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COMMUNICABLE DISEASE CONTROL IN COLORADO: A RATIONAL APPROACH TO AIDS

EDWARD P. RICHARDS*

I. INTRODUCTION

Protecting the public from communicable diseases is a fundamental duty of a civilized society. As history has demonstrated, the fear of disease is a primal fear that can, and has, torn apart civilizations.¹ Sometime between the end of the last polio epidemic in the 1950's,² and the beginning of the AIDS epidemic³ in the 1980's,⁴ Americans lost their traditional fear of communicable diseases. This loss of fear was the product of a reasonable recognition of the growing ability of medicine to treat or prevent traditional illnesses, and an unreasonable perception that communicable diseases were a problem of the past. While this period saw a massive epidemic of an incurable and frequently deadly disease (hepatitis B)⁵ and the recognition and spread of new epidemic diseases (Lyme Disease and Legionnaires' Disease),⁶ there was little public awareness that communicable diseases constituted a continuing threat to the public health. AIDS shattered this false sense of security.⁷

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1. In earlier ages, pestilence were mysterious visitations, expressions of the wrath of higher powers which came out of a dark nowhere pitiless, dreadful, and inescapable. In their terror and ignorance, we did the very things which increased death rates and aggravated calamity. . . . Panic bred social and moral disorganization; farms were abandoned, and there was shortage of food, famine led to civil war, and, in some instances, to fanatical religious movements which contributed to profound spiritual and political transformations.

H. ZINSSER, RATS, LICE AND HISTORY 129 (1963).

2. H. WAIN, A HISTORY OF PREVENTIVE MEDICINE 359-67 (1970).

3. AIDS (Acquired Immunodeficiency Syndrome) is a collection of symptoms and infectious secondary to infection with HIV (Human Immunodeficiency Virus). While AIDS has gotten most of the news coverage, many persons become sick and die of ARC (AIDS Related Complex) without progressing to AIDS. Persons infected with HIV are infectious to other persons irrespective of whether they have manifested AIDS, ARC, or are totally asymptomatic. It is the larger universe of HIV carriers that poses the threat to the public health.

4. See generally, U.S. Department of Health and Human Services, *Human Immunodeficiency Virus Infection in the United States: A Review of Current Knowledge*, 36 MORBIDITY AND MORTALITY WEEKLY REPORT (6th Supp. Dec. 18, 1987).

5. M. ROSENAU, PUBLIC HEALTH AND PREVENTIVE MEDICINE 181 (1986) [hereinafter M. ROSENAU].

6. A. BENENSON, CONTROL OF COMMUNICABLE DISEASES IN MAN 221 (1985) [hereinafter A. BENENSON].

7. See generally D. BLACK, THE PLAGUE YEARS: A CHRONICLE OF AIDS, THE EPIDEMIC OF OUR TIMES (1986).

This article has two objectives; to provide practical information to Colorado professionals dealing with communicable diseases, including AIDS,⁸ and to give persons outside of Colorado an overview of the legal premises and practical details of the Colorado AIDS control law. Colorado physicians may use this article as a guide to compliance with the Colorado communicable disease laws. Colorado attorneys must be prepared to counsel their clients who are affected by these laws, whether these clients are health care providers, disease sufferers, or employers. Attorneys should also endeavor to understand these laws to better participate in the ongoing public debate over the proper role of public health in a modern society.

For persons outside of Colorado, this is an attempt to explain how one state has developed a rational approach to AIDS, based on existing public health principles. While the confusion over the Colorado AIDS control law⁹ engendered this article, it is impossible to understand the AIDS control law outside of the context of the larger framework of disease control laws and administrative rules. (The Colorado Department of Health (CDH) Rules and Regulations pertaining to communicable disease control are included as an appendix to this article).

Colorado is a leading state in the fight to control AIDS. The Colorado approach to AIDS stands in contrast to some states, which have chosen to ignore important principles of public health practice. Colorado has attempted to give its homosexual citizens the same public health protections as other Coloradans, but Colorado cannot fight AIDS alone. As long as the majority of states do not adopt a proper public health approach to AIDS, then AIDS control efforts are doomed to failure. The Colorado AIDS control law is not perfect, but it is hoped that a broader understanding of the law will stimulate other states to reconsider their AIDS control measures.

II. PURPOSES OF DISEASE CONTROL LAWS

A. *Controlling the Spread of Disease*

The prime purpose of disease control laws is inherent in their name: they exist to control the spread of disease. Few communicable diseases are amenable to eradication or even substantial prevention. For example, there are between one and three million cases of gonorrhea each year.¹⁰ While gonorrhea is easily treatable,¹¹ there is neither a screening test nor a vaccine for the gonococcus, making it impossible

8. This article does not purport to review legal issues that are unrelated to the Colorado experience. In particular, since Colorado has a specific statute requiring the reporting of HIV positive persons to the Colorado Department of Health (CDH), there is no need to carry out a full analysis of the common law duty to warn third parties of a potentially infectious patient. However, in states that do not require, or permit, the reporting of HIV infection this common law duty will be a source of extensive litigation.

9. COLO. REV. STAT. § 25-4-1401 (Supp. 1987).

10. Cutler & Arnold, *Veneral Disease Control by Health Departments in the Past: Lessons for the Present*, 78 AM. JOUR. PUB. HEALTH 372 (1988) [hereinafter Cutler & Arnold].

11. There are strains of gonorrhea that are resistant to the antibiotics used as first line

to eradicate. Given the large number of carriers, and the societal unease with state controls on sexual activity, it is also impossible to curtail the activities of persons carrying the disease. For individuals at risk of contracting gonorrhea, the most realistic disease control goal is to identify and treat new cases before they lead to permanent injuries such as sterility.¹² At the societal level, it is only possible to prevent the gradual increase of the disease and to be on guard against the emergence of new drug resistant strains.

For other diseases, such as typhoid fever, it is impossible to cure the disease in some persons. It is possible, however, to prevent its spread as an endemic disease in the community. Typhoid is easily controlled for three reasons: (1) there are relatively few cases;¹³ (2) the risk to the community arises from easily identifiable occupations;¹⁴ and (3) the public accepts that a health officer must actively supervise the disease carrier to prevent further spread of the disease.¹⁵ In contrast with gonorrhea, it is reasonable for individuals to expect to be protected from infection with typhoid fever.

B. Disease Reporting

The scientific control of communicable diseases rests on the identification of infected individuals, the investigation of how these individuals contracted the disease, interventions to prevent the further spread of the disease, and, in some cases, the treatment of infected individuals. All of these activities are predicated on identifying the universe of infected individuals. Without effective disease reporting, one cannot know the number of persons infected,¹⁶ the rate at which the disease is spreading in the community, the mode of spread of the disease, or the natural history of the disease. For a new disease, such as Lyme disease or HIV infection, this information is critical to such basic tasks as determining who is at risk for the disease and how the disease is spread.¹⁷ Disease reports are also critical to maintaining the surveillance of well controlled diseases to assure that the patterns of spread and the prevalence of these diseases do not change.¹⁸

therapy. These strains are treatable with other, more expensive and toxic, antibiotics. A. BENESON, *supra* note 6, at 161.

12. W. PERNOLL & R. BENSON, CURRENT OBSTETRIC AND GYNECOLOGICAL DIAGNOSIS AND TREATMENT 718 (1987).

13. A. BENESON, *supra* note 6, at 420. If any jurisdiction had a substantial number of cases, the resources necessary to maintain surveillance would be prohibitive.

14. A typhoid carrier is only a threat if he works as a food handler.

15. "Exclude infected persons from handling food. Identify and supervise typhoid carriers. . . . Chronic carriers should not be released from supervision and restriction of occupation until 3 consecutive negative cultures . . . taken at least 1 month apart." A. BENESON, *supra* note 6, at 422.

16. "Prevalence" is the total number of persons in a population who have a disease at a given point in time. R. FLETCHER AND E. WAGNER, CLINICAL EPIDEMIOLOGY-THE ESSENTIALS 76 (1982).

17. For a discussion of the investigation of Legionnaires' Disease see G. THOMAS AND M. MORGAN-WITTS, ANATOMY OF AN EPIDEMIC (1982). For a discussion of the Swine Flu non-epidemic see R. NEUSTADT AND H. FINEBERG, THE EPIDEMIC THAT NEVER WAS (1983).

18. For example, tuberculosis is on the increase, secondary to HIV infection. See U.S.

The mainstay of disease reporting is the identification of infected persons by name and address. Other information, such as occupation or dietary history may be obtained during the investigation of a specific disease outbreak.¹⁹ If the disease is spread by personal contact, then the infected individual will also be questioned about who may have given him the disease and who he may in turn have infected. Because of the intrusive nature of the contact investigation, the reporting and investigation of communicable diseases has always been most problematic for sexually transmitted diseases ("STD's").

Persons with STD's must contend with societal censure and the embarrassment of having to discuss intimate personal information with disease investigators. Yet the requirement that information about sexual habits and partners be disclosed to public health authorities has not been controversial until recently. Historically, persons with STD's have readily complied with the reporting of their contacts and have supported efforts by health departments to warn friends and lovers who might have become infected.²⁰ Most tellingly, homosexual men and prostitutes sought treatment in public health clinics in preference to private practitioners. Until AIDS, public health clinics were valued for their non-judgmental treatment of STD's and their strict protection of the patient's privacy.

A central dilemma of the AIDS hysteria has been a systematic effort by homosexual and civil rights advocacy groups to prevent the application of disease control measures to HIV infection. Since no health departments have seriously considered restricting HIV carriers, the major focus has been on preventing the mandatory reporting of HIV infection and limiting the notification of persons who have been exposed to the disease. Homosexual activists have resisted reporting and contact tracing because they fear that the health department records will be used to persecute homosexual men. The American Civil Liberties Union has resisted the reporting of HIV infection out of a vague sense that there is a constitutional right to conceal a communicable disease. In both cases, these efforts to prevent basic disease control activities are rooted in a naive view of disease control that assumes that diseases are only controlled through treatment, and that education is the best way to control the spread of communicable diseases. Unfortunately, there are no magic bullets for HIV infection, and education has had a dismal record in the control of STD's.

The tragedy is that since these groups have not been able to make a

Department of Health and Human Services, *Tuberculosis and Acquired Immunodeficiency Syndrome*, 36 MORBIDITY AND MORTALITY WEEKLY REPORT 785 (Dec. 11, 1987) [hereinafter U.S. Department of Health]; See also Salgo, *A Focus of Rocky Mountain Spotted Fever Within New York City*, 318 NEW ENG. J. MED. 1345 (May 26, 1988).

19. M. ROSENAU, *supra* note 5, at 312.

20. Historically, the problem has been persuading private practice physicians to comply with the reporting requirements. One of the few studies on physician compliance with reporting laws was done in Colorado. See Rothenberg, Bross and Vernon, *Reporting of Gonorrhea by Private Physicians: A Behavioral Study*, 70 AM. J. PUB. HEALTH 983 (1980) [hereinafter Rothenberg].

valid scientific argument against the reporting of HIV infection, they have instead chosen to attack the integrity of public health officials. Despite evidence that public health departments have an essentially unblemished record in protecting patient information,²¹ homosexual advocacy groups have convinced most state legislatures that health departments cannot be trusted with information on the spread of HIV. This attack on the integrity of public health has been made with the tacit support of many public health officers. These public health officers have become captives of the rhetoric of patient autonomy. They speak of protecting the patient's right to privacy, rather than the patient's right to life. The legacy of this schizophrenic view of the role of public health officials²² has been the unnecessary death of tens of thousands of people, primarily homosexual men.²³

These groups have been successful in preventing the reporting of HIV status and the warning of persons exposed to HIV. Except for Colorado and a few other jurisdictions, state, local and federal public health authorities have refused to support HIV reporting. Since HIV is a national problem, with mobile carriers and great regional variation, the data from the small number of jurisdictions that require the reporting of HIV are not adequate to describe the dynamics of HIV infection. As a result of the failure of most jurisdictions to require reporting of HIV status, it is impossible to determine the number of persons infected with HIV, or the rate and mode of its spread in the United States. The Centers for Disease Control cannot determine—within the range of 100,000 to 5,000,000—the actual prevalence of HIV infection. While statutory reporting requirements provide less accurate prevalence information than properly conducted seroprevalence studies, they would provide valuable information that is not otherwise available.

III. DISEASE CONTROL IN COLORADO

A. Federal Efforts

Public health has traditionally been a state rather than federal activity. The Federal government operates the United States Public Health Service,²⁴ but this was, historically, merely a uniformed service to provide medical care for members of the merchant marine. The Federal government became actively involved in disease control, specifically the

21. Association of State and Territorial Health Officers, *Guide to Public Health Practice: AIDS Confidentiality and Anti-Discrimination Principles* 24 (March 1988) [hereinafter ASTHO].

22. The contradiction is epitomized in the criticism of public health officials for not treating AIDS as aggressively as other diseases, while castigating public health officials whenever it is suggested that traditional disease control measures are applicable to HIV control.

23. Don't offend the gays and don't inflame the homophobes. These were the twin horns of the dilemma on which the handling of this epidemic would be torn from the first day of the epidemic. Inspired by the best intentions, such arguments paved the road toward the destination good intentions inevitably lead.

R. SHILTS, *AND THE BAND PLAYED ON* 69 (1987).

24. For a discussion of the role of the public health service in venereal disease control see Cutler & Arnold, *supra* note 10, at 372-73.

control of STD's, during World Wars I and II. This involvement began because of the debilitating effect of STD's on the troops. The federal efforts continued through the early 1950's, resulting in the lowest rates of STD's in United States history. The rate of syphilis and gonorrhea is now higher than forty years ago.²⁵ Since World War II the Public Health Service has evolved to include medical research at the National Institute of Health and other federal facilities.

The government also operates the Centers for Disease Control ("CDC"). The CDC: 1) conducts research on public health problems, including disease control; 2) maintains a clearinghouse for statistical information on health matters, including communicable diseases; 3) administers both general and categorical disease control grant funds; 4) oversees maritime disease control efforts; 5) engages in professional standard setting for laboratory and disease control activities; 6) provides special drugs and antitoxins; and 7) represents the United States in the World Health Organization. The Epidemic Investigation Service is also based at the CDC.²⁶ This is a group of investigators that will assist state and local health officers in the investigation of unusual disease outbreaks.

While the CDC attempts to coordinate and encourage state disease control efforts, its effectiveness is limited because the United States does not have a national disease control policy. Congress has preferred to leave disease control activities to the states. Each state is free to ignore CDC standards and resources, irrespective of the effect on national disease control efforts. While states should be free to adopt more rigorous disease control standards than those proposed by the CDC, there should be federally mandated minimum standards and greater standardization of disease control efforts.

B. State Powers

1. General Powers

States have almost unfettered authority to protect their citizens from communicable disease. In a few old cases, the courts have declared blatantly racist laws unconstitutional,²⁷ but sustained even Draconian measures when applied to persons suspected of spreading a communicable disease. In modern times, the courts have seldom limited the authority of state and local public health officers to protect the public health.²⁸ The universe of available powers includes the authority

25. *Id.*

26. For a discussion of the work of the Epidemic Investigation Service at the CDC, see B. ROUCHE, *THE MEDICAL DETECTIVES* (1981).

27. Typical of these cases were the laws in San Francisco, California that attempted to use fire safety rules to limit Chinese laundries under the guise of protecting the public health. *Yick Wo v. Hopkins*, 118 U.S. 356 (1886).

28. *Dunbar v. Giordano*, 173 Colo. 567, 481 P.2d 415 (1971); *Winkler v. Colorado Dep't of Health*, 193 Colo. 170, 564 P.2d 107 (1977); *Reynolds v. McNichols*, 488 F.2d 1378 (10th Cir. 1973). For a good discussion of the state's police power to close homosexual bathhouses, see *City of New York v. St. Mark's Baths*, 497 N.Y.S.2d 979 (Sup. 1986).

to:

- (1) require the reporting of private medical information to governmental agencies;²⁹
- (2) search medical records held by physicians and hospitals to locate information about the spread of communicable diseases;³⁰
- (3) immunize persons against communicable diseases;³¹
- (4) perform medical examinations, collect specimens, and perform laboratory analyses without, or against, a person's consent;³²
- (5) treat persons without, or against, their consent;³³
- (6) restrict the occupation of a disease carrier;³⁴
- (7) restrict the freedom of movement and association of a disease carrier;³⁵ and
- (8) seize and destroy property that poses a threat to the public health.

2. Colorado's General Powers

The powers stated above are available to all states, but the state must pass legislation to empower the state health officer to exercise the state's power. In Colorado, as in most states, this legislation takes the form of a general authorization to protect the public health and safety, combined with legislation for specific diseases. The general authorization for the CDH is quite broad:

- (1) To investigate and control the causes of epidemic and communicable diseases affecting the public health;
- (2) "[t]o establish, maintain, and enforce isolation and quarantine, and, in pursuance thereof and for this purpose only, to exercise such physical control over property and the persons of the people within this state as the department may find necessary for the protection of the public health;"
- (3) to close theatres, schools, and other public places, and to forbid gatherings of people when necessary to protect the public health;
- (4) to abate nuisances when necessary to protect the public health; and
- (5) to collect, compile, and tabulate reports of marriages, dissolution of marriages, declaration of invalidity of marriages, births, deaths, and morbidity, and to require any person having information with regard to the same to make such reports and

29. *Whalen v. Roe*, 429 U.S. 589 (1977).

30. COLO. REV. STAT. § 25-4-508 (1982).

31. *Brown v. Stone*, 378 So. 2d 218 (Miss. 1979); *Pierce v. Board of Educ.*, 30 Misc. 2d 1039, 219 N.Y.S.2d 519 (1961); *Jacobson v. Massachusetts*, 197 U.S. 11 (1905).

32. *Ex parte Woodruff*, 90 Okla. Crim. 59, 210 P.2d 191 (1949); *Ex parte Kilbanoe*, 32 Ohio Op. 530, 67 N.E.2d 22 (1945).

33. *Reynolds v. McNichols*, 488 F.2d 1378 (10th Cir. 1973); *Welch v. Shepherd*, 165 Kan. 394, 196 P.2d 235 (1948).

34. 6 COLO. CODE REGS. § 1009-1 (1988) (Regulation 6).

35. *Ex parte Fowler*, 85 Okla. Crim. 64, 184 P.2d 814 (1947); *Board of Health v. Court of Common Pleas*, 83 N.J.L. 392, 85 A. 217 (1912); *Jewish Hosp. v. Williamson*, 103 F. 10 (N.D. Cal. 1900); *Ex parte McGee*, 105 Kan. 574, 185 P. 14 (1919); *Ex parte Clemente*, 61 Cal. App. 666, 215 P. 698 (1923); *Application of Halko*, 246 Cal. App. 2d 553, 54 Cal. Rptr. 661 (1966).

submit such information as the board shall by rule or regulation provide.³⁶

In addition to these general powers, there are specific laws governing alcoholism and intoxication treatment,³⁷ cholera and smallpox on trains,³⁸ prenatal examinations for syphilis,³⁹ "inflammation of the eyes of the newly born",⁴⁰ venereal diseases,⁴¹ tuberculosis,⁴² rabies,⁴³ psittacosis,⁴⁴ phenylketonuria,⁴⁵ school entry immunizations,⁴⁶ newborn screening and genetic counseling,⁴⁷ and HIV infection.⁴⁸

IV. DISEASE REPORTING

A. *Disease Reporting in Colorado*

The CDH has the general authority to require anyone to report communicable diseases, even attorneys. In Regulation Two of the Rules and Regulations Pertaining to Communicable Disease Controls, the CDH has established which individuals, in addition to attending physicians, must report communicable diseases: "other persons either treating or having knowledge of a reportable disease, such as superintendents or persons in charge of hospitals or other institutions licensed by the Colorado Department of Health, (or their designees), persons in charge of schools (including school nursing staff) and licensed day-care centers."⁴⁹ Regulation Two attempts to limit the duty to report to health care providers and the supervisors of licensed institutions through the qualification of persons with knowledge of a reportable disease, "such as superintendents." This qualification still leaves open the question of whether other persons, such as attorneys, have a legal duty to report communicable diseases. While the vague language might prevent prosecution under the public health laws, it might not foreclose liability for a civil lawsuit for failure to warn.⁵⁰

The CDH has promulgated administrative regulations requiring the reporting of many diseases that are not the subject of specific statutes.⁵¹ These regulations list the diseases that must be reported, the form of

36. COLO. REV. STAT. § 25-1-107(a) to (d), (f) (1982).

37. *Id.* at § 25-1-301 (1982 and Supp. 1987).

38. *Id.* at § 25-1-606 (1982).

39. *Id.* at § 25-4-201.

40. *Id.* at § 25-4-301.

41. *Id.* at § 25-4-401.

42. *Id.* at § 25-4-501.

43. *Id.* at § 25-4-602.

44. *Id.* at § 25-4-701 *et seq.* (1982 and Supp. 1987).

45. *Id.* at § 25-4-801 *et seq.* (1982).

46. *Id.* at § 25-4-901 *et seq.*

47. *Id.* at § 25-4-1001 *et seq.* (1982 and Supp. 1987).

48. *Id.* at § 25-4-1401 *et seq.* (Supp. 1987).

49. 6 COLO. CODE REGS. § 1009-1 (1988) (Regulation 2).

50. While the duty to report HIV is clearly limited to health care related personnel, a question might arise if an attorney was counseling a person with tuberculosis as to how to avoid detection by the health department.

51. 6 COLO. CODE REGS. § 1009-1 (1988) (State of Colorado Rules and Regulations pertaining to communicable disease control). These rules and regulations are reprinted as an appendix to this article.

the required reports, and how quickly the report must be made. The regulations divide diseases into five categories: (1) those that must be reported within twenty-four hours (List A);⁵² (2) those that must be reported within seven days (List B);⁵³ (3) laboratory reporting of venereal diseases;⁵⁴ (4) laboratory reporting of non-venereal diseases,⁵⁵ and (5) reporting requirements for HIV infection.⁵⁶

The disease reports must contain the following information: "patient's name, address (including city and county), age, sex, name and address of responsible physician, and such other information as is needed to locate the patient for follow-up."⁵⁷ This information is also required in reports of HIV infection. There is an exemption for "influenza-like illness, animal bites and mumps, in which only the number of cases seen need be reported."⁵⁸ All List A diseases and certain List B diseases⁵⁹ must be reported by a clinical diagnosis, irrespective of laboratory confirmation. The remainder of List B diseases are only to be reported when the diagnosis is supported by laboratory confirmation. These reports may be made to the local health officer, his designate, or the CDH Epidemiology Division.⁶⁰

Lists A & B delineate the diseases that the CDH believes are of public health significance, and that are likely to be seen in Colorado. Regulation One of the Colorado Department of Health also requires the reporting of:

[A]ny unusual illness or outbreak of illnesses which may be of public concern whether or not known to be, or suspected of being, communicable, regardless of its absence from lists A and B. A physician who observes any unusual pattern of illness, or, more broadly, any threat to the public health,⁶¹ should contact the state or local health department.⁶²

More importantly, the CDH protects the confidentiality of all disease control reports: "All records and reports submitted to the Colorado Department of Health in compliance with these regulations are deemed to be confidential public health information and are to be used by the Department as source material for problem analysis and necessary disease control efforts."⁶³ As with all public health departments, the CDH has an exemplary record of maintaining the confidentiality of disease con-

52. *Id.* (1988) (Regulation 1).

53. *Id.*

54. *Id.* (1988) (Regulation 4).

55. *Id.* (1988) (Regulation 3).

56. *Id.* (Regulations 1 to 3). The legislature choose to establish separate rules for reporting HIV. These statutory rules are reflected in the regulations and are discussed in detail later in this paper.

57. *Id.* (Regulation 1).

58. *Id.*

59. These selected diseases are marked with an asterisk which are listed in the appendix.

60. Physicians and others who need information on where to report disease should contact the Epidemiology Division at (303)331-8331.

61. A threat to the public health may include toxic exposures or radiation exposures.

62. 6 COLO. CODE REGS. § 1009-1 (1988) (Regulation 1).

63. *Id.* (1988) (Regulation 8).

trol reports. This was recently highlighted in a report prepared by the Association of State and Territorial Health Officers ("ASTHO").⁶⁴ As part of this report the committee conducted a national survey attempting to show that new laws are necessary to protect the confidentiality of HIV carriers. The study showed that the number of documented cases of breaches of confidentiality were very low, and that breaches by disease control workers were essentially nonexistent.⁶⁵

B. *The Duty to Protect Others*

A person infected with a communicable disease has a duty to prevent the spread of the disease to others. If a person transmits a disease through a negligent failure to prevent harm to others, then the disease carrier could be sued for damages.⁶⁶ In Colorado and other states which criminalize certain reckless conduct, an action based on a negligence per se theory could be supported. The reckless or intentional transmission of a communicable disease could also be grounds for prosecution under a state's criminal laws.⁶⁷ While it might be difficult to obtain a conviction for specific intent crimes such as murder, a person who knowingly exposes others to a dangerous communicable disease could be successfully prosecuted for reckless endangerment.⁶⁸ The health department may also prosecute such conduct under the public health laws.⁶⁹

Physicians and other health care workers have a duty to prevent the spread of communicable diseases. They must counsel an infected person on how to prevent the spread of disease.⁷⁰ They also have a duty to

64. ASTHO, *supra* note 21, at 24.

65. There was only one possible case of a breach of confidentiality by an epidemiology disease reporting center. This survey was sent to all state health departments, most big city health departments, civil rights groups, and national homosexual rights advocacy groups. There was no attempt to conduct a random sample. The survey found only 75 reported instances of breaches of confidentiality throughout the United States. The assumption of many committee members was that this reflected a failure of the research design rather than an indication that breaches of confidentiality are a sham issue. While this assumption echoes the conventional wisdom that breaches of confidentiality are a major problem that requires special laws for HIV, this study does not support the hypothesis that HIV records pose special confidentiality problems.

66. *Tort Liability for AIDS?*, 24 HOUS. L. REV. 957 (1987).

67. There have been several cases charging HIV carriers with murder. See Berg, *AIDS Patient Convicted of Murder Attempt*, L.A. DAILY J., Jan. 29, 1988 at 3, col. 1; Thompson, *AIDS Case Turning Up in Criminal Courts*, L.A. DAILY J., Jan. 3, 1986 at 3, col. 1.

68. COLO. REV. STAT. § 18-3-208 (1986); *but see* United States v. Moore, 669 F. Supp. 289 (D. Minn. 1987): "On June 24, 1987, defendant, an inmate at the Federal Medical Center in Rochester, was convicted by a jury of two counts of assault with a deadly or dangerous weapon in violation of 18 U.S.C. §§ 111 and 1114. The indictment alleged that he had tested positive for the Human Immunodeficiency Virus (HIV) antibody and that later he assaulted two federal correctional officers with his mouth and teeth. . . . Defendant had been informed that he had both the AIDS virus and the hepatitis antibody and that he could potentially transmit the diseases to other persons. Defendant bit Officer McCullough on the leg twice, leaving a four inch saliva stain. He bit Officer Voight on the leg, breaking the skin and leaving a mark that was visible five months later at trial. After the incident, defendant stated that he intended to kill the officers" (footnote omitted).

69. *Id.* at § 25-1-114(4) (Supp. 1987) (unlawful acts—penalties).

70. The recent cases deal with the duty to warn a patient about the risk he poses to

warn persons that might be infected through contact with the disease carrier.⁷¹ An important function of a state's disease control laws is to allow the discharge of a physician's duty to warn persons who his patients might endanger.

A central dilemma in the treatment of persons with communicable diseases is the conflict between the physician's duty to warn third persons and the duty to protect the patient's confidentiality. Many physicians believe that they have both the right and the duty to personally warn persons who may be put at risk by their patients. This belief is strongest among family practitioners who, rightly, abhor the notion that they cannot warn a wife, for example, that her husband has syphilis. Unfortunately, assuming the duty to personally warn third parties is fraught with liability,⁷² and may even violate specific statutes designed to protect a patient's privacy.

In Colorado, it is illegal for a physician to contact a third party without the patient's consent. Colorado is unusual in that its statutory protection for patient confidentiality is part of the criminal code.⁷³ This statute applies to all medical records⁷⁴ and medical information,⁷⁵ imposing a criminal penalty⁷⁶ on any person, "who, without proper authorization, . . . discloses to an unauthorized person a medical record or

others while he (the patient) is on medication. In *Gooden v. Tipps*, 651 S.W.2d 364, 369 (Tex. Civ. App. 1983), Doctor Tipps was sued by a person whose car was struck by the patient Doctor Tipps was treating. The patient was under the influence of Quaalude, and there was an issue as to whether the physician had warned the patient that the drug would interfere with her driving. The court held: "[I]t is apparent that, under proper facts, a physician can owe a duty to use reasonable care to protect the driving public where the physician's negligence in diagnosis or treatment of his patient contributes to plaintiff's injuries." In reviewing the precedent for this decision, the court specifically referred to the venereal disease control laws as an example of a physician's duty to the public, and by analogy, an area of potential liability if the physician violates that duty. The court also pointed "out that the imposition of a duty upon a physician for the benefit of public is not a new concept. Art. 4445 . . . [the venereal disease control act] was originally enacted in 1918." *Gooden*, 651 S.W.2d at 370.

71. Many commentators derive this duty from *Tarasoff v. Regents of Cal.*, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976). *Tarasoff* involves the duty to warn the potential victim of homicidal psychiatric patient. While the language of this case is broad, the facts are very narrow. *Tarasoff* deals only with the situation of a patient that a therapist determines, or should determine, is dangerous to others. *Id.* at 432, 551 P.2d at 340, 131 Cal. Rptr. at 20. It is acknowledged that the term "dangerousness" is difficult, or close to impossible, to determine. Specifically, the assertion by a psychiatric patient that he plans on killing someone is not enough. Doctor *Tarasoff's* problem was that he made the determination of dangerousness, then did not follow-up on his efforts to have the patient restricted. Had he chosen to *not* make the diagnosis, he would *not* have had the duty to warn. Since contagiousness does not require a determination of the patient's state of mind, *Tarasoff* may be better disease control precedent than mental health precedent.

72. If the physician passes on incorrect information he may be sued for libel or slander. If the information is correct, he may be sued for invasion of the patient's privacy.

73. See COLO. REV. STAT. § 18-4-412 (1986).

74. *Id.* at (2)(a). "[T]he written or graphic documentation, sound recording, or computer record of services pertaining to medical and health care which are performed at the direction of a physician or other licensed health care provider on behalf of a patient . . ."

75. *Id.* at (2)(b). "[A]ny information contained in the medical record or any information pertaining to the medical and health care services performed at the direction of . . . [any] licensed health care provider. . . ."

76. *Id.* at (3).

medical information”⁷⁷ Proper authorization means the written consent of the patient or his duly designated representative, an appropriate court order, or that the record or information is being used in various designated health care related functions.⁷⁸ This law accepts the reality of health care as a team activity, but strictly limits disclosures to third persons who are not involved in the health care system.

The restrictions on warning third persons are balanced by the duty to report specific diseases, and other conditions that pose a threat to the public health, to the public health officials. This provides Colorado physicians with a solution to the dilemma of public versus private trust: they are required to report communicable diseases to the CDH, which then warns third parties as necessary, and they are forbidden to personally warn third parties without their patients’ consent.⁷⁹

Physicians in jurisdictions that do not accept or act on reports of communicable diseases, such as HIV, are in an unenviable position. They cannot discharge their duty to warn (and the liability for failing to warn) third persons through the public health department, but personal attempts to warn others may subject the physicians to liability for breaching their patients’ confidences. A physician in such a jurisdiction has three choices:

- (1) Do nothing beyond counseling the patient to warn persons that he might be put at risk of becoming infected with the communicable disease;
- (2) Personally warn the persons at risk himself, thus assuming the threat of litigation for invasion of privacy, libel or slander, and the risk that the physician’s actions will establish the patient’s dangerousness while being ineffective in warning all appropriate persons; or
- (3) Carefully document the details of each case in which there is a danger to third parties. This should include giving the patient a written form explaining the dangers to others and his duty to act responsibly. The physician should, unless specifically forbidden by state law, copy this documentation and send it to his state health department. This will put the health department on notice that the patient poses a risk to the public health.⁸⁰

In Colorado, a physician or another health care provider who complies with the Colorado laws and regulations governing the reporting of communicable diseases should have a complete defense to lawsuits based on a failure to warn third persons. This compliance is especially important for HIV reporting, where there is both a statutory duty to report and a statutory protection from litigation for physicians who re-

77. *Id.* at (1).

78. *Id.* at (2)(c). These designated functions include quality assurance, insurance claims processing, possession by hospital personnel for billing and medical persons, and transferring the information to a consulting physician.

79. 6 COLO. CODE REGS. § 1009-1 (1988).

80. Putting the health department on notice may not cause them to act, but it will dispel the myth that communicable disease carriers, specifically HIV carriers, do not pose a threat to others.

port.⁸¹ To assure that this protection is available, the person making the disease control report should document the fact of the report in the patient's medical record, including time, date, and person contacted at the health department.

C. *Liability for Failing to Report Communicable Diseases*

The communicable disease control laws and regulations are evidence of the state's interest in protecting the public health. As such, their violation gives rise to legal liability for the damages related to the particular consequences of the breach. The best known of these duties, and one that is shared with certain other health care providers, is to report the disease to the public health authorities.⁸² Failing to report a communicable disease is punishable under the law.⁸³ Physicians also have a duty to counsel the infected person on measures to avoid the spread of the disease.⁸⁴ Persons who violate these laws may be sued if their patients infect others. In such a lawsuit the violation of the statute would be evidence of negligence per se. While negligence per se has not been specifically adopted by a Colorado court in a disease control case, it is well accepted in other contexts.⁸⁵

The Colorado Supreme Court recently reviewed negligence per se.⁸⁶ The court held that "[t]he standard of conduct is adopted by the court from the statute or ordinance, and violation of the enactment conclusively establishes negligence."⁸⁷ Merely showing that the defendant violated the statute is not enough. The plaintiff must also "show that he is a member of the class the statute was intended to protect and that the injuries were of the kind that the statute was enacted to prevent."⁸⁸ In the case under consideration, the defendant violated the law against selling liquor to an intoxicated person. The plaintiffs were the family of a man killed by the intoxicated person. The court had no trouble in finding that the purpose of the Dramshop law was to protect both the drinker and the "safety of those with whom the drinker comes into contact."⁸⁹ Thus, the court found for the plaintiffs on the issue of negligence per se.

In a case alleging negligence per se for violation of a communicable disease law, there would typically be a plaintiff who contracted a communicable disease from the defendant's patient. If this patient had contracted HIV, then the legislative intent for part fourteen of the communicable disease control laws⁹⁰ would be in issue. The introduc-

81. COLO. REV. STAT. § 25-4-1404 (Supp. 1987); see also *id.* at § 25-4-402 (1982).

82. *Id.* at § 25-1-107 (1982 and Supp. 1987).

83. *Id.* at § 25-4-407 (Supp. 1987).

84. Failure to carry out the duty to counsel does not always result in a penalty for the treating physician. *Id.* at §§ 25-4-407, 408 (Supp. 1987).

85. See *infra* notes 87-94 and accompanying text.

86. *Largo Corp. v. Crespin*, 727 P.2d 1098 (Colo. 1986).

87. *Id.* at 1107.

88. *Id.* at 1108.

89. *Id.*

90. COLO. REV. STAT. § 25-4-1401 *et seq.* (Supp. 1987).

tion of part fourteen establishes: (1) that the legislature supports the Colorado Department of Health's efforts at controlling HIV infection; (2) that restrictive measures should only be used to protect the public health; and (3) that the legislature wants to control the spread of HIV. In particular, the legislature explicitly endorsed the reporting of HIV infection and the notification of persons known to be exposed to HIV infection as a method of controlling the spread of HIV.⁹¹

When a bar owner serves alcohol to a drunk, the owner does not know which members of the general public that the drunk may injure. It is sufficiently foreseeable, for the purpose of assigning liability in tort, that a drunk will engage in driving under the influence, and that the drunk will injure a member of the general public. Similarly, it is foreseeable that a person carrying a communicable disease will pass that disease on to a member of the general public. Thus, the public health duty to counsel and report is designed to protect third parties in the same way as the Dramshop laws. Irrespective of the physician's common law duty to warn of communicable diseases,⁹² there is clearly a duty to warn through notification of the public health department. Any person injured through this failure to warn would be entitled to recover damages.⁹³

2. Constitutional Considerations: Restricting the Innocent

Public health law occupies that nether world between criminal and civil law. While public health proceedings may constitutionally be carried out without the rigor of a criminal proceeding, they may result in the incarceration of a disease carrier. Most interestingly, public health laws are seldom litigated (a recurring explanation is that judges are not interested in having infectious litigants in their court rooms). Consequently, there is little case law on communicable disease control measures. While this invisibility is often taken as evidence that the courts

91. *Id.* The general assembly further declares that reporting of HIV infection to public health officials is essential to enable a better understanding of the disease, the scope of exposure, the impact on the community, and the means of control. The general assembly further declares that the purpose of part 14 is to protect the public health and prevent the spread of said disease.

92. *Skillings v. Allen*, 143 Minn. 323, 173 N.W. 663 (1919); *Davis v. Rodman*, 147 Ark. 385, 387, 227 S.W. 612, 614 (1921); *but see Gammill v. United States*, 727 F.2d 950 (10th Cir. 1986) (construing Colorado law). The *Gammill* court recognized that a physician has a common law duty to warn family members, treating attendants, or other persons likely to be exposed to the patient, but did not believe that this duty to warn extended to members of the general public. This case involved a physician employee of the United States who failed to report a case of hepatitis. To the extent that this case holds that the public health laws do not allow private attorney general actions, it is correct. It also implies that the provision of a criminal penalty in a statute prevents the application of negligence per se. This was directly refuted in *Largo*. "A criminal statute may be relied upon to establish negligence per se even though the statute is silent on the issue of civil liability." *Largo*, 727 P.2d at 1108.

93. In *Jones v. Stanko*, 118 Ohio St. 147, 160 N.E. 456 (1928), the physician failed to report smallpox as required by the state law. The court found this actionable and allowed damages for the estate of a person who died after contracting smallpox from the defendant's patient. *Id.*

must have curtailed disease control activities, it is more accurately a reflection of the courts' acquiescence in these activities.

Only one recent case, *Reynolds v. McNichols*,⁹⁴ has examined the constitutional reach of the Colorado communicable disease laws. *Reynolds* arose when a prostitute challenged the public health officer's authority to require her to be examined and treated for venereal disease. The case demonstrates the level⁹⁵ of constitutional scrutiny that has historically been applied to disease control cases. *Reynolds* is important because it refutes the charge, levied by civil rights activists and homosexual advocacy groups, that Colorado's disease control laws are antiquated and would not withstand constitutional scrutiny.⁹⁶

The Denver ordinance under which *Reynolds* was prosecuted provided that persons suspected of having a venereal disease could be examined, detained, and treated. The statute defined a person under suspicion as any person arrested and charged with "vagrancy, prostitution, rape, a violation of this article, or another offense related to sex"⁹⁷, or:

Any person reasonably suspected to have had a contact with another individual reasonably believed to have had a communicable venereal disease at the time of such contact and any person who is reasonably believed to have transmitted any such disease to another individual. Any person who has had any such disease or who has been convicted of any offense of the kinds herein specified within twelve months next past, and who is reasonably believed to be engaged in any activity which might have occasioned exposure to a communicable venereal disease.⁹⁸

The ordinance provides that persons who have been arrested may be detained in jail pending examination and treatment. Detention may be circumvented if the prisoner agrees to accept treatment without further testing.⁹⁹ The Director of Denver Health and Hospitals is empowered to order persons suspected of carrying a venereal disease, who are not in jail, to present themselves for examination and treatment.¹⁰⁰ The ordi-

94. 488 F.2d 1378 (10th Cir. 1973).

95. *Id.* at 1383. "The court only asserts that there is no equal protection claim available and, thus, refuses to discuss the level of scrutiny which would be applicable to this case.

96. Accepting this argument, the Colorado Legislature unnecessarily limited the power of the CDH to restrict persons with HIV who pose a threat to the public health. *See infra* note 162-64 and accompanying text.

97. *Reynolds*, 488 F.2d at 1384. While vagrancy was not at issue in this case, it would be expected that vagrancy would only be an acceptable ground for testing and treatment if it was correlated with communicable disease transmission.

98. *Id.* at 1384.

99. The prisoner is given epidemiologic treatment, which is treatment based on probable exposure to a communicable disease. Epidemiologic treatment is based on the principle that the health of the community is best served by treating persons who are exposed to the disease, although they may not have become infected. This is a critical strategy for controlling diseases such as gonorrhea for which the usual diagnostic tests have a high rate of false negative results.

100. Every suspected person in the categories enumerated in Section 735.1-1(2) [of the Denver City Code], and in the categories enumerated in Section 735.1-

nance provides that the Denver police have the authority to order persons to present themselves at Denver Health and Hospitals for examination and treatment.¹⁰¹

The court found both the detention and the walk-in orders to Denver Health and Hospitals to be constitutional:

Involuntary detention, for a limited period of time, of a person reasonably suspected of having a venereal disease for the purpose of permitting an examination of the person thus detained to determine the presence of a venereal disease and providing further for the treatment of such disease, if present, has been upheld by numerous state courts when challenged on a wide variety of constitutional grounds as a valid exercise of the police power designed to protect the public health.¹⁰²

While this case is fifteen years old, the United States Supreme Court has not weakened its authority.

In 1987, the United States Supreme Court reiterated the right of the government to restrict the freedom of individuals to protect the public safety. In *United States v. Salerno*,¹⁰³ the Court upheld the preventive detention provision of the Bail Reform Act of 1984.¹⁰⁴ Preventive detention, for the purpose of protecting the public safety, was found to be an allowable regulatory function, rather than an impermissible punishment.¹⁰⁵

In the companion case of *Hilton v. Braunskill*,¹⁰⁶ the Court applied the same individual liberty/public safety balancing test to support a decision not to release a successful habeas corpus petitioner, pending final appeal, because he might pose a threat to the community.¹⁰⁷

In both of these cases, the Court stresses the right of the govern-

1(1) who is not detained in jail shall be examined at the department of health and hospitals on an in-patient or out-patient basis as determined in individual instances by the manager of health and hospitals or his authorized representative. Each such person shall submit to examinations as necessary and permit specimens to be taken for laboratory analyses and shall comply with the directions of the manager or his authorized representative with relation to hospitalization on an in-patient basis or attendance at clinic on an out-patient basis, as the case may be.

Reynolds, 488 F.2d 1378, 1385 (10th Cir. 1973).

101. *Id.* at 1386.

102. *Id.* at 1382. The court held that "[t]he provisions of the ordinance permitting limited detention for involuntary examination and treatment of a venereal disease being in themselves constitutional, the fact that the city provides a less onerous alternative, which the plaintiff in this case elected to follow, does not violate any constitutional right of the plaintiff." *Id.* at 1383.

103. 107 S. Ct. 2095 (1987).

104. 18 U.S.C. § 3142(e) (1982).

105. As an initial matter, the mere fact that a person is detained does not inexorably lead to the conclusion that the government has imposed punishment. To determine . . . permissible regulation, we first look to the legislative intent. Unless Congress expressly intended to impose punitive restrictions, the punitive/regulatory distinction turns on, "whether an alternative purpose to which (the restriction) may rationally be connected is assignable for it, and whether it appears excessive in relation to the alternative purpose assigned (to it)."

Salerno, 107 S. Ct. 2101.

106. 107 S. Ct. 2113 (1987).

107. *Id.*

ment to restrict, though not punish, persons who pose a threat to the public safety. While these restrictions must be accompanied by appropriate due process, proceedings need only show by "clear and convincing evidence after an adversary hearing"¹⁰⁸ that the restrictions are necessary to protect the public safety. Given the highly suspect nature of pre-trial detention, it is reasonable to assume that the court would support public health restrictions based on clear and convincing evidence, without requiring that the person actually be caught in the act of harming another.

The basic premise that the state has the power to order individuals to be examined and be treated for communicable disease is still good law.¹⁰⁹ As to the detention in jail, as opposed to the walk-in orders to Denver Health and Hospitals, the *Reynolds* court found this acceptable because the plaintiff in this case was a prostitute, who had been arrested for prostitution. Noting that venereal disease is an occupational disease for prostitutes,¹¹⁰ the court found nothing impermissible in detaining the plaintiff in jail a little longer for examination and treatment. While this case dealt with a prostitute, it is clear precedent for all persons arrested and charged with a crime reasonably related to the spread of a communicable disease. This creates a broad reaching precedent in Colorado because of the acceptance of reckless endangerment as a chargeable criminal offense.¹¹¹

Even in states where spreading a communicable disease is not a chargeable offense, the *Salerno* case provides guidance for the restriction of persons who pose a threat to the public safety. The *Salerno* Court listed several situations where potentially dangerous persons, or classes of persons, may be detained without trial: enemy aliens during time of war; persons detained by executive order during time of insurrection; potentially dangerous aliens during pending deportation proceedings; mentally unstable persons who present a danger to the public; dangerous persons who become incompetent to stand trial; post arrest detention of juveniles; and persons who might flee the jurisdiction before trial.¹¹²

"Dangerous" is a more objective determination when dealing with

108. *Salerno*, 107 S. Ct. at 2098. If the detention is limited, such as the detention that accompanies arrest, there is no need for a formal adversary hearing:

The sole issue is whether there is probable cause for detaining the arrested person pending further proceedings. This issue can be determined reliably without an adversary hearing. The standard is the same as that for arrest. That standard—probable cause to believe that a suspect has committed a crime—traditionally has been decided by a magistrate in a nonadversary proceeding on hearsay and written testimony, and the Court has approved these informal modes of proof.

Gerstein v. Pugh, 420 U.S. 103, 120 (1975).

109. See *supra* notes 33 and 35 and accompanying text.

110. "It is not illogical or unreasonable, and on the contrary it is reasonable, to suspect that known prostitutes are a prime source of infectious venereal disease. Prostitution and venereal disease are no strangers." *Reynolds*, 488 F.2d at 1382. The court also implies that prostitutes are no strangers to jail. *Id.*

111. See *supra* note 92 and accompanying text.

112. *Salerno*, 107 S. Ct. at 2102.

communicable diseases. For example, a person with a deadly disease that is spread through respiratory contact poses a threat to the public safety. In contrast to determining the threat posed by a pretrial detainee, the diagnosis of this disease, and the probability of its spread, are determined by relatively unambiguous physiologic measures. This is an extreme case, but not an unusual one. There are many communicable diseases for which dangerousness, and the type and degree of restriction necessary to protect the public safety, is an objective, technical determination. These cases should not require the extensive procedural protections that are necessary when the determination of dangerous is more subjective.

3. Colorado Statutory Public Health Law Penalties

Since Colorado uses both general public health authority and specific disease control laws, there are varying penalties for disease control law violations. The penalty for violations of the general public health law is fairly severe:

Any person, association, or corporation, or the officers thereof, who violates any provision of this section is guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine not more than one thousand dollars, or by imprisonment in the county jail for not more than one year, or by both such fine and imprisonment, and in addition to such fine and imprisonment, shall be liable for any expense incurred by health authorities in removing any nuisance, source of filth, or cause of sickness.¹¹³

This penalty applies to the violation of any order or rule promulgated under the general powers of the CDH, or under the provisions of specific laws that do not have designated penalties. Physicians and others with a duty to report communicable diseases may be prosecuted if they "fail to make or file reports required by law or rule of the board relating to the existence of disease or other facts and statistics relating to the public health."¹¹⁴

4. Specific Colorado Public Health Statutes

a. *Food Handling*

Colorado law makes it illegal to employ a person as a food handler who has a contagious, infectious, or venereal disease. It is also a violation for the infected person to accept the employment.¹¹⁵ This is an old statute, but it has not been superceded. The CDH regulations on communicable disease in food handling establishments assume that the law

113. COLO. REV. STAT. § 25-1-114(4) (Supp. 1987).

114. *Id.* at (1)(b) (1982).

115. COLO. REV. STAT. § 25-4-108 (1982) (work that is forbidden by diseased persons). It is unlawful for any employer to permit any person who is affected with any contagious, infectious, or venereal disease to work, or for any person so affected to work, in a building, room, basement, enclosure, premises, or vehicle occupied or used for the production, preparation, manufacture, packing, storage, sale, distribution, or transportation of food.

means that the person cannot be employed if he has a disease that may be transmitted through the handling of food.¹¹⁶ An employer or employee who does not comply with the provisions of this regulation will be subject to the statutory penalty.¹¹⁷

The problem is that the law as written applies to persons who have any communicable disease, not merely those that are communicable through food handling. However, this law is probably preempted by the Rehabilitation Act¹¹⁸ for most employers. The CDH will not prosecute employers not covered by the Rehabilitation Act who comply with the CDH regulation rather than the statute. While this leaves the theoretical risk of a negligence per se based lawsuit, causation would fail if the disease were not communicable through food. Employers and infected persons must comply with the CDH regulation. Violation of state and federal antidiscrimination laws would occur when employers attempt to fire food handlers who have a communicable disease (thus technically illegal to employ), but who do not pose a threat of contagion.

b. Prenatal Examinations

Colorado requires that the physician attending a pregnant woman test the woman for syphilis within ten days of her first patient visit. If the woman is attended by a midwife or faith healer who is not permitted to draw blood, then the woman must be sent to a physician to have a blood sample drawn for testing.¹¹⁹ The person reporting the birth or stillbirth of a child must state that the test was done and provide the approximate date of the test.¹²⁰ The result of the test is not reported with the birth certificate, but if the test is positive it must be reported to the CDH. A person who violates this law is subject to a fine of not more than three hundred dollars. If the person attending the woman requests that the blood test be done, but the woman refuses, there is no violation of the statute. This request must include full information about the con-

116. 6 COLO. CODE REGS. § 1009-1 (1988) (regulation 6). Food Handling and Infected Persons—No person, while infected with a disease in a communicable form which can be transmitted by foods or who is afflicted by a boil, or an infected wound, shall work in a food processing, milk producing, milk processing or food service setting in any capacity in which there is a likelihood of such person contaminating food or food contact surfaces with pathogenic organisms or transmitting diseases to other persons. The employer is responsible for ensuring the absence from work of an employee with an infectious disease for which there is evidence of transmission to consumers in a food service, food processing, milk producing, or milk processing setting, as determined by the State Department of Health. *Id.*

117. A person violating this law: "shall be punished for the first offense by a fine of not more than two hundred dollars and for the second and subsequent offenses by a fine of not more than two hundred dollars, or by imprisonment in the county jail for not more than ninety days, or both such fine and imprisonment. Each day . . . constitutes a separate offense." COLO. REV. STAT. § 25-4-111 (1982). The provision that each day of violation constitutes a separate offense creates the possibility of quite onerous penalties.

118. See Comment, *School Board of Nassau County v. Arline*: An Extension Within Manageable Bounds Protecting the Handicapped, this issue.

119. COLO. REV. STAT. § 25-4-201 (1982) (pregnant woman required to take blood test).

120. *Id.* at § 25-4-203 (1982) (birth certificate blood test).

sequences of having a baby with congenital syphilis if it is to also discharge tort liability for not testing a pregnant woman for syphilis.¹²¹

c. *Prophylaxis for Ophthalmia Neonatorum*¹²²

Colorado requires that physicians, nurses, and other persons attending the birth of a baby treat the baby with an ophthalmic prophylaxis approved by the CDH. Although the CDH is empowered to require the reporting of ophthalmia neonatorum,¹²³ it has not chosen to do so. If the inflammation is caused by an otherwise reportable disease, it must be reported pursuant to the appropriate regulation.¹²⁴ This statute contains a specific exclusion for parents who belong to a "well-recognized church or religious denomination and whose religious convictions, in accordance with the tenants or principles of his church or religious denomination, are against medical treatment for disease."¹²⁵

d. *Venereal Diseases*

This statute deals explicitly with syphilis, gonorrhea, chancroid, granuloma inguinale, and lymphogranuloma venereum.¹²⁶ There are at least fifty additional venereal diseases not listed in this act. While it is not certain whether the legislature intended this to be an exhaustive list, it is clear that diseases excluded from the statutory list could be managed under the general powers of the Health Department. In fact, before the AIDS Control Bill went into effect in 1987, the CDH regulated HIV infection through its general power.

The venereal disease statute creates a specific reporting duty for a large class of persons: "Any physician, intern, or other person who makes a diagnosis in, prescribes for, or treats a case of venereal disease and any superintendent or manager of a state, county, or city hospital, dispensary, sanitarium, or charitable or penal institution in which there is a case of venereal disease. . . ."¹²⁷ The CDH, through its rule making authority,¹²⁸ has broadened this duty to the "attending physician . . . [and] other persons either treating or having knowledge of a reportable

121. Rathbun, *Congenital Syphilis (Review)*, 10 SEXUALLY TRANSMITTED DISEASES 93 (1983); Rathbun, *Congenital Syphilis: A Proposal for Improved Surveillance, Diagnosis, and Treatment*, 10 SEXUALLY TRANSMITTED DISEASES 102 (1983).

122. "Prophylaxis for Ophthalmia Neonatorum" is the prevention of infection of the eyes of newborns.

123. COLO. REV. STAT. § 25-4-302 (1982) (duties of department of health).

124. Since most cases of ophthalmia neonatorum are caused by gonorrhea, they will be reported to the health department.

125. *Id.* at § 25-4-304 (duties of local health officers). A health care provider who is refused permission to apply the approved prophylaxis to a child's eyes should report such prohibition to the child welfare authorities.

126. These diseases are listed in the statute itself: "(1) Syphilis, gonorrhea, chancroid, granuloma inguinale, and lymphogranuloma venereum, referred to in this part 4 as 'venereal diseases', are declared to be contagious, infectious, communicable, and dangerous to the public health." *Id.* at § 25-4-401 *et seq.* (1982 and Supp. 1987) (venereal diseases).

127. *Id.* at § 25-4-402 (1982).

128. *Id.*

disease."¹²⁹ The CDH has also promulgated rules that require laboratories to report the results of certain clinical tests for venereal diseases. While the statute does not mandate that infected persons be named in the reports,¹³⁰ the CDH requires that the infected person be identified pursuant to the general regulations for reporting communicable diseases. Since these are statutorily required reports, making the reports will not subject a person to any liability. This common law notion is elaborated in the statute, which absolves physicians of any liability "whatever" for reporting a venereal disease carrier.¹³¹ The statute also codifies the duty of a physician who diagnoses or treats a venereal disease in a patient. The physician is "to instruct him in measures for preventing spread of such disease, to inform him of the necessity for treatment until cured, and to hand him a copy of the circular of information regarding venereal disease from the department of health."¹³²

The venereal disease control law contains one of only two explicit statutory authorizations for the treatment of minors.¹³³ This authorization is a model of clarity:

Any physician, upon consultation by a minor as a patient and with the consent of such minor patient, may make a diagnostic examination for venereal disease and may prescribe for and treat such minor patient for venereal disease without the consent of or notification to the parent or guardian of such minor patient or to any other person having custody of such minor patient. In any such case, the physician shall incur no civil or criminal liability by reason of having made such diagnostic examination or rendered such treatment, but such immunity shall not apply to any negligent acts or omissions.¹³⁴

This section provides clear authority for the treatment of minors, while not taking away the minor's right to non-negligent treatment. Unlike statutory provisions for other diseases, the venereal disease control law does not have an exemption from treatment for persons with religious objections to medical treatment.¹³⁵ This would give the physician the ability to treat minors who consent, even if their parents have religious objections to medical treatment. Given the danger that communicable

129. 6 COLO. CODE REGS. § 1009-1 (1988) (Regulation 2); *see also* COLO. REV. STAT. §§ 25-1-107 to 109 (1982 and Supp. 1987) (CDH general powers).

130. "Nothing in this part 4 shall be construed to require reporting of the name or address of persons afflicted with venereal disease . . ." COLO. REV. STAT. § 25-4-204(3) (1982). *Compare* *Id.* at § 25-4-203 (1982) (prohibits the reporting of test result on a birth certificate).

131. *Id.* at § 25-4-402(3). This absolution for physicians creates the interesting question: What about the other persons who have a duty to report communicable diseases? Since there would be a common law immunity for obeying a statute, perhaps subject to a good faith requirement, can there be any significance to these persons being left out of the immunity section?

132. *Id.* at § 25-4-408 (Supp. 1987).

133. *Id.* at § 25-4-202(4) (1982). The second statutory authority for the treatment of minors is in the AIDS control law, as will be discussed later in this article.

134. *Id.* at § 25-4-402(4).

135. Perhaps the legislature found infection with a venereal disease to be incompatible with their notion of deeply held religious beliefs.

diseases pose to the public health, authorization for treating minors should be part of all the disease control laws.¹³⁶

A person—who knows, or has reasonable grounds to know, that he is infected with a venereal disease—commits a crime by willfully exposing or infecting another with the disease. It is also unlawful to knowingly perform an act that exposes or infects another with a venereal disease.¹³⁷ The public health authorities are given broad authority to control the spread of venereal diseases:

- (1) To make examinations of persons reasonably suspected¹³⁸ of being infected with venereal disease [without or against their consent];
- (2) to detain such persons examined for venereal disease until the results of the examination are known;
- (3) to require persons with a venereal disease to obtain treatment from a physician; and
- (4) to isolate and quarantine persons infected with venereal disease.¹³⁹

These provisions are consistent with the state's police power. Although they have not been litigated, they have been upheld by implication in *Reynolds*.¹⁴⁰ Violation of a health officer's order, or of the duty to report venereal diseases, is a misdemeanor, punishable by a \$300 fine, ninety days in jail, or both.¹⁴¹

e. Tuberculosis

Tuberculosis may be the once and future disease.¹⁴² It was once a scourge in this country, and it is again on the increase. The surge of new tuberculosis cases has many roots. One is the increase in the urban homeless. Another is introduction into the United States of a large number of Southeast Asian refugees who were not properly screened and treated for tuberculosis. The most legally challenging increase has been among persons who are infected with the HIV virus. For example, New York has recently seen a substantial increase in its tuberculosis rate, mainly attributable to HIV carriers.¹⁴³ Most troubling, for many of these persons, tuberculosis is their first HIV related illness. This is further evidence that even "asymptomatic" infection with HIV carries seri-

136. See, e.g., TEX. FAM. CODE ANN. § 35.03(3) (Vernon's Supp. 1987).

137. COLO. REV. STAT. § 25-4-401(2) (1982). Knowingly exposing others to a venereal disease constitutes reckless endangerment.

138. Reasonable suspicion would usually mean being named as the sexual contact of an infected person.

139. *Id.* at § 25-4-404(1) (1982). The isolation and quarantine provisions are reserved for persons who will not willingly submit to treatment when the treatment takes several days either to administer or to become effective.

140. 488 F.2d 1378 (10th Cir. 1973).

141. COLO. REV. STAT. § 25-4-407 (1982).

142. See generally R. DUBOS, *THE WHITE PLAGUE* (1952); J. MYERS AND J. STEEL, *BOVINE TUBERCULOSIS—CONTROL IN MAN AND ANIMALS* (1969); H. RIEMANN AND F. BRYAN, *FOOD-BORNE INFECTIONS AND INTOXICATION* (1979).

143. See U.S. Department of Health, *supra* note 18.

ous medical consequences.¹⁴⁴

Tuberculosis is an important disease to understand because its control demands the full range of public health restrictions acceptable under the United States Constitution. While the peculiarities of HIV transmission have shaped much contemporary thinking about disease control laws, tuberculosis is a much better disease to use as a heuristic for determining the proper extent of the state's police power to protect its citizens from communicable diseases.

Tuberculosis is frightening because it is communicable through respiratory contact. A cough or sneeze can spread the tuberculosis bacillus, although more prolonged contact, such as in the home or workplace, is usually required.¹⁴⁵ Unlike HIV, where it is easy to assume that a person is not at risk unless he chooses to be, there need be no element of personal choice in tuberculosis exposure. Tuberculosis is disturbing to civil libertarians because a carrier will expose other individuals by just being around them. A tuberculosis carrier may need to be restricted irrespective of his best efforts to not infect others.

The pathophysiology of tuberculosis is such that it is able to hide in the community. Persons who are exposed to tuberculosis frequently become infected, in that the tuberculosis bacillus lodges in their bodies and lives there, usually without causing any symptoms. Most of these asymptomatic carriers are not infectious because their immune systems prevent the bacillus from growing fast enough to be excreted. If this infected person then is weakened, either through another illness or other physiological stress such as starvation, the bacillus will multiply and the individual will become both ill and infectious.

Children are especially susceptible to tuberculosis because they are not as efficient as adults in keeping the bacillus suppressed. Children often become infected, sick, and infectious in a short period of time. Once a person becomes symptomatic with tuberculosis he may die unless he is provided prolonged treatment with antituberculosis drugs. It is a difficult disease to treat, and requires treatment with somewhat toxic drugs for several months.¹⁴⁶ In some cases, the bacillus becomes resistant to the drugs and thus becomes untreatable. Patients with infectious, drug resistant tuberculosis pose a particular problem because some of the persons that they infect will also develop drug resistant tuberculosis. Pan-drug resistant tuberculosis is frequently fatal in adults and children, despite all available treatments.

As expected, the disease control laws for tuberculosis are quite strict. They are also used on a regular basis. A common tuberculosis enforcement action involves a derelict who does not want, or is not able, to take his antituberculosis medication. The local health officer will have the derelict picked up and medicated. This sometimes requires that the

144. *Id.*

145. M. MIKEY, OCCUPATIONAL DISEASES: A GUIDE TO THEIR RECOGNITION 59 (1977).

146. B. KETCHER, L. YOUNG, AND M. KODA-KIMBEL, APPLIED THERAPEUTICS: THE CLINICAL USE OF DRUGS 682 (1983).

person be held for treatment until he is no longer infectious. The Colorado tuberculosis control law provides for the following:

- (1) That it is "the duty of the department of health to conduct an active program of hospitalization and treatment of persons suffering from said disease;"¹⁴⁷
- (2) "every attending physician in this state shall make a report in writing, on a form furnished by the department of health, on every person known by said physician to have tuberculosis within 24 hours after such fact comes to the knowledge of said physician;"¹⁴⁸
- (3) all laboratories providing diagnostic services must also report a diagnosis of tuberculosis within 24 hours;¹⁴⁹
- (4) the CDH will perform tuberculosis tests for physicians without charge;¹⁵⁰
- (5) the CDH will maintain a register of tuberculosis reports and investigations, which are not to be opened for inspection except to the health authorities and as necessary for tuberculosis control under the statute;¹⁵¹ and
- (6) the CDH is authorized to provide treatment and hospitalization to indigent persons suffering from tuberculosis.¹⁵²

The tuberculosis control act¹⁵³ also contains specific provisions for the investigation of suspected tuberculosis cases, the examination of persons suspected of having tuberculosis, and the isolation and quarantine of persons who threaten the public health.

Every chief medical health officer is directed to use every available means to investigate immediately and ascertain the existence of all reported or suspected cases of tuberculosis in the infectious stages within his jurisdiction and to ascertain the sources of such infections. In carrying out such investigations, such chief medical officer is invested with full powers of inspection, examination, and quarantine or isolation of all persons known to be infected with tuberculosis in an infectious stage and is directed to make or cause to be made such examinations as are deemed necessary of persons who, on reasonable grounds, are suspected of having tuberculosis in an infectious stage and to isolate or isolate and quarantine such persons whenever he deems it necessary for the protection of the public health.¹⁵⁴

The test for invoking these broad powers is that the health officer must

147. *Id.* at § 25-4-501 (1982) (tuberculosis declared to be an infectious and communicable disease).

148. *Id.* at § 25-4-502(2). The chief officer of hospitals, dispensaries, asylums, or other similar public or private institutions also has a duty to report.

149. *Id.* at § 25-4-505 (laboratories to report).

150. *Id.* at § 25-4-503 (1982) (examination of sputum).

151. *Id.* at § 25-4-504 (1982) (statistical case register). This section should also prevent the subpoena of these records into court.

152. *Id.* at § 25-4-511 (1982) (duties of the state board of health and the department of health).

153. *Id.* at § 25-4-407 (Supp. 1987).

154. *Id.* at § 25-4-506 (1982) (investigation and examination of suspected tuberculosis cases— isolation; quarantine).

have "reasonable grounds" to believe that an examination is necessary.¹⁵⁵ These powers are reviewable through a habeas corpus proceeding, but there is no right to a hearing to contest the order. A person does have the right to be examined by his own physician.¹⁵⁶ If the person "depends exclusively on prayer for healing" he may not be forced to accept treatment for tuberculosis.¹⁵⁷ He may, however, be quarantined and restricted, for an indefinite time, so as not to pose a threat to the public health.¹⁵⁸

The Colorado tuberculosis control act grants the CDH powers which are broad, but within constitutional constraints. Many persons argue that the state should rewrite the communicable disease laws, limiting the power of the CDH by requiring elaborate due process protections before a person could be examined, treated, or quarantined. While increased due process requirements would protect the right of the carrier to be free from governmental interference in his personal life, this would be at the price of unduly compromising the rights of the carrier's fellow citizens to be protected from easily communicated deadly diseases. If, for example, the due process provisions of the Colorado AIDS control law were applied to tuberculosis, a person with drug resistant tuberculosis could roam the community for weeks before CDH could restrict his actions. During this period of time, the carrier might infect numerous other persons, perhaps including many children if the infected individual were to volunteer at a day care center. Many of these newly infected persons would die. Given the resurgence of tuberculosis, and the continuing threat posed by other communicable diseases, it is critical not to abandon the necessary legal tools for controlling dangerous communicable diseases.

V. THE COLORADO AIDS CONTROL LAW

Colorado has been a pioneer in the control of HIV infection. This position is best expressed in the principles expressed by the CDH and Denver Health and Hospitals:

Public Health must not apply a lesser standard of control to AIDS than to syphilis and other STDs, since AIDS was spreading far more rapidly, was far more deadly, and could not be averted through prevention. . . . AIDS case reports are inadequate to monitor the course of the HIV epidemic. AIDS cases occurred on average 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 for multiple positive results from a sin-

155. *Id.* at § 25-4-506(2).

156. *Id.*

157. *Id.* at (3).

158. *Id.* He may request to be confined in his own house, if he can establish that such confinement will not pose a threat to the public health. Given the usual long course of untreated infectious tuberculosis, this confinement could be for years until the patient died or recovered. The patient would also have to assure the health officer that he would have only limited contact with other persons during this confinement. *Id.*

gle person would assist in better understanding of the epidemic. Approximately ten to 20% 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 in unsafe sex or needle sharing activities. 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.¹⁵⁹

Unfortunately, HIV control is an area where being a pioneer simply means treating HIV as if it were a communicable disease rather than a political issue. When the HIV antibody test became available in 1985, the CDH added HIV infection to its list of reportable diseases. When a physician made a diagnosis of HIV infection, or a laboratory determined that a person's blood contained antibodies to HIV, the test results and the person's identity were reported to the CDH. As with other communicable diseases, the CDH required the reporting of the "patient's name, address (including city and county), age, sex, name and address of responsible physician, and such other information as is needed to locate the patient for follow-up."¹⁶⁰

When a person was reported as carrying HIV, a health department investigator would be sent to talk to the person. The investigator would assure that the person had been properly counseled as to the implications of HIV infection and how to avoid spreading the disease to others. The investigator also obtained an epidemiologic history to try to determine how the person became infected and whom he might have unknowingly infected.

Since HIV is transmitted only through exposure to blood¹⁶¹ and through sexual activity, the person would be asked to voluntarily provide information about intravenous drug use, exposure to blood through transfusions or workplace accidents, and sexual activity and partners. If the person volunteered the names of sexual or needle sharing partners, the investigator would contact these partners, without divulging the identity of the informant. These contacts would be counseled as to their exposure to HIV, the availability of voluntary testing, and the necessary precautions to avoid further exposure to them-

159. Judson and Vernon, *The Impact of AIDS and HIV on State and Local Health Department*, 78 AM. J. PUB. HEALTH 387 (1988).

160. 6 COLO. CODE REGS. § 1009-1 (1988) (regulation 1).

161. U.S. Department of Health and Human Services, *Guidelines for Effective School Health Education to Prevent the Spread of Aids*, 37 MORBIDITY AND MORTALITY WEEKLY REPORT 5 (2d Supp. Jan. 29 1988).

selves and others. This process of tracing contacts is done in precisely the same manner for persons exposed to syphilis and several other communicable diseases.

The CDH's policy of providing basic public health services to persons exposed to HIV drew the ire of homosexual and civil rights activist groups from around the United States.¹⁶² Tragically, many public health officials joined in this condemnation. Forced by political expediency to abnegate their duty to apply public health measures to HIV, health officials attacked Colorado's implicit questioning of their handling of the spread of HIV in their communities. Confronted by these pressures, the CDH sought legislative sanction for its attempts to control HIV.

The CDH proposed bill had three objectives: (1) to gain legislative approval for the application of traditional disease control strategies to HIV infections; (2) to clarify the protection of public health records from discovery in legal proceedings; and (3) to quiet the hysteria over the potential use of restrictive measures against persons who posed a danger to the public health.¹⁶³ The hysteria over quarantine and isolation arose from both the political right and from homosexual advocacy groups. The political right has sought to impose inappropriate restrictive measures.¹⁶⁴ Homosexual advocacy groups champion a schizophrenic agenda: Do not identify or contact persons potentially infected with HIV, but stop ignoring the problem of HIV in the homosexual community. The national office of the American Civil Liberties Union ("ACLU") opposes both confidential disease control reporting and the restriction of disease carriers whose actions pose a threat to the public health. Only the homosexual groups and the ACLU chose to lobby the Colorado legislature on the AIDS control bill. Had the opposition views of the political right been forcefully presented, a more balanced AIDS control bill might have resulted.

The position of the homosexual lobby was that the legislature should take away the power of the CDH to require the reporting of HIV, to trace the contacts of HIV carriers, to restrict persons with HIV who pose a threat to the public health, and, in general, revoke the public

162. The irony is the difficulty of determining whether the right to conceal a communicable disease supercedes the right to not be exposed to a communicable disease. The traditional liberal/conservative labels certainly do not work. Why is it liberal to limit the freedom of smokers and conservative to limit the freedom of disease carriers?

163. H.B. 1177 (March 19, 1987) (original draft proposed by CDH); see also *A Quarantine of AIDS Carriers Should be Option in Rare Cases*, Rocky Mountain News, Nov. 25, 1986, at 86, col. 1.

164. The concern of the political right, particularly the Lyndon LaRouche faction, is that public health officials are not taking proper steps to protect the public from HIV carriers. While some of the political right's demands (reporting of HIV status, contact tracings, etc.) are merely echoing good public health policy, others (preventing HIV carriers from working in food handling establishments or schools) are contrary to what is known about the transmission of HIV. Interestingly, the anticipated pressure to adopt Draconian restrictions in Colorado never materialized. It appears that this faction draws most of its strength from California's refusing to adopt basic disease control measures for HIV.

health laws as they apply to HIV. The CDH bill was supported by the Colorado Medical Society and the Colorado Bar Association.¹⁶⁵ The bill was opposed by the ACLU and by homosexual advocacy groups from all over the United States. The final bill represented the legislature's compromise of these competing agendas. The authority of the CDH to require the reporting and investigation of HIV was preserved. In addition, the legislature gave HIV-related public health records absolute protection from discovery and disclosure. On the minus side, the CDH was saddled with a nearly unworkable statutory scheme for restricting the actions of HIV carriers who pose a threat to the public health.¹⁶⁶ On balance, the CDH is better off for the passage of the bill.

A. *Legislative Declaration*

The bill as passed by the legislature is a strong endorsement of the disease control activities of the CDH:

The general assembly hereby declares that infection with human immunodeficiency virus, the virus which causes acquired immune deficiency syndrome (AIDS), referred to in this part 14 as 'HIV', is an infectious and communicable disease that endangers the population of this state. The general assembly further declares that reporting of HIV infection to public health officials is essential to enable a better understanding of the disease, the scope of exposure, the impact on the community, and the means of control. Those efforts to control the disease should include public education, counseling, and voluntary testing. Restrictive enforcement measures should be used only when necessary to protect the public health. The general assembly further declares that the purpose of part fourteen is to protect the public health and prevent the spread of disease.¹⁶⁷

B. *Reporting Requirements*

The core of The Colorado AIDS control law is the sections that codify the reporting requirements for HIV. These sections amplify the regulations that had been promulgated pursuant to the CDH's general authority to control communicable diseases. Physicians in Colorado must report AIDS or "HIV related illness" within twenty-four hours. The physician must make this report irrespective of reports by other persons.¹⁶⁸ The CDH, relying on the CDC definition of HIV related

165. The author represented the Colorado Bar Association in the legislative hearings.

166. As will be discussed later, while the CDH may still theoretically be able to restrict persons, they do not have the resources to comply with the Byzantine procedural requirements. An unfortunate side effect of the bill will be to encourage the prosecution of HIV carriers under the criminal laws.

167. COLO. REV. STAT. § 25-4-1401 (Supp. 1987) (legislative declaration). Given the language of this declaration, and the stated intent of several legislators, it is this author's conclusion that the majority of the legislature did not intend to make it functionally impossible to restrict the actions of HIV carriers who pose a threat to the public health.

168. *Id.* at § 25-4-1402 (Supp. 1987) (reports of HIV infection).

Every attending physician in this state shall make a report in writing to the state

illness, requires the reporting of a positive HIV antibody test as part of "HIV related illness".¹⁶⁹ The legislature also provided that persons other than physicians have a duty to report HIV infection.¹⁷⁰ The statute requires any person treating a person suffering from, or dying of, HIV related illness to file an HIV disease control report with the CDH. Since the language refers to treating a "case of HIV infection", it can be inferred that treating the patient for conditions unrelated to the HIV infection would not create a duty to report. Interestingly, this provision creates a duty to report in behalf of psychologists and counselors, who see a patient in any of the named institutions and provide psychological counseling about living with HIV.

This requirement—that persons other than physicians report HIV related illness—is tempered by the stipulation that only one report is required for each infected person.¹⁷¹ While the regulations are not clear on this point, a person other than a physician or someone affiliated with a laboratory might be able to argue that his duty to report would be fulfilled if the patient had otherwise been reported to the CDH. Since the CDH currently considers it reasonable for persons other than physicians to assume that the treating physician has reported the patient, most nonphysicians do not report HIV.¹⁷² If, however, the treating physician has failed to report the infected individual, then the nonphysician who is relying on the physician's report to discharge his duty could be sued by any third party who is injured through his failure to report.

1. Contents of a Report

The statute requires physicians and non-laboratory medical care providers to report the patient's "name, date of birth, sex, and address of the individual reported on and the name and address of the physician or other person making the report."¹⁷³ The CDH also requires the reporting of any additional information necessary to locate the patient.¹⁷⁴

or local department of health, in a form designated by the state department of health, on every individual known by said physician to have a diagnosis of AIDS or HIV related illness, including death from HIV infection, within twenty-four hours after such fact comes to the knowledge of said physician.

Id.

169. 6 COLO. CODE REG. § 1009-1 (1988) (regulation 1). Classifications include Centers for Disease Control ("CDC") Group I, II with abnormal immune system tests, III or IV for persons greater than 13 years and CDC Classification Group P-1 Subclass B or Group P-2 for persons less than 13 years." *Id.*

170. COLO. REV. STAT. § 25-4-1402(2) (Supp. 1987) states:

All other persons treating a case of HIV infection in hospitals, clinics, sanitariums, penal institutions, and other private or public institutions shall make a report to the state or local department of health, in a form designated by the state department of health, on every individual having a diagnosis of AIDS or HIV related illness, including death from HIV infection, within twenty-four hours after such fact comes to the knowledge of said person.

Id. This section of the Act was intended to deal with the problem that many physicians fail to report communicable diseases. See Rothenberg, *supra* note 20.

171. COLO. REV. STAT. § 25-4-1402(3) (Supp. 1987).

172. 6 COLO. CODE REG. § 1009-1 (1988) (regulation 2).

173. COLO. REV. STAT. § 25-4-1402(4) (Supp. 1987).

174. 6 COLO. CODE REGS. § 1009-1 (1988) (regulation 1).

The requirement of reporting the names of infected individuals was resisted by homosexual activists for fear that this list would fall into the "wrong" hands and result in discrimination against persons with HIV infection.

A small number of physicians attempt to circumvent the reporting duty by placing false names on the reports. While the CDH has tolerated this practice, as long as it was otherwise able to locate the patient, there is no statutory support for the use of incorrect names on reports. Although a physician may rely on the patient's self identification, the physician must report the patient's true name if it is known to the physician. The knowing use of an incorrect name would subject the physician, or anyone else with a duty to report, to a fine.¹⁷⁵ More critically, it would demonstrate intentional disregard for the statute if the physician were sued in tort. This might be sufficient to support cause for punitive damages.

2. Laboratory Reporting

The law requires laboratories to report all positive HIV antibody or virus tests.¹⁷⁶ A laboratory's duty to report is not discharged by a physician's report or the report of any other person or entity. This provision requires the reporting of positive ELISA tests even though the confirmatory Western Blot test is negative.¹⁷⁷ The reporting of intermediate test results identifies patients who only receive the ELISA, giving the CDH the opportunity to assure that they receive a proper confirmatory test. The CDH does not initiate counseling and contact tracing efforts without a confirmatory test such as the Western Blot. If the laboratory does its own Western Blot tests within twenty-four hours, with allowances for weekend and holidays, then the negative Western Blot result may be bundled with the positive ELISA.¹⁷⁸

Laboratory reporting serves to track persons who are tested outside of a medical care setting. It also gives the CDH some power to control the testing of persons without their knowledge, or to control testing that

175. COLO. REV. STAT. § 25-4-1409(1) (Supp. 1987).

176. COLO. REV. STAT. § 25-4-1403 (Supp. 1987) (reports of HIV infection by laboratories).

All clinical laboratories rendering diagnostic service shall report to the state department of health or appropriate local department of health, within twenty-four hours after diagnosis, the name, date of birth, sex, and address of any individual whose specimen submitted for examination tests positive for HIV antibody or virus. Such report shall include the test results and the name and address of the attending physician and any other person or agency referring such positive specimen for clinical diagnosis.

Id.

177. The ELISA (Enzyme Linked Immunosorbent Assay) is a screening test with every high sensitivity and a low specificity. It tends to produce false positive test results. The test is fast and cheap. The Western Blot is a very specific test, but it is expensive and time consuming.

178. While the CDH does not investigate cases with a positive ELISA and a negative Western Blot, these cases are important because they provide information about the rate of ELISA false positives. They also allow research into issues such as the what causes a false positive ELISA result and its implications for future seropositivity.

is done without proper counseling. While the CDH has the statutory authority to regulate laboratories,¹⁷⁹ this power is not currently exercised. Consequently, the HIV laboratory reporting requirement is the only procedural safeguard to prevent improper HIV testing.

3. Immunity for Reporting

“Good faith reporting or disclosure pursuant to this section or section 25-4-1403 shall not constitute libel or slander or a violation of the right of privacy or privileged communication.”¹⁸⁰ This is the traditional statement of immunity for compliance with statutory reporting duties. The use of “good faith” in this context probably covers reports that are negligently incorrect, but would not cover a report that is intentionally incorrect.¹⁸¹ This immunity only applies to information disclosed through the statutory reporting process. If the physician accidentally sends the CDH report to the patient’s employer, there would be no immunity for damages flowing from this error.

In addition to immunity for libel and slander claims arising from reporting requirements, the statute also grants immunity for other actions taken pursuant to the act.¹⁸² These actions might include participating in the involuntary examination of a suspected HIV carrier, participating in the determination that a person should be restricted, or treating a minor without the parent’s consent. Physicians are also given immunity from third party lawsuits if they comply with the reporting requirements of the act and applicable disease control regulations.¹⁸³ The possibility of tort liability for failure to warn third parties about a patient with HIV makes this a valuable protection. It also strengthens the argument that failure to report is negligence per se.¹⁸⁴

C. Protection of Public Health Records

1. Distinction Between Public Health and Medical Records

A central issue in adoption of the AIDS law was the concern with preserving the confidentiality of disease control reports and information gathered during investigation of HIV infections by health department

179. COLO. REV. STAT. § 25-1-107(h) (1982) (“To establish, maintain, and approve chemical, bacteriological, and biological laboratories, and to conduct such laboratory investigations and examinations as it may deem necessary or proper for the protection of the public health.”). This is sometimes confused with the authority of the state chemist. The state chemist is charged with actually performing tests on food and drug samples collected by the health department, but has no authority to regulate other laboratories. *Id.* at § 25-1-401 *et seq.*

180. *Id.* at § 25-4-1403(5) (Supp. 1987).

181. This poses the question of whether a report containing a fake name is prima facie evidence of bad faith.

182. COLO. REV. STAT. § 25-4-1406(6) (Supp. 1987).

183. *Id.* (“Any person who in good faith complies completely with this part 14 shall be immune from civil and criminal liability for any action taken in compliance with the provisions of this part 14.”).

184. See *supra* notes 89-94 and accompanying text.

personnel. An analysis of other state laws¹⁸⁵ purporting to protect public health records leads to the conclusion that these protections need to be explicit and comprehensive. In general, state laws either do not provide for the protection of public health records, or the protection is fatally flawed. Most state laws fail to establish a clear distinction between medical and public health records. Failing to make this distinction results in statutes that allow public health records to be released to the patient. Patients need, and are entitled, to have access to their medical records. The experience in other states, however, is that allowing patient access to public health records merely encourages others to coerce patients into releasing otherwise unavailable public health records. The CDH sought to differentiate medical and public health records in such a way as to assure that the public health records do not contain any information about the named patient that is not available to the patient in his or her medical record. This distinction was based on the assumption that public health information is information: (1) in the possession of a governmental public health agency or its agent; (2) that has implications for the health or safety of persons other than the subject of the information; (3) that has been obtained through activities pursuant to a public health statute or regulation; and (4) that is duplicative of any information that is necessary for the personal medical care of the individual patient.

For example, if a patient is being treated for HIV related illness, then the information held by the patient's physician and by the hospital would be medical information. The health department would have a case report that contained the patient's name and information about his condition, but this would be information obtained secondarily from the patient and his medical care providers. The health department might also have information about the patient's sexual partners that was obtained through interviews with the patient and others. Such information, pertaining to the sexual history of the patient, is public health information which is not relevant to the patient's treatment. If the investigation uncovers exposure to other diseases, this information would be made available to the patient to become part of his medical record.

2. The Release of Medical Records

The AIDS law provides absolute protection for public health records. In essence, these records "shall not be released, shared with any agency or institution, or made public, upon subpoena, search warrant, discovery proceedings, or otherwise"¹⁸⁶ However, the law

185. See generally INTERGOVERNMENTAL HEALTH POLICY PROJECT, A SYNOPSIS OF STATE AIDS RELATED LEGISLATION (JANUARY TO JUNE, 1987) (1987).

186. COLO. REV. STAT. § 25-4-1404(1) (Supp. 1987). The law also prevents the examination of public health personnel:

No officer or employee of the state or local department of health shall be examined in any judicial, executive, legislative, or other proceeding as to the existence or content of any individual's report retained by such department pursuant to this part 14 or as to the existence of the contents of reports received pursuant to sections 25-4-1402 and 25-4-1403 or the results of investigations in section 25-

allows public health information to be released in three situations:

[1] Release may be made of medical or epidemiologic information for statistical purposes in a manner such that no individual person can be identified.¹⁸⁷

[2] Release may be made of medical or epidemiological information to the extent necessary to enforce the provisions of this part 14 and related rules and regulations concerning the treatment, control, and investigation of HIV infection by public health officials.¹⁸⁸

[3] Release may be made of medical or epidemiological information to medical personnel in a medical emergency to the extent necessary to protect the health or life of the named party.¹⁸⁹

It is critical to note that these recommendations do not include the release of information with the consent of the patient. The patient does not have the right to consent to the release of HIV related public health information held by the CDH. The CDH records only contain information that is either available to the patient in his medical records, or concerns persons other than the named patient and has been collected for disease control or law enforcement purposes. While access to this public health information would not benefit the patient, it could harm the patient if made public.

The Colorado AIDS law recognizes that allowing information to be released with the patient's informed consent does not prevent third parties from coercing the patient into giving consent. A patient may be forced to consent to the release of information as a condition of insurance, as a condition of employment, or as part of a judicial proceeding. In one state which allows the release of public health information with the patient's consent,¹⁹⁰ judges routinely require patients to consent to the release of this information and the examination of health department employees involved with the patient's treatment.¹⁹¹

This section also specifically defines the records that are protected public health records, which are *the reports filed with the health department on health department forms*.¹⁹² If medical records had been included within this statutory umbrella, it would have been impossible for an infected patient to obtain medical care.¹⁹³ The existing Colorado statute on re-

4-1405. This provision shall not apply to individuals who are under restrictive actions pursuant to section 25-4-1406 or 25-4-1407.

Id. at § 25-4-1404.

187. *Id.* at (1)(a).

188. *Id.* at (1)(b).

189. *Id.* at (1)(c).

190. TEX. HEALTH AND SAFETY CODE ANN § 4419b-1(3.06(a) & (b)) (1987).

191. Interview with Katharine C. Rathbun, former Director of Health of San Antonio (March 1, 1988).

192. COLO. REV. STAT. § 25-4-1404 (use of reports) ("The reports required to be submitted by sections 25-4-1402, 25-4-1403, and 25-4-1405 (8) and held by the state or local department of health or a health care provider or facility, third-party payor, physician, clinic, laboratory, blood bank, or other agency shall be strictly confidential medical information.").

193. Records could not be shared among the patient's medical care providers or used

lease of medical records¹⁹⁴ provides an excellent protection for patient privacy, while respecting the rights and needs of patients to control their own medical records.

D. Education

A major objective of the Colorado AIDS law is to endorse widespread educational efforts as a means to control HIV.¹⁹⁵ To this end, the CDH is mandated to participate in the following activities:

- [1] Prepare and disseminate to health care providers circulars of information and presentations describing the epidemiology, testing, diagnosis, treatment, medical, counseling, and other aspects of HIV infection;
- [2] Provide consultation to agencies and organizations regarding appropriate policies for testing, education, confidentiality, and infection control;
- [3] Conduct health information programs to inform the general public of the medical and psychosocial aspects of HIV infection, including updated information on how infection is transmitted and can be prevented. The department shall prepare for free distribution among the residents of the state printed information and instructions concerning the dangers from HIV infection, its prevention, and the necessity for testing.
- [4] Prepare and update an educational program on HIV infection in the workplace for use by employers;
- [5] Develop and implement HIV education risk-reduction programs for specific populations at higher risk for infection; and
- [6] Develop and update a medically correct AIDS prevention curriculum for use at the discretion of secondary and middle schools.¹⁹⁶

While the CDH is mandated to participate in these activities, the legislature stopped short of requiring that children be educated about HIV control. School districts are encouraged, but not required, to provide CDH approved education about HIV control.¹⁹⁷

for billing. More critically, the patient would not have access to his own records or the right to release those records to others.

194. COLO. REV. STAT. § 18-4-412 (1986) (theft of medical records or medical information—penalty).

195. See U.S. Department of Health and Human Services, *Understanding AIDS: An information Brochure Being Mailed to All U.S. Households*, 37 MORBIDITY MORTALITY WEEKLY REPORT 261 (May 6, 1988).

196. COLO. REV. STAT. § 25-4-1405(3)(a)-(f) (Supp. 1987) (disease control by state and local health departments).

197. *Id.* at (4). School districts are urged to provide every secondary school student, with parental consent, education on HIV infection and AIDS and its prevention. Since the teen pregnancy rates have clearly established that children are sexually active, the question arises: Will we wait until HIV is rampant among teenagers before deciding that education on HIV prevention should be mandated in the schools?

E. *Notification of Persons Exposed to HIV*

The AIDS control law mandates that a physician inform his patients of a positive HIV test.¹⁹⁸ This provision requires that patients be told how the virus spreads and how to stop the spread. This statutory requirement would be evidence of the proper standard of care if a physician is sued for not counseling a patient who subsequently infects a third party. In the case of HIV and other communicable diseases, the patient's right to refuse information must be subsumed to the patient's duty to protect others from his infection. Many patients do not want counseling on HIV because they do not want their physicians to criticize their sexual or drug habits. For patients who do not return for their test results, the physician should document his efforts to contact and counsel the patient.¹⁹⁹

F. *Testing and Examining Minors*

The AIDS control law allows the testing and examination of a minor without the consent of the minor's parents or guardian:

Any local health department, state institution or facility, medical practitioner, or public or private hospital or clinic may examine and provide treatment for HIV infection for any minor if such physician or facility is qualified to provide such examination and treatment. The consent of the parent or guardian of such minor shall not be a prerequisite to such examination and treatment.²⁰⁰

If the minor is sixteen or older, or emancipated, the physician may not talk to the minor's parent or guardian without the minor's permission. The physician or other health care provider is required to counsel the minor on the importance of bringing a parent or guardian into the minor's confidence about the consultation, examination, or treatment. If the minor is less than sixteen and not emancipated, then the physician *may* inform the parents or guardian, but the physician is not required to do so. This section does not supersede the Child Protection Act.²⁰¹ If a physician believes that child abuse or neglect is at issue, then this must be reported.²⁰²

G. *Involuntary Testing*

Involuntary testing is potentially the most divisive issue in the pub-

198. *Id.* at (5): "It is the duty of every physician who, during the course of an examination, discovers the existence of HIV infection or who treats a patient for HIV infection to inform the patient of the interpretation of laboratory results and measures for preventing the infection of others."

199. Conversely, the physician should give the patient his HIV test results in person. The profound psychological impact of any lab test that implies a dread disease must be considered when a patient is being informed.

200. COLO. REV. STAT. § 25-4-1405 (Supp. 1987).

201. Child Protection Act of 1975, COLO. REV. STAT. § 19-10-101 *et seq.* (1986).

202. *See* *Bross, Child Welfare Laws*, this issue. The reference to reports under section 1405 (8) is an error. The originally referenced section did not survive into the final law.

lic health management of HIV infection.²⁰³ Persons at risk of HIV infection do not want to be identified as HIV carriers. For some persons, the fear of knowing (versus worrying) that they have HIV, combined with apprehension over possible discrimination, outweighs the personal and societal benefits of knowing that they are infected. Many physicians have been beguiled by these same arguments, denying HIV carriers proper medical care because of political concerns.

The AIDS control law establishes the requirement that persons not be tested without their consent.²⁰⁴ This statutory requirement that specific consent be obtained for HIV testing should not be misunderstood as creating a presumption against testing. A physician who is considering not testing a patient for HIV infection should be aware that there is great inherent liability in not ordering a medically indicated test.

Physicians must offer the HIV test to their patients and they must fully inform patients of the consequences of refusing the test.²⁰⁵ If a patient refuses an HIV test, the physician must be prepared to defend the patient's "informed refusal."²⁰⁶ One scenario might be a woman planning to become pregnant. Assume that the woman refuses the HIV test, or the physician fails to offer her the test. The woman becomes pregnant, delivers a baby with HIV who progresses to AIDS, and develops AIDS herself. At this point, the woman sues the physician.²⁰⁷ To successfully defend this action, the physician would need to document that the patient was told: (1) that in the physician's judgment she should be tested for HIV; (2) the medical risks of the test;²⁰⁸ (3) other risks of

203. Public health efforts to control the AIDS epidemic often are caught in a cross fire of fears epitomized by two small, vocal groups of individuals within our communities. On the one side are heterosexual parents of school children who have unsupported fears of HIV contagion in the schools, while on the other side are gay men (usually educated and white) who have unsupported fears that AIDS control efforts will become a weapon for discrimination. Neither side seems able to overcome its fears except through an impossible guarantee that the perceived risks will be reduced to zero. Parents may fail to place in perspective a reality in which vehicular accidents, voluntary and involuntary exposure to tobacco smoke, and alcohol present greater risks to their children than does infection with the AIDS virus through casual contact. In like manner, gay men may fail to place in perspective an historical reality in which the threats to their own rights to life, liberty, and pursuit of happiness are greater from contracting the AIDS virus, and from other life-style related risks, than they are from public health AIDS prevention actions. Paradoxically, education is touted by some gay community leaders as a cure for societal fears of AIDS, but not as a cure for their own fears of responsible and confidential HIV testing.

Judson and Vernon, *supra* note 138, at 392.

204. COLO. REV. STAT. § 25-4-1405(8)(a) (Supp. 1987). No physician, health worker, or any other person and no hospital, clinic, sanitarium, laboratory, or any other private or public institution shall test, or shall cause by any means to have tested, any specimen of any patient for HIV infection without the knowledge and consent of the patient. *Id.*

205. An ironic trend in HIV testing is for physicians, and even public health personnel, to inform the patient of the political risks of being tested, without informing them of the medical risks of not being tested.

206. For a discussion of a physician's duty to persuade a patient to have a PAP smear, see *Truman v. Thomas*, 27 Cal. 3rd 285, 165 Cal. Rptr. 308, 611 P.2d 902 (1980).

207. The most apt analogy would be the cases that assigned liability for failing to test a pregnant woman for measles.

208. The medical risks are twofold: (1) the risks associated with drawing blood; and (2) the risk of a false positive or false negative test.

the treatment;²⁰⁹ and (4) the medical risks of not being tested.²¹⁰

The AIDS control law requires the patient's "knowledge and consent,"²¹¹ rather than the patient's written consent. While written consent is usually desirable, there are situations where it is contrary to the patient's interests to engage in a formal consent ritual. Knowledge and consent is subtly different from informed consent. The patient must be told that he is to be tested, and must consent to the test, but the statute does not require an informed consent in the broad sense.²¹²

There are four situations where the patient may be tested without, or against, his consent:

- (I) Where the health of a health care provider or a custodial employee of the department of corrections or the department of institutions is immediately threatened by exposure to HIV in blood or other bodily fluids;
- (II) When a patient's medical condition is such that knowledge and consent cannot be obtained;
- (III) When the testing is done as part of seroprevalence surveys if all personal identifiers are removed from the specimens prior to the laboratory testing;
- (IV) When the patient to be tested is sentenced to and in the custody of the department of corrections or is committed to the Colorado state hospital and confined to the forensic ward or the minimum or maximum security ward of such hospital.²¹³

Exception one is narrowly drawn. "Threatened by" exposure to HIV is different from "threatened with" exposure to HIV. This section is not meant to authorize testing for vague, future risks, such as a future needle stick injury. "Immediately threatened" means more than being spit upon, but probably would include any situation where a person's skin or mucus membranes come in direct contact with a patient's blood or other virus rich bodily fluids. It is debatable whether merely performing surgery on a patient would trigger this exception. While exposure to blood is a hazard in all surgery, only in certain procedures is this risk high enough to prospectively invoke exception one.²¹⁴

Exception two is also closely drawn. This could either be acute confusion or unconsciousness, or a person who is medically or legally incompetent. It is implicit that knowledge of the patient's HIV status be relevant to the management of the patient's medical condition. This exception, however, cannot be used to test every unconscious patient.

Exception three recognizes the magnitude of the threat that HIV

209. No court has required a person to be informed of the political risks of a medical test or procedure.

210. In this albeit sympathetic case, the jury would view the transaction retrospectively. In hindsight, the assumption is that a person would not refuse a medically necessary (inexpensive and medically safe) test unless her physician failed to properly inform her of the risks of refusing the test.

211. COLO. REV. STAT. § 25-4-1405(8)(a) (Supp. 1987).

212. *Id.*

213. *Id.*

214. Any surgical accident (needle stick, cut glove, etc.) that exposes a health care worker to the patient's blood would be grounds for testing the patient without his consent.

infection poses to the people of Colorado. Caring for persons infected with HIV will be an enormous expenditure for the state, an expenditure so large as to be crippling if it is not properly anticipated. Unfortunately, it will be impossible to persuade the citizens of Colorado to accept the necessary taxes to pay for this care without an accurate measure of the prevalence of HIV infection in the population. It is also difficult to target limited state disease control resources without knowing how the disease spreads in different segments of the population. This exception gives the CDH authority to carry out proper randomized screening to determine the prevalence of HIV.²¹⁵

Exception four allows the testing of prisoners and certain involuntarily confined mental patients.²¹⁶ This exception is consistent with the limited civil rights of these segments of the population.

If a person is tested under exceptions one, two, or four, he must be notified that he was tested and told the results.²¹⁷ The assumption is that there cannot be notification of test results for persons tested under exception three (anonymous screening) because the CDH will not know how to contact them.

H. *Restricting HIV Carriers*

The Colorado legislative debates on restrictive measures in public health highlighted a general ignorance of disease control law and practice. The initial premise was that the existing disease control law provisions for quarantine were too vague to withstand constitutional scrutiny. The central complaint, and one remedied by the legislature, was that these laws did not contain sufficient due process provisions to protect the rights of HIV carriers. While a state legislature has the power to limit its own authority to protect the public health of its citizens, there is no constitutional mandate that it do so. The old public health code did not contain specific due process guarantees, but the necessary judicial review was available through habeas corpus proceedings.

Public health law analysis suffers from analogies to criminal law and mental health law. Criminal law is intended to punish and deter inten-

215. This authority would include the involuntary testing of individuals selected through the randomization process. *Id.* at (III). While this is politically unfeasible, it is the only way of actually determining the prevalence of HIV.

216. *Id.* at (IV). While this statute requires that a person be sentenced before being involuntarily tested for HIV, this is not a constitutionally mandated limitation. In *Bell v. Wolfish*, 441 U.S. 520, 540 (1979), the Supreme Court ruled that pretrial detainees may be subjected to the same regulatory actions as convicted inmates: "We need not here attempt to deal with the precise extent of the legitimate governmental interests that may justify pretrial detention. It is enough simply to recognize that in addition to ensuring the detainees' presence at trial, the effective management of the detention facility once the individual is confined is a valid objective that may justify imposition of conditions and restrictions of pretrial detention and dispel any inference that such restrictions are intended as punishment." *Id.*

217. *Id.* at (b). "Any patient tested for HIV infection pursuant to this subsection (8) without his knowledge and consent shall be given notice promptly, personally, and confidentially that a test sample was taken and that the results of such test may be obtained upon his request."

tional actions. One may be a hero for killing in self defense, and a murderer if the facts are only slightly different. The key is intent. Conversely, if a person has drug resistant tuberculosis, he is a menace to the health of the community. He must be restricted, irrespective of his intent to spread the disease. It may seem unjust to restrict a person's actions for a condition that is not his "fault", but it is no more just to allow a disease carrier to infect others. Having a disease is not an intentional act, but neither is a public health restriction a punishment.²¹⁸

On the surface, the more attractive analogy is to the mental health commitment laws. It is easy to compare mentally ill people with physically ill people. However, the analogy fails because most mentally ill people are only a danger to themselves. The state's power to protect a person from himself has been limited by United States Supreme Court decisions. Even mentally ill persons who pose a threat to others seldom pose a highly probable, quantitative threat. There is almost always a substantial question as to likelihood of the person being a danger to others. While these uncertainties have led the courts to require elaborate due process protections before a mentally ill person may be confined in an institution, even these protections are tempered by use of a lesser standard of proof than is necessary in a criminal case.²¹⁹ In contrast, it is possible to determine the probability that a person carrying a communicable disease will be a threat to the community. By reference to the natural history of the communicable disease, its infectivity and severity, and to the special physiological and occupational characteristics of the patient, relatively refined predictions can be made about the threat the person poses to the community.

In applying this risk calculus to HIV infection, the severity of the disease is tempered by the difficulty of transmission. AIDS is relentlessly fatal and the mortality of HIV infection appears to increase with the duration of the disease. Even asymptomatic HIV carriers have compromised immune systems that leave them susceptible to other communicable diseases, such as tuberculosis.

In contrast, an HIV carrier only poses a threat to his sexual and needle partners, and persons performing invasive medical proce-

218. *United States v. Salerno*, 107 S. Ct. 2095 (1987).

219. *Addington v. Texas*, 441 U.S. 418, 424 (1979). This case concerned the proper standard for establishing dangerousness for the purpose of civilly committing a mentally ill individual. While accepting that a "preponderance of the evidence" standard compromised the individual's right to be left alone, and the "beyond a reasonable doubt" standard compromised society's right to restrict a dangerous person, the court admitted that the intermediate standard of "clear and convincing" evidence was not very rigorous:

"Candor suggests that, to a degree, efforts to analyze what lay jurors understand concerning the differences among these three tests or the nuances of a judge's instructions on the law may well be an academic; there are no directly relevant empirical studies. Indeed, the ultimate truth as to how the standards of proof affect decisionmaking may well be unknowable, given that factfinding is a process shared by countless thousands of individuals throughout the country. We probably can assume no more than that the difference between a preponderance of the evidence and proof beyond a reasonable doubt probably is better understood than either of them in relation to the intermediate standard of clear and convincing evidence."

dures.²²⁰ Society is reluctant to restrict a person's right to catch a disease.²²¹ The pressure has been to identify carriers and stress their duty to warn their partners, combined with exhortations that everyone should practice safe sex.

While health departments routinely use various restrictive measures, such measures are used against persons carrying diseases that are more easily transmissible than HIV, diseases that may be caught through less value loaded behavior.²²² The effect of the intense anti-restriction lobbying by homosexual rights groups has been to reinforce the societal prejudice that homosexuals should not be protected from HIV. The result is that health departments have only considered restricting HIV infected prostitutes and obvious psychopaths.²²³

IV. RESTRICTIVE MEASURES FOR HIV CONTROL

The Colorado AIDS control law, while generally salutary, has badly damaged the CDH's authority to restrict persons with HIV, institutionalizing disrespect for the authority of the CDH to protect the public health. The misunderstanding of public health law and practice by many legislators that lead to this attack on the CDH was fueled by intense lobbying by homosexual groups opposed to HIV related restrictions, and by civil rights groups opposed to all communicable disease related restrictions. The result was a final bill that rejects traditional disease control standards in favor of the "one bite rule", so beloved of dog case litigators. The law requires that a person be allowed to repeatedly expose others to HIV as part of the due process requirements. More ab-

220. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, 1988 *Agent Summary Statement For Human Immunodeficiency Virus and Report on Laboratory-Acquired Human Immunodeficiency Virus*, 39 MORBIDITY MORTALITY WEEKLY REPORTS (4th Supp. April 1, 1988).

221. Cigarette smoking is a good example. Restrictions on the right to smoke have been justified as protections for third parties, either non-smokers, or employers, rather than as protections for the smokers themselves. The exception would be employers, such as fire departments, who ban smoking because it is impossible to differentiate cigarette related disability from workplace smoke related disability. These restrictions benefit the worker, but are enacted to reduce worker's compensation claims.

222. Society regards having sex as an avoidable, morally questionable act and thus deserving little protection. Eating a hamburger is entitled to greater protection because there are many innocent hamburger eaters.

223. R. SHILTS, *supra* note 23, at 200.

Gaetan Dugas's eyes flashed, but without their usual charm, when Selma Dritz bluntly told him he must stop going to the bathhouses. The hotline at the Kaposi's Sarcoma Foundation was receiving repeated calls from people complaining of a man with a French accent who was having sex with people at various sex parlors and then calmly telling them he had gay cancer. It was one of the most repulsive things Dritz had heard in her nearly forty years in public health.

'It's none of your goddamn business,' said Gaetan. 'It's my right to do what I want to do with my own body.'

'It's not your right to go out and give other people disease,' Dritz replied, keeping her professional calm. 'Then you're making decisions for their bodies, not yours.'

'It's their duty to protect themselves,' said the airline steward. 'They know what's going on there. They've heard about this disease.'

Dritz tried to reason further but got nowhere.

'I've got it,' Gaetan said angrily. 'They can get it too.'

Id.

surdly, the public health officials are required to counsel persons who pose a threat to the public health that they may ignore the CDH's orders to restrict their behavior.

A. *Non-Emergency Restrictions*

The AIDS control law provides for both emergency²²⁴ and non-emergency restrictions.²²⁵ It was anticipated that these sections would be directed at persons who are infected with HIV and continue to endanger the public health, either through donation of blood, unprotected sexual intercourse, or the sharing of syringes. The language of this section stresses the legislature's concern that the CDH would mount a program against HIV carriers:²²⁶

Orders directed to individuals with HIV infection or restrictive measures on individuals with HIV infection, as described in this part 14, shall be used as the last resort when other measures to protect the public health have failed, including all reasonable efforts, which shall be documented, to obtain the voluntary cooperation of the individual who may be subject to such an order. The orders and measures shall be applied serially with the least intrusive measures used first. The burden of proof shall be on the state or local health department to show that specified grounds exist for the issuance of the orders or restrictive measures and that the terms and conditions imposed are no more restrictive than necessary to protect the public health.²²⁷

The threshold for considering restrictive measures is when the public health officer "knows or has reason to believe, because of medical or epidemiological information, that a person has HIV infection and is a danger to the public health . . ." ²²⁸ This establishes the basic standard for identifying a person who might be a candidate for restrictive measures.

The term "knows" would imply that the person has a positive HIV antibody test or has met other CDC criteria for diagnosis. The phrase "has reason to believe" allows the health director to draw reasonable inferences from medical and epidemiologic data. These inferences might include the reasonable belief that an intravenous drug user or the sexual contacts of an HIV carrier are infected.

Once the health officer has identified a person who is a candidate for restrictive measures, he may order the person to: (1) be examined and tested for HIV infection;²²⁹ (2) to report to a qualified physician or health worker for counseling on the disease and how to avoid infecting others;²³⁰ and (3) cease and desist from specified conduct which endan-

224. COLO. REV. STAT. § 25-4-1407 (Supp. 1987).

225. *Id.* at § 25-4-1406.

226. The CDH, which had full restrictive powers prior to this act, had not considered or implemented any systematic restrictions against HIV carriers.

227. COLO. REV. STAT. § 25-4-1406(1) (Supp. 1987).

228. *Id.* at § 25-4-1406(2).

229. *Id.* at (a).

230. *Id.* at (b).

gers the health of others.²³¹ These "orders" are legally meaningless admonitions.²³² They are not enforceable. Their purpose is to allow the recalcitrant carrier to demonstrate his bad faith through violation. Once the orders have been violated, the health officer may invoke the next phase of the process.

Once a person has demonstrated his bad faith by violating a health department order, the local health director, with the approval of the CDH, may issue a restrictive order.²³³ The order must be in writing, setting out the person to be restricted, the nature of the restrictions, the duration of the order (not to exceed three months), and any special considerations related to the protection of the public health.²³⁴ When the order has been reduced to writing, the Alice in Wonderland section of the AIDS control law comes into play.²³⁵ The health director must not only notify the person of the details of the restrictive order, but must then counsel the person that he or she has legislative permission to refuse to comply with the order and continue to expose others to HIV. After notifying the person that he or she is under a restrictive order, the health director must wait until the order is violated before seeking judicial enforcement of the order.

After there is evidence that a person is refusing to comply with the order, perhaps by exposing others to the virus, the health director may petition the court to proceed with enforcement. The court must set a hearing within ten days.²³⁶ At the hearing, the court may issue orders implementing, modifying, or dismissing the order. If the health director does not petition the court for enforcement of the order within thirty days, the person may ask the court to dismiss the order.²³⁷ If dismissed, the order must be expunged from the records of the state or local department of health.

The net result of section 25-4-1406 is to hopelessly hobble the health director's ability to protect the public health and safety. Accordingly, it is expected that restrictive measures will be applied through either section 25-4-1407 or through the criminal code.

B. *Emergency Restrictions*

The AIDS control law provides an expedited procedure for restrictive measures when the provisions of section 25-4-1406 have been exhausted or when threatened criminal behavior makes the delays inherent

231. *Id.* at (c).

232. For example, a person cannot be ordered to cease and desist dangerous activities unless he is first ordered to receive counseling, receives the counseling (or ignores the order for a reasonable period), continues to engage in dangerous conduct, and again comes to the attention of the health department.

233. *Id.* at § 25-4-1406(3) (Supp. 1987).

234. *Id.*

235. *Id.* at § 25-4-1406 (4)(a).

236. *Id.* at § 25-4-1406(5) ("Any hearing conducted pursuant to this section shall be closed and confidential, and any transcripts or records relating thereto shall also be confidential").

237. *Id.* at (4)(b).

in 25-4-1406 unacceptable.²³⁸ Interestingly, with the exception of the reference to threatened criminal conduct, this section is a good statement of a constitutionally acceptable procedure for routine public health enforcement. While threatened criminal behavior seems a high standard for invoking emergency provisions, it is an easy standard to make in Colorado. The Colorado criminal code establishes the offense of reckless endangerment: “[a] person who recklessly engages in conduct which creates a substantial risk of serious bodily injury to another person commits reckless endangerment, which is a class 3 misdemeanor.”²³⁹ Since this is not a specific intent crime, any high risk behavior by an HIV carrier would be a class three misdemeanor. This is also the gateway into the use of the criminal law for the control of conduct that is a threat to the public health and safety.

Section 25-4-1407 states the general authority of the court to issue appropriate injunctive orders, including confinement, to protect the public health and safety.²⁴⁰ There is an example of an order to confine for seventy-two hours for testing and counseling, but it is also clear that this is not the limit of the court’s authority to restrict HIV carriers. The carrier must be notified of the court’s order and told that he may choose to disregard it. In this case, however, the refusal would put the carrier in contempt of court. The carrier is entitled to a hearing before being subjected to invasive medical procedures, but is not entitled to be let out of custody pending the hearing. The carrier has a right to have a hearing to review any court orders.²⁴¹

The restrictive orders must be based on “clear and convincing” evidence. It is not clear what this means in a public health context, but it should include reasonable inferences from medical and epidemiological information. It does not mean that the CDH has to prove that its control strategies are fool-proof, that the person sought to be restricted is “guilty” of the threatened criminal behavior that underlies the request for emergency restrictions, or that the restriction that is sought cannot be evaded. It should be enough for the CDH to demonstrate that the proposed restriction is related to controlling HIV, and that there is “clear and convincing” evidence the person sought to be restricted may engage in the behavior that the CDH seeks to restrict.²⁴² If there is

238. *Id.* at § 25-4-1407(1) (Supp. 1987) (Emergency Public Health Procedures). There is no constitutional requirement that the CDH go through an adversary factfinding before ordering the detention of a person who poses a threat to the public health and safety. See *Gerstein v. Pugh*, 420 U.S. 103, 120 (1975).

239. COLO. REV. STAT. § 18-3-208 (1986).

240. *Id.* at § 25-4-1407(2) (Supp. 1987).

241. *Id.* at (3).

242. *Id.* at (4). See also *Addington*, *supra* note 219 and *City of New York v. St. Mark’s Baths*, 497 N.Y.S.2d 979 (Sup. 1986). The court in *St. Mark’s Baths* was asked to enjoin the operation of a homosexual bathhouse. The New York Department of Health based its request for an injunction on the evidence that high risk sexual activities were taking place in the bathhouse. The defendants alleged, among other claims, that certain sexual practices were less risky than the Department of Health maintained. In dismissing these attacks on the scientific basis of the Department of Health’s request, the court cited with approval the language of *Williams v. Mayor of Baltimore*, 289 U.S. 36, 42 (1933): “It is not

evidence that the person has already engaged in high risk behavior, then that behavior could be used to support a prosecution for reckless endangerment.

C. Penalties

The AIDS control law provides for a \$100 fine for violating the reporting requirements.²⁴³ There would also be tort liability for failure to comply if the failure resulted in injury to a third party. There is a substantial penalty for violating the confidentiality of the public health reports (contained on the CDH approved forms) required by the act.²⁴⁴ This provision does not apply to medical records or other information, only to the actual public health reports. Since there are no specific penalties for violating health department orders, the general penalty section of the public health code should apply.

VI. CONCLUSIONS

The unimpeded spread of HIV during the first four years of the epidemic demonstrates the tragic condition of American public health law and practice. The people of the United States have developed a naive faith in medical technology. This belief, combined with a failure to appreciate that the price of unrestricted personal behavior may be death, leads to political paralysis on public health issues that require either money or the making of difficult decisions. Public health officials have always faced political pressures, but in the last forty years political concerns have outweighed public health considerations. The sacrificing of public health judgement for political expediency made us complacent in the face of the hepatitis epidemic, the gonorrhea epidemic, and many other significant disease outbreaks. This complacency set the stage for the failure of political will when it became medically clear that HIV was spreading among sexually active homosexual men.

If there is a hopeful note in the HIV experience, it is that society is lucky that HIV is difficult to transmit. Many persons, including medical personnel, appear to believe that there is an inverse relationship between the communicability of a disease and its severity. The assumption is that the universe of easily communicable diseases is somehow limited to those that are easy to treat, self limiting, or susceptible to a simple

for the courts to determine which scientific view is correct in ruling upon whether the police power has been properly exercised. The judicial function is exhausted with the discovery that the relation between means and ends is not wholly vain and fanciful, an illusionary presence" *Id.*

It is important not to predicate the imposition of temporary or emergency restrictions on the probability that permanent restrictive orders would be approved. This was an issue in *Schall v. Martin*, 467 U.S. 253, 272 (1984), where the Supreme Court rejected a lower court's determination that pretrial detention under a state law was a punishment because so few of the detainees were subsequently prosecuted and confined: "We are unpersuaded by the Court of Appeals' rather cavalier equation of detentions that do not lead to confinement after an adjudication of guilt and wrongful' or punitive' pretrial detentions."

243. *Id.* at § 25-4-1409(1) (Supp. 1987) (penalties).

244. *Id.* at (2).

vaccine. There was no natural law that prevented the HIV virus from being transmitted with the ease of measles. More troublingly, there is nothing to prevent the resurgence of a plague, or the appearance of a infectious agent more virulent than HIV.

As AIDS and ARC have so graphically demonstrated, our medical technology is no guarantee that the ravages of a communicable disease can be managed on even an individual basis. On a societal basis, medical technology is almost irrelevant. We have approximately four to six hospital beds per thousand persons. A disease, such as the Spanish Influenza, which infected a great percentage of the population at one time, would rapidly overwhelm our medical resources.

Physicians and attorneys must take communicable disease control seriously. Physicians must realize that blind advocacy of the rights of individual patients may compromise the care of those patients and leave them susceptible to the ravages of epidemic diseases. Attorneys must realize that public health departments are the poor step children of government. It may be unfashionable to accept that there are times when individual rights must be summarily sacrificed for the health or safety of the community. However, imposing arcane due process requirements on health departments makes it impossible for them to function.

This is not because all communicable disease problems are emergencies which require immediate action. It is because health departments have no legal resources. Police departments, district attorneys, and attorneys' general all have their own jobs to do, and devoting substantial resources to public health enforcement is not on their agenda. Criminal law style due process requirements could be workable in public health, but at two costs: (1) the enormous financial cost of providing each health department with fleets of prosecutors, public health police, and public health courts (or the substantial expansion of the criminal court system); and (2) the reduction in our freedom that would accompany the creation of a system of public health police. As a society we must reappraise our economic, political, and intellectual commitment to public health. HIV is a human tragedy, but it is also a warning. Shifting patterns of urbanization, transportation, and class stratification will disrupt the dormancy of traditional plagues and set the stage for new disease agents and vectors. HIV has demonstrated that we are not prepared to meet these challenges.

APPENDIX
STATE OF COLORADO
RULES AND REGULATIONS
PERTAINING TO COMMUNICABLE
DISEASE CONTROL

Regulation 1. *Reportable Diseases*

For the purpose of these regulations, the diseases named in lists A and B below are declared to be dangerous to the public health and shall be reportable in accordance with the provisions of these regulations.

The Colorado Department of Health also requires the reporting of any unusual illness or outbreak of illnesses which may be of public concern whether or not known to be, or suspected of being, communicable, regardless of its absence from lists A and B. Such illnesses include, but are not limited to, Lassa fever, smallpox, typhus, or yellow fever, which have the potential to be brought into Colorado, are readily transmitted, and are likely to be fatal. Such outbreaks of illnesses include those which may be a risk to the public and which may affect large numbers of persons or be outbreaks of a newly recognized entity; such outbreaks shall include but are not limited to those related to contaminated medical devices or products or suspected to be related to environmental contamination by any infectious agent or toxic product of such an agent.

Manner of Reporting

The diseases in list A shall be reported within 24 hours of diagnosis by telephone or in person to the local health officer of the case's county of residence or to his designate, usually the county nursing service. In counties where no local health department or nursing unit exists, cases shall be reported directly to the Epidemiology Division, Colorado Department of Health. Cases may also be reported to the Epidemiology Division or to the reporting agent's local health department if reporting the case to the ill person's local health department of residence would require a long distance telephone call.

Reports to the State or Local Department of Health required of every attending physician by Section 25-4-1402 (1) may be transmitted to the State or Local Department of Health by telephone within twenty-four hours after the individual is known by said physician to have a diagnosis of AIDS or HIV related illness. The written report transcribed by the State or Local Department of Health shall be considered sufficient for compliance by the attending physician with Section 25-4-1402 (1).

Reports to the State or Local Department of Health required by Sections 25-4-1402 and 25-4-1403 shall be recorded on a form designated by the State Department of Health.

LIST A - REQUIRE TELEPHONE REPORT WITHIN 24 HOURS:

AIDS or HIV related illness (the latter defined as Department of Health and Human Services, U. S. Public Health Service, Centers for Disease

Control (CDC) Classification Group I, II with abnormal immune system tests, III or IV for persons ≥ 13 years [Reference *MMWR* 1986; 35:334-339] and CDC Classification Group P-1 Subclass B or Group P-2 for persons ≤ 13 YEARS [REFERENCE *MMWR* 1987; 36:225-2361]. This regulation does not include later editions or amendments to the CDC classification groups referenced above. Copies of the referenced material may be obtained from the State Epidemiologist, Colorado Department of Health, 4210 East 11th Avenue, Denver, Colorado 80220.)

Anthrax

Botulism

Diphtheria

Gonococcal Pelvic Inflammatory Disease

Group outbreaks, including food poisoning

Measles (rubeola)

Meningitis, Haemophilus Influenzas

Meningococcal disease (Meningococcal meningitis and

Meningococemia)

Plague

Poliomyelitis

Rabies in man (suspected)

Rubella

Syphilis, early (primary, secondary, or early latent)

Tuberculosis

Typhoid Fever

All cases are to be reported with patient's name, address (including city and county), age, sex, name and address of responsible physician, and such other information as is needed to locate the patient for follow-up.

The diseases in list B shall be reported to local health units according to protocols established by each unit, but in no case later than 7 days after the diagnosis is made by the physician or confirmed in the laboratory. Local health unit protocols may require more rapid reporting of diseases in this list, or may exempt certain reporting agents from the reporting of influenza-like illness.

List B

Amebiasis
Animal bites*
Brucellosis*
Campylobacter infection
Chancroid
Colorado Tick Fever*
Encephalitis*
Giardiasis*
Gonorrhea
Granuloma inguinale
Hepatitis A*
Hepatitis B*
Hepatitis unspecified*
Hepatitis non-A, non-B
Hydatidosis
Influenza-like illness*
Kawasaki Syndrome
Legionnaires' disease*
Leprosy
Leptospirosis*
Lymphogranuloma venereum
Malaria*
Meningitis, Aseptic*
Meningitis, Streptococcus pneumonia
Mumps*
Pertussis syndrome*
Psittacosis*
Q Fever*
Relapsing Fever*
Reye's Syndrome*
Rheumatic fever*
Rocky Mountain Spotted Fever*
Rubella, congenital*
Salmonellosis
Shigellosis
Taeniasis
Tetanus*
Toxic Shock Syndrome
Trichinosis*
Tularemia*
Visceral larva migrans

All cases to be reported with patient's name, age, sex, address (including city and county), and name and address of responsible physician, and such other information as is needed to locate the patient for follow-up, except for influenza-like illness, animal bites and mumps, in which only the number of cases seen need be reported.

All cases of diseases in list A, and all cases of diseases marked with an asterisk in list B, shall be reported based on the attending physician's diagnosis, whether or not supporting laboratory data are available. Cases will be counted by State and local health agencies when confirma-

tory laboratory data become available. All other diseases in list B shall be reported only when the physician's diagnosis is supported by laboratory confirmation.

Regulation 2. *Reporting by Individuals*

Cases of diseases listed in Regulation 1 shall be reported by the attending physician, and except for AIDS or HIV related illness, by other persons either treating or having knowledge of a reportable disease, such as superintendents or persons in charge of hospitals or other institutions licensed by the Colorado Department of Health (or their designees), persons in charge of schools (including school nursing staff) and licensed day-care centers.

Cases of AIDS or HIV Related Illness shall be reported by attending physicians, as required by Regulation 1, and by all other persons treating a case of HIV infection in hospitals, clinics, sanitariums, penal institutions, and other private or public institutions.

Regulation 3. *Laboratory Reporting*

Cases of diseases listed in Regulation 1 shall also be reported with the information required in Regulation 1 by clinical laboratories whether or not associated with a hospital, and by out of state clinical laboratories that maintain an office or collection facility in Colorado or arrange for collection of specimens in Colorado. A case shall be deemed reportable by a laboratory when any of the following highly diagnostic results are found:

POSITIVE CULTURES.	SITE
Neisseria meningitidis	blood, CSF.
Salmonella species, include typhi	all
Shigella species	all
Campylabacter jejuni	all
Brucella species	all
Bacillus anthracis	all
Corynebacterium diphtheriae	all
Bordetella pertussis	all
Yersinia pestis	all
Mycobacterium tuberculosis	all
Francisella tularensis	all
Clostridium botulinum	all
Hemophilus influenzae	blood, CSF.
Streptococcus pneumoniae	CSF
POSITIVE SEROLOGIES.	
Colorado Tick Fever	4-fold rise in titer
Western equine encephalitis	4-fold rise in titer
St. Louis encephalitis	4-fold rise in titer
Q fever	4-fold rise in titer
Hepatitis A	positive IgM
Psittacosis	4-fold rise in titer
Rocky Mountain Spotted Fever	4-fold rise in titer

Rubella	4-fold rise in titer
Measles	4-fold rise in titer
Legionellosis	4-fold rise in titer

Human Immunodeficiency Virus (HIV) Positive ELISA test or positive supplementary test such as Western blot or positive test for antigenemia—all of the above according to test manufacturers' directions.

POSITIVE TISSUE EXAMINATIONS.

AFB smear at any site except gastric washings
 Direct FA for Legionellosis
 Direct FA for rabies in animals or man
 Direct FA for Pertussis
 Gram negative diplococci on CSF
Borellia species on peripheral smear

POSITIVE VIRAL CULTURES.

Poliomyelitis, both wild and vaccine strains
 Colorado Tick Fever
 Arboviruses (e.g., St. Louis, Western, dengue)
 Measles
 Rubella
 Influenza
 Human Immunodeficiency Virus (HIV)1

POSITIVE TOXIN ASSAYS.

Botulism

POSITIVE PARASITE EXAMS.

Entamoeba histolytica (any site)
Giardia lamblia (any site)
Taenia species (any site)
Plasmodium species (peripheral blood smear or tissue examination)
Echinococcus species (any site)

Laboratories shall follow the same procedures as other reporting sources in regard to telephone reporting within 24 hours of list A diseases and following county protocols on list B diseases, except that

— Regulation 4 controls procedures for laboratory reporting of gonorrhea, syphilis, chancroid, lymphogranuloma venereum and granuloma inguinale.

— hospital laboratories may discharge their reporting responsibility as part of a report made by the hospital as a whole, such as the one made by the infection control coordinator.

— non-hospital laboratories which serve patients from many counties may make weekly reports of list B diseases and telephone reports of list A diseases directly to the Epidemiology Division, Colorado Department of Health, which will disseminate the reports to appropriate local health agencies.

Report of a case by a laboratory does not relieve the attending physician of his obligation to report the case, nor does report by the physician relieve the laboratory of its obligation, except that reports on

hospitalized patients may be made part of a report by the hospital as a whole.

Report of a positive HIV antibody test by a laboratory does not relieve the attending physician of his obligation to report cases of AIDS and HIV Related Illness, nor does report by the physician relieve the laboratory of its obligation.

The Department shall develop report forms for the use of hospital and non-hospital laboratories.

Regulation 4. *Venereal Disease Reporting by Laboratories*

1. The directors and/or supervisors of all clinical laboratories performing tests for venereal diseases shall submit to the Colorado Department of Health, Venereal Disease Control Program written reports of all tests for venereal diseases as follows:

- (a) All reactive (positive) and weakly reactive (doubtful) serologic tests for syphilis;
- (b) All reactive (positive) and weakly reactive (doubtful) spinal fluid serologic tests for syphilis;
- (c) All positive darkfield microscopic tests for *treponema pallidum*;
- (d) All positive gonococcal smears and cultures; and
- (e) All positive tests indicating the presence of *Ducrey bacillus* or *Donovan bodies*.

2. These reports will be submitted within one (1) working day after testing directly to the Epidemiology Division, Colorado Department of Health, in a manner and on forms so prescribed and provided by the Department.

Regulation 5. *Information sharing*

Whenever a local health department, county health officer or county nursing service learns of a case of a reportable disease in list A, it shall notify the Epidemiology Division of the report in a timely and confidential manner, usually by telephone or other personal contact within 24 hours.

Local health departments, county health officers or their designates who receive communicable disease reports shall forward the collected information for each week to the Epidemiology Division either in writing or by telephone at the end of each week.

The Epidemiology Division shall, in turn, notify the appropriate local health agency in a timely and confidential manner whenever it learns of a case of a reportable disease in list A, usually by telephone or other personal contact. For diseases in list B, the Epidemiology Division shall also notify the appropriate local health agency in a timely manner whenever it learns of a case not reported by the local health agency to the Division, except that such notification of gonorrhea cases need only be done on the request of the local health agency.

Information concerning cases of AIDS or HIV Related Illness or results of laboratory tests for HIV infection shall be shared between the appropriate Local Health Department and the Epidemiology Division as provided by Section 25-4-1404.

Regulation 6. Food handling and infected persons

No person, while infected with a disease in a communicable form which can be transmitted by foods or who is afflicted by a boil, or an infected wound, shall work in a food processing, milk producing, milk processing or food service setting in any capacity in which there is a likelihood of such person contaminating food or food contact surfaces with pathogenic organisms or transmitting diseases to other persons. The employer is responsible for ensuring the absence from work of an employee with an infectious disease for which there is evidence of transmission to persons in a food service, food processing, milk producing, or milk processing setting, as determined by the State Department of Health.

Regulation 7. Reporting of Diseases Among Animals

Every veterinarian, livestock owner, veterinary diagnostic laboratory director, or other person having the care of, or knowledge of, the existence of animals having or suspected of having any disease which may endanger the public health such as rabies, anthrax, encephalitis, etc., shall promptly report the facts to the local health officer or the Epidemiology Division, Colorado Department of Health.

Regulation 8. Confidentiality

All records and reports submitted to the Colorado Department of Health in compliance with these regulations are deemed to be confidential public health information and are to be used by the Department as source material for problem analysis and necessary disease control efforts. Individual identifiers shall be removed from all information released to the public. Consultation with the attending physician or medical facility caring for the patient will precede any further follow-up by the Department of Health or local health agencies, whether the case was reported initially by a laboratory or a physician, providing the name of the attending physician or medical facility is given.

The "reports" referred to in Section 25-4-1404 (1) are defined as the information required by Sections 25-4-1402, 25-4-1403, 25-4-1405 (8) and recorded on forms designated by the Colorado Department of Health: 1) which is submitted to and received by the State or Local Health Department on a form designated by the State Department of Health; or 2) which is transcribed to such a form by a Health Department employee when that information has been submitted verbally or by telephone; or 3) which subsequent to being received by the State or Local Health Department is maintained, filed, or stored by the Health De-

partment; or 4) which is maintained on forms designated by the Colorado Department of Health by an institution or agency which screens individuals for HIV infection without providing ongoing health care, such as a public HIV counseling and testing site.

This definition of report does not include information incorporated into and part of a patient's medical record. For purposes of this regulation, a patient's medical record is defined 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. Furthermore, this definition of report applies only to the reports required by Sections 25-4-1402, 25-4-1403, and 25-4-1405 (8) and does not apply to any other reports made pursuant to state statute, regulation, or rules.

The terms "such information" in Section 25-4-1404 (1) and "confidential medical information" in Section 25-4-1409 (2) refer to the reports in Section 25-4-1404 (1) and do not refer to clinical or laboratory information, including examination results and clinical diagnoses, in a patient's medical record.

