous confidentiality protections is testimony that a balance can be found for public health interventions which protects both the public's health as well as individual rights and confidentiality.

Responses to the AIDS epidemic have varied widely from state to state and city to city, as is predictable with an event of such political and cultural complexity. Public health leaders in Colorado share a consensus that the AIDS epidemic should be addressed with no less vigor than other communicable diseases of lesser magnitude that have successfully been resolved. The traditional public health practices of patient follow-up, third-party notification (assisting a societal duty to warn), and better understanding of the epidemic require confidential reporting of AIDS virus antibody positive persons to public health agencies as well as the noncontroversial reporting of AIDS patients. But in the context of this extraordinary epidemic, the traditional measure of confidential reporting also requires assurances of near absolute protections of the public health records. Public health officials also retain the responsibility of protecting the public from the actions of persons who continue to expose others after receiving appropriate and intensive counseling, but must exercise that responsibility in ways which incorporate appeal rights and confidentiality protections.

Colorado has taken steps to achieve the necessary balance of these seemingly conflicting goals. The debates have been contentious, and in some quarters the criticism of the Colorado "model" has been vociferous. But early in 1988, the results of Colorado's efforts are highly encouraging. National coverage of Colorado's partner notification program has been laudatory. Additional states have adopted the confidential reporting of antibody positive persons. Of greatest importance, while the antibody testing program in Colorado continues to be a success, there has been no known instance of inappropriate breach of confidentiality from public health records.

We sense a wide agreement in Colorado that a balance is achieved between protections of individual rights and public health. The contentious nature of the debates, especially over House Bill 1177, and the attendant news coverage have helped form a consensus and educate all of us on the complex social and political issues of this epidemic.