No. 21-617

In the Supreme Court of the United States

CHRISTOPHER N. PAYNE, PETITIONER,

v.

JAHAL TASLIMI; MS. SMITH, LPN

ON PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

BRIEF OF AMICI CURIAE AMERICAN ACADEMY OF HIV MEDICINE, GLMA, THE HIV MEDICINE ASSOCIATION, AND THE LEGAL ACTION CENTER IN SUPPORT OF PETITIONER

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QUESTION PRESENTED

Amici will address the following question:

> Did the court of appeals err by relying on information outside of the record—including misguided and outdated scientific premises—to determine that the well-established right to medical privacy does not apply to the HIV status of prisoners?

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INTEREST OF AMICI[1]

Amici are advocacy groups advancing the interests of individuals who have been diagnosed with HIV and the health professionals who care for those individuals. Amici are deeply interested in this case because its outcome could affect the medical care, health privacy rights,

[1] Both parties have consented in writing to the filing of this amicus curiae brief. No counsel for any party authored this brief in whole or in part, and no person or entity, other than amici curiae or their counsel, made a monetary contribution intended to fund the preparation or submission of this brief.

and dignity of people with HIV.

The American Academy of HIV Medicine (the Academy) is the nation's leading independent organization of healthcare professionals dedicated to providing excellence in HIV care and prevention. The Academy comprises physicians, physician assistants, nurse practitioners, and pharmacists who manage the health of the majority of people with and at risk for HIV in the United States. The Academy is committed to educating these providers about HIV's rapidly evolving treatment and prevention landscape and advocating for efforts to eliminate stigma around those with and at risk for HIV.

GLMA: Health Professionals Advancing LGBTQ Equality (previously known as the Gay & Lesbian Medical Association) is the world's largest and oldest association of lesbian, gay, bisexual, transgender and queer (LGBTQ) healthcare professionals. GLMA was founded in 1981, as the American Association of Physicians for Human Rights, with the mission of ensuring equality in healthcare for LGBTQ individuals and healthcare professionals. GLMA is a leader in public policy advocacy related to HIV/AIDS and LGBTQ health. GLMA's membership includes approximately 1,000 member physicians, nurses, advanced practice nurses, physician assistants, researchers and academics, behavioral health specialists, health profession students and other health professionals across the United States and in several other countries.

The HIV Medicine Association of the Infectious Diseases Society of America (the Association) is an organization of medical professionals who practice HIV medicine. The Association represents the interests of HIV health care providers and researchers and their patients

by promoting quality in HIV care and by advocating for policies that ensure a comprehensive and humane response to the AIDS pandemic informed by science and social justice.

The Legal Action Center (LAC) was founded in 1973, and uses legal and policy strategies to fight discrimination, build health equity, and restore opportunity for people with arrest and conviction records, substance use disorders, and HIV or AIDS. LAC provides free legal services to individuals who have arrest or conviction records, substance use disorders, HIV, or AIDS and face discrimination in health care, employment, housing, education, and other areas. LAC also advocates for important precedents to defend the civil rights of individuals with HIV/AIDS and others in their constituent group and fights to protect access to health care, opportunity, and justice for all.

Amici present this brief to provide analysis regarding the grave constitutional concerns raised by the Fourth Circuit court of appeals' decision, which threatens to entrench an antiquated and fear-driven approach to HIV that would jeopardize the constitutional medical privacy rights of individuals with the virus, including in the prison setting.

SUMMARY OF ARGUMENT

The decision of the court of appeals merits review because it represents a dangerous abandonment of judicial process in which the court based its decision on a pseudo-scientific premise, without support in the record or scientific fact. If courts are able to simply hypothesize scientific truth outside of the record—untested by evidence and argument—the court abandons its role as an

arbiter of evidence and becomes little more than an uninformed commentator. This abdication of the legal process is particularly pernicious with respect to misunderstood and marginalized groups, such as individuals with HIV, who suffer through the ignorance of others.

Individuals with HIV have long been the subjects of stigma and discrimination. In the early years of the HIV/AIDS pandemic, this stigma was tied to fears about how the virus might possibly be transmitted, which led to unfair biases and prejudices against some groups affected by the virus, including the LGBTQ community. As a consequence, people with HIV faced housing and employment discrimination, mistreatment, abuse, and even violence.

Thankfully, advances in science have transformed HIV into a manageable condition and have given individuals who adhere to HIV therapy regimens the freedom to engage in the full breadth of human experiences, including increasingly long lifespans and active sexual relationships, without fear of transmitting the disease to others. Still, as the court of appeals' decision reflects, the vast majority of citizens do not appreciate that modern antiretroviral treatments are able to suppress HIV viral load to such an imperceptible level that individuals undergoing such treatments are able to engage in the full range of human relationships, including full-contact physical sports and even sexual activity without any measurable risk of transmitting the virus to another person. Unfortunately, while there have been great leaps in treatment of the virus, much of the social stigma related to HIV remains, especially where individuals are ill-informed about these scientific advances. Amici are committed to fighting such misinformation and protecting the lives and dignity of people with HIV.

The court of appeals' decision in this case threatens to entrench retrograde, misguided beliefs and erode the rights and freedoms of individuals with HIV. The court cited *Anderson* v. *Romero*, 72 F.3d 518 (7th Cir. 1995), a case which was decided last century, in the year *before* the current leading therapy for HIV was developed, for the proposition that prisoners' rights to medical privacy do not extend to HIV status because it is a "communicable" disease. The court then went one step further, transforming that opinion into pseudo-science, by suggesting that the assumed communicability of HIV is similar to the current COVID-19 pandemic—a comparison unsupported by the record, science, or common sense. It further betrays the type of hysterical attitudes that have stoked HIV stigma and discrimination over the decades and kept people from getting care.

Based on this unsupportable pseudo-science, the court then weighed fear of this easily communicable disease against the interests of the other incarcerated persons and staff. From this flawed foundation, the court concluded that individuals in the prison setting do not have an expectation of privacy in their HIV-status because the information "is especially relevant in a prison where disease can spread rapidly."

The court of appeals' decision is wrong on the science and wrong on the law. No court should be allowed to reach results based on the creation of scientific comparisons that lack record support.

An individual's right to medical privacy, and especially privacy of HIV status, has been widely recognized by federal courts as well as federal and state statutes. Given how HIV is actually transmitted (which will be addressed in detail later in the brief) and the advances in

treatment of HIV, there is no reason to believe that there is a threat of rapid spread of the disease, even in the close and sometimes violent quarters of the prison setting. Indeed, the "risk of transmission to prison workers and other inmates" from an individual on effective treatment for HIV is essentially nonexistent. There is therefore no reason that prisoners should not enjoy the same constitutional right to privacy in their medical information afforded other individuals in the United States.

ARGUMENT

I. WHEN EFFECTIVELY MANAGED, HIV TRANSMISSION CAN BE PREVENTED

It has been forty years since the initial published report about what would later be recognized as the first reported U.S. cases of acquired immunodeficiency syndrome (AIDS), the chronic disease caused by HIV.[2] During that time, revolutionary advances have made HIV—which was once a fatal condition—a chronic, manageable one, especially for those who have reliable access to HIV therapies that suppress the virus to very low levels in the body, also referred to as viral suppression. Individuals with HIV who maintain viral suppression further reduce their risk of transmitting the virus to sexual partners to effectively zero.[3] Moreover, there are limited

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[2] Centers for Disease Control & Prevention, *HIV and AIDS Timeline* (Oct. 21, 2020), https://npin.cdc.gov/pages/hiv-and-aids-timeline#1980.

[3] See Centers for Disease Control & Prevention, *Evidence of HIV Treatment and Viral Suppression in Preventing the Sexual Transmission of HIV* 2 (Dec. 2020), https://www.cdc.gov/hiv/pdf/risk/art/cdc-hiv-art-viral-suppression.pdf (CDC, *Evidence of HIV*).

routes for transmission that include sexual contact, sharing needles or blood contamination even for persons who are not virally suppressed. Unlike other viruses, HIV cannot spread by touching, coughing, sneezing, sweating, kissing, or sharing silverware or straws.[4] Despite these indisputable scientific facts, misinformation about HIV persists in society and, unfortunately, even in the courts. In the present case, the Fourth Circuit invokes antiquated attitudes about the contagiousness of HIV to make a false case for a penological interest that outweighs the right to health privacy. This Court must reject such pseudoscience and remain informed by firmly-established epidemiological evidence. As Justice Breyer eloquently expressed the idea in an academic setting, "Our decisions should reflect a proper scientific and technical understanding so that the law can respond to the needs of the public."[5]

A. Adherence to Antiretroviral Therapy (ART) effectively eliminates the risk of HIV transmission

Understanding HIV therapy begins with a scientifically sound awareness of the underlying disease. HIV attacks and destroys infection-fighting CD4 cells in the immune system, making it difficult for the body to stave off infections.[6] Since the approval of the drug zidovudine,

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[4] U.S. Dep't of Health & Human Servs., *How is HIV Transmitted?*, https://www.hiv.gov/hiv-basics/overview/about-hiv-and-aids/how-is-hiv-transmitted (last updated June 24, 2019) (HHS).

[5] See Stephen Breyer, *Science in the Courtroom*, 16 Issues Sci. & Tech. Online (2000), https://issues.org/breyer-science-courtroom.

[6] Centers for Disease Control & Prevention, *HIV Basics: About HIV*, https://www.cdc.gov/hiv/basics/whatishiv.html (last updated June 1, 2021).

commonly known as AZT, in 1987, antiretroviral therapy (ART) has been the first line of HIV treatment.[7] When an individual begins ART, the amount of virus in the system decreases until the viral concentration of HIV in the bloodstream ("viral load") drops to an undetectable or low level.[8] In the early years of single-drug ART, the treatment was not potent enough to durably stop the virus from replicating, which led to the inevitable development of virus mutations that rendered the medication ineffective,[9] but in 1996 researchers discovered that a three-drug combination of antiretrovirals reliably and persistently suppressed viral replication and prevented the virus from developing drug resistance.[10] The discovery revolutionized HIV treatment and, for the first time, enabled people to suppress their viral load to undetectable levels and live longer lives.[11] This combination therapy remains the standard treatment today and results in

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[7] U.S. Food & Drug Admin., *The History of the FDA's Role in Preventing the Spread of HIV/AIDS*, https://www.fda.gov/about-fda/fda-history-exhibits/history-fdas-role-preventing-spread-hiva-ids (last updated Mar. 14, 2019).

[8] National Inst. of Allergy & Infectious Diseases, *When Undetectable Is Unachievable: Study Offers Insights into HIV Persistence* (Mar. 5, 2019), https://www.hiv.gov/blog/when-undetectable-unachievable-study-offers-insights-hiv-persistence.

[9] National Inst. of Allergy & Infectious Diseases, *Antiretroviral Drug Discovery and Development*, https://www.niaid.nih.gov/diseases-conditions/antiretroviral-drug-development (last visited Nov. 22, 2021) (NIAID).

[10] Anthony S. Fauci et al., *HIV Viral Load and Transmissibility of HIV Infection: Undetectable Equals Untransmittab*le, 321 JAMA 451, 451 (2019), https://www.natap.org/2019/HIV/jama_eisinger_2019_vp_180174opy.pdf.

[11] See NIAID.

sustained viral suppression.[12]

While adherence to ART—regular medication intake and consistent attendance of outpatient appointments—is critical for reducing the risk of transmission,[13] the Fourth Circuit's assumption that an individual with HIV like Payne could "forgo taking medicine and thus become contagious again" after a single delayed or missed dose[14] defies both science and common sense. The exact optimum level of ART adherence is disputed, but there is consensus that it falls somewhere between 80 and 95 percent; for years, HIV treatment guidelines dictated that individuals must maintain a 95 percent or greater adherence to ART to sustain an undetectable viral load.[15] For a daily single-pill ART regimen, 95 per-

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[12] *Ibid.* Combination therapy is referred to as cART (combination antiretroviral therapy), HAART (highly active antiretroviral therapy), and ART, the acronym preferred in the medical community and used here to describe single and multi-drug antiretroviral therapy.

[13] See Surajudeen A. Abdulrahman et al., *HIV Treatment Adherence: A Shared Burden for Patients, Health-Care Providers, and Other Stakeholders*, 12 AIDS Rev. 28, 30 (2019), https://www.researchgate.net/publication/331849722_HIV_Treatment_Adherence_-_A_Shared_Burden_for_Patients_Health-Care_Providers_and_Other_Stakeholders#read.

[14] Pet. App. 15.

[15] See, *e.g.*, Abdulrahman 31; Kenneth L. Schaecher, *The Importance of Treatment Adherence in HIV*, 19 Am. J. Manag. Care S231, S231 (2013), https://cdn.sanity.io/files/0vv8moc6/ajmc/2c3d3cfc8f07952e3fe1eb48d886314088baa31e.pdf/A472_09_13_Schaecher_S231to7.pdf ("For HIV therapeutic regimens in which an unboosted protease inhibitor is a component, there exists a substantial risk of failed viral suppression with treatment adherence less than 95%.").

cent adherence translates to approximately 14 non-consecutive missed doses over the course of a year.[16] However, recent studies have indicated that newer ART drugs show similar viral load suppression with adherence in the 80 to 85 percent range, which is in line with target adherence levels commonly used for other diseases, such as hypertension, diabetes, and tuberculosis.[17] Furthermore, when ART is entirely stopped, full viral rebound usually occurs within two to three weeks—not hours or days.[18]

Provided that an individual does not miss many doses of ART treatment, even at an adherence rate of 95 percent or higher, as Payne was here, the likelihood of

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[16] James Myhre & Dennis Sifris, *How Much HIV Drug Adherence Is Enough?*, Verywell Health (May 23, 2021), https://www.verywellhealth.com/how-much-adherence-is-enough-adherence-49307.

[17] See Shilpa Viswanathan et al., *Level of Adherence and HIV RNA Suppression in the Current Era of Highly Active Antiretroviral Therapy (HAART)*, AIDS Behav. 8 (2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4393774/pdf/nihms-638199.pdf ("Adherence levels as low as 80 to 84 percent may be sufficient for viral load suppression in populations using newer ART formulations"); see also Kathy Byrd et al., *Antiretroviral Adherence Level Necessary for HIV Viral Suppression Using Real-World Data*, 82 J. Acquired Immune Deficiency Syndromes 245, 249-250 (2019), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6854523/pdf/nihms-1055707.pdf (concluding that the adherence rate required to achieve viral suppression is 82 percent; suggesting that today's ART medications are much more forgiving than those of years past).

[18] Fauci et al. 452; see also Abdulrahman et al. 31 ("*Repeated* missed appointments have been shown to result in non-adherence to medication, faster disease progression, and eventual treatment failure." (emphasis added)).

transmission of the disease is effectively zero.[19] It is now widely accepted in the scientific and health care communities that individuals with HIV who did not have another sexually-transmitted infection and who achieved and maintained an undetectable viral load for at least six months could not sexually transmit the virus.[20] According to the CDC today, when individuals with HIV adhere to ART and maintain undetectable or suppressed viral levels, their risk of transmitting the virus to sexual partners is effectively zero.[21] In fact, there has not been even one reported case of transmission of the virus *through sex* from a person with an undetectable viral load.[22]

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[19] Fauci et al. 451.

[20] Pietro L. Vernazza & Edwin J. Bernard, Editorial, *HIV Is Not Transmitted Under Fully Suppressive Therapy: The Swiss Statement—Eight Years Later*, Swiss Med. Wkly. (Jan. 29, 2016); see *also* CDC, *Evidence of HIV* 2 (analyzing data from recent studies—HPTN052, PARTNER, Opposites Attract, and PARTNER2—and concluding that the combined transmission risk estimate for sex without a condom among serodiscordant couples is virtually zero).

[21] See CDC, *Evidence of HIV* 3. According to the CDC, viral suppression is defined as having less than 200 copies of HIV per milliliter of blood, and an "undetectable" viral load is generally measured as fewer than 50 copies per milliliter. The CDC uses the word *effectively* to reflect the fact that while "non-zero risk[s]" can never be ruled out, evidence suggests that it is not possible to transmit HIV during periods of non-detection or viral suppression.

[22] *Id.* at 1.

B. HIV cannot be transmitted by casual contact

HIV can be transmitted only in limited circumstances, leading the CDC[23] and some states[24] to exclude it from lists of communicable diseases. HIV can be transmitted only through direct contact with certain bodily fluids from a person with detectable levels of the virus in their system; these fluids include blood, semen and pre-seminal fluid, rectal fluid, vaginal fluid, and breast milk.[25] HIV cannot be transmitted by air or water, mosquitos, ticks or other insects, saliva, tears, sweat, nasal secretions, shaking hands, hugging, sharing toilets or dishes, or other person-to-person contact where these fluids are not exchanged. For transmission to occur, the

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[23] See Centers for Disease Control & Prevention, *Final Rule: Removal of HIV Entry Ban* (Nov. 2, 2009), https://www.cdc.gov/immigrantrefugeehealth/laws-regs/hiv-ban-removal/final-rule.html ("HIV infection is no longer defined as a communicable disease of public health significance and testing for HIV infection is no longer required as part of the U.S. immigration medical screening process. Additionally, HIV infection no longer requires a waiver for entry into the United States.").

[24] For example, HIV/AIDS is not classified as a communicable disease in New York for communicable disease reporting requirements. See N.Y. State Dep't of Health, *Communicable Disease Reporting Requirements*, https://health.ny.gov/forms/instructions/doh-389_instructions.pdf. Other states, like Virginia, do require reporting of presumptive and confirmed cases of HIV/AIDS within three days, but use the term communicable or place it in the same critical ("report immediately") category with severe coronavirus infection or other highly communicable diseases like measles and pertussis ("whooping cough"). See Va. Dep't of Health, *Virginia Reportable Disease List*, https://www.vdh.virginia.gov/disease-prevention/disease-reporting/ (last updated Feb. 1, 2021).

[25] See HHS 4.

virus present in these fluids must pass into the bloodstream of a person without HIV through a mucus membrane, open cuts or sores, or by direct injection; the most common ways HIV is spread is by having unprotected vaginal or anal sex, or by sharing intravenous drug equipment, with someone who has a detectable viral load.[26]

Accordingly, the Fourth Circuit's comparison of HIV to COVID in terms of transmissibility is completely false. Transmissibility of disease sits on a spectrum, with HIV on one end and droplet or airborne diseases—such as COVID-19 and influenza—firmly on the other. This is even more true in cases, like the present one, where HIV is under effective management. In such cases, as discussed above, even sexual transmission is virtually impossible, so all other forms of social interaction, even interaction that involves close contact with another person like the act of restraining an incarcerated person, would be exceptionally unlikely to result in transmission.

II. The Right To Privacy Of Medical Information, Particularly HIV Status, Is Widely Recognized

A. Individuals have a constitutional right to medical privacy

This Court and lower courts have widely recognized an individual's constitutional right to privacy of their medical information. See *Ferguson* v. *City of Charleston*, 532 U.S. 67, 78 (2001) (recognizing an individual's right under the Fourth Amendment not to have sensitive medical information disclosed to "nonmedical personnel without her consent"); *Moore* v. *Prevo*, 379 F.

[26] *Ibid.*

App'x 425 (6th Cir. 2010) (same); *Doe* v. *Delie*, 257 F.3d 309, 315 (3d Cir. 2001) ("We have long recognized the right to privacy in one's medical information."); *Powell* v. *Schriver*, 175 F.3d 107, 112 (2d Cir. 1999) (acknowledging the "constitutional stature [of] the right to maintain the confidentiality of previously undisclosed medical information").

An individual's constitutional right to the privacy of their medical information has been codified by Congress's passage of the Health Insurance Portability and Accountability Act of 1996, 110 Stat. 1936 (HIPAA). With limited exceptions, HIPAA precludes health care providers, health plans, health care clearinghouses, and their business associates from using or disclosing "protected health information" (PHI). See 45 C.F.R. 164.502 (the HIPAA Privacy Rule). While HIPAA does not provide a private right of action for individuals whose information is exposed, it does impose civil and criminal penalties for violations. See 45 C.F.R. 160.402; 42 U.S.C. 1320d-6.

B. Various statutes recognize a heightened right to privacy of HIV status

The right to medical privacy is even more closely held when addressing HIV status due to the history and risk of discrimination of HIV based on social stigmas related to homophobia and misguided fear of the disease, which can lead to violence against individuals with HIV. HIV status is one of only a handful of health-related categories that legislators have singled out for additional confidentiality protections. In addition to the risk of discrimination and violence, one motivation behind laws protecting the confidentiality of HIV status is that this actually *reduces* the risk of HIV transmission because

individuals will not be afraid to get tested and treated.[27] As such, the Fourth Circuit's assertion that protecting the privacy rights of individuals with HIV undermines the institutional safety of the prison seems especially misplaced.

Indeed, the vast majority of state legislatures have recognized the importance of protecting the confidentiality of an individual's HIV status. These states have enacted statutes explicitly governing the disclosure and use of HIV/AIDS positive test results in at least some contexts, such as providing standards for court-ordered disclosures or prohibiting disclosures by insurers, public health entities, or health care facilities and their employees in most instances.[28] These state laws further empha-

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[27] See, *e.g.*, Fla. Stat § 381.004 (1989) (explaining that "many members of the public are deterred from seeking * * * testing because they * * * fear that test results will be disclosed without their consent" and that "the public health will be served by facilitating informed, voluntary, and confidential use of tests designed to detect [HIV]"); see also *Doe* v. *State of New York*, 152 Misc. 2d 922, 923 (N.Y. Ct. Cl. 1991) (describing the legislative intent behind the confidentiality components of the state's public health law to "encourage the expansion of voluntary confidential testing for human immunodeficiency virus (HIV) so that individuals may * * * change the behavior that puts them and others at risk of infection" (internal citation omitted)).

[28] See Al. Code § 22-11A-54 (protecting privacy of HIV status); Ariz. Rev. Stat §§ 20-448.01, 36-664 (same); Cal. Health & Safety Code § 120975 (same); Colo. Rev. Stat. § 10-3-1104.5 (same); Conn. Gen. Stat. § 19a-583 (same); Del. Code tit. 16, § 717 (same); Fla. Stat. § 381.004 (same); Ga. Code §§ 24-12-20, 24-12-21 (same); Haw. Rev. Stat. § 325-101 (same); Idaho Code § 39-610 (same); 410 Ill. Comp. Stat. 305/9 (same); Iowa Code § 141A.9 (same); Kan. Stat. § 65-6002 (same); Ky. Rev. Stat. § 214.625 (same); La. Stat. Ann. § 40:1171.4 (same); Me. Rev. Stat. tit. 5, §§ 19203, 19204-C (same); Md. Code,

size the common understanding that HIV status is an extremely sensitive piece of personal information and should be kept confidential.

Several federal courts have also recognized the right to privacy as applied to HIV status. See, *e.g.*, *Powell*, 175 F.3d at 110 ("Individuals who are infected with the HIV virus clearly possess a constitutional right to privacy regarding their condition." (quoting *Doe* v. *City of New York*, 15 F.3d 264, 267 (2d Cir. 1994)); *Moore*, 379 F. App'x at 427 ("It is beyond question that information about one's HIV-positive status is information of the most personal kind and that an individual has an interest in protecting against the dissemination of such information."). HIPAA likewise permits the disclosure of HIV status, along with other protected health information, for only certain limited permissible purposes, including for treatment, payment, and healthcare operations. See, *e.g.*, *Warren* v. *Corcoran*, No. 9:09-CV-1146, 2011 WL 5599587, at *7 (N.D.N.Y. Oct. 20, 2011), R. & R. adopted, No. 9:09-CV-1146, 2011 WL 5599620 (N.D.N.Y. Nov. 17, 2011) (distinguishing disclosure of an inmate's

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Health-Gen. § 18-338.1 (same); Mass. Gen. Laws ch.111, § 70F (same); Mich. Comp. Laws § 333.5131 (same); Mo. Rev. Stat. § 191.656 (same); Mont. Code Ann. § 50-16-1009 (same); Nev. Rev. Stat. § 433A.220 (same); N.H. Code Admin. R. Ins. 1103.02 (same); N.J. Rev. Stat. § 26:5C-7 (same); N.M. Stat. § 24-2B-6 (same); N.Y. Pub. Health Law 27-F (same); N.C. Gen. Stat. § 130A-143 (same); N.D. Cent. Code 23-07-02.2 (same); Ohio Rev. Code § 3701.24 (same); Or. Rev. Stat. §§ 135.139, 433.045 (same); (same); (same); (same); (same); 35 Pa. Cons. Stat. § 7607 (same); R.I. Gen. Laws §§ 23-6.3-7, 23-6.3-8 (same); Tenn. Code § 68-5-703 (same); Tex. Health & Safety Code § 81.103 (same); Utah Code § 26-6-27 (same); Vt. Stat. tit. 8, § 4724 (same); Va. Code Ann. § 32.1-36.1 (same); Wash. Rev. Code § 70.24.050 (same); W. Va. Code § 16-3C-2 (same); Wis. Stat. § 252.15 (same).

HIV status to correctional officers, who were present at the inmate's telemedicine visit for security purposes and who were subject to HIPAA obligations, from disclosure of the same information to "other inmates or staff").

III. Incarceration Does Not Obliterate The Right To Medical Privacy

Contrary to the court of appeals' assumption, the mere fact of incarceration does not destroy rights to medical privacy. Several federal courts have extended the constitutional right to medical privacy, and privacy of HIV status in particular, to individuals in the prison setting. This extension of rights to prison inmates is consistent with this Court's acknowledgment that a prisoner retains those constitutional rights that "are not inconsistent with his status as a prisoner or with the legitimate penological objectives of the corrections system." *Turner* v. *Safley*, 482 U.S. 78, 95 (1987) (upholding a prisoner's right to marry) (quoting *Pell* v. *Procunier*, 417 U.S. 817, 822 (1974) and broadening the language in *Pell* from "First Amendment" rights to all "constitutional" rights); see also *Powell* v. *Schriver*, 175 F.3d 107, 112 (2d Cir. 1999) ("[T]his Court already has accorded constitutional stature to the right to maintain the confidentiality of previously undisclosed medical information. It follows that prison officials can impinge on that right only to the extent that their actions are 'reasonably related to legitimate penological interests.'" (citing *Doe* v. *City of New York*, 15 F.3d 264, 267 (2d Cir. 1994) and *Washington* v. *Harper*, 494 U.S. 210, 221, 223 (1990)); *Moore* v. *Prevo*, 379 F. App'x 425, 428 (6th Cir. 2010) ("[I]nmates have a Fourteenth Amendment privacy interest in guarding against disclosure of sensitive medical information [specifically HIV status] from other inmates subject to legitimate penological interests.").

* * * *

The Fourth Circuit court of appeals' decision threatens to entrench an antiquated and fear-driven approach to HIV that would jeopardize the constitutional privacy rights of individuals with the virus.

CONCLUSION

The court of appeals' decision warrants this Court's review and reversal.

Respectfully submitted,

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