MINUTES

MONTANA SENATE
54th LEGISLATURE - REGULAR SESSION

COMMITTEE ON PUBLIC HEALTH, WELFARE & SAFETY

Call to Order: By **CHAIRMAN JIM BURNETT**, on January 27, 1995, at 1:08 pm

ROLL CALL

Members Present:
Sen. James H. "Jim" Burnett, Chairman (R)
Sen. Steve Benedict, Vice Chairman (R)
Sen. Sharon Estrada (R)
Sen. Arnie A. Mohl (R)
Sen. Mike Sprague (R)
Sen. Dorothy Eck (D)
Sen. Eve Franklin (D)
Sen. Terry Klampe (D)

Members Excused: Sen. Larry L. Baer (R)
Senator Baer joined meeting later.

Members Absent: None

Staff Present: Susan Fox, Legislative Council
Karolyn Simpson, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Committee Business Summary:
Hearing: SB 17
Executive Action: SB 95

{Tape: 1; Side: 1}

HEARING ON SB 17

Opening Statement by Sponsor:

SENATOR TOM KEATING, SD 5, Billings, said SB 17 deals with HIV, AIDS testing and how it's supposed to fit into the law. Preceding his presentation, he directed attention to the statutes to give a better idea of how the bill fits into the law, and how this bill melds with the law.

The handout with Part 10, that deals with AIDS education and prevention, the first paragraph is a statement of purpose. **EXHIBIT 1.** The whole purpose of SB 17 deals with public health. Consider that AIDS education and prevention is in Part 10 of the

codes. The handout of the general provisions of Part 1, 50-18-101, Sexually Transmitted defined. **EXHIBIT 2.**

SB 17 doesn't do much more than is already in the statutes, with regard to dealing with this infectious disease as a public health matter. The NEW SECTION, Section or SB 17 reads: "It is the intent of the legislature to treat AIDS, HIV-related conditions, and HIV infection in the same manner as other communicable and sexually transmitted diseases, with regard to testing, reporting, partner notification, and disease intervention." SB 17 will move part of the language from the AIDS education and prevention section of the code, to the sexually transmitted disease section of the code. It will remove anonymous testing and will require the public health officers to follow-up on positive HIV tests to notify sexual partners that they have been exposed.

The handout with Part 6, Government Health Care Information, 50-16-603. **EXHIBIT 3.** Confidentiality of health care information is specific. Keep in mind, that confidentiality is written into the statutes. Page 3,(18) of SB 17, "Written informed consent" is deleted. Consent can now be given orally, written consent is not required under this proposal. Under Testing and Counseling (Section 3 of SB 17), there is still a requirement for counseling. Page 4, Ln 25 of SB 17, Consent need not be given. There are some very limited occasions when consent is not needed. It deals with the use of human body parts for research or for transfer of body parts. Still under those two sections, there is not identification of the person whose body parts or blood has been tested. Even though, the person is gone and this has to do with research, there is no identification of the individual. Confidentiality is the byword of this proposal.

When a health care provider or custodial employee of the Department of Corrections and Human Services is exposed to blood or other body fluids that may be HIV infected, consent need not be given. That person can have a test of that fluid without his consent. This is for the public health worker. There are exemptions from consent for medical providers, in certain cases. Those exceptions are very limited and very specific, and confidentiality is maintained.

Confidentiality is explicit on Page 7, Section 4, section 50-16-1009 of SB 17, Confidentiality of records. Health care providers who do the followup after the test are required by law to treat the testing with extreme confidentiality.

Under anonymous testing, a person can go into a clinic or test, not give a name, address, phone number, or any identification at all, given a number, and remain anonymous. The test is taken, then the person can come back and for the results of the test, or they can call on the phone, give their identification number and obtain the results of the tests. If they test positive, there is no obligation for them to reveal their identification, and there is no obligation or requirement for a followup that their sexual partners be notified. Under SB 17, if it is accepted by the legislature, identification would be required in a positive test. The results of the test would then be made known to the public health officer, through the

confidential process. The public health officer then, without revealing the identification of the person, the time, place or any other information about that contact between that person and names of those who have been given as sexual contacts, would then go to those have been exposed and explain to them that they have been exposed to HIV, and suggest that they go get tested. Confidentiality remains throughout.

It is difficult to describe, to the committee, how the public health is threatened by HIV. HIV is a virus. There are 103 strains of the HIV virus and is the fastest mutating virus that is known today. There is no cure. There is no vaccine. It is extremely dangerous. Over 1% of our population is now infected with HIV. He said that he has been told, that the person infected with HIV is most infectious in the early stage of infection. So, time is of the essence of reporting. People must be educated that it is an epidemic - it's serious. All of the public must be aware that HIV is a sexually transmitted disease. It takes a specific decision to engage in an act in which the transmission is possible. Education is important so that people will know what they are being exposed to when they engage in sexuality. Education is essential to protecting the public health.

HIV is not necessarily a homosexual disease. About 70% of those who have tested positive for HIV have engaged in homosexual activity. But it is a heterosexual disease as well. The number of females who are carriers is increasing. Because the virus is transmitted to a fetus, there are children being born who test HIV positive.

Once HIV is in the body, about 10 years later you can expect that the virus will develop into AIDS, with the life expectancy of about 10 years. Most of the people who are infected now are in their late teens and twenties. By age 35, a lot of these individuals will be dead because of this disease.

To those who fear if anonymous testing is no longer available, that somehow they will be exposed to public knowledge, that is not the case - that is not the intent of this legislation. The confidentiality was there long ago when syphilis was put on this list in the 1930's - that was the stigma of the age. Confidentiality was essential to get people to come in for testing to get control of the epidemic. The confidentiality law has never been breached.

SB 17 does not intend any list of names and addresses that would be published, exposed, revealed, or available to casual observers. The information from these tests would be as confidential as medical doctor's file, the privilege of confidentiality between the physician the patient.

Many of those who have tested positive, are concerned about their partners and don't want them to be infected, and want them to be notified and tested. But, there are many more who do not.

He urged consideration of applying SB 17 into the sexually transmitted section of the codes, so that we can have a better handle on this epidemic, the public health officers will do their duty, the state of Montana will fulfill its obligation to the people of the state by protecting them under the public health law.

Proponents' Testimony:

Joanne Shearer,RD, MS read her written testimony in support of SB 17. **EXHIBIT 4.**

Dr. William Wise, an internal medicine physician who recently retired after practicing medicine for 34 years, spoke in support of SB 17. For the last 10 years he worked at the VA hospital at Ft. Harrison, MT, with 6 of those years in the out-patient department. He is President of the Montana Health Alliance, a group of Montanans of medical and interested people who came together 2 years ago.

He read some of the regulations that are on the books in Health and Safety regulations. 50-17-105 on TB. **EXHIBIT 5.** He asked the rhetorical question "How many people have you seen die of TB?" But this regulation is on the books. You don't see anything like that for AIDS, and people are dying from AIDS. There's a very small percentage of those with AIDS that have out-lived the averages. 95% of the people who contract AIDS die.

He continued reading the regulations for TB, 50-17-108. The regulations are for TB, and people rarely die from it. 50-18-101, 50-18 106, 50-18-107, 50-18-112 Sexually Transmitted Diseases. When he worked in the Ft. Harrison VA out-patient department,they saw approximately 20 patients per day in 6-year period, and saw several patients wanting anonymity for HIV testing, but there isn't anonymity in the VA any more than in the military. There is a computerized record of all who enter the VA for treatment.

They explained the differences between anonymity and confidentiality to the patients and the patients were not worried about confidentiality because the information wouldn't get out. He feels that a lot of people are confused about the difference between anonymity and confidentiality.

The Center for Disease Control and Prevention estimates that there are about one million or more people in the U.S. that have HIV, with about 375,000 of those that are known. This means that about 60% of those with HIV, carriers, who don't know they have it, and if they have it, almost all are promiscuous or drug users.

Fifteen years ago AIDS, HIV was not even known. Ten years ago it was defined and record keeping was started. Now it is known that the primary cause of death in men ages 25 to 44 is HIV-AIDS. The fifth most common cause of death in females is HIV-AIDS, and sixth in the 15-24 years olds. AIDS is not stopping it with the present methods.

Ben L. Lindeman, R.N. and Physician Assistant, in Helena spoke in support of SB 17. He has been in some form of medicine for fourteen years, as a orderly, an R.N., and now as a Physician Assistant. During the last fourteen years, he has experienced a great deal of frustration dealing with patients who have HIV or other communicable diseases, the frustration being, educating both those people with disease and those with whom they have had

contact. In clinical practice, many patients don't understand the difference between anonymity and confidentiality. He feels that the medical practitioners in the state of Montana needs to have their hands untied to be able to educate and prevent the spread of AIDS.

Gary Swant, a biology, human anatomy, and sex education instructor at the high school level read his written testimony in support of SB 17. **EXHIBIT 6.**

Diane Hoffman, from Helena, and has been an educator for 24 years, presently teaching in the Helena school system. She is also a wife and mother, has been involved in promoting health and fitness in her classes. For fifteen years, she has served on FOCUS (Friends of Children Under Stress), which approached children's dysfunctions in their lives. She attended the last three HIV-AIDS conferences, the last being the 1994 conference. She read excerpts from a statement from W. Shepherd Smith, of A.S.A.P. (Americans for a Sound AIDS/HIV Policy). **EXHIBIT 7.**

Russ McCurdy, a Respiratory Therapist at St. Peter's Hospital, in Helena spoke in support of SB 17. He feels that, as a health care worker, that health care providers should be assured that testing will be done before being exposed to possible HIV body fluids. As a taxpayer, who ultimately pays for the testing and treatment of AIDS, feels that there needs to be more done for the money being paid in taxes. There needs to be a complete job, rather than a half-way job.

Laurie Koutnik, executive director of Christian Coalition of Montana, read her written testimony in support of SB 17. **EXHIBIT 8.**

Arlette Randash, representing the Eagle Forum spoke in support of SB 17. She read a column from the January 2, 1995 edition of the Independent Record. "Ambulance crews and other emergency medical workers must be told when they handled a person with an infectious disease, even if the workers were not exposed to the disease, Attorney General Joe Mazurek ruled Friday. In a formal opinion, he said the law contains no prerequisite for such notification. Mr. Mazureks's decision, which has the force of law unless overturned by a court, was issued to Bob Robinson, Director of the Department of Health and Environmental Sciences. The list of diseases includes AIDS virus, hepatitis, tuberculosis, meningitis, plague, diphtheria, and rabies. Mr. Mazurek told Robinson that the notification mandate does not conflict with another law protecting the confidentiality of health care information." She feels that if Attorney General Mazurek thinks that ambulance crews and other emergency medical workers deserve that kind of treatment, that the sexual partners of those who are infected deserve it also.

<u>Opponents' Testimony:</u>

Elizabeth Olberding, M.D., a member of the Governor's AIDS Advisory Council, spoke in opposition to SB 17. The council has fourteen members, appointed for Governor Marc Racicot. These members represent many facets of Montana. She read the Position Statement on Anonymous Testing, Written Informed Consent and Partner Notification for HIV infection from the Governor's AIDS Advisory Council. **EXHIBIT 9.**

She feels that if the point of SB 17 is to improve public health, it will not do so. If people do not come in for testing, then those who have HIV-AIDS will not be known. The fear level for this disease still exists and education is important. It's very important to get people in for testing. If anonymous testing is eliminated, as was shown in Oregon, does not work. There is no data available to show what happens when testing is confidential rather than anonymous.

Joan Miles, Lewis & Clark County Health Officer and Director of the City/County Public Health Department, testified against SB 17. She feels that SB 17 will not protect the public health. There are two reasons that HIV infection cannot be treated like other communicable and sexually transmitted diseases. First, it doesn't act like other diseases. People can walk around, asymptomatic for years, unlike other sexually transmitted diseases where people can have lesions, are sick, and know they have the disease and come in for treatment. People who have HIV can walk around asymptomatic, and will never come in for testing unless they know they can come in anonymously. HIV-AIDS does not have a cure and nothing can be done to improve the status of people who have the infection. As a public health worker, she encourages people to come in for testing, encourages them to let her know who their partners are, and teach them ways to minimize the spread of the disease. She said that another reason that AIDS cannot be treated like other sexually transmitted disease is that the victims who have HIV are not treated like the victims of other diseases. There is a great stigma attached. Unless people can get past the fear of not remaining anonymous, they won't come in for testing. She gave some state-wide statistics for 1994. More people come in for testing when the tests are anonymous.

{Tape: 1; Side: B}

Kathy Hayes, R.N., employed by the Missoula County Health Department as a Disease Intervention specialist with the AIDS program, read her written testimony in opposition to SB 17. **EXHIBIT 10.**

Brien Barnett, representing the Associated Students of the University of Montana, in Missoula, read his written testimony in opposition to SB 17. **EXHIBIT 11.**

James Christensen, a Montana native and has AIDS, read his written testimony in opposition to SB 17. **EXHIBIT 12.**

Dr. Connie O'Conner, a General Practitioner at the Leo Pocha Clinic in Helena and a member of the Governor's AIDS Advisory Council, spoke in opposition to SB 17. Accounting for more than 7% of Montana's population, people of color account for 13% of Montana's AIDS cases. 23% of female AIDS cases in Montana are Native Americans. The numbers are increasing and minority populations are disproportionately affected by this disease. The Leo Pocha Clinic is an urban clinic funded by the Indian Health Service. They offer confidential HIV testing to their patients and do about forty tests per year on Indian people. Eighteen patients had anonymous test done at the Lewis and Clark Health Department in a year. About one-third of the tests on Indian people in Helena were done anonymously, knowing there was a confidential site available. Many times, they hear from their patients that they come to the urban clinic because confidentiality on the reservations is a problem. Everyone knows everyone else's business. Data has shown that Indian people choose anonymous testing even when confidential testing is available.

She said that doctors are being sued for breaches of confidentiality with respect to HIV disease. Because the cases are settled out of court, there are no numbers available to support this.

She feels that informed consent in writing is very important for HIV testing. Written informed consent verifies that the patient is aware of risk of the given procedure. With this test, the patient must be informed that a negative test today may not be valid if he was exposed to HIV during a high-risk behavior three weeks ago. If he is not informed, he may assume that he is negative and never return for retesting, which may delay the treatment and put others at risk. Written informed consent protects physicians from legal action if the patient claims he was not told by the doctor about the test. She thinks the best way to get people to come for testing is to offer them a choice between confidential and anonymous testing.

SENATOR BAER came in to meeting.

Sharon Howard, Public Health Nurse, with twenty years of experience in the state of Montana, read her written testimony in opposition to SB 17. **Exhibit 13.**

REP. CARLEY TUSS, HD 47, Black Eagle,in Great Falls, MT spoke in opposition to SB 17. She said that anonymous testing in an acute care setting is very important. In her work with risk management, with a background in nursing, she often tests employees who have inadvertently been stuck and tests the patients whose blood was involved. For them, she offers anonymous testing because of the possibility of erroneous reports going to insurance companies, and the resulting negative consequences.

Questions From Committee Members and Responses:

SENATOR FRANKLIN asked about what is currently being done in practice for contact and interviewing.

Kathy Hayes said that when someone comes into an anonymous testing site, a number is given, no name is given. When the individual comes back for the results, and if the result is positive, the public health worker talks to the individual about the disease, and how can they protect their partner. The individual can give only the information that they wish to divulge.

SENATOR KLAMPE asked how, under SB 17, would the public health officer know the name of the individual being tested.

SENATOR KEATING replied that at the time of testing the name of the person would be revealed to the doctor, medical provider or tester. If the test is positive, the public health office would be notified of the carrier, with name and address. The public health officer would then interview the individual to obtain the names and addresses of the partners.

SENATOR BAER asked about the difference between the confidentiality given to HIV positive patient now, and does it differ from what is proposed in SB 17.

SENATOR KEATING replied that Part 6, Government Health Care Information, Communicable Diseases 50-16-603, confidentiality of health care information. Confidentiality is written into the law.

David Herrera, an HIV and AIDS counselor from Billings replied that with the issue of confidentiality, the concern is really with anonymity. With anonymity the individual has a guarantee that there will not be a breach in confidentiality. Most people with HIV receive services, not anonymously, but they do build trust with their provider and give names. Most people realize that there is confidentiality in the health care system, but testing was set up on an anonymous basis to encourage people to come in for testing.

SENATOR SPRAGUE asked what can be offered to those who test positive for HIV.

Dr. Elizabeth Olberding replied that it's necessary to get people in for testing and education about modifying high risk behaviors. There are treatments available for those who are HIV positive and asymptomatic that may or may not be useful, but there are medications that can be offered that will decrease the risk of contracting some of the opportunistic infections.

SENATOR SPRAGUE asked if the risk of identification would be offset by the medical treatment available.

Dr. Olberding responded "Yes,removing the fear and getting someone to access and developing a relationship with a provider." The fear is great, but if someone comes in and education is provided, so they can handle the situation better, and have a contact person to deal with.

SENATOR KLAMPE referred to page 5, Part C of SB 17, when a health care provider is exposed to blood or other body fluids that may be affected. He asked who determines whether the sample should be tested.

SENATOR KEATING replied that he did not have an answer to that question.

Closing by Sponsor:

SENATOR KEATING said that there are both citizens and medical people on both sides of the issue. He referred to the statute Part 1, 50-18-101, Sexually transmitted diseases. HIV is the causal virus of AIDS, is a sexually transmitted disease, and should be treated as such. There are specific directions in subsequent sections of the codes specifying powers and duties of the public health officers. Section 50-18-105, the Department of Health and Environmental Sciences has the duty and obligation to promogate rules dealing the HIV. SB 17 will remove the anonymous testing and informed written consent, which are the things that create the fear of this bill. The question is confidentiality and anonymity. Because of anonymity, the numbers of those infected with HIV and the spread are estimates. Anonymity allows some to fall through the cracks. Under confidentiality, the concern is that with those who are now testing anonymously will no longer test because they are afraid that confidentiality won't work. What needs to be decided, is anonymity the way to go or is confidentiality the way to go. Education and knowledge are the things that are needed to educate against this epidemic, with imperial data being necessary for this. It is important to know the carrier so the partners can be notified. Early detection is not a cure but it is helpful. He feels that with confidentiality, there can be early response to notify the partners that they have been exposed, then be tested, and can then notify their partners, so that at some point the spread of this disease can be interdicted. The most important thing that can be done is education about this disease, and how to protect against it. Getting rid of anonymity, and imposing confidentiality is the best way to go, with regards to protecting all of the people against this disease.

EXECUTIVE ACTION ON SB 95

Motion/Vote: **SENATOR BENEDICT moved the AMENDMENTS to SB 95 DO PASS. The motion CARRIED UNANIMOUSLY.**

ADJOURNMENT

Adjournment: 2:50 PM

JIM BURNETT, Chairman

KAROLYN SIMPSON, Secretary

JB/ks

MONTANA SENATE
1995 LEGISLATURE
PUBLIC HEALTH, WELFARE AND SAFETY COMMITTEE

ROLL CALL DATE 1/27/95

NAME	PRESENT	ABSENT	EXCUSED
LARRY BAER			X
SHARON ESTRADA	X		
ARNIE MOHL	X		
MIKE SPRAUGE	X		
DOROTHY ECK	X		
EVE FRANKLIN	X		
TERRY KLAMPE	X		
STEVE BENEDICT, VICE CHAIRMAN	X		
JIM BURNETT, CHAIRMAN	X		

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SENATE STANDING COMMITTEE REPORT

January 27, 1995

MR. PRESIDENT:

We, your committee on Public Health, Welfare, and Safety having had under consideration SB 95 (first reading copy -- white), respectfully report that SB 95 be amended as follows and as so amended do pass.

Signed: Jim Burnett
Senator Jim Burnett, Chair

That such amendments read:

1. Page 5, line 2.
Following: "15,"
Insert: "or a person practicing pursuant to 37-15-305"

2. Page 5, line 24.
Strike: "a qualifying"
Insert: "the practical or written"

3. Page 5, line 25.
Following: "required to"
Insert: ": (a)"
Following: "37-16-402"
Insert: ";
(b) take a test of the applicant's knowledge of the provisions of Title 37, chapter 16, and applicable rules;"
Following: "and"
Insert: "(c)"

-END-

Amd. Coord.
Sec. of Senate

(4) specify recommended medical precautions and treatment for each infectious disease subject to this part.

History: En. Sec. 4, Ch. 390, L. 1989; amd. Sec. 5, Ch. 476, L. 1993.

Compiler's Comments

1993 Amendment: Chapter 476 in three places, before "exposure", deleted "unprotected".

50-16-706 through 50-16-710 reserved.

50-16-711. Health care facility and emergency services organization responsibilities for tracking exposure to infectious disease. (1) The health care facility and the emergency services organization shall develop internal procedures for implementing the provisions of this chapter and department rules.

(2) The health care facility shall have available at all times a person to receive the form provided for in 50-16-702 containing a report of exposure to infectious disease.

(3) The health care facility shall designate an infectious disease control officer and an alternate who will be responsible for maintaining the required records and notifying designated officers in accordance with the provisions of this chapter and the rules promulgated under this chapter.

(4) The emergency services organization shall name a designated officer and an alternate.

History: En. Sec. 7, Ch. 476, L. 1993.

Parts 8 and 9 reserved

Part 10
AIDS Education and Prevention

Part Cross-References
Right of privacy guaranteed, Art. II, sec. 10, Mont. Const.
Uniform health care information, Title 50, ch. 16, part 5.

SENATE HEALTH & WELFARE
EXHIBIT NO. 1
DATE 1/27/95
BILL NO. SB 17

50-16-1001. Short title. This part may be cited as the "AIDS Prevention Act".

History: En. Sec. 1, Ch. 614, L. 1989.

50-16-1002. Statement of purpose. (1) The legislature recognizes that the epidemic of human immunodeficiency virus (HIV) infection, the causative agent of acquired immune deficiency syndrome (AIDS), and related medical conditions constitutes a serious danger to the public health and welfare. In the absence of a vaccine or a cure and because of the sexual and intravenous drug use behaviors by which the virus is predominately spread, control of the epidemic is dependent on the education of those infected or at risk for infection.

(2) It is the intent of the legislature that education directed at preventing the transmission of HIV be provided to those infected and at risk of infection and to entreat such persons to come forward to determine their HIV infection status and to obtain appropriate education.

History: En. Sec. 2, Ch. 614, L. 1989.

50-16-1003. Definitions. As used in this part, the following definitions apply:

(1) "AIDS" means acquired immune deficiency syndrome as further defined by the department in accordance with standards promulgated by the centers for disease control of the United States public health service.

(2) "Contact" means:

(a) an individual identified by the subject of an HIV-related test as a past or present sexual partner or as a person with whom the subject has shared hypodermic needles or syringes; or

(b) any other person who has been exposed to the test subject in a manner, voluntary or involuntary, that may allow HIV transmission in accordance with modes of transmission recognized by the centers for disease control of the United States public health service.

(3) "Department" means the department of health and environmental sciences provided for in 2-15-2101.

(4) "Health care facility" means a health care institution, private or public, including but not limited to a hospital, nursing home, clinic, blood bank, blood center, sperm bank, or laboratory.

(5) "Health care provider" means a person who is licensed, certified, or otherwise authorized by the laws of this state to provide health care in the ordinary course of business or practice of a profession. The term does not include a person who provides health care solely through the sale or dispensing of drugs or medical devices.

(6) "HIV" means the human immunodeficiency virus, identified as the causative agent of AIDS, and all HIV and HIV-related viruses that damage the cellular branch of the human immune or neurological systems and leave the infected person immunodeficient or neurologically impaired.

(7) "HIV-related condition" means a chronic disease resulting from infection with HIV, including but not limited to AIDS and asymptomatic seropositivity for HIV.

(8) "HIV-related test" means a test approved by the federal food and drug administration, including but not limited to an enzyme immunoassay and a western blot, that is designed to detect the presence of HIV or antibodies to HIV.

(9) "Legal guardian" means a person appointed by a court to assume legal authority for another who has been found incapacitated or, in the case of a minor, a person who has legal custody of the minor.

(10) "Local board" means a county, city, city-county, or district board of health.

(11) "Local health officer" means a county, city, city-county, or district health officer appointed by the local board.

(12) "Next of kin" means an individual who is a parent, adult child, grandparent, adult sibling, or legal spouse of a person.

(13) "Person" means an individual, corporation, organization, or other legal entity.

(14) "Posttest counseling" means counseling, conducted at the time the HIV-related test results are given, and includes, at a minimum, written materials provided by the department.

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EXHIBIT 1
DATE 1-27-95
SB 17

(15) "Pretest counseling" means the provision of counseling to the subject prior to conduct of an HIV-related test, including, at a minimum, written materials developed and provided by the department.

(16) "Release of test results" means a written authorization for disclosure of HIV-related test results that:

(a) is signed and dated by the person tested or the person authorized to act for the person tested; and

(b) specifies the nature of the information to be disclosed and to whom disclosure is authorized.

(17) "Significant other" means an individual living in a current spousal relationship with another individual but who is not legally a spouse of that individual.

(18) (a) "Written informed consent" means an agreement in writing that is freely executed by the subject of an HIV-related test, by the subject's legal guardian, or, if there is no legal guardian and the subject is unconscious or otherwise mentally incapacitated, by the subject's next of kin, significant other, or a person designated by the subject in hospital records to act on the subject's behalf, and that includes at least the following:

(i) an explanation of the test, including its purpose, potential uses, limitations, and the meaning of its results;

(ii) an explanation of the procedures to be followed for confidentiality, blood drawing, and counseling, including notification that the test is voluntary and that consent may be withdrawn at any time until the blood sample is taken;

(iii) an explanation of whether and to whom the subject's name and test results may be disclosed;

(iv) a statement that the test may be obtained anonymously if the subject wishes;

(v) the name and address of a health care provider whom the subject approves to receive the subject's test results and to provide the subject with posttest counseling; and

(vi) if the consent is for a test being performed as part of an application for insurance, a statement that only a positive test result will be reported to the designated health care provider and that negative test results may be obtained by the subject from the insurance company.

(b) The department shall develop a form agreement that may be used for purposes of this subsection.

History: En. Sec. 3, Ch. 614, L. 1989; amd. Sec. 1, Ch. 544, L. 1991.

50-16-1004 through 50-16-1006 reserved.

50-16-1007. Testing — counseling — informed consent — penalty. (1) An HIV-related test may be ordered only by a health care provider and only after receiving the written informed consent of:

(a) the subject of the test;

(b) the subject's legal guardian;

(c) the subject's next of kin or significant other if:

(i) the subject is unconscious or otherwise mentally incapacitated;

(ii) there is no legal guardian;

(iii) there are medical indications of an HIV-related condition; and

(iv) the test is advisable in order to determine the proper course of treatment of the subject; or

(d) the subject's next of kin or significant other or the person, if any, designated by the subject in hospital records to act on the subject's behalf if:

(i) the subject is in a hospital; and

(ii) the circumstances in subsections (1)(c)(i) through (1)(c)(iv) exist.

(2) When a health care provider orders an HIV-related test, the provider also certifies that informed consent has been received prior to ordering an HIV-related test.

(3) Before the subject of the test executes an informed consent agreement, the health care provider ordering the test or the provider's designee must give pretest counseling to:

(a) the subject;

(b) the subject's legal guardian;

(c) the subject's next of kin or significant other if:

(i) the subject is unconscious or otherwise mentally incapacitated; and

(ii) there is no guardian; or

(d) the subject's next of kin or significant other or the person, if any, designated by the subject in hospital records to act on the subject's behalf if:

(i) the subject is in the hospital; and

(ii) the circumstances in subsections (1)(c)(i) and (1)(c)(ii) exist.

(4) A health care provider who does not provide HIV-related tests on an anonymous basis shall inform each person who wishes to be tested that anonymous testing is available at one of the counseling-testing sites established by the department, or elsewhere.

(5) The subject of an HIV-related test or any of the subject's representatives authorized by subsection (1) to act in the subject's stead shall designate, as part of a written informed consent, a health care provider to receive the results of an HIV-related test. The designated health care provider shall inform the subject or the subject's representative of the results in person.

(6) At the time the subject of a test or the subject's representative is given the test results, the health care provider or the provider's designee shall give the subject or the subject's representative posttest counseling.

(7) If a test is performed as part of an application for insurance, the insurance company must ensure that:

(a) negative results can be obtained by the subject or the subject's representative upon request; and

(b) positive results are returned to the health care provider designated by the subject or the subject's representative.

(8) A minor may consent or refuse to consent to be the subject of an HIV-related test, pursuant to 41-1-402.

(9) Subsections (1) through (6) do not apply to:

(a) the performance of an HIV-related test by a health care provider or health care facility that procures, processes, distributes, or uses a human body part donated for a purpose specified under Title 72, chapter 17, if the test is necessary to assure medical acceptability of the gift for the purposes intended;

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(b) the performance of an HIV-related test for the purpose of research if the testing is performed in a manner by which the identity of the test subject is not known and may not be retrieved by the researcher;

(c) the performance of an HIV-related test when:

(i) the subject of the test is unconscious or otherwise mentally incapacitated;

(ii) there are medical indications of an HIV-related condition;

(iii) the test is advisable in order to determine the proper course of treatment of the subject; and

(iv) none of the individuals listed in subsection (1)(b), (1)(c), or (1)(d) exists or is available within a reasonable time after the test is determined to be advisable; or

(d) the performance of an HIV-related test conducted pursuant to 50-18-107 or 50-18-108, with the exception that the pretest and posttest counseling must still be given.

(10) (a) If an agent or employee of a health care facility, a health care provider with privileges at the health care facility, or a person providing emergency services who is described in 50-16-702 has been voluntarily or involuntarily exposed to a patient in a manner that may allow infection by HIV by a mode of transmission recognized by the centers for disease control of the United States public health service, the physician of the patient shall, upon request of the exposed person, notify the patient of the exposure and seek written informed consent in accordance with guidelines of the centers for disease control for an HIV-related test of the patient. If written informed consent cannot be obtained, the health care facility, in accordance with the infectious disease exposure guidelines of the health care facility, may, without the consent of the patient, conduct the test on previously drawn blood or previously collected bodily fluids to determine if the patient is in fact infected. A health care facility is not required to perform a test authorized in this subsection. If a test is conducted pursuant to this subsection, the health care facility shall inform the patient of the results and provide the patient with posttest counseling. The patient may not be charged for a test performed pursuant to this subsection. The results of a test performed pursuant to this subsection may not be made part of the patient's record and are subject to 50-16-1009(1).

(b) For the purposes of this subsection, "written informed consent" means an agreement in writing that is freely executed by the subject of an HIV-related test, by the subject's legal guardian, or, if there is no legal guardian and the subject is incapacitated, by the subject's next of kin, significant other, or a person designated by the subject in hospital records to act on the subject's behalf.

(11) A knowing or purposeful violation of this section is a misdemeanor punishable by a fine of $1,000 or imprisonment for up to 6 months, or both.

History: En. Sec. 4, Ch. 614, L. 1989; amd. Sec. 2, Ch. 544, L. 1991; amd. Sec. 6, Ch. 476, L. 1993.

Compiler's Comments

1993 Amendment: Chapter 476 in (10)(a) deleted reference to subsection (1) of 50-16-702; and made minor changes in style.

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50-16-1008. Testing of donors of organs, tissues, and semen required — penalty. (1) Prior to donation of an organ, semen, or tissues, HIV-related testing of a prospective donor, in accordance with nationally accepted standards adopted by the department by rule, is required unless the transplantation of an indispensable organ is necessary to save a patient's life and there is not sufficient time to perform an HIV-related test.

(2) A knowing or purposeful violation of this section is a misdemeanor punishable by a fine of up to $1,000 or imprisonment of up to 6 months, or both.

History: En. Sec. 5, Ch. 614, L. 1989; amd. Sec. 3, Ch. 544, L. 1991.

Cross-References

Uniform Anatomical Gift Act, Title 72, ch. 17.

50-16-1009. Confidentiality of records — notification of contacts — penalty for unlawful disclosure. (1) Except as provided in subsection (2), a person may not disclose or be compelled to disclose the identity of a subject of an HIV-related test or the results of a test in a manner that permits identification of the subject of the test, except to the extent allowed under the Uniform Health Care Information Act, Title 50, chapter 16, part 5.

(2) A local board, local health officer, or the department may disclose the identity of the subject of an HIV-related test or the test results only to the extent allowed by the Government Health Care Information Act, Title 50, chapter 16, part 6, unless it is in possession of that information because a health care provider employed by it provided health care to the subject, in which case the Uniform Health Care Information Act governs the release of that information.

(3) If a health care provider informs the subject of an HIV-related test that the results are positive, the provider shall encourage the subject to notify persons who are potential contacts. If the subject is unable or unwilling to notify all contacts, the health care provider may ask the subject to disclose voluntarily the identities of the contacts and to authorize notification of those contacts by a health care provider. A notification may state only that the contact may have been exposed to HIV and may not include the time or place of possible exposure or the identity of the subject of the test.

(4) A person who discloses or compels another to disclose confidential health care information in violation of this section is guilty of a misdemeanor punishable by a fine of $1,000 or imprisonment for 1 year, or both.

History: En. Sec. 6, Ch. 614, L. 1989; amd. Sec. 4, Ch. 544, L. 1991.

50-16-1010 through 50-16-1012 reserved.

50-16-1013. Civil remedy. (1) A person aggrieved by a violation of this part has a right of action in the district court and may recover for each violation:

(a) against a person who negligently violates a provision of this part, damages of $5,000 or actual damages, whichever is greater;

(b) against a person who intentionally or recklessly violates a provision of this part, damages of $20,000 or actual damages, whichever is greater;

(c) reasonable attorney fees; and

(d) other appropriate relief, including injunctive relief.

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(2) An action under this section must be commenced within 3 years after the cause of action accrues.

(3) The department may maintain a civil action to enforce this part in which the court may order any relief permitted under subsection (1).

(4) Nothing in this section limits the rights of a subject of an HIV-related test to recover damages or other relief under any other applicable law or cause of action.

(5) Nothing in this part may be construed to impose civil liability or criminal sanctions for disclosure of an HIV-related test result in accordance with any reporting requirement for a diagnosed case of AIDS or an HIV-related condition by the department or the centers for disease control of the United States public health service.

History: En. Sec. 7, Ch. 614, L. 1989; amd. Sec. 5, Ch. 544, L. 1991.

Cross-References

Statutes of Limitations, Title 27, ch. 2.

CHAPTER 17

TUBERCULOSIS CONTROL

Part 1 — General Provisions

Part 1
General Provisions

Part Cross-References

Municipal power to establish detention hospital to prevent spread of disease, 7-34-4101.

Montana State Hospital, 53-21-601.

Quarantine for tuberculosis control in livestock, Title 81, ch. 2, part 1.

50-17-101. Policy of state. It is the public policy of the state to:

(1) protect persons from the danger of tuberculosis;

(2) provide and maintain a comprehensive program for the prevention, abatement, and adequate control working toward eradication of the disease;

(3) cooperate with other state agencies and the federal government in

to witnesses the same fees and mileage provided for attendance in court;

to persons other than the sheriff or his deputies who transport a person om a hospital, witness fees and expenses as verified by the court.

Expenses of transporting a person to a hospital for commitment shall d from the general fund of the county from which the person is ted.

ory: (1), (2)En. Sec. 38, Ch. 197, L. 1967; Sec. 69-4315, R.C.M. 1947; (3)En. Sec. 39, L. 1967; amd. Sec. 46, Ch. 349, L. 1974; Sec. 69-4316, R.C.M. 1947; R.C.M. 1947, 69-4316(part).

eferences

age allowance, 2-18-503, 2-18-504, .

Mileage and expenses of Sheriff, 7-32-2143.

Witness fees, Title 26, ch. 2, part 5.

17-115. Emergency detainment — petition — detention. (1) If a an, the department, or a local health officer reasonably believes that on has communicable tuberculosis and that he is likely to attempt to he jurisdiction to avoid a hearing on commitment to a hospital, the an, department, or local health officer shall notify the sheriff of the in which the person is found, who shall cause the person to be detained ospital. At least by the next regular business day, the physician, ment, or local health officer shall petition for an order from the district f the county in which the person is found for continued detention of the and to require examination or treatment for tuberculosis pursuant to 105. The sheriff must serve the summons required by 50-17-106 on the the same day the petition is filed.

Immediately after the petition is filed the court will decide whether r emergency detention is required and may order continued hospital ion of the person for no more than 7 days if it finds that the person is cceptable danger to the public health and safety in that he probably mmunicable tuberculosis and unless detained will probably leave the ction to avoid a hearing pursuant to this part.

The district court of the county in which the person is found has ction over the person for the purposes of this section. The district court n the interests of justice, order that jurisdiction over further proceed- e transferred to the district court of the county of the person's residence.

tory: En. Sec. 1, Ch. 460, L. 1989.

CHAPTER 18

SEXUALLY TRANSMITTED DISEASES

Part 1 — General Provisions

X SENATE HEALTH & WELFARE

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Part 1 General Provisions

50-18-101. Sexually transmitted diseases defined. Human immunodeficiency virus (HIV), syphilis, gonorrhea, chancroid, chlamydia genital infections, lymphogranuloma venereum, and granuloma inguinale are sexually transmitted diseases. Sexually transmitted diseases are contagious, infectious, communicable, and dangerous to public health.

History: En. Sec. 97, Ch. 197, L. 1967; R.C.M. 1947, 69-4601(part); amd. Sec. 1, Ch. 440, L. 1989; amd. Sec. 2, Ch. 71, L. 1993.

Compiler's Comments

1993 Amendment: Chapter 71 at beginning substituted "Human immunodeficiency virus (HIV)" for "Acquired immunodeficiency syndrome (AIDS)". Amendment effective February 23, 1993.

50-18-102. Powers and duties of department. The department of health and environmental sciences shall undertake to prevent, control, and prescribe treatments for sexually transmitted diseases and may conduct education campaigns for this purpose.

History: En. Sec. 98, Ch. 197, L. 1967; amd. Sec. 57, Ch. 349, L. 1974; R.C.M. 1947, 69-4602(part); amd. Sec. 2, Ch. 440, L. 1989.

50-18-103. Cooperation with federal agencies — federal funds. (1) The department of health and environmental sciences shall cooperate with federal agencies and may expend federal funds made available to the state for the prevention, control, and treatment of sexually transmitted diseases.

(2) The department may accept federal funds available for the prevention, control, and treatment of sexually transmitted diseases, deposit funds in the state treasury, and disburse the funds.

History: En. Secs. 98, 99, Ch. 197, L. 1967; amd. Secs. 57, 58, Ch. 349, L. 1974; R.C.M. 1947, 69-4602(part), 69-4603; amd. Sec. 3, Ch. 440, L. 1989.

50-18-104. Serological test for syphilis. (1) The department of health and environmental sciences shall approve a standard serological test for syphilis. It shall also approve laboratories which may make such tests.

(2) On request the department shall make laboratory tests required by this chapter.

History: En. Sec. 107, Ch. 197, L. 1967; R.C.M. 1947, 69-4611; amd. Sec. 1, Ch. 41, L. 1985; amd. Sec. 4, Ch. 440, L. 1989.

50-18-105. Rules of department binding. Rules adopted by the department of health and environmental sciences for carrying out the provisions of this chapter are binding on all persons and have the effect of law.

History: En. Sec. 112, Ch. 197, L. 1967; amd. Sec. 107, Ch. 349, L. 1974; R.C.M. 1947, 69-4616.

Cross-References
Adoption and publication of rules, Title 2, ch. 4, part 3.

50-18-106. Duty to report cases. If a physician or other person knows or has reason to suspect that a person who has a sexually transmitted disease is conducting himself in a way which might expose another to infection, he shall immediately notify the local health officer of the name and address of the diseased person and the essential facts in the case.

History: En. Secs. 100, 103, Ch. 197, L. 1967; R.C.M. 1947, 69-4604, 69-4607; amd. Sec. 5, Ch. 440, L. 1989.

Cross-References
Physicians to report cases of communicable disease, 37-2-301.

50-18-107. Powers and duties of health officers. (1) If found necessary or desirable to protect public health, state and local health officers or their authorized deputies or agents shall:

(a) examine or have examined persons reasonably suspected of being infected with a sexually transmitted disease;

(b) require persons infected to report for treatment to a reputable physician and continue treatment, which may be at public expense, until cured;

(c) isolate or quarantine persons who refuse examination or treatment;

(d) investigate sources of infection of a sexually transmitted disease.

(2) No one but the state or local health officer may terminate the isolation or quarantine. Examinations may be made repeatedly as deemed advisable or desirable.

History: En. Sec. 101, Ch. 197, L. 1967; R.C.M. 1947, 69-4605; amd. Sec. 6, Ch. 440, L. 1989.

50-18-108. Examination and treatment of prisoners. Any person confined or imprisoned in any state, county, or municipal prison within the state may be examined for a sexually transmitted disease. If infected, the person must be treated by health authorities.

History: En. Sec. 102, Ch. 197, L. 1967; R.C.M. 1947, 69-4606; amd. Sec. 7, Ch. 440, L. 1989.

Cross-References
County jails, Title 7, ch. 32, part 22.
Municipal jails, Title 7, ch. 32, part 42.
State corrections, Title 53, ch. 30.

50-18-109. Permissible release of information concerning infected persons. (1) Information concerning persons infected or reasonably suspected to be infected with a sexually transmitted disease may be released only:

(a) to personnel of the department of health and environmental sciences;

(b) to a physician who has written consent of the person whose record is requested;

(c) to a local health officer; or

(d) by the department of health and environmental sciences or a local health officer or board under the circumstances allowed by Title 50, chapter 16, part 6.

(2) For the purposes of this section, the term "information" includes all knowledge or intelligence and all communications of all knowledge or intelligence, oral or written or in record form, and also includes but is not limited to information concerning the location or nature of the activities or work of all local, state, or federal employees or officers engaged in sexually transmitted disease eradication work, and such personnel are privileged.

(3) The purpose of this section is to protect and preserve the principle of confidentiality in sexually transmitted disease work by public personnel, local, state, and federal, such confidentiality being all important to the success of all sexually transmitted disease eradication work and endeavor, and to require that the principle of confidentiality in such work remain inviolate.

History: En. Sec. 106, Ch. 197, L. 1967; amd. Sec. 1, Ch. 135, L. 1971; amd. Sec. 109, Ch. 349, L. 1974; R.C.M. 1947, 69-4610; amd. Sec. 8, Ch. 440, L. 1989.

Cross-References
Right of privacy guaranteed, Art. II, sec. 10, Mont. Const.

50-18-110. Unlawful dispensing of drugs for cure or alleviation of sexually transmitted disease. It is unlawful to prescribe, sell, or recommend any drugs, medicines, or other substances for the cure or alleviation of a sexually transmitted disease except upon prescription signed by a person legally authorized to do so by the pharmacy laws of this state.

History: En. Sec. 104, Ch. 197, L. 1967; R.C.M. 1947, 69-4608; amd. Sec. 9, Ch. 440, L. 1989.

Cross-References
Licensing of physicians, Title 37, ch. 3, part 3.

50-18-111. Certificate of freedom from sexually transmitted disease not to be issued. No person shall issue a certificate of freedom from a sexually transmitted disease. However, a physician or health officer may issue a statement of freedom from diseases in an infectious state only if it is written in such form or given under safeguards that will prevent its use in solicitation for sexual intercourse. These statements shall not be used for solicitation for immoral purposes.

History: En. Sec. 105, Ch. 197, L. 1967; R.C.M. 1947, 69-4609; amd. Sec. 10, Ch. 440, L. 1989.

50-18-112. Infected person not to expose another to sexually transmitted disease. A person infected with a sexually transmitted disease may not knowingly expose another person to infection.

History: En. Sec. 97, Ch. 197, L. 1967; R.C.M. 1947, 69-4601(part); amd. Sec. 11, Ch. 440, L. 1989.

50-18-113. Violation a misdemeanor. A person who violates provisions of this chapter or rules adopted by the department of health and environmental sciences concerning a sexually transmitted disease or who fails or refuses to obey any lawful order issued by a state or local health officer is guilty of a misdemeanor.

History: En. Sec. 113, Ch. 197, L. 1967; amd. Sec. 107, Ch. 349, L. 1974; R.C.M. 1947, 69-4617; amd. Sec. 12, Ch. 440, L. 1989.

Cross-References
Penalty when none specified, 46-18-212.

(7) If a plaintiff prevails, the court may assess reasonable attorney fees and all other expenses reasonably incurred in the litigation.

(8) An action under this part is barred unless the action is commenced within 3 years after the cause of action accrues.

History: En. Sec. 25, Ch. 632, L. 1987.

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Part 6
Government Health Care Information

50-16-601. Short title. This part may be cited as the "Government Health Care Information Act".

History: En. Sec. 1, Ch. 481, L. 1989.

50-16-602. Definitions. As used in this part, unless the context requires otherwise, the following definitions apply:

(1) "Department" means the department of health and environmental sciences provided for in Title 2, chapter 15, part 21.

(2) "Health care information" means information, whether oral or recorded in any form or medium, that identifies or can readily be associated with the identity of an individual, including one who is deceased, and relates to that individual's health care or status. The term includes any record of disclosures of health care information and any information about an individual received pursuant to state law or rules relating to communicable disease. The term does not include vital statistics information gathered under Title 50, chapter 15.

(3) "Local board" means a county, city, city-county, or district board of health provided for in Title 50, chapter 2, part 1.

(4) "Local health officer" means a county, city, city-county, or district health officer appointed by a local board.

History: En. Sec. 2, Ch. 481, L. 1989.

Cross-References
Uniform health care information — definition of health care information, 50-16-504.

50-16-603. Confidentiality of health care information. Health care information in the possession of the department, a local board, a local health officer, or their authorized representatives may not be released except:

(1) for statistical purposes, if no identification of individuals can be made from the information released;

(2) when the health care information pertains to a person who has given written consent to the release and has specified the type of information to be released and the person or entity to whom it may be released;

(3) to medical personnel in a medical emergency as necessary to protect the health, life, or well-being of the named person;

(4) as allowed by Title 50, chapters 17 and 18;

(5) to another state or local public health agency, including those in other states, whenever necessary to continue health services to the named person or to undertake public health efforts to prevent or interrupt the transmission of a communicable disease;

(6) in the case of a minor, as required by 41-3-201 or pursuant to an investigation under 41-3-202. If the health care information is required in a subsequent court proceeding involving child abuse, the information may be disclosed only in camera and documents containing the information must be sealed by the court upon conclusion of the proceedings.

(7) to medical personnel, the department, a local health officer or board, or a district court when necessary to implement or enforce state statutes or state or local health rules concerning the prevention or control of diseases designated as reportable pursuant to 50-1-202, if the release does not conflict with any other provision contained in this part.

History: En. Sec. 3, Ch. 481, L. 1989.

Cross-References
Uniform health care information, Title 50, ch. 16, part 5.

50-16-604. Secondary release of health care information. Information released pursuant to 50-16-603 may not be released by the person or entity it is released to unless the release conforms to the requirements of 50-16-603.

History: En. Sec. 4, Ch. 481, L. 1989.

50-16-605. Judicial, legislative, and administrative proceedings — testimony. (1) An officer or employee of the department may not be examined in a judicial, legislative, administrative, or other proceeding about the existence or content of records containing individually identifiable health care information, including the results of investigations, unless all individuals whose names appear in the records give written consent to the release of information identifying them.

(2) Subsection (1) does not apply if the health care information is to be released pursuant to 50-16-603(7).

History: En. Sec. 5, Ch. 481, L. 1989.

Cross-References
Uniform health care information — when available by compulsory process, 50-16-535.

50-16-606. Correlation with Uniform Health Care Information Act. Health care information in the possession of a local board, local health officer, or the department because a health care provider employed by any of these entities provided health care to a patient, either individually or at a public health center or other publicly owned health care facility, is subject to the Uniform Health Care Information Act and not subject to this part.

History: En. Sec. 1, Ch. 432, L. 1991.

Cross-References
Uniform Health Care Information Act, Title 50, ch. 16, part 5.

50-16-607 through 50-16-610 reserved.

50-16-611. Penalty. A person who knowingly violates the provisions of this part is guilty of a misdemeanor and upon conviction shall be fined not less than $500 or more than $10,000, be imprisoned in the county jail not less than 3 months or more than 1 year, or both.

History: En. Sec. 6, Ch. 481, L. 1989.

Cross-References
Uniform health care information — criminal penalty, 50-16-551.

TESTIMONY IN SUPPORT OF SB 17
AN ACT TO TREAT HIV INFECTION AS OTHER STDS

Submitted by: Joanne Shearer RD, MS
PO Box 232, E. Helena, MT 59635 227-5177

1. In the fight against AIDS, medicine and public health abandoned the tried and true public health and medical practices that had been effective in combating other epidemics. These practices included.

*Early diagnosis and knowledge of infection through routine testing of the general population

*Reporting by name to the public health department for those testing positive

*Breaking the chain of transmission through confidential partner notification and tracking of the epidemic by public health

Instead of using this classical model, public health took the approach that if you provided super confidentiality, anonymous testing, and civil rights protections for those that carry the virus then they would voluntarily come forward to be tested. This approach has been a failure. In 1989, Montana passed the AIDS control act that provided these protections. Those coming forward to be tested actually declined in 1989 with no significant increases in testing until 1992 with the Magic Johnson disclosure. Denial is a powerful emotion.

2. Another example of the failure of anonymity and voluntary testing is highlighted by the San Francisco based National AIDS Behavior Survey. Of the 14,000 individuals at highest risk of acquiring HIV, 38% of the gay men and 47% of the injecting drug users had not gotten themselves test for HIV. Denial is a powerful emotion.

Three fourths of Americans visit a doctor each year. Doesn't it make sense to advocate for more routine testing with partner notification so that these people that are in denial regarding their HIV status can benefit from early diagnosis?

3. You retain the stigma of HIV disease when you keep it a special disease. If HIV were mainstreamed and treated like other sexually transmitted diseases(STDs) you help erase the stigma associated with HIV infection.

2. Anonymity and written informed consent gives the impression that public health workers and doctors can't be trusted to retain confidentiality when in fact there has never been a report of breach of confidentiality in the 400,000 cases of AIDS reported to the CDC. Public health can do much toward alleviating irrational fears regarding testing.

3. With anonymous testing and a lack of confidential reporting to public health, a person carrying the HIV virus can continue to engage in irresponsible behavior and continue to spread this deadly disease without being held accountable.

4. With anonymous testing it is impossible for public health to conduct the necessary partner notification of those persons diagnosed at private clinics. According to January 23 IR news report, of the 38 HIV positives diagnosed in 1994, 17 were diagnosed at medical clinics. Doctors have neither the staff, training, or time to do the necessary partner notification and follow up. Whereas specially trained public health professional have a very high success rate in obtaining the names of partners. Repealing anonymity will result in a net gain of HIV testing not a loss since the partner notification program results in many more people being tested.

5. Anonymity creates a serous problem when someone tests positive for HIV then does not return to pick up their results. In Maryland four cases of HIV-2 were discovered at an anonymous testing center. Having a coded label, but no name or address, they were able to identify only one person when that code was requested. The other three never returned for their test.

6. Repealing anonymity will not drive the HIV epidemic underground, it's already there-driven there not by fear but by a lack of proper response from the medical and public health communities. North Carolina recently adopted the classical public health model in its fight against HIV/AIDS. Dr. Milton Guigless, HIV policy maker in North Carolina stated, "When anonymous centers are phased out entirely, we can finally treat this as the sexually transmitted disease it really is through the confidential partner notification program we have in North Carolina. It's a shame we have to wait until 1994 to begin practicing medicine and public health as it should be."

Montana HIV Testing

MT Public Health Lab 1985-1993

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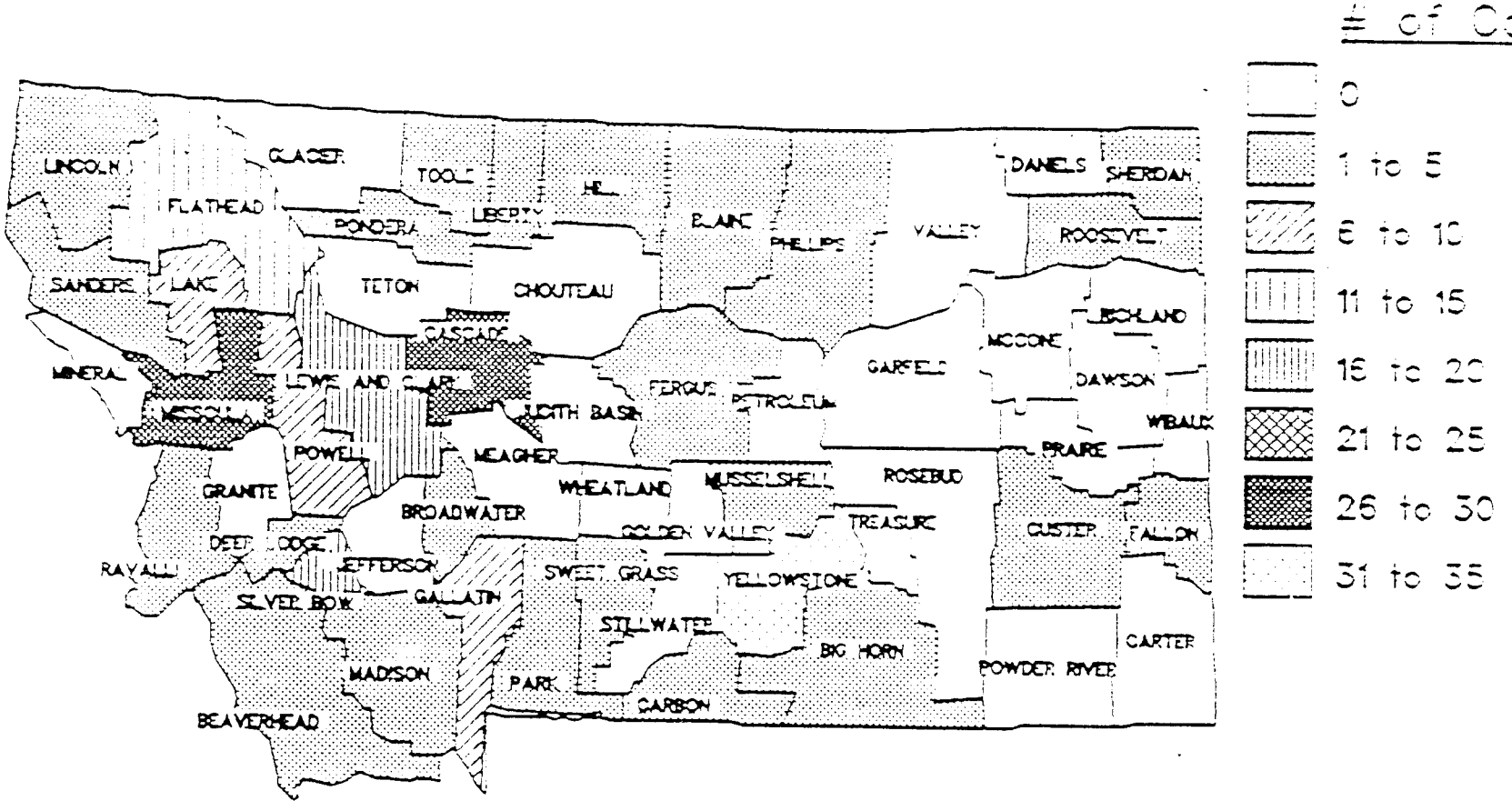
FIGURE 3.

Montana AIDS Cases by County
As of December 31, 1993



HIV INFECTION IS TREATED DIFFERENTLY THAN OTHER STDs IN MONTANA

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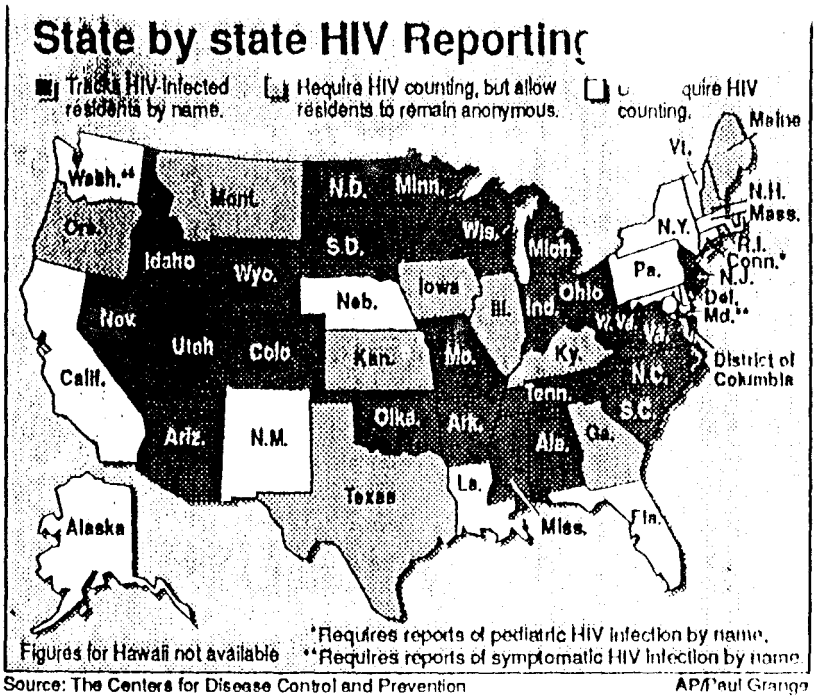
CURRENT STATUTES/ POLICY	HIV INFECTION	SYPHILIS GONORRHEA
Early diagnosis/knowledge of infection	NO	YES
Pre-test written informed consent	YES	NO
Confidential reporting by name to public health	NO	YES
Anonymous testing	YES	NO
Inform the subject of the test results in person	YES	NO
Partner notification	SPORADIC	YES
Tracking of the epidemic	NO	YES
Civil remedies	YES	NO

Prepared by: Joanne Shearer, PO Box 232, E. Helena, MT 59635



Source: The Centers for Disease Control and Prevention AP/Paul Grange

Privacy rights limit accurate HIV count

DECATUR, Ga. (AP) — Federal health authorities and AIDS experts, struggling to get a more accurate estimate of the number of HIV-infected Americans, argued Wednesday over whether states should count HIV patients by taking names.

"We need to balance our goals of surveillance with human rights burdens — does it deter testing?" asked Lawrence Gostin, executive director of the American Society of Law and Medicine.

The Centers for Disease Control and Prevention had hoped a panel of about 50 AIDS experts, meeting in this Atlanta suburb, would answer that question instead of ask.

The CDC convened the meeting to help it develop guidelines for states to accurately report how many people have HIV, the virus that causes AIDS. Although the CDC estimates 1 million Americans are HIV-infected, that's a very rough guess.

"It's really hard to know how far off you are," said Dr. John Ward, CDC's chief of surveillance.

Since the start of the epidemic, state health departments have collected the names of patients with full blown AIDS and forwarded that number to the CDC. The tally is now about 240,000.

But only 24 states count by name the people who have HIV but not AIDS, so there's no real data on HIV cases. Montana counts HIV patients but gives them anonymity.

The CDC is considering whether all states should track HIV patients by name or by a special code, so they won't count some patients twice and so doctors can better ensure that patients get appropriate follow-up care. But the agency acknowledged that anonymity may attract more people to be tested.

Whatever it decides will merely be a guideline, not an edict, but the decision is important because states that follow its guidelines get more CDC funding. For example, the 24 states that track HIV patients by name got most of the $5 million the CDC spent for HIV reporting efforts this year.

The states tightly guard the names — not even the CDC sees them. The CDC and AIDS activists agree there have been no breaches of confidentiality.

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-TUBERCULOSIS CONTROL-

50-17-105 THE DEPARTMENT OR A LOCAL BOARD MAY APPLY FOR AN ORDER FROM THE DISTRICT COURT IF A PERSON IS REASONABLY SUSPECTED TO HAVE OR TO HAVE BEEN EXPOSED TO TUBERCULOSIS. THAT PERSON WOULD BE ORDERED TO SUBMIT TO AN EXAMINATION FOR TUBERCULOSIS AND, IF FOUND TO HAVE TB, TO COMPLETE AN APPROVED COURSE OF TREATMENT OR ENTER OR RETURN TO A HOSPITAL FOR TREATMENT OR FOLLOW AN APPROVED COURSE OF TREATMENT OUTSIDE A HOSPITAL.

50-17-108 IF A PERSON FAILS TO COMPLY WITH AN ORDER TO SUBMIT TO AN EXAMINATION FOR TUBERCULOSIS WITHIN THE TIME SET OR COMPLETE AN APPROVED COURSE OF TREATMENT, THE COURT SHALL ORDER HIM COMMITTED TO A HOSPITAL.

-SEXUALLY TRANSMITTED DISEASES-

50-18-106 IF A PHYSICIAN OR OTHER PERSON KNOWS OR HAS REASON TO SUSPECT THAT A PERSON WHO HAS A SEXUALLY TRANSMITTED DISEASE IS CONDUCTING HIMSELF IN A WAY WHICH MIGHT EXPOSE ANOTHER TO INFECTION, HE SHALL IMMEDIATELY NOTIFY THE LOCAL HEALTH OFFICER OF THE NAME AND ADDRESS OF THE DISEASED PERSON AND THE ESSENTIAL FACTS IN THE CASE.

50-18-101 SEXUALLY TRANSMITTED DISEASES DEFINED: HIV, SYPHILIS, GC CHLAMYDIA (NSU), ETC

50-18-107 POWERS AND DUTIES OF HEALTH OFFICERS: IF FOUND NECESSARY OR DESIRABLE TO PROTECT PUBLIC HEALTH, STATE AND LOCAL HEALTH OFFICERS OR THEIR AUTHORIZED DEPUTIES OR AGENTS SHALL;

(a) EXAMINE OR HAVE EXAMINED PERSONS REASONABLY SUSPECTED OF BEING INFECTED WITH A SEXUALLY TRANSMITTED DISEASE;

(b) REQUIRE PERSONS INFECTED TO REPORT FOR TREATMENT TO A REPUTABLE PHYSICIAN AND CONTINUE TREATMENT UNTIL CURED;

(c) ISOLATE OR QUARANTINE PERSONS WHO REFUSE EXAMINATION OR TREATMENT;

(d) INVESTIGATE SOURCES OF INFECTION OF A SEXUALLY TRANSMITTED DISEASE.

50-18-104(3) THE PURPOSE OF THIS SECTION IS TO PROTECT AND PRESERVE THE PRINCIPLE OF CONFIDENTIALITY IN SEXUALLY TRANSMITTED DISEASE WORK BY PUBLIC PERSONNEL, LOCAL, STATE, AND FEDERAL SUCH CONFIDENTIALITY BEING ALL IMPORTANT TO THE SUCCESS OF ALL STD EDUCATION WORK AND ENDEAVOR, AND TO REQUIRE THAT THE PRINCIPLE OF CONFIDENTIALITY IN SUCH WORK REMAIN INVIOLATE.

50-18-112 A PERSON INFECTED WITH A STD MAY NOT KNOWINGLY EXPOSE ANOTHER TO INFECTION.

CONFIDENTIALITY HAS NEVER BEEN A PROBLEM. HEALTH CARE PROVIDERS ARE TRAINED IN THE PROCESSES OF CONFIDENTIALITY. THEY USE IT EVERY WORKING DAY IN RESPECT TO SYPHILIS, GC AND TB. WHY IS THERE A DIFFERENCE WITH HIV/AIDS.

SENATE HEALTH & WELFARE
EXHIBIT NO. 6
DATE 1/27/95
BILL NO. SB 17

January 27, 1995

To: Public Health Committee
From: Gary D. Swant, 113 North Frontage, Deer Lodge, MT, 59722, Phone/fax- 406-846-2451
Subject: Senate Bill 17

I am not medically trained, or have expertise in the pathology of sexually transmitted disease. I was however, a biology, human anatomy, and sex education instructor at the high school level in Montana for 25 years. I am currently the president of SAFE Inc. (Sexual Abstinence and Family Education). In 1994 I made 68 presentations to approximately 6,000 teens and adults here in Montana about teens and their sexuality.

As an individual I have made a few observations I want to share. In the early years that I taught sex education, I taught comprehensive sex education (CSE). However, I changed, and now endorse abstinence only sex education. Why? Because, CSE didn't work. Research proves the fact, look at the October, 1994 Atlantic Monthly for an excellent article entitled "The Failure of Sex Education". You don't continue more of the same if it doesn't work. You look for a new model, a new method.

Lets look at those infected with the HIV virus in Montana	Dec. 92	135 cases	7 females by heterosexual contact
	Mar. 93	152	8
	May 93	161	8
	Dec. 93	193	11
	May 94	211	12
	Oct. 94	220	12
	Dec. 94	235	14 (61% of all cases)
Percent increase		74%	50%

Maybe its time to try a new model, a new method. The HIV virus is transferred in general by exchanging body fluids during high risk behavior. These behaviors include pre-marital and extra-marital sex, IV drug use, especially sharing needles, and anal intercourse.

The December, 94, AIDS/HIV statistics show that 24 percent of Montana cases are in the age bracket of 20-29. This means that a number of them were possibly infected in high school. The recent research study, Sex in America, A Definitive Survey shows that by age 25 the average number of sex partners for American men is 5. However, the same study shows that the number of partners does not increase by age 50. Marriage changes the sexual patterns of most Americans. My own study of Montana teens shows that one third of sexually active teens have had more than 3 sex partners. If the HIV virus significantly moves into the heterosexual population, sexually active singles are at serious risk of infection. Condoms are at best risk reduction, Susan Weller's study in Social Science and Medicine shows a failure rate of 31 percent for HIV transmission. Because you ultimately die of the HIV infection or opportunistic diseases related to the infection, we must realize that any thing short of our best effort to identify carriers and stop the transmission is unacceptable. HIV must be treated like others STD's.

I understand the political nature of the history of HIV, but the time has come to stop being political, stop making the concerns of minorities the priority, and identify infectious individuals, protect health care workers and researchers, and have a legal means of reaching their sexual contacts. If the HIV virus significantly enters the heterosexual community at large, the medical cost and lost lives of today will be pale in comparison.

I believe that Senate Bill 17 is a step in the right direction. It deserves to be tried, I don't believe that we will be any worse off for trying new ideas in our fight against HIV transmission.

SENATE HEALTH & WELFARE
EXHIBIT NO. 7
DATE 1/27/95
BILL NO. SB 17

A.S.A.P.

Americans for a Sound AIDS/HIV Policy

P.O. Box 17433 • Washington, D.C. 20041 • 703/471-7350

January 25, 1995

Montana has an opportunity most other states no longer have--the chance to never have a significant HIV problem. With eight active years in this fourteen-year-old epidemic, I can accurately share what has worked and what hasn't. . .separate the myths from reality, so to speak. In doing so, I hope to give a strong endorsement to the HIV legislation you all are trying to get enacted.

Perhaps the biggest mistake made in the early years of the epidemic was treating AIDS and HIV differently from other serious contagious and/or sexually transmitted diseases. Because we did not encourage routine HIV diagnosis (testing) in medical settings, nor routinely report individuals on a confidential basis to public health authorities for voluntary and confidential partner notification, we have an epidemic today in the United States that is truly underground.

Sadly, it might not surprise you that as a result of our offering inducements, instead, for people to come forward on their own to be tested--like anonymous testing and super-restrictive privacy protections--we have fewer than half those thought to be infected in our country today who know their HIV status. It is a pipe dream to believe we can ever get this epidemic under control when a majority of those carrying this fatal disease have no idea they are infected. The result of this failed policy is infections keep occurring which are preventable and most of those infected are being denied optimal medical care.

Fortunately the trend away from this ill-conceived course is finally happening. When we first started ASAP fewer than five states were doing any partner notification, now more than half are. Anonymous testing is also being phased out in many states, being replaced by confidential HIV testing. And restrictions blocking routine diagnosis in medical settings are also being removed.

Why is this change occurring? It's simple. Medicine and public health work for the benefit of the sick and the continued good health of those who are well, and the paradigm of anonymity and super-confidentiality simply have proven inconsistent with sound medical and public health policy. This was inevitable, yet it has taken a long time to arrive here; at the cost of countless lives and needless suffering.

The primary reason the unusual "volunteer" system hasn't worked is because if was based mostly on fear. . .fear of disclosure of lifestyle as pointed out by Randy Shilts in his book "And the Band Played On." Having participated in many of the early legislative debates on this, I recall that the most often expressed fear was that people were afraid their identities would somehow be disclosed through breaches of medical confidentiality and discrimination would result. The argument was then made that folks should (and would) voluntarily come forward to be tested--often anonymously--if we offered them civil rights and privacy protections or else we'd drive the epidemic underground. And based on this reasoning we did succeed to drive it underground because it is sophistry at its best, and fear-motivated policy at its worst.

Well over four hundred thousand cases of AIDS have been reported to the CDC by all fifty state public health departments without a single breach of confidentiality. There are numerous lists of people infected, from blood banks to insurance companies, to AIDS groups, and the military with few, if any, breaches of confidentiality ever having occurred. We served over eight thousand children and families affected by HIV last year with no breaches of confidentiality, incidentally. It just isn't the problem it was made out to be, and should never have been the basis for policy formation.

Beyond the experience of the medical/public health community actually being able to keep such information confidential, many began to see the benefits of reporting and partner notification through the experience of states like Colorado and South Carolina and the United States military. In fact, the military's aggressive testing, reporting, and partner notification program has led to a three-fold reduction in the rate of HIV infections of active duty military personnel over the past five years. States with aggressive interventions have their epidemics pretty much in check, where those states who have ignored these tried and true fundamentals of medicine and public health really have little idea of whether or not their HIV epidemics are getting better or worse.

While ASAP has largely been supportive of having anonymous alternatives, we now believe anonymous testing is probably not in the best interest of limiting disease spread. The CDC did an analysis of doing away with anonymous testing in North Carolina and concluded that there would be a net gain of people learning their HIV status by abolishing anonymous testing and utilizing

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confidential partner notification more often. In other words, even without expanded testing in medical settings, partner notification of those getting confidential testing would find more people infected and not be offset by any possible decrease in total numbers of people tested.

The actual experience of states implementing partner notification is no decrease of people being tested. Those who have argued against partner notification have consistently warned of dire consequences. The truth is, none have occurred. Even where written informed consent is abolished, it is done virtually without incident. We have learned the world does not end when sound medical/public health policy is implemented.

As this epidemic spreads to more people of color, more heterosexuals, and more underserved communities, we find very high acceptance of instituting more traditional interventions. You have a great opportunity in Montana to limit total suffering in the future in respect to HIV disease if you do treat AIDS/HIV as we do other serious contagious diseases. However, if you listen to the old failed arguments that more testing will somehow lead to more infections, then you will pretty much guarantee yourselves a long-term epidemic.

In hopes this helps to some extent, I remain

Sincerely yours,

W. Shepherd Smith, Jr.
President

SENATE HEALTH & WELFARE
EXHIBIT NO. 8
DATE 1/27/95
BILL NO. SB 17

January 27, 1995

Mr. Chairman, members of the committee:

For the record,my name is Laurie Koutnik, executive director of Christian Coalition of Montana, our state's largest grassroots family advocacy organization concerned on issues of importance facing families.

Truly HIV is of concern to families. All of us have become increasingly aware over the years the impact has not only on the infected, but the uninfected as well. Curriculums have been designed to instruct our children. Health care standards have been modified in an attempt to protect providers while guaranteeing anonymity to the patient. Parents and loved ones stand helpless by and watch the devastating effects it has on their kids and their friends. Yes all our lives have been greatly impacted by HIV.

The question really is : "How long will we be satisfied with tracking the end result of this disease, rather then addressing its prevention?" My concern is where is the common sense in all of this devastation? Why is it no one is complaining nor is their a problem of the reporting of AIDS, the tail end result of the disease, but we oppose the reporting of its onset, HIV. This is the same disease, and never has there been a violation of confidentiality in the reporting of AIDS.

Doesn't it make sense that we should be focusing our efforts on breaking the chain of transmission by earlier diagnosis, earlier notification, earlier follow-up of treatment to help the infected live a healthier and longer life. What is the controversy?

When we treat HIV disease differently then we treat AIDS, you continue to perpetrate the stigma of the HIV disease. When we treat it like we do other sexually transmitted diseases, we demystify this disease.

What we are doing now is only as effective as the infected cares for it to be.
Let's not continue to ignore those who are going undetected. Please pass SB17 for the health and well being of all Montana's citizens.

PREVENTION: THE NAME OF THE GAME

'Twas a dangerous cliff, as they freely confessed,
Though to walk near its crest was so pleasant;
But over its terrible edge there had slipped
A duke and full many a peasant.
The people said something would have to be done,
But their projects did not at all tally.
Some said, "Put a fence 'round the edge of the cliff,"
some, "An ambulance down in the valley."

The lament of the crowd was profound and was loud,
As their hearts overflowed with their pitty;
But the cry for the ambulance carried the day
As it spread through the neighboring city.
A collection was made, to accumulate aid,
And the dwellers in highway and alley
Gave dollars or cents - not to furnish a fence-
But an ambulance down in the valley.

"For the cliff is all right if you're careful," they said;
"And if folks ever slip and are dropping,
It isn't the slipping that hurts them so much
As the shock down below - when they're stopping."
So for years (we have heard), as these mishaps occurred
Quick forth would the rescuers sally,
To pick up the victims who fell from the cliff
With the ambulance down in the valley.

Said one, to his pleas, "It's a marvel to me
That you'd give so much greater attention
To repairing results than to curing the cause;
You had much better aim at prevention.
For the mischief, of course, should be stopped at its source,
Come, neighbors and friends, let us rally
It is far better sense to rely on a fence
Than an ambulance down in the valley."

"He is wrong in his head," the majority said;
"He would end all our earnest endeavor,
He's a man who would shirk this responsible work,
But we will support it forever.
Aren't we picking up all, just as fast as they fall,
and giving them care liberally?
A superfluous fence is of no consequence,
If the ambulance works in the valley."

The story looks queer as we've written it here,
But things oft occur that are stranger.
More humane, we assert, than to succor the hurt,
Is the plan of removing the danger.
The best possible course is to safeguard the source
Attend to things rationally.
Yes, build up the fence and let us dispense
With the ambulance down in the valley.

Author unknown

SENATE HEALTH & WELFARE
EXHIBIT NO. 9
DATE 1/27/95
BILL NO. SB 17

Governor's AIDS Advisory Council

Position Statement on Anonymous Testing, Written Informed Consent and Partner Notification for HIV infection

Adopted January 9, 1995

Position: The Governor's AIDS Advisory Council opposes any legislation that would eliminate anonymous HIV testing, eliminate written informed consent for HIV testing, or make changes to partner notification procedures. We support efforts to simplify the written informed consent procedures as they relate to HIV testing.

Rationale: Currently, AIDS is treated like all communicable diseases and is reportable to the Department of Health and Environmental Sciences (DHES) by name. Individuals that test positive for HIV, the virus that causes AIDS, access Montana's health care system in a confidential manner, not anonymous. Programs such as the AIDS Drug Reimbursement Program, the insurance continuation program or other medical and social services offered by the Ryan White Care funds are not provided anonymously.

The DHES, public health agencies, physicians, and the Montana Medical Association support anonymous testing as an option for those that would not test for HIV otherwise. Many Montanans, especially people engaging in high risk behaviors for HIV will not seek out testing and education unless they feel that they can trust their provider and know that their results are anonymous. Oregon had name reporting for HIV, but for eight months offered anonymous testing at public sites. Testing increased during this time by 125% for homosexual men, 56% for female prostitutes and 17% for intravenous drug users. (Reported in *The Lancet*, 8/13/88)

The stigma and fear surrounding HIV disease and AIDS continues to exist. There is no cure and our best weapon remains education. The consequences of a positive test for HIV are very different than those for gonorrhea or chlamydia.

Written informed consent is a symbol that the person about to engage in a medical procedure such as HIV antibody testing understands what has been told to him/her in the informing session. Persons presenting for HIV testing need more information than is given for most types of tests because of the medical and psychological consequences.

Partner notification for communicable and sexually transmitted diseases has always been a basic component of public health and has been included in AIDS work since the disease was recognized. DHES has taught partner notification for HIV since the counselor courses began in 1985. DHES has not seen any need to change partner notification procedure for HIV, though they have had the authority to do so at any time.

Public Health

TRIAL OF ANONYMOUS VERSUS CONFIDENTIAL HUMAN IMMUNODEFICIENCY VIRUS TESTING

LAURA J. FEHRS[1] DAVID FLEMING[2]
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Division of Field Services assigned to Oregon State Health Division, Epidemiology Program Office, Centers for Disease Control, Atlanta, Georgia, USA;[1] Office of Health Status Monitoring, Oregon State Health Division, Portland, Oregon,[2] Multnomah County Health Department, Portland, Oregon,[3] and Public Health Laboratory, Oregon State Health Division, Portland, Oregon[4]

Summary Before December, 1986, all public human immunodeficiency virus (HIV) testing in Oregon was done confidentiallly (using names). In December, clients were offered the option of either anonymous or confidential services. As judged by questionnaire responses, the availability of anonymity increased overall demand for testing by 50%: 125% for homosexual/bisexual (gay) men, 56% for female prostitutes, 17% for intravenous drug users, and 32% for other clients. The number of gay clients who had tests increased from a mean of 42 per month during the 4 months before anonymity was available to 108 per month during the 4 months after, whereas, at public sites in Colorado or California and private sites in Oregon, the number of gay clients tested did not increase. Twice as many seropositive persons were identified during the 3½ months after anonymity became available (n = 85) as in the 3½ months before (n = 36). Thus, availability of anonymous HIV testing and counselling drew gay men who had not sought services under a confidential testing system.

INTRODUCTION

IN 1985, state and local health departments in the United States made antibody testing for human immunodeficiency virus (HIV) infection available at public testing sites. These programmes were designed to provide an alternative to blood donation for persons who wanted to know their HIV antibody status, but they now offer comprehensive counselling and testing and are thus a primary means of preventing the spread of HIV infection.[1,2] However, there has been controversy over whether these programmes should offer anonymous testing. In some states public HIV testing is offered only after clients have been asked for personal identifying information, while in others some or all of public HIV testing is offered anonymously and clients are identified by number only.

Those who favour the latter system claim that the option of anonymity attracts clients who would not otherwise present for counselling and testing. We examined this notion by conducting a trial of offering anonymous testing in Oregon.

METHODS

From August, 1986, to March, 1987, county health departments provided all public HIV counselling and testing in Oregon. Before December, 1986, only confidential HIV counselling and testing were offered. Under confidential testing, clients were asked for their name, birthdate, address, and telephone number, but no attempt was made to verify responses. This information was stored confidentially and was not forwarded to the testing laboratory or to the Oregon State Health Division.

TABLE I—SEROPREVALENCE BY RISK FACTOR, FIRST-TIME CLIENTS, AUGUST 1986 TO MARCH 15, 1987

Risk factor	No	Percent of all clients	HIV antibody positive	
			No	Percent of risk group
Gay non-iv drug user	468	29·0	88	18·8
Gay iv drug user	70	4·3	23	32·9
Heterosexual IV drug user	212	13·1	4	1·9
Female prostitute*	51	3·2	1	2·0
Haemophiliac	2	0·1	2	100·0
High-risk partner only	627	38·9	4	0·6
Other	214	13·3	1	0·5
Overall	1613	100·0	122	7·6

*Includes 31 who were also iv drug users.

In December, 1986, 25 Oregon counties, including the city of Portland, began offering anonymous as well as confidential HIV counselling and testing. The availability of anonymous testing was first announced to the public through a press release on the day before anonymous testing became available and was widely publicised in the media. Three sites that tested small numbers of clients declined to participate.

From the start of the trial, clients received pre-test counselling without being asked to identify themselves. They were then provided with an information sheet describing the differences between anonymous and confidential testing and were asked to choose one option. Clients who chose anonymous testing were identified by number only. Clients who chose confidential testing were handled as before the trial. Demographic and risk factor data were collected from the serology form submitted by the testing site to the Public Health Laboratory. Men who reported that they had a history of homosexual or bisexual contact were defined as gay. Analysis of demographic, risk factor, questionnaire, and serological data was restricted to clients being tested for HIV antibody for the first time. Additional information was collected from a self-administered client questionnaire. This information included knowledge of the availability of anonymous testing, assessment of whether it was the availability of anonymity that had drawn the client to testing, self-assessed risk of exposure to someone with HIV infection in such a way that client could be infected, and waiting time for client between first deciding that he or she wanted testing and actually coming in for testing. On March 15, 1987, use of the questionnaire was discontinued because of the increase in demand for testing that occurred after the Centers for Disease Control recommendations on testing of multiply-transfused persons.[3]

According to responses to these questions, clients were classified into three groups: those stating that they knew anonymous testing was available and that they would not otherwise have come for counselling; those who either did not know anonymous testing was available, or did know but stated that they would have come anyway; and those who stated that they knew anonymous testing was available, but were not sure whether they would have come if the only option had been confidential testing. We estimated the

TABLE II—CHOICE OF TESTING BY CLIENT GROUP DEC 2, 1986 TO MARCH 15, 1987*

Client group	No	Percent of all clients	Testing option selected No
Would not have come without anonymity	343	29	Anonymous 305 (89%) Confidential 38 (11%)
Would have come without anonymity	695	58	Anonymous 323 (46%) Confidential 372 (54%)
Undecided	160	13	Anonymous 142 (89%) Confidential 18 (11%)

*Excludes 52 persons for whom complete data were not available.

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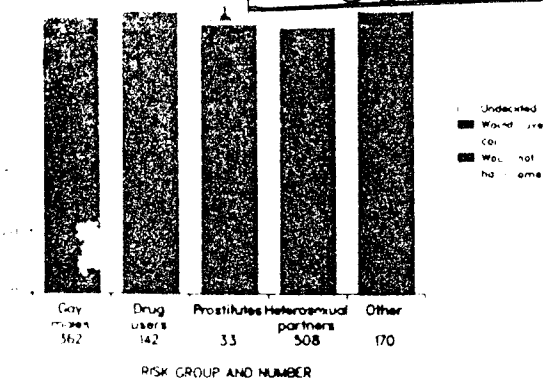

Fig 1—Effect of anonymous testing, by risk group, Dec 2, 1986 to March 15, 1986.

impact of anonymous testing by calculating the ratio of the number of persons who would not have come in the absence of anonymous testing to the number who would have come if confidential testing had been the only option. This ratio excluded those clients who were undecided.

All blood specimens were tested for HIV antibody by enzyme immunoassay (EIA). Specimens non-reactive by EIA were reported as negative. Repeatedly reactive specimens were tested by immunofluorescent antibody or western blot. A positive specimen was defined as one repeatedly reactive by EIA and either positive or equivocal on confirmatory testing.

RESULTS

From August to November, 1986, 363 first-time clients were tested. From December, 1986, to March 15, 1987 (after the anonymous testing option was available) the number was 1250. Of the 1613 total clients, 63·5% were male and 96·2% were white. Percentages positive for HIV antibody are shown in table I.

Of the 1250 clients tested after anonymous testing was available, 1198 provided information on both their awareness of the availability of anonymous testing and whether they would have come for testing if only confidential testing had been offered. 29% stated that they would not have come if the option had been only confidential testing; 58% either did not know that anonymous testing was available (307) or stated that they would have come anyway (388); and 13% were unsure whether the option of anonymity had drawn them to testing. 11% of the clients drawn by anonymity ultimately chose confidential testing. Conversely, 47% of the clients who stated that they would have come under a confidential system chose to be tested anonymously (table II).

Risk factor for HIV infection was strongly associated with the likelihood that a client had been drawn to testing by the option of anonymity (fig 1). 49% of gay men tested after anonymous testing became available said that they would not have come if only confidential testing had been offered, compared with 13% of iv drug users, 30% of female prostitutes, 21% of persons with a heterosexual high-risk partner, and 21% of other clients. Gay men were 2·4 times more likely than non-gay men to say that they would not have been tested had anonymous testing not been offered ($p < 0.001$). As judged by these subjective responses, demand for testing among gay men increased 125% as a result of the availability of anonymity, compared with 17% for heterosexual iv drug users, 56% for female prostitutes, 33% for persons with high-risk heterosexual partners only, and 31% for other persons.

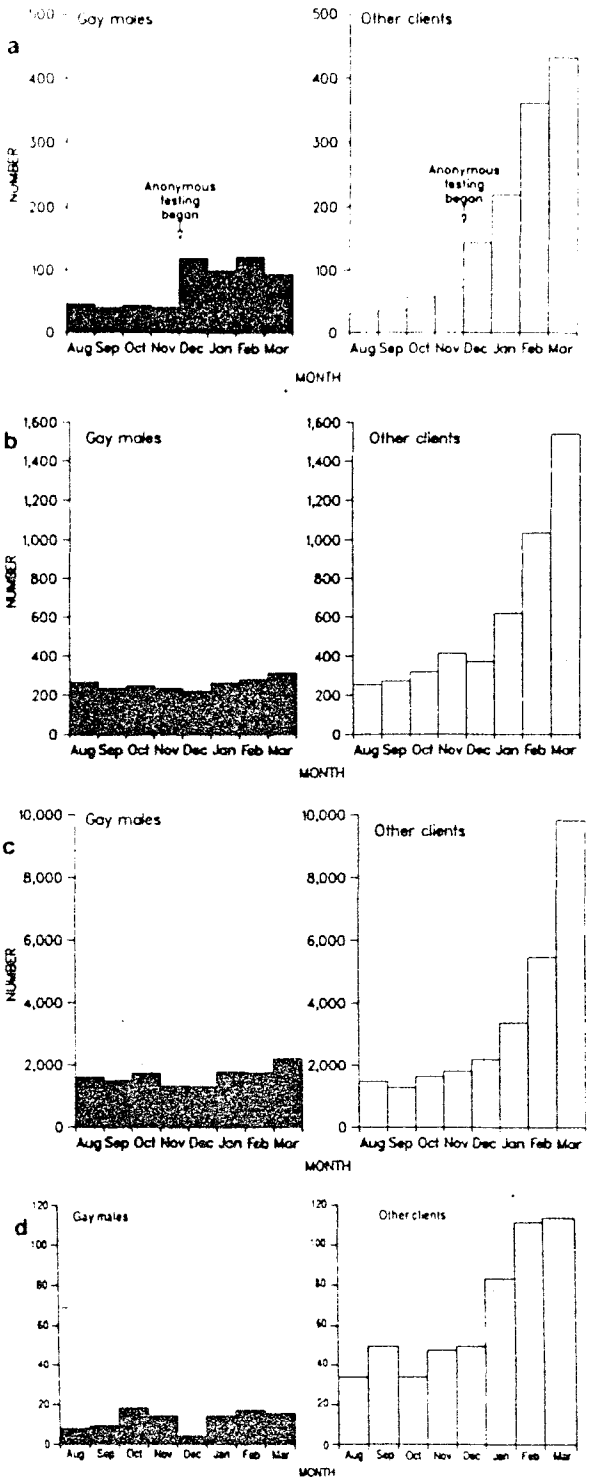

Fig 2—Demand for testing, by month, August, 1986, to March, 1987.

(a) Oregon; (b) Colorado; (c) California (only anonymous testing available); (d) Oregon private sites.

The validity of these subjective data was assessed by examining the temporal relation between demand for testing and availability of anonymity. Demand for testing among gay men increased sharply from a median of 42 per month in the 4 months before anonymity was offered to a mean of 108 per month in the 4 months after anonymous testing became

available ($p = 0.03$, Mann-Whitney-U test). In contrast, the demand for testing in non-gay clients increased steadily throughout this period, and was not similarly affected by the anonymous option (fig 2a).

The conclusion that the sharp increase in demand from gay clients resulted from the anonymous option depends on the assumption that demand among gay clients would have remained constant had anonymous testing not been available. Data on number of clients tested, by risk group, were examined for three settings in the western United States—Colorado, where confidential testing is the only public testing option; California, where state-funded HIV testing is conducted anonymously; and private sites in Oregon that use the state Public Health Laboratory for testing. In all three settings, testing among gay men remained steady from August, 1986, through March, 1987 (Dillion B, AIDS Education and Risk Reduction, Colorado Department of Health, and Ramirez-Rude A, Office of AIDS, Department of Health Services, State of California, personal communications). Demand among non-gay clients in all three settings showed the steady increase seen in Oregon public sites (fig 2 b-d).

The availability of an anonymous testing option in Oregon was also associated with a decrease in the length of time that gay clients reported waiting between deciding that they wanted testing and obtaining counselling and testing. In December, gay clients who would not have come in but for anonymity stated that they had been waiting a mean of 12 months; this waiting period decreased to a mean of 5 months by February. In contrast, the average waiting period for gay clients who stated that they would have come even if only confidential testing had been available remained constant at 4 months from December through February.

Gay men who judged themselves likely to be exposed to someone with HIV infection in such a way that they could be infected were more likely to be antibody positive. 55% (16/29) of those who stated that they were certain that they could have been so exposed were antibody positive compared with 27% (42/154) of those who thought that it was likely, 11% (11/99) of those who thought it was unlikely, and 7% (4/58) of those who thought it was very unlikely. 18% (12/67) of clients who did not know their likelihood of exposure and 25% (1/4) of clients who gave no response were antibody positive. Neither actual nor perceived antibody status was associated with the choice of anonymous or confidential testing.

85 clients tested positive during the 3½ months after the trial of anonymous testing began, compared with 36 positive in the 3½ months before the trial—an increase of 136%. 95% (81/85) of the clients who tested positive after the trial began were gay; of these, 48% (39/81) stated that they would not have come in if the only option had been confidential testing, 41% (33/81) said they would have, and 11% (9/81) were undecided.

94% of clients who received pre-test counselling and testing returned for test results and post-test counselling, and this proportion was almost identical for the anonymous and confidential groups and for gay and non-gay clients.

DISCUSSION

In this trial, the option of anonymity seems to have increased testing by 50% overall and by 125% among gay men. There was less impact on demand for testing among female prostitutes and still less among iv drug users. The number of seropositive persons identified was twice that before the trial.

As well as drawing clients who were averse to confidential testing, the option of anonymous testing shortened the time that gay clients said they waited before coming for counselling and testing. To the extent that HIV counselling and testing is of value in changing behaviours that lead to the spread of HIV infection,[3,9] the ability to draw high-risk clients without delay is advantageous.

The effect of an anonymous testing option on demand for HIV counselling and testing may differ in other areas. We tried to limit the ability of individuals to affect the outcome of the study by giving no advance notice to the public of the trial of anonymous testing and by restricting our analyses to clients being tested for the first time. The effect of anonymity on demand for testing may be time-limited; however, demand for testing among Oregon gay men through September, 1987, has continued to be more than double that seen before anonymity became available. Furthermore, some of the clients who stated that they would not have come for testing unless assured of anonymity might eventually have come anyway, but anonymity seems to have drawn them sooner to counselling and testing.

There are potential disadvantages as well as advantages to anonymity. In particular, it prevents a counsellor from contacting clients who do not return for test results or from recontacting clients in case of laboratory error. HIV counselling and testing centres in other areas might evaluate the results in Oregon in the light of the goals of their testing programme.[10] A flexible HIV testing programme should consider offering both confidential and anonymous HIV testing—confidential testing in some settings such as prenatal or sexually transmitted disease clinics, and an option of either anonymous testing or confidential testing in others.

In Oregon, anonymity provided a strategy that preferentially drew gay males, the population in the state currently at highest risk for infection. As groups at risk for HIV infection and public perception of AIDS change over time, it will be necessary to periodically re-evaluate the impact of anonymous testing.

We thank the county health departments of Oregon for their cooperation with this study; the AIDS programmes in Colorado and California for providing data on demand for HIV testing in their states; and Derrick Diggs, Peg Murray, Geri Washington, and Joyce Grant-Worley for their assistance with data management and entry.

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References continued at foot of next page

SENATE HEALTH & WELFARE
EXHIBIT NO. 10
DATE 1/27/95
BILL NO. SB 17

Testimony opposing SB 17

My name is Kathy Hayes, I am a Registered Nurse, I have been employed by the Missoula County Health Department as a Disease Intervention specialist with the AIDS program since 1988.
My duties include coordination of the Counselling and Testing site, Partner notification, and Early Intervention for individuals newly diagnosed with HIV.

Senator Barnett and members of the committee;

I am opposed to the passage of SB 17.

I feel that at this time in our state that the adverse effects of name reporting far out weigh the proposed benefits of tracking the epidemic.

My concern is that name reporting discourages individuals at highest risk for this disease from seeking testing due to fear of breaches of confidentiality and discrimination.

This would in effect decrease our ability to track the epidemic in our state.

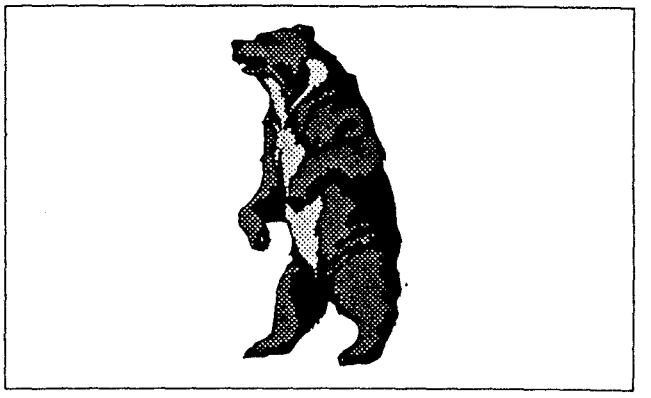
A study performed in AZ in 1989 showed that when anonymous testing was provided in 7 counties where it had not been previously available 22% of men who had sex with men and 10% of IDU's reported that their decision to test for HIV was delayed until an anonymous test option became available.

A second point that I would like to make is that our department and all other anonymous test sites are successfully carrying out the duties of partner notification. We have found an overwhelming majority of the people testing positive at our site are willing to divulge information about past partners. In my scores of experiences it is not knowing someones name that allows for the successful outcomes of name elicitation. It is developing a sense of trust with that person so that they feel safe in telling the truth about past partners with the end product being more people at high risk for HIV are notified of their potential risk without breaching the confidentiality of the index case.

In closing I would like to say that the only thing SB 17 will accomplish at this time is a decrease in the numbers of people with HIV who find our their serostatus and poses a large threat to our efforts at preventing the spread of this disease.

SENATE HEALTH & WELFARE
EXHIBIT NO. 11
DATE 1/27/95
BILL NO. SB 17

Testimony to House Public Health Cmte. on behalf of the Associated Students of the University of Montana. Presented by Brien Barnett, legislative liason for ASUM.



1/27/95

Mr. Chairman (Madam Chairwoman), members of the committee

My name is Brien Barnett

I come before you today representing the more than 11,000 Associated Students of the University of Montana.

AIDS is a plague, but it is a plague with unique consequences and stygmas. Unlike plagues of the past which have affected great numbers of people indiscrimanately, AIDS affects certain classes of citizens, generally classes with specific behaviors. However, AIDS can, and does affect others, not of those classes who have come into contact with HIV infected blood. For this reason along with the fear of retribution, many prefer to dissociate themselves from direct identification when seeking to be tested. According to reliable HIV counselors and testers, anonymous testing is the overwhelmingly preferred means of testing by those in the 16-27 age group. This age group, because of the high degree of sexual activity and experimentation with illicit narcotics, faces the greatest prospects of becoming HIV infected. For this reason, ASUM believes it is not in the interests of public health to remove this option.

Currently, when a student enters our health service seeking to be tested, they feel very assured that their anonymity will be guaranteed. What we must realize is that perceptions, particularly in regards to feared retribution, are the reality in which AIDS counselors deal with those coming in to see them. Supporters of this bill point to a very good record of confidentiality in regards to dealing with other STD's. However, there are fundamental differences between HIV infection and other STD infection. As well, by treating HIV solely as a Sexually Transmitted Disease, we appear to discount cases of transmission by other means, particularly by means of infected needles shared by drug users.

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EXHIBIT NO. 6
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BILL NO. SB 17

Mr. Chairman (Madam Chairwoman), There is an additional concern with SB17 in regards to "written, informed consent." By removing this provision, their is some concern within the medical community that they could be held liable for testing which is performed without the required documentation. Certainly we understand the need for suspending this consent in emergency type situations, or where a provider has been exposed to potential HIV-positive blood. However, within the normal context of HIV testing, we firmly believe that detailed, specific, and written consent is not only necessary, but wise when dealing with an issue of this sensitivity.

Mr. Chairman (Madam Chairwoman) I urge you to protect this vital means of testing; and further, to protect both the tester and the person seeking testing, by ensuring the need for "written, informed consent. Thank you.

#30

SENATE HEALTH & WELFARE
EXHIBIT NO. 12
DATE 1/27/95
BILL NO. SB 17

Testimony of
James N. Christensen
in opposition to
Senate Bill No. 17
before the
Senate Health and Human Services Committee
Friday, January 27, 1995

I am a native of Montana and also a Person Living With AIDS. After graduating high school in 1975 I attended the University of Montana in Missoula. I transferred to North Carolina School of the Arts to pursue a career in Dance Performance. The next logical step for someone who is interested in the performing arts, especially dance, is to go directly to New York City. I arrived in New York in the fall of 1981 and found myself in what was to become one the epicenters for AIDS. This was certainly not apparent at the time.

Those years in the early eighties were marked by the deaths of acquaintances, peers and close friends who had been among the first to be diagnosed with HIV or AIDS. It was not called AIDS back then: GRID (Gay Related Immune Disorder), Gay cancer, to name a few. As we pressed forward not knowing what to do or how to handle these losses, my partner and I chose to withdraw and in a sense deny what could be a reality for us. We were scared to think that AIDS could affect us but we also seemed to think that it would never affect us because those things always happend to other people, not us. Even though we followed what was happening to our community with serious attention, we felt helpless. We

were unsure how to give support to our friends who were suffering from this illness, or how to become involved. And most of all, we were afraid. Afraid of finding out that we might be in danger ourselves.

In 1983 my health was poor and I needed to find out the source of the problems. Reluctanctly, I volunteered to participate in a study that would follow the participant for immune suppression. The only reason I came forward is because I was at the point where I felt that I needed to know if I had AIDS. The test involved in the study was the first test of its kind and was not the HIV antibody test that we have today. The test was not accurate and it could be easily be misread if a person had antibodies for hepatitis. Six months prior to my making an appointment for this test, I had hepatitis which was not diagnosed. I did not exhibit the normal characteristics of hepatitis such as jaundice and fatigue. So I was unware of the my infection and was turned away from the study with the instructions to have further blood work done to determine if I had had hepatitis before. I did not pursue that question until I went through another series of poor health: fatigue and weight loss. I found a doctor who told me that the results of my blood test showed that I indeed had had hepatitis some time in the past. I felt sure that my only problem was that I was not taking care of my health since I was unaware of my hepatitis infection. My condition improved and my fears of HIV infection were allayed because of this progression. I decided against pursuing my HIV status feeling that it was not relevant to my situation and I still was very much

afraid.

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The idea of not coming forward to be tested for HIV was encouraged by many groups who felt that knowing your status was positive did not give you much of a chance in fighting the virus. The medical community did not have many answers and a positive test meant living with a death sentence. Not knowing at that time seemed like a better option than knowing.

In 1986, I came down with a very bad case of shingles or Herpes Zoster (adult chicken-pox). It was strongly suggested that I get an HIV antibody test. Many health care professionals felt that shingles was a precursor to full-blown AIDS and for many people at that time, it was part of the onset of the illness. I reacted rather naively and said that I wanted to see if I could get over this bout with shingles first before I dealt with anything else that might be looming over my head such as HIV infection. I managed within a year to regain my strength and build back muscle where it had atrophied. Since my health seemed to be improving again and the shingles incident was behind me I assumed that there must not be anything wrong with my immune system. Again, I avoided the isssue of getting tested for HIV out of fear.

Through the next several years, more of our friends became ill and passed away in what seemed like a very short time. My partner and I still did not consider

taking the test.

In the spring of 1989, my partner came down with AIDS-related pneumocystis pneumonia (PCP). Even though we were initially shocked by the diagnosis, it was more of a sense of confirming what we had always feared: to be HIV positive. My status was confirmed positive shortly after he entered the hospital to battle his PCP. The **only** reason we were tested is because we had to know not because we wanted to know. Our years of denial had caught up with us and there was no way we could pretend that we had ignored the signs and signals which might have given us a jump start on combatting this illness. My partner passed away almost three years ago.

What seems quite obvious to me is that fear and denial played a huge role in our decision not to be tested. In looking back, if we had learned of our HIV status before the onset of my partner's opportunistic infection, we could have possibly changed the course of his illness. The worst time to find out that you are HIV positive is after being diagnosed with a life-threatening infection. At that point, the immune system is already severely compromised. The progress in treating infections is much different now than it was in the eighties. We want to encourage people to become tested not discourage them.

Because of my personal experience with HIV and AIDS I have become an

advocate for testing. I feel that a person should not hesitate to learn his sero-status if there has been any risk involved. Having that kind of information allows a person to make choices or decisions which could lead to changing behavior patterns and extending life. I feel strongly that there are many people who are at risk but will refuse to get tested if name reporting becomes mandatory. The only way they will find out that they are positive is with the onset of an opportunistic infection. Again, that is the worst time to become aware of your status. Name reporting only adds a roadblock to the already difficult decision process of those considering an HIV test.

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There was a great deal of stigma involved with syphilis in the 1800s because there was no cure to offer anyone. When a cure was finally discovered in the 1930s, that stigma was lessened. To demand that HIV testing involve name reporting only adds to the stigma which is heaped on the AIDS virus. Until you can offer a cure there will always be fear and reluctance to deal with this virus in a positive manner.

This disease is not like other Sexually Transmitted Diseases. To treat it as such only acknowledges the lack of understanding about this illness. I strongly urge you to vote against SB 17.

SENATE HEALTH & WELFARE
EXHIBIT NO. 13
DATE 1/27/95
BILL NO. SB 17

Sharon Kiely Howard, MS, RNC
Professional Nurse
January 27, 1995
The following testimony was prepared in response to SB 17.

HIV and the resultant disease process called AIDS is a **CHRONIC** illness in our society. As the years pass we will speak of this disease as we speak of other communicable diseases like syphilis, tuberculosis, polio and gonorrhea. Our language will soften, the sometimes damning to hateful to polarized language which surrounds today's discussion will subside and we will move on to the next health issue which demands attention.

Historically, we have responded to other disease processes in a fashion reflective of the polarized pattern of HIV. Families who have had a loved one diagnosed with polio can relate to the social isolation experienced by today's family with HIV. In our State, travel through Browning during the 1950's may have been accompanied by adults cautioning children to "Stay in the car and don't open the windows". Fear and ignorance allowed for the erroneous labeling of Native American as carriers of Polio. A diagnosis of Cancer in the 1960's was often treated with silence by families. Fear of a negative community response dictated caution. I can remember as a nursing student in the 1970's, the day a surgeon created a memorable stir by leaving the surgical suite when the patient was discovered to have cancerous lesions. The surgeon believed that Cancer was spread through airborne droplets and his fear of contact resulted in a seemingly irrational response.

Today, you are challenged to sort through the testimony to decide what tools Public Health Practitioners need to help control of the spread the HIV. The questions you ask will be guided by the queries " what will help the process?, what will hinder the process?" in the identification of infected people.

One of the main functions of Public Health is the control of the communicable disease. For Public Health Practitioners the skills needed to illicit responses from people with sexually transmitted diseases are based in trust and respect. Any Public Health Nurse can tell you that a statute which states that an infected client must tell you with whom they have had sexual contact is not going to yield sexual contact information. Infected individuals can withhold or distort information just as you or I can. **Why then are we in Public Health successful in controlling the spread of sexually transmitted diseases**? Success is based in the conduct of the practitioner, the skilled interviewer, who conveys competence and trust. Information is released to the nurse when the client perceives, through word and action, that they are being

dealt with in a fair and unbiased fashion.

Successful Public Health Nurses educate and interview in an interwoven pattern. Clients leave knowing how to protect themselves from infection and how not to spread disease to others. The Nurse leaves the interview with the information needed to control the spread of communicable disease.

Name reporting and the negation of written consent will not assist us in our work. Those actions will add more barriers to testing by increasing the paranoia and fear surrounding HIV. I can relate multiple incidents where persons seeking HIV testing had their blood drawn, but only after continued reassurance of confidentiality. I also known of the many times people came to me from other counties stating "fear" of being recognized within their own community.

Presently, some health personnel are citing pregnancy as a condition which warrants HIV testing without consent. In the course of prenatal care, it is the history of the patient that uncovers the risk factors that need medical attention. Vague ideas of "looking at risk" are not reasons for medical action. Certainly, the Practitioner should convey the need for HIV testing along with the need for other screening modalities deemed medically sound when indicators arise. Difficult conversations abound in obstetrical care when situations like fetal abnormality and or fetal death present. The need for HIV testing should not create an obstacle to written consent and education. Pregnant women are highly motivated to protect their growing baby from harm. A statute change in not going to alter the maternal impulses, but it may add to the adversarial dynamic surrounding HIV.

HIV is a viral infection; AIDS is a disease. Management calls for wise, compassionate care from early diagnosis until death. Control of the spread of this infection will be achieved through education that emphasizes facts and self responsibility. Public Health needs community and legislative support to decrease the paranoia surrounding the disease, so that more people can seek testing with confidence. Legislation that acts to marshall will not assist in control.

DATE 1/29/95

SENATE COMMITTEE ON Public Health

BILLS BEING HEARD TODAY: SB17

< ■ > PLEASE PRINT < ■ >

Name	Representing	Bill No.	Check One: Support	Check One: Oppose
Steven Shapiro	MT Nurses Assn	SB17		X
Elizabeth Oberling	Gov AIDS Council	SB17		X
Carl J Donovan	Region II HIV Planning	SB17		X
Shawn Howard	Nurse	SB17		X
Ben L. Lindeman	PAC - R.N.	SB17	X	
Russell McCurdy	Resp Therapist	SB17	X	
Laurie Kaatsuk	Christian Coalition of MT	SB17	✓	
Sandra L. Hale	PRIDE!	SB17		X
Dianne Dickman	Health	SB17	X	
Gary Hobbs		SB17		X
David Herrera	Governor's AIDS Advisory Council FDH & Associates	SB17		X
JAMES N. CHRISTENSEN	self	SB17		X
David C. Holley	Self	SB17		X
Jonathan Proctor	Self	SB17		X

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

DATE 1-27-95

SENATE COMMITTEE ON Public Health

BILLS BEING HEARD TODAY: SB 17

< ■ > PLEASE PRINT < ■ >

Name	Representing	Bill No.	Check One: Support	Check One: Oppose
Marilyn Tatsunker	Mt Youth Homes	SB 17		✓
Scott Christ	ACLU / MT			✓
Dale Taliaferro	MDHES	SB17		
Deborah Schaaf	LCAP	SB17		✓
MARK CADWALLADER	self	SB17		✓
Sheri Anderson	MT. Advocacy Program	SB17		✓
Brien Barnett	ASUM	SB17		✓
Pam Dale	self	SB17		✓
Beverly Hanna	self	SB 17	✓	
Andrea LaRose	self	SB17		✓
Joan McDonald	self	SB17		✓
Kate Cholewa	MT Womens Lobby	SB17		✓
Bob Runkel	DHES	SB17		
Elsie Arntzen	self	SB17		✓

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

DATE 1-27-95

SENATE COMMITTEE ON PUBLIC HEALTH

BILLS BEING HEARD TODAY: SB 17

< ■ > PLEASE PRINT < ■ >

Name	Representing	Bill No.	Check One: Support	Check One: Oppose
WM. C. SUMMERS	SELF	17		✓
Kathy Hayes	Missoula City County Health	17		✓
Brant Goode	Missoula City-County Health Dept.	17		✓
Steve Christianson	self	17		✓
Joanne Shearer	Self	17	X	
Brittany McLaughlin	self			
Carla Cairns	self			
Barb Dooher	MNA	17		✓
Gary D Smith	self	17	✓	
[illegible] Mont Health Alliance		17	✓	
Connie O'Connor	Governors AIDS Advisory & Self Council	17		✓
Joan Miles	LHC City/County Health	17		✓
Diane Schauer	self			
Christine Kaufmann	MT Human Rights Network	17		✓

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY