The Law and Ethics of Representing Clients Living with HIV/AIDS

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I. Introduction

Clients with HIV are in many ways like other clients with a serious illness. They share many of the same concerns about access to health care, insurance, public benefits, and the need to plan for the future with wills and advance directives. But HIV is not just another serious illness. It carries with it a unique stigma that can insidiously affect almost every aspect of a client’s life, often completely cutting them off from social and familial ties. As a consequence, most HIV-positive people in South Carolina keep their diagnosis a secret, hidden from employers, coworkers, members of their church, neighbors, family and friends. HIV carries with it a unique stigma that affects nearly every aspect of the client’s life.

Lawyers working with HIV-positive clients need to understand the role of HIV stigma so that they may more effectively represent their clients. For starters, lawyers must think carefully about how to safeguard their client’s confidentiality. Although unintended, unauthorized disclosures of HIV status have devastating consequences for our clients. Our clients have been shunned by their families, refused a hug or touch, and forced to use separate dishes and utensils. They have been thrown out of churches and fired from jobs. They have faced community harassment as word of their HIV status spread. This vilification happens all too frequently – even today.

Lawyers must become aware of the special privacy concerns of people living with HIV/AIDS (“PLWHA”) and the legal framework around privacy. And they must understand how discrimination may affect people with HIV and how discrimination may be redressed. This manuscript attempts to provide lawyers with the background to be effective, compassionate advocates for people living with HIV/AIDS.

II. Understanding HIV Stigma

This manuscript will first provide a conceptual framework for understanding the HIV/AIDS epidemic, the experience of people living with HIV/AIDS (PLWHA), and the pervasive stigma associated with HIV and assigned to PLWHA. It aims to convey the importance of maintaining the confidentiality of sensitive health information, HIV status in particular, in all legal settings.

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1 This manuscript was prepared by Carolyn McAllaster, Clinical Professor of Law, Duke University School of Law, Allison Rice, Senior Lecturing Fellow, Duke University School of Law, & Genevieve Ankeny M.S.Ed., Duke University Center for Health Policy and Inequalities Research.
“Stigma” is defined as “a mark of disgrace or infamy; a stain or reproach, as on one’s reputation.” Goffman defined “stigma” in 1963 as “an attribute that is significantly discrediting which, in the eyes of society, serves to reduce the person who possesses it.” Stigma can be the result of particular undesirable characteristics, such as physical deformities, or it can stem from negative attitudes toward an entire group and the behaviors associated with that group, such as homosexuals and prostitutes. “Under Goffman’s definition, stigmatization is the societal labeling of an individual or group as different or deviant.” Some HIV/AIDS related stigmatization research has focused on stigmatizing attitudes and the correlation between such attitudes and misunderstanding and misinformation about the modes of HIV transmission or the risk of infection through normal social behavior.

Social science researchers generally agree that HIV/AIDS-related stigma undermines public health efforts to combat the epidemic. AIDS stigma negatively affects preventive behaviors such as condom use, submitting to HIV testing, and seeking appropriate care following diagnosis, to name a few. This stigma also diminishes the quality of care given to HIV-positive patients and the perception and treatment of PLWHA by their communities, families, and partners. “Decreasing AIDS stigma is a vital step in stemming the epidemic.”

A. The Historical Underpinnings of the AIDS Epidemic

HIV/AIDS has been stigmatized since it was first diagnosed in the United States. AIDS was first recognized as an unexplained pattern of illness in 1981, and the American public has since undergone episodes of panic, witnessed the identification of HIV as the cause of AIDS, and experienced the development and dissemination of promising antiretroviral drugs. This illness has morphed from being initially associated exclusively with Caucasian men to having an increasing impact on African Americans, Latinos, and women.

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5 Id.
6 Parker, supra note 2, at 15
7 Brown et al, supra note 3, at 3
8 Id.
9 Id.
10 Id.
11 Centers for Disease Control and Prevention, Thirty Years of HIV – 1981-2011, 60(21) MORBIDITY AND MORTALITY WEEKLY REPORT, at 689 (2011). http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6021a1.htm
13 Id.
Despite the spread of the disease into increasingly more communities, the Kaiser Family Foundation has found that the percentage of Americans reporting AIDS as the most urgent health problem facing the country declined from 68% in 1987 to 49% in 1990, to single digits in 2009 and 2011, and 10% in 2012. Thus, the perceived urgency of AIDS has decreased, but stigmatizing perceptions of the disease remain entrenched.

Stigma toward people living with HIV has had a devastating impact on the HIV epidemic. The World Health Organization cites “fear of stigma and discrimination as the main reason why people are reluctant to be tested, to disclose their HIV status or to take antiretroviral drugs.”

In South Carolina, AIDS continues to conjure thoughts of death and for many, embarrassment. Many HIV related deaths in SC have been hidden by families and explained away as cancer or other diseases because of possible shame to the family. This perpetuates stigma and leaves families with the burden of heavy secrets and questions unanswered for those family members who may want to openly discuss HIV.

Denial and lack of communication is common when there is an overriding fear of stigma. The very basic fear of rejection and loss of privacy can hamper a person’s ability to communicate effectively. This can lead to failure to negotiate condom use and often leads to more sexual behavior, where methods of safer sex are not used to prevent HIV transmission. Ignorance around HIV transmission and the fact that many people are indeed ostracized after revealing their HIV positive status makes disclosure a difficult step for many to take. For this reason, many PLWHA are still finding it challenging to tell new partners about their status and negotiate sexual encounters, despite legal requirements to notify past and present partners.

1) In South Carolina

In 2013, 15,771 South Carolinians were living with HIV. According to the South Carolina HIV Epidemiological Profile, 36% of persons living with HIV/AIDS in South Carolina were not in care. Columbia, SC had the 10th highest death rates for HIV positive men and women in the United States in 2011 and ranked 7th in the country in HIV diagnoses among 13-24 year old males.

The following chart shows the breakdown in HIV disease cases by race and sex in South Carolina in 2013:

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17 South Carolina’s STD/HIV/AIDS Data Surveillance Report, December 31, 2012
African Americans represent 69% of new HIV/AIDS diagnoses in 2013 in South Carolina. The rate of black females living with an HIV diagnosis was 12.1 times that of white females in South Carolina.\textsuperscript{18}

Another marginalized group impacted early in the HIV epidemic and more recently, are gay and bisexual men. In South Carolina and nationally, MSM (men who have sex with other men) are particularly impacted by HIV. In 2010, MSM activity accounted for 70 percent of all males living with HIV in South Carolina (including MSM/IDU).\textsuperscript{19} Specific risk factors for young African American males are homophobia, racism, and poverty (N.C. Department of Health and Human Services, EPI Profile, 2010). “Homophobia, stigma, and discrimination are social determinants of health that can affect physical and mental health, whether MSM seek and are able to obtain health services, and the quality of the services they receive. Such barriers to


\textsuperscript{19} Id.
health need to be addressed at different levels of society, such as health care settings, work places, and schools in order to increase opportunities for improving the health of MSM.\textsuperscript{20}

2) \textit{Current Misconceptions About Transmission}

Enduring public misconceptions about HIV transmission are at the root of much HIV stigmatization. While Americans have learned a great deal since the beginning of the so-called “AIDS Epidemic,” the learning curve flattened out in the early 1990’s, and the remaining myths about modes of transmission stubbornly remain.\textsuperscript{21} Over the past twenty years, roughly one in four Americans have continued to either believe that one can get HIV from sharing a drinking glass, or remain unsure whether this is the case.\textsuperscript{22} Similarly, one in six believe the same about HIV transmission via shared toilet seats, and 11\% either think you can get HIV by swimming in a pool with someone with HIV, or are not sure.\textsuperscript{23} Overall, in 2012, one in three gave an incorrect answer to at least one of these three questions about means of transmission.\textsuperscript{24} This chart (above) shows the percentage of people in the United States who have certain misconceptions about the transmission risk posed by common activities.\textsuperscript{25} In addition, 34\% had an incorrect answer to at least one of the questions about whether HIV could be transmitted these ways.

3) \textit{The Role of Moral Condemnation}

A recent Kaiser Family Foundation survey asked participants to agree or disagree with this statement: “In general, it’s people’s own fault if they get AIDS.”\textsuperscript{26} The number of people who agree with that statement has increased since the 90s. (see chart below.) This blame-the-victim mentality works to maintain HIV stigma.

The reasoning fueling this stigma is multi-faceted, complex, and fluid, often layered atop other stigmas associated with homosexuals, prostitutes, intravenous drug-users and those who engage in casual sex.\textsuperscript{27} The interconnected nature of these stigmas deepens the prejudice against those with HIV.\textsuperscript{28}

\begin{itemize}
\item \textsuperscript{20} \textit{Stigma and discrimination}, \url{http://www.cdc.gov/msmhealth/stigma-and-discrimination.htm}, CDC, 2011.
\item \textsuperscript{21} Kaiser, HIV/AIDS at 30, at 6.
\item \textsuperscript{22} Kaiser 2012 Survey, supra note 12 at 13.
\item \textsuperscript{23} Id.
\item \textsuperscript{24} Id.
\item \textsuperscript{25} Id.
\item \textsuperscript{26} Id.
\item \textsuperscript{27} Brown, “Interventions to Reduce HIV/AIDS Stigma,” supra note 3, at 5.
\item \textsuperscript{28} Id.
\end{itemize}
Additionally, lingering misconceptions about how HIV is transmitted contribute to prejudice against PLWHA. 29 “People who harbor misconceptions about how HIV is transmitted are much more likely to express discomfort about working with someone who has HIV or AIDS than those who know that HIV cannot be transmitted in these ways.” 30 In their research on HIV/AIDS and stigma, the Kaiser Foundation discovered a statistically significant correlation between misconceptions about means and modes of transmission and an individual’s inclination to stigmatize PLWHA. Respondents were asked, “In general, how comfortable would you be working with someone who has HIV/AIDS?” The chart below shows that people who gave correct answers about HIV transmission were also much more likely to be comfortable working with someone with HIV/AIDS or having their food prepared by someone who is HIV-positive. 31

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30 Id.
31 Id.
HIV stigma is a complex part of a larger societal prejudice toward people who are other—those who are: HIV positive, of color, gay or lesbian, transgender, addicted to drugs or alcohol, homeless, or mentally ill. Moreover, these struggles contain deeply embedded external and internalized racism, sexism and homophobia and affect the well-being of the community and how individuals adapt to hardships.

III. The Legal Rights and Responsibilities of a Client with HIV/AIDS

PLWHA have certain rights and certain responsibilities with regard to their positive status. One of the most important rights is the right to confidentiality regarding their health status, while the foremost responsibility is to reduce the risk of transmission. The law in South Carolina provides some guidance on both issues.

Many of the problems facing individuals with HIV/AIDS “stem from the unnecessary disclosure of one’s HIV status -- a disclosure that might have been prevented had the individual been informed of his or her rights and/or been provided with preventative legal counseling at an earlier point in time. Indeed, it is widely recognized among AIDS experts that unnecessary disclosures serve to inflame the stigma and discrimination associated with HIV/AIDS. The stigma and discrimination, in turn, further deter vulnerable persons from getting tested for HIV and receiving prevention counseling. Thus, the disease continues to spread. In fact, of the
roughly one million people living with HIV/AIDS in the United States, it is estimated that about one-third do not know they have the disease.\textsuperscript{32}

“Virtually every complaint of AIDS discrimination begins with an unnecessary disclosure of AIDS or HIV information to someone without the training and understanding to handle it properly.”\textsuperscript{33} The next section discusses these particular confidentiality breaches and discusses the effects of unauthorized disclosure of seropositive status on the lives of PLWHA.

A. Right to Confidentiality

1) Confidentiality: What’s at Stake?

There is an old Jewish story that illustrates the difficulties of undoing a disclosure:

A man goes before his Rabbi and admits to having spread harmful information about his neighbor. He asks the Rabbi what he should do to repent. The Rabbi says, “You need to do the following: go home, find a feather pillow, and release the feathers into the wind.” The man follows the Rabbi’s instructions and returns the next day. The Rabbi then says, “Now, to gain forgiveness, you must go back to your home and retrieve all of the feathers.” “But Rabbi,” the man exclaims, “the feathers by now have scattered throughout the village!” “Precisely!” the Rabbi says. “And so too has the damage you have caused your neighbor’s reputation.”

Persons living with HIV and other stigmatizing conditions have justifiably high levels of concern about confidentiality. They do not need to be told this story. Those of us who work with these clients need to be repeatedly reminded of just how devastating a careless disclosure can be. The case managers at Access Network serving Beaufort, Colleton, Hampton and Jasper Counties regularly see the direct impact of HIV stigma on their clients. The Duke Legal Project has represented many clients who have faced discrimination after their HIV status was disclosed without permission. We have had clients fired from jobs in restaurants, nursing homes, health care facilities, a homeless shelter, and a poultry factory; we’ve had other clients who have faced adverse employment actions due to their HIV status—a nurse’s aide moved to the file room, a deli worker moved to the warehouse, for example. Other clients have been refused services by medical providers, hospitals, chiropractors, and others. Many others have been shunned by families, friends, classmates, and/or church communities because of unauthorized disclosures. A report by the ACLU AIDS Project documents how “[b]reaches of confidentiality can and do unravel people’s lives, forcing them to find new jobs, new schools, and new homes.”\textsuperscript{34}

\textsuperscript{32} American Bar Association’s Young Lawyers Division, Answering the Call: HIV Legal Check-Up, American Bar Association, 1 (2005), http://www.americanbar.org/content/dam/aba/multimedia/aids_coordinating_project/aba_hiv_checkup_web.authcheckdam.pdf.
\textsuperscript{33} Id. at 5.
\textsuperscript{34} Tamara Lange, HIV & Civil Rights: A Report from the Frontlines of the HIV/AIDS Epidemic, ACLU AIDS Project (Nov. 2003).
2) **Categories of Confidentiality Breaches**

The motivations of the persons responsible for unauthorized confidentiality breaches of sensitive information like HIV status or mental illness can be described as follows:

a) **Inadvertent or unplanned breaches without malicious intent**

Many professionals, especially in high stress situations like emergency departments or courtrooms, may be desensitized to the stigma that an illness like HIV or substance addiction presents. When a physician or an attorney talks openly about someone’s HIV status in the emergency room (ER) waiting area or during a trial, it is unlikely that s/he does so with malicious intent. The damage done to the patient or client whose friends and neighbors now know his or her health status is no less, however, than if the physician or attorney intentionally set out to breach his or her confidentiality.

b) **Gossip**

Another category of breach can be characterized as simply gossip. A person discovers someone’s sensitive health diagnosis and just has to tell. The Legal Project has had several clients who have while seeking treatment or services in the community necessitating a confidential disclosure of HIV status, have encountered a neighbor or church member working at the service provider’s office, and later discovered that the neighbor/church member talked about the clients’ health status in their community. Often the disclosers work for professionals—people the clients have reason to trust with their confidential information. This category of breach may not be intended to harm the clients, but they are certainly getting closer to a breach with malicious intent and again, the harm to the client can be substantial.

c) **“Protective” Breaches**

In the HIV context, many breaches occur in part because people feel the need to “protect” others. For example, the restaurant manager who erroneously feels that the HIV positive waiter poses a threat to customers or the teacher’s aide who erroneously feels that parents must be warned about the HIV positive student. More often than not the threat to others is nonexistent, but once the breach occurs, it cannot be undone.

d) **Malicious Breaches**

Finally, there are those who breach confidentiality of sensitive health information solely for malicious reasons—ex-spouses, estranged family members, former employers or employees can all have vindictive motives for spreading such information.

3) **Federal Laws**

a) **Health Insurance Portability and Accountability Act (HIPAA)**\(^{35}\)

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HIPAA is a federal law designed to protect patient health information maintained by health care providers, insurance companies and other “covered entities” who transmit health information in electronic form. The U.S. Department of Health and Human Services (“HHS”) has issued standards to implement the requirements of HIPAA (hereinafter referred to as “Privacy Rule.”)\(^\text{36}\) HIPAA protects

[A]ll ‘individually identifiable health information’ held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information ‘protected health information’ (PHI). Individually identifiable health information is information, including demographic data, that relates to: the individual’s past, present or future physical or mental health or condition; the provision of health care to the individual, or the past, present, or future payment for the provision of health care to the individual; and that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual. Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).\(^\text{37}\)

Most health care providers and health plans are covered by HIPAA. Many other organizations, however, are probably not covered by HIPAA. These typically include life insurers, employers, or law enforcement agencies.\(^\text{38}\)

HIPAA does allow certain disclosures of individually identifiable health information with the patient’s consent. These exceptions include disclosures, for example, to the patient’s health care providers for treatment and care coordination, to health insurance companies for claims documentation, disclosures made pursuant to written authorization of the patient, disclosures to protect the public health, or disclosures to law enforcement required by law.\(^\text{39}\)

HIPAA’s Privacy Rule provides that “[a] covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request.” Covered entities must ensure that “reasonable safeguards” are in place to protect the information.\(^\text{40}\) Interpreting what is meant by “reasonable safeguards” is challenging and will depend on the particular circumstances of the situation. HIPAA and the Privacy Rule do not require, for example, that health care providers provide private or soundproof rooms. HIPAA also allows providers to leave phone messages on answering machines or with family members. If a patient requests that

\(^\text{37}\) Id. at 3.
\(^\text{39}\) 45 CFR § 164.502, 164.514(d).
the provider communicate with him/her in a more confidential manner, however, the request must be accommodated if reasonable. Providers are allowed to place patient charts on the exam room door, but must take appropriate measures to safeguard private health information. Examples of safeguards that should be taken include placing the chart on the door with the front cover facing the wall; ensuring that patient sign-in sheets do not display a person’s medical diagnosis; asking waiting customers at pharmacies to “stand back a few feet from the counter used for patient counseling”; and making sure that “areas housing patient files are supervised or locked.”

The Duke Legal Project has represented many patients who have had their HIV status disclosed when visiting hospital emergency departments while either in the waiting room or in the curtained area. For instance, one client, who had suffered a medical emergency, had his physician talk with his wife in the waiting room about his HIV medications—within earshot of extended family members and several others in the waiting room. Another client’s neighbor was in the next curtained area and overheard the discussion about the client’s AIDS diagnosis. These disclosures are devastating to clients: They often have devastating consequences, and could be avoided by taking the reasonable precautions required by HIPAA—“by speaking quietly when discussing a patient’s condition with family members in a waiting room or other public area.”

Within HHS, the Office for Civil Rights (“OCR”) has responsibility for implementing and enforcing HIPAA. A client who believes his or her HIPAA rights have been violated may file a complaint with OCR within 180 days of the HIPAA violation. The client may also file a complaint directly with the covered entity. After notice to the covered entity and a hearing, OCR has the authority to impose a civil monetary fine of up to $100 per violation (paid to the government, not to the client) and a total amount of $25,000 for identical violations during a calendar year.

b) Americans with Disabilities Act (ADA)

Title I of the Americans with Disabilities Act prohibits discrimination on the basis of disability against qualified individuals in all aspects of employment including hiring, advancement, discharge or terms and conditions of employment. Relevant to our discussion of confidentiality, the ADA provides that covered employers may not require medical examinations or inquire about whether an applicant is a person with a disability before an offer of employment has been made. An employer may ask questions related to the ability of the applicant to perform job-related functions. After an offer of employment has been made, a

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46 Id.
covered employer may require a medical examination but only if all prospective employees are required to undergo such an examination regardless of disability and the results of the examination are not used to violate the ADA.\textsuperscript{47}

For existing employees, the ADA provides that covered employers may not require medical examinations or inquire as to whether an employee has a disability or as to the nature or severity of a disability, “unless such examination or inquiry is shown to be job-related and consistent with business necessity.”\textsuperscript{48}

Finally, the ADA requires that confidential medical information generated from post-offer examinations or voluntary employee medical exams be maintained in separate medical files and be kept confidential. Such confidential medical information can only be disclosed in the following situations: supervisors or managers may be informed about any restrictions on the employee’s ability to perform work duties; first aid/safety personnel may be informed if the disability requires emergency treatment; and government officials investigating compliance with the ADA may be given this information.\textsuperscript{49}

In situations where a client chooses to voluntarily disclose his or her health status to the employer—outside the context of a required medical examination or an employer sponsored voluntary medical exam—the confidentiality provisions of the ADA would not apply to the employer. An attorney might be able to argue, however, that the unauthorized disclosure was discriminatory and violated other provisions of the ADA.

4) South Carolina Statutes

a) S.C. GEN. STAT. § 44-29-135. Confidentiality of sexually transmitted disease records

South Carolina law has a specific provision protecting the confidentiality of all records held by the Department of Health and Environmental Control and its agents related to a known or suspected case of a sexually transmitted disease. This statute provides in relevant part:

\textit{All information and records held by the Department of Health and Environmental Control and its agents relating to a known or suspected case of a sexually transmitted disease are strictly confidential except as provided in this section.}\textsuperscript{50}

The statute allows disclosure in certain circumstances including release made with the person’s written consent, release made for statistical purposes as long as no identifying information is released, release necessary to enforce the public health laws concerning the

\textsuperscript{47} 42 U.S.C. § 12112(d).
\textsuperscript{48} Id.
\textsuperscript{49} Id.
\textsuperscript{50} S.C. Gen. Stat. §44-29-135.
control and treatment of a sexually transmitted disease, or release made pursuant to subpoena or court order.\textsuperscript{51}

South Carolina law sets out strict requirements\textsuperscript{52} which must be in place before a court may issue an order releasing a person’s sexually transmitted diseases test results. The court must find that there is a compelling need for the test results. In determining whether there is a compelling need, the court must weigh the need for disclosure against the privacy interest of the test subject and the potential harm to the public interest in terms of deterring persons from getting HIV testing or donating blood, organs, or semen. The statute prohibits a court from issuing a court order based on anonymous tips or information and the order must be based on a sworn affidavit setting forth the facts necessitating the order. Before an order is issued, the person signing the affidavit must appear at a hearing to be subjected to examination and cross-examination to determine whether an order requiring disclosure should be granted.\textsuperscript{53} The subject of the test must be referred to by pseudonym and all files referring to the subject’s true name shall be sealed. Court proceedings related to disclosure of test results shall be held in camera unless the subject of the test requests an open hearing. Once the court issues a disclosure order, the court may impose appropriate safeguards against unauthorized disclosure of the information.\textsuperscript{54}

Regarding HIV+ minors attending public school in kindergarten through fifth grade, the department is allowed to disclose HIV status to the superintendent of the school district and the nurse or other health professional assigned to the school the minor attends. The notification and information contained in the notification must be kept confidential and cannot be recorded in the minor’s permanent record and if it gets into the permanent record, must be purged before the child enters the sixth grade.\textsuperscript{55}

South Carolina public health regulations provide that the department or the attending physician may disclose to a lay healthcare giver a person’s HIV+ status if the care being given poses a significant risk of exposure that may result in HIV…to the lay healthcare giver and the physician or the department has reason to believe that the HIV+ person has not disclosed the illness to the lay healthcare giver.\textsuperscript{56}

b) Enforcement of Confidentiality Statutes

The South Carolina confidentiality statute discussed here is contained in Public Health Chapter 29 of the General Statutes. Pursuant to S.C. Gen. Stat. 44-29-140, it is a misdemeanor to violate a provision of the Contagious and Infectious Diseases Chapter subject to a fine up to two hundred dollars and up to 30 days in prison. There is no private civil right of action for violation of the confidentiality statute. Victims are left with the inadequate remedy of persuading a prosecutor to pursue criminal misdemeanor charges should their confidentiality be breached.

\textsuperscript{51} Id. See Statute for full list of disclosure exceptions.
\textsuperscript{52} S.C. Gen. Stat. §44-29-136.
\textsuperscript{53} Id.
\textsuperscript{54} Id.
\textsuperscript{55} Id., SC ADC 61-21 H.
\textsuperscript{56} Id. at G.
c) **Tort Remedies**

Persons who have had the confidentiality of their sensitive health information breached may have remedies under tort causes of actions recognized in South Carolina. Depending on the facts of the breach and its consequences, these could include: breach of physician’s duty of confidentiality,\(^\text{57}\) or the privacy tort of wrongful publicizing of private affairs.\(^\text{58}\) South Carolina’s public health statutes do provide that a physician or state agency that notifies a spouse or contact of an HIV+ person is not liable for damages resulting from the disclosure.\(^\text{59}\)

**Legal Responsibilities of the HIV positive client**

1) **South Carolina Public Health Felony Statute.**

It is unlawful in South Carolina for an HIV+ person to:

1. knowingly engage in sexual intercourse, vaginal, anal, or oral, with another person without first informing that person of his HIV infection;
2. knowingly commit an act of prostitution with another person;
3. knowingly sell or donate blood, blood products, semen, tissue, organs, or other bodily fluids;
4. forcibly engage in sexual intercourse, vaginal, anal, or oral, without the consent of the other person, including one’s legal spouse, or;
5. knowingly share with another person a hypodermic needle, syringe, or both, for the introduction of drugs or any other substance into, or for the withdrawal of blood or body fluids from the other person’s body without first informing that person that the needle, syringe, or both, has been used by someone infected with HIV.\(^\text{60}\)

Violation of this public law is a felony in South Carolina subject to a maximum fine of five thousand dollars and a prison sentence up to ten years. In order to be found guilty of this HIV criminal law, it is not necessary to show that the defendant have either the intent to transmit HIV or to show that HIV was transmitted. Ground-breaking research has shown that HIV positive persons who adhere to their medications and achieve an undetectable HIV viral load are highly unlikely to transmit the virus.\(^\text{61}\) Steps that the defendant may have taken to reduce or eliminate transmission risk—such as use of a condom or maintaining an undetectable viral load are not taken into account in the HIV felony law.

2) **HIV Positive Students**

The general rule in South Carolina is that HIV positive children are allowed to attend school and participate in school activities without restriction. They should have regular health monitoring by their primary health care provider and if appropriate, the potential for HIV transmission may be monitored by appropriate public health or school personnel. Any

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\(^{59}\) S.C. Gen. Stat. § 44-29-146.  
\(^{60}\) S.C. Gen. Stat. §44-29-145.  
information obtained during monitoring must be kept strictly confidential. 62

For HIV positive students in kindergarten through fifth grade in the public schools only, the Department of Health and Environmental Control must notify the superintendent of the school district and the nurse or other health professional assigned to the school attended by the minor. The information in the notification must be kept confidential and not placed in the child’s permanent record. 63

IV. Attorney Responsibilities Regarding Clients with HIV/AIDS

The key ethical obligation that comes into play when dealing with clients with HIV or other stigmatizing diseases is that of confidentiality. Rule 1.6, Confidentiality of Information, provides, in relevant part, the following:

(a) A lawyer shall not reveal information related to the representation of a client unless the client gives informed consent, the disclosure is impliedly authorized in order to carry out the representation or the disclosure is permitted by paragraph (b).

(b) A lawyer may reveal information relating to the representation of a client to the extent the lawyer reasonably believes necessary:

1. to prevent the client from committing a criminal act;
2. to prevent reasonably certain death or substantial bodily harm;
3. to comply with other law or a court order. 64

All lawyers know, without referring to the Rules of Professional Conduct, that we need to keep our client’s confidences, but that basic understanding doesn’t answer several other pressing questions, such as:

A. “What is covered by confidentiality?”
B. “What practices are required to protect confidential information?”
   ...In the office?
   ...In court?
   ...In filings?
   ...In dealing with witnesses, family members, etc?
C. “What additional precautions might be necessary when the client’s confidential information is especially sensitive or stigmatizing?”
D. “When might we be permitted or required to disclose confidential information?”

62 SC ADC 61-21 H.
A. What is covered by confidentiality under the rules?

As lawyers, we have internalized certain basic instincts – keeping confidences, avoiding conflicts, letting client’s make decisions – that are set out in the Rules. But we don’t usually open up the rule book unless we need guidance on a specific problem. It is worth reviewing what is actually covered by the rule.

Rule 1.6 protects a broad range of information. Unless there is consent of the client, a lawyer must refrain from revealing “information related to the representation of a client.” Information protected under Rule 1.6 is broader than that protected by attorney-client privilege. The information need not come from the client or have been given in confidence. Under a strict reading of the rule, there is nothing that you know about your client that is not covered by confidentiality, though in general, the client impliedly consents to certain customary releases that are necessary for representation. Depending on the circumstances, however, the client may want the lawyer to keep confidential even basic information such as the client’s name. The rule prohibits not only disclosures of confidential information, but also disclosures that could lead to the discovery of such information.

Most of the time you represent clients with HIV or other stigmatizing illnesses, you may never know it. Unless the diagnosis is germane to the representation, your client is unlikely to share this sensitive information with you. However, lawyers do learn of HIV. If you represent an HIV positive client in a workers compensation, personal injury, health or disability insurance, or social security disability case, you will find out about the HIV even if it has no bearing on your case. The diagnosis will be in the medical records you obtain in the course of representation. In a family law or other personal dispute, one party may want to use their opponent’s HIV diagnosis against them in the case. You may find out your client is HIV positive in a criminal representation when the client is in jail and needs access to his or her HIV medications. Needless to say, once you learn this information, regardless of its source, it is covered by Rule 1.6. Because of the sensitivity of this information, there is a heightened responsibility to aggressively safeguard this information.

B. What practices are required to aggressively safeguard the confidentiality of a client with HIV or other stigmatizing disease?

The lawyer’s duty of confidentiality includes an obligation to adhere to practices that will protect the client’s information. What practices will be sufficient to fulfill the lawyer’s obligation to competently safeguard information? How should a lawyer guard against disclosures by others participating in the representation, including office staff?

Although we were unable to find any Ethics Advisory Opinions on point, few would disagree that when the confidential information is extremely sensitive, greater care must be taken to prevent disclosure. In dealing with information about a diagnosis of HIV or other stigmatizing medical condition, lawyers must go beyond standard client confidentiality.

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65 “The confidentiality rule, for example, applies not only to matters communicated in confidence by the client but also to all information relating to the representation, whatever its source.” SCRCP Rule 1.6, Comment 3.
66 SCRCP Rule 1.6, Comment 5.
procedures. As discussed above, the disclosure of HIV status, as well as other stigmatizing diseases, can be devastating and lead to rejection, abuse, and discrimination.

Sometimes it may be harder than we think to adequately safeguard this information. Lawyers, like physicians and others who have access to very private information, may sometimes become desensitized to it. Think of the doctors we’ve heard discussing a patient in the hospital elevator. The kinds of lapses in protecting confidentiality that might happen in law offices are the inadvertent or unplanned breaches or gossip discussed above. Like the physicians in the emergency room, lawyers become so absorbed in the professional practice that can lose track of the client’s privacy. Lawyers can do the same thing. Sensitive information is all in a day’s work.

1) Suggestions for Protecting Client Confidentiality

Having a client with HIV or other stigmatizing disease may provide an opportunity to assess your practices, office procedures, and staff training around confidentiality. Here are a few specific suggestions to protect the confidentiality of HIV or similar diagnoses.

a) Never assume that an HIV positive client’s friends or family know about the diagnosis.

People with stigmatizing illnesses such as HIV may not tell anyone other than their medical providers about their diagnosis. Even when friends and family may be serving as witnesses or supporters in a client meeting, they may not know about the diagnosis, even if the diagnosis is germane to the case. If there is a possibility that HIV may come up in a meeting with a client and others, first ask the client whether the other person(s) know about the diagnosis.

In one case we handled, our client was seeking the appointment of a standby guardianship for her minor child. Under this law, a parent with a terminal or chronic disease can have a guardian appointed to serve in the event that she can no longer care for the minor child. Our client planned to appoint her mother as the standby guardian. We assumed the client’s mother must know about her diagnosis. Wrong. Before interviewing the proposed guardian to assess her fitness, we learned that our client had never told her mother about her diagnosis. Or even that she was sick. She asked us to say she had cancer.

b) Be careful with any paperwork in your office that references HIV status.

There is little gossip as juicy as a diagnosis of HIV or another STD. Even if you are careful about medical or other records that reference your client’s HIV status, others who have access to your office may not be. Consider your staff, other client you see in your office, the cleaning crew or the tech guy when you think about where to put that piece of paper. At the Duke Legal Project, we avoid leaving sensitive paperwork face up on our desks at night or when others visit our offices.
c) **Be careful about referring to the HIV diagnosis in correspondence with the client or others.**

If there is a need to refer to the client’s illness in a letter, consider whether the letter could be seen by unintended eyes. A letter to a client with a reference to her HIV status could be seen by others in the home who are unaware of the diagnosis. Consider whether the reference is necessary. Or check with the client before sending the letter. In any correspondence that might reference the diagnosis, consider whether there is a need to explicitly reference HIV.

d) **Properly dispose of medical records and other papers referencing HIV.**

Is there anyone left who doesn’t have a shredder? If nothing else, waste paper with this level of sensitive information should be shredded. In our office, our waste paper is either shredded or placed in a locked bin that is disposed of by a company that also disposes of sensitive waste paper from the Duke Medical Center. Place a shredder or shredding box next to the printer/copier so that mistakes are disposed of appropriately. In this day of high security, take RPC 133 with a grain of salt.

e) **Be discreet in discussing HIV and other sensitive information in your office or elsewhere.**

Just like the busy physicians, lawyers can easily make inadvertent disclosures when talking in the office within earshot of other clients, or in the elevator or courthouse hallways.

f) **Train your staff well.**

If you have clients with HIV or other stigmatizing illnesses, make sure they are trained to take the same precautions you do. In dealing with breaches of confidentiality in the medical setting, we find that it is often low level employees with access to sensitive information (e.g. the medical records clerk or lab tech) who finds it irresistible to gossip about an HIV positive patient. This is particularly a risk in small communities where everyone knows everyone else. Make sure your staff understand the potentially devastating consequences of a breach of confidentiality as well as the impossibility of fixing it – once the information is disclosed, it cannot be undisclosed.

g) **Try to protect your client’s diagnosis within the court system.**

As discussed above, be aware of the damage that can be done by having your client’s HIV status disclosed in legal proceedings. We are aware of an episode in which a criminal defense attorney disclosed the HIV status of his client’s mother as an attempt to gain sympathy for his client. This not only harmed the mother, but, by association the client. And we know that in many other instances, a client’s HIV status has been referred in open court without consideration of the effect this disclosure would have on the client.
i. **Is the diagnosis relevant?** If you have a client with HIV or another stigmatizing condition in the court system, and you expect that the client’s status will be raised in the proceeding, first determine whether the diagnosis is even relevant. Often, it may not be. In such cases you may want to file a motion in limine to have the information excluded.

ii. **If the diagnosis is relevant.** In some cases, the HIV status may arguably be relevant. Such instances might include a custody case where a parent’s health may be an issue or a criminal prosecution for violation of public health measures.

iii. **Seek protection in courtroom settings.** If records are to be released under a subpoena or court order, request that those records be reviewed in camera. If the setting is a more chaotic, such as a first appearance session, seek to have the matter heard at the bench. Try to persuade the judge and/or prosecutor that disclosure of the health information would be damaging to the client. Educate opposing counsel about the stigma of HIV or other similar diseases.

iv. **Proceed anonymously in a civil case.** If you are prosecuting a civil case in which the client’s HIV or other stigmatizing condition must be disclosed, such as a discrimination or breach of confidentiality case, we recommend that you move to file anonymously. Duke Legal Project has a sample motion, order, and memorandum of law on Jane/John Doe filings. Clients should be informed, of course, that even proceeding anonymously, there is no guarantee that the client’s identify will not be revealed as a result of the litigation.

v. **Seek a protective order.** If you anticipate that an opponent intends to delve into the client’s HIV or other stigmatizing condition in discovery, consider filing a motion for a protective order under Rule 26(c) of the Rules of Civil Procedure. The court may issue an order to “protect a party or person from annoyance, embarrassment, [or] oppression.”\(^\text{67}\) The relief can take the form of forbidding inquiry into certain matters or requiring a deposition to be sealed and opened only in court.\(^\text{68}\)

C. **Are there any circumstances under which HIV or other health information may be disclosed by a lawyer?**

Only under extremely narrow circumstances may a lawyer disclose the confidential health information of a client. These particular situations are described by Rule 1.6(b). Most relevant here are the exceptions to the confidentiality rule:

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\(^{67}\) Rule 26 (c) S.C. Rules of Civil Procedure.

\(^{68}\) Id.
A lawyer may reveal information relating to the representation of a client to the extent the lawyer reasonably believes necessary:

1. to prevent the client from committing a criminal act;
2. to prevent reasonably certain death or substantial bodily harm.
7. to comply with other law or a court order

I) To prevent commission of a crime by the client - 1.6(b)(2)

It is not difficult to conceive of a situation in which a client you know to be HIV positive and in an intimate relationship reveals that s/he has not told her/his partner about the diagnosis, as required by South Carolina law. As discussed above, violation of S.C. Gen. Stat. §44-29-145 is a felony.

Rule 1.6(b)(1) permits a lawyer to disclose information “to prevent the client from committing a criminal act.” Past crimes do not fall under this exception. So the rule gives no discretion to disclose past public health law violations to the partner, law enforcement, or public health officials. However, the rule does by its terms give the lawyer permission to report the client if s/he intends to continue violating the public health law, thereby committing further crimes. In this scenario, the client might have indicated that s/he would continue to violate. Or you might gain this knowledge if you decided to address the issue directly with the client. When challenged on the public health law violation, the client might say s/he is not ready to tell the partner. Or that the partner would abuse or reject the client if s/he disclosed the HIV. There may be an understandable reason for the violation.

The rule does not require the lawyer to disclose in this situation. It is entirely at the lawyer’s discretion. In exercising this discretion, the lawyer should bear in mind the challenges discussed above in connection with the client’s navigation of disclosure. We suggest the goal should be to reduce the risk of harm while maintaining the client’s confidentiality and autonomy. Help the client find a solution that would eliminate or at least reduce the risk to the partner. Through counseling the client, the lawyer could potentially persuade the client to comply with the law without undermining the lawyer-client relationship. The lawyer could function as a partner to brainstorm ways to make the feared disclosure and enlist the support of other professionals to help the client.

Determining how to exercise the discretion allowed in rule 1.6(b)(1) involves balancing the potential health consequences to the partner-victim against the likely damage to the lawyer-client relationship that would result from the lawyer’s breach of confidentiality, as well as the potential consequences of the disclosure to the client. Some would argue that the potential harm from the client’s conduct should weigh heavily in favor of disclosure. Others would argue that the risk is speculative and that the better path would be persuasion rather than disclosure.

The wrongfulness of the client’s purpose is also relevant. A lawyer would want to take into account the level of risk involved in the public health law violation (e.g. is the client on HIV medication and maintaining an undetectable HIV viral load?). The balance might be different if
the client’s public health violations were more egregious than nondisclosure. Or the client’s purpose might be cavalier or wrongful. A lawyer might learn in a domestic or criminal case that the client is no adhering to medications, is engaging in condomless sex and failing to disclose her/his HIV status. Though rare, situations have arisen nationally where an individual has intentionally exposed people to HIV. In such situations, the potential risk to the victim is greater, the likelihood of persuading the client to stop is smaller, and the client is much less sympathetic. A lawyer might be more comfortable disclosing in such an extreme situation.

Another consideration that might come into play is risk management. There are cases in which professionals have been sued by victims under a negligence theory when the professional knew that the victim’s sex partner had a sexually transmitted disease and did not tell the victim. With South Carolina’s rather conservative tort law, however, this is probably not much of a worry.

In summary, Rule 1.6(b)(1) would permit, but not require, a lawyer to disclose HIV or other sexually transmitted diseases to prevent the commission of a public health violation. If the lawyer opted to make such a disclosure, s/he should disclose no more than the lawyer reasonably believes necessary to accomplish the purpose. Less damaging ways of making the disclosure might be to enlist the client’s doctor in an effort to persuade the client to adhere to public health measures, letting the client know ahead of time that you will be making the disclosure, and if disclosing directly to the partner, urging the partner to keep the information confidential.

2) To prevent reasonably certain death or substantial bodily harm – Rule 1.6(b)(2)

Rule 1.6(b)(2) permits a lawyer to disclose confidential information, “to the extent the lawyer reasonably believes necessary . . . to prevent reasonably certain death or substantial bodily harm.” As the comments state, this exception “recognizes the overriding value of life and physical integrity.”

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70 The success of these cases varies depending on jurisdiction. See e.g. C.W. v. Cooper Health System, 906 A.2d 440 (N.J. Super. Ct. App. Div., 2006) (recognizing that the partner of a patient diagnosed with HIV has a cause of action against the physicians who failed to notify the partner of the HIV diagnosis); N.O.L. v. District of Columbia, 674 A.2d 498 (D.C. 1995) (rejecting the claim of a patient’s husband that his wife’s doctors had a duty to disclose her HIV diagnosis as a matter of law); see also Lemon v. Stewart, 682 A.2d 1177 (Md. Ct. Spec. App., 1996) (rejecting suit against the hospital of the family of a patient with HIV for failing to disclose diagnosis to the family members who were caring for patient).

71 SCRPC Rule 1.6, comment 7.
On first blush, a lawyer may conclude this rule permits disclosure if the client is having condomless sex with a partner without revealing her/his HIV or other STD. But the rule requires that there be a threat of “reasonably certain death or substantial bodily harm.” So the risk must be “reasonably certain,” and it must be a risk of “death or substantial bodily harm.” This determination requires an understanding of the scientific facts about transmission risk as well as the course of HIV disease in the modern era. Without this knowledge, a lawyer could improperly assess the risk and thus the applicability of the rule.

Just how “reasonably certain” is it that the sex partner of our client would be infected with HIV? A common misconception about HIV transmission is that the virus is easy to transmit. This is a message that is understandably part of prevention campaigns – one exposure can lead to infection. However, transmission risk is much more complicated than that. The risk of transmission varies widely depending on a number of facts, including the amount of virus in the HIV positive person’s bloodstream. Numerous scientific studies have concluded that people whose viral load is undetectable are much less infectious than those with high levels of virus. This includes a very recent study, led by a UNC researcher, of couples in which one partner was HIV positive and the other negative. The study found that when the infected partner’s viral load was undetectable due to treatment with antiretroviral medications, there was a 96 percent reduction in HIV transmission. Thus the risk of transmission of HIV, especially in a person who is receiving antiretroviral therapy, is very low. So it is by no means clear that the harm under Rule 1.6(b)(2) is “reasonably certain.”

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72 Suzanna Attia et al., Sexual transmission of HIV according to viral load and antiretroviral therapy: systematic review and meta-analysis, 23 AIDS 11 (2009) (compiling study results and finding no record of transmission when persons having intercourse have undetectable viral loads), David P Wilson et al., Relation between HIV viral load and infectiousness: a model-based analysis, 372 LANCET 9635, 314-320 (2008) (finding low transmission rates related to viral load, but pointing out that statistical probability of infection increases with frequency of intercourse).

Even if the disease is transmitted, it is by no means clear that in the era of modern HIV treatment, there is a significant risk of death. It is estimated that a person becoming infected with HIV today has almost the same lifespan as a non-infected person. The disease is very treatable and many people with HIV live long, healthy lives. We all know that deaths from HIV/AIDS have declined since the introduction of effective treatments. In 2007, there were only 11,295 deaths from HIV, as compared with 50,610 who died in 1995 before the advent of the new drugs.

Given the advances in treatments for HIV, it may be also difficult to argue that HIV infection qualifies as “substantial bodily harm” under Rule 1.6(2).

3) Disclosure to comply with law or court order — Rule 1.6(b)(7)

As discussed above, South Carolina law requires that all information and records held by the Department of Health and Environmental Control pertaining to known or suspected cases of sexually transmitted diseases be “strictly confidential.” There is no law in South

74 David A. Cooper, Comment: Life and death in the ART era, 372 Lancet 9635, 266-67 (2008) (pointing out that the live expectancy of someone living with HIV is about 10 years shorter than those without); the Antiretroviral Therapy Cohort Collaboration, Life expectancy of individuals on combination antiretroviral therapy in high-income countries: a collaborative analysis of 14 cohort studies, 372 Lancet 9635, 293-99 (2008) (finding that antiretroviral treatment has drastically improved life expectancy).


Carolina that would require a lawyer to disclose HIV status. The public health laws and rules discussed above do require certain persons to make disclosures, but a lawyer is not among them.

The confidentiality requirement set forth in 44-29-135 has 6 listed exceptions, which are limited to public health, research, treatment, or other legal requirements. As discussed above, release may be when necessary to enforce regulations concerning the control and treatment of a sexually transmitted disease.

We are aware of no situation in the United States where a lawyer has been ordered by a court to disclose a client’s HIV status, though admittedly, our research has not been exhaustive. Further, it is difficult to conceive of a situation where a court would require a lawyer to disclose a client’s HIV, another communicable disease, or other private health information. If such an order were made, a lawyer would have no basis in the ethics rules for refusing to disclose, however, the lawyer should insist on the protective provisions of S.C. Gen. Stat. §44-29-136 that related to confidentiality safeguards for court orders for disclosure of sexually transmitted disease test result and, discussed above.

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