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CONFIDENTIALITY ISSUES CONCERNING HIV/AIDS AND PRIVILEGED COMMUNICATIONS IN HEALTHCARE

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ABSTRACT

The management of confidentiality concerning HIV/AIDS status represents one of the most ethically fraught intersections of medical ethics, patent autonomy and public health obligation in contemporary India. This article comprehensively examines the legal architecture governing physician-patient confidentiality in HIV cases, analyzing the HIV/AIDS (Prevention and Control)Act 2017, Indian Evidence Act provisions on privileged communication, National Medical Commission (NMC) 2023 Regulations, Bharatiya Sakshya Adhiniyam (BSA) 2023, and seminal Supreme Court precedents including Mr.X v. Hospital Z(1999). The analysis reveals a complex framework balancing fundamental rights- patient dignity and privacy under Article 21 of the Indian Constitution against public health imperatives and third-party protection obligations. Drawing on victimological perspectives that frame confidentiality breaches as secondary victimization exacerbating stigma and healthcare avoidance, and examining comparative international approaches from Commonwealth and global bioethics frameworks, this article argues that India's current legal landscape inadequately balances competing interests. The article proposes reformed protocols integrating: narrow, necessity-based disclosure standards; robust data protection mechanism; informed consent frameworks for information sharing;ethics committee oversight; and community-based stigma reduction strategies aligned with the UN 2030 agenda and India's National AIDS Control Programme (NACP-V).Through constitutional, statutory, case law and ethical analysis, the article demonstrates how protective confidentiality regimes paradoxically enhance both individual rights protection and public health outcomes by facilitating treatment-seeking behaviour and enabling genuine informed consent. The framework proposed emphasizes that confidentiality protection for people living with HIV (PLHIV) represents not obstacle to public health but essential precondition for effective disease control in India's evolving healthcare landscape.

Keywords: HIV/AIDS, confidentiality, privileged communication, India legal framework, NMC 2023 Regulations, informed consent, etc.

CHAPTER 1 - INTRODUCTION

The anonymity of HIV status creates a unique ethical quandary: safeguarding individual privacy appears to conflict with protecting public health. Upon closer examination, however, this apparent antagonism dissipates. Strong confidentiality protections encourage treatment-seeking behavior (people delay testing and treatment if they fear disclosure), allow for really informed consent (patients cannot make autonomous decisions without trust), and prevent secondary victimization due to stigma and prejudice. Conversely, breaching confidentiality by coerced disclosure or institutional misuse of information exacerbates stigma, drives infection underground, and undermines the very public health objectives that confidentiality limitations purport to protect.[1739] The anonymity of HIV status raises a unique ethical quandary: maintaining individual privacy appears to be incompatible with ensuring public health. On closer inspection, however, this seeming animosity fades. Conversely, breaking confidentiality by coerced disclosure or institutional misuse of information exacerbates stigma, drives infection underground, and undermines the very public health goals that confidentiality restrictions are intended to defend.

Despite this comprehensive framework, implementation remains fragmented, institutional practices vary dramatically, and vulnerable populations (particularly PLHIV from marginalized communities, sex workers, men who have sex with men, and transgender people) face ongoing confidentiality violations with few options. Confidentiality in healthcare, particularly with regard to HIV/AIDS, requires a delicate balance between a patient's right to privacy and the ethical and legal obligation to safeguard third parties from harm.

This study investigates India's legal and ethical framework for HIV/AIDS confidentiality, identifies systemic deficiencies, and offers revised protocols. The approach incorporates victimological perspectives, acknowledging that confidentiality breaches are secondary victimization—institutional harms that exacerbate the core disease burden through stigma, discrimination, and exclusion.

CHAPTER 2 - CONFIDENTIALITY ISSUES

HIV status disclosure discloses intimate details about sexual behavior, partner relationships, and sexual orientation. Unlike disclosing diabetes or hypertension status (conditions unrelated to sexual behavior), HIV disclosure[1740] has ramifications for sexual history, sexual orientation (especially for men who have sex with men), and sexual behaviors. This intimate dimension heightens privacy concerns, as sexual orientation and practices are protected realms of personal autonomy under constitutional frameworks. Privacy is a fundamental right recognized by constitutional frameworks (Article 21 of the Indian Constitution), international human rights agreements (the International Covenant on Civil and Political Rights), and ethical traditions emphasizing autonomy and dignity.

1) DEFINITION

Confidentiality in HIV/AIDS care can be defined as: the ethical and legal obligation of healthcare providers, institutions, and other authorized parties to refrain from disclosing a patient's HIV status, related health information, and circumstances of infection without the patient's informed consent, except in narrowly defined circumstances where legal requirements mandate disclosure or serious imminent harm to identifiable third parties justifies limited, proportionate disclosure. Confidentiality imposes obligations on multiple parties, including healthcare providers (physicians, nurses, counselors), institutions (hospitals, clinics, laboratories), support staff (administrative personnel, clerical workers), and other authorized parties (epidemiologists conducting research, public health officers, insurance company personnel). The confidentiality duty extends beyond treating physicians to any individuals who obtain HIV information in a professional capacity.[1741]

Privacy refers to people' fundamental right to restrict access to personal information and to keep their personal space free of unwanted intrusion or surveillance. The patient has the right to privacy, which is equivalent to personal autonomy. In HIV situations, privacy includes (1) information privacy (control over health information), (2) bodily privacy (control over physical examinations and medical

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[1739] Navaneeta & Gokul, VIDHI Centre of Legal Policy, 'Must we criminalise Silence?' (Oct 22, 2025 21:04), https://vidhilegalpolicy.in/blog/must-we-criminalse-silence/

[1740] S Abraham, J Prasad, Confidentiality, partner notification & HIV injection, IJME (Jan 1, 2002, 21:10)

[1741] Dr Kathryn Leask, Confidentiality concerns & complaints in HIV cases, https://mdujournal.themdu.com/issue-archive/summer-2020/confidentiality-concerns-and-complaints-in-hiv-cases (26 Nov, 2020, 21:15) treatments), and (3) decisional privacy (the freedom to make medical decisions without compulsion).

2) SCOPE

HIV/AIDS encompasses multiple dimensions, each presenting distinctive challenges;

a) The greatest immediate secrecy problem is with individual patients' HIV information. Healthcare personnel must maintain confidentiality regarding the patient's diagnosis (if HIV-positive), clinical information (CD4 count, viral load, treatment regimen), and personal circumstances disclosed during care.[1742]

b) Beyond individual providers, healthcare institutions must create systems to protect information at the collective level.

c) HIV prevalence, transmission channels, and impacted populations are all important details for public health surveillance and epidemiological study.

d) HIV/AIDS confidentiality is unique among diseases with transmission risks since it includes the management of third-party information.

e) HIV status disclosure frequently reveals linked information such as sexual orientation (for males who have sex with men), drug usage (for those who inject drugs), sex work status (for sex workers), and other stigmatized identities.

CHAPTER 3 – STATUTORY & LEGAL FRAMEWORK

1) CONFIDENTIALITY MANDATE & LEGAL REQUIREMENTS

The HIV/AIDS (Prevention and Control) Act of 2017, India's fundamental statutory framework for HIV management, expressly requires secrecy of HIV status. Section 12 prohibits the disclosure of information about people living with HIV except with informed consent, by court order, to blood/organ bank recipients about donor status, for notifiable disease reporting, as required by law, or to protect the community from serious communicable disease risk. Sections 14-17 establish data protection mechanisms: establishments that store HIV-related information must apply security measures, limit access, keep records for audit purposes, and guarantee that information is destroyed when no longer needed. Unauthorized disclosure violates "reasonable care" responsibilities, resulting in both criminal liability (possible prosecution under IPC Sections 269-270 for exposing others to disease risk through negligent disclosure) and civil liability (damage claims by affected individuals).[1743]

2) NON-DISCRIMINATION PROVISIONS

Sections 18-24 ban HIV-related discrimination in employment, education, healthcare, insurance, housing, and public accommodations. The Act acknowledges that discrimination causes public health harms: stigmatized individuals avoid testing, postpone treatment, suffer impediments to preventative services, and have little incentive to disclose to partners (fearing discrimination rather than virus transmission). Section 18 expressly specifies that "no person living with HIV will be denied employment or exposed to discrimination in employment on the basis of HIV status."

3) IMPLEMENTATIONAL CHALLENGES & GAPS

Despite these statutory safeguards, execution is insufficient. According to research, healthcare providers routinely test individuals without informed consent or pre-test counseling, divulge status to family members without consent, perpetuate stigma through differential treatment, and fail to adopt data protection procedures. Low HIV health literacy among clinicians, which includes insufficient awareness of transmission channels, prevention, treatment, and ethical

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[1742] Shuvangi Gupta, Healthcare Data Protection Laws in India: An Overview, 2 ISSN 642, 646-648 (May, 2023, 21:27)

[1743] Mangesh Jawlekar, Confidentiality & Privileged Communication in law & Medicine, Law Tribune, https://lawtribune.in/?p=1231 (Jan 28, 2024) requirements, promotes discriminatory practices. Enforcement methods remain ineffective. The Act does not create a specialized enforcement authority; instead, complaints are filed with state AIDS control programs or general consumer protection forums. Many people living with HIV are unaware of their rights or how to file a complaint. Social stigma prevents people from identifying as PLHIV in formal complaints.[1744]

4) LEGAL FRAMEWORK

A) The Indian Evidence Act of 1872, India's founding evidence act, specifies privileged communication rules that distinguish absolute from relative privilege. Absolute privilege shields certain communications from required disclosure even in court proceedings, including spousal conversations (**Section 122**), attorney-client communications (**Sections 126-129**), and religious discussions with clergy. Relative privilege applies to communications between doctors and patients (**Section 126** by extension through common law norms, while not specifically legislated), and disclosure may be required if courts judge that the public interest outweighs confidentiality.

B) The BSA 2023, which replaces the Indian Evidence Act, modernizes evidence standards, including provisions for privileged communication. While the BSA preserves basic protections for doctor-patient confidentiality, it changes information access processes, notably those involving electronic medical records. **Section 65** of the BSA addresses electronic records, including improvements to the authentication, production, and admission of digital health information. The BSA also contains changing judicial theory on exceptions to medical confidentiality. While the Act does not explicitly state exceptions, judicial interpretation (based on Mr. X v. Hospital Z and subsequent cases) recognizes that confidentiality yields when:

(1) Court orders require disclosure;

(2) Patient consents;

(3) Notifiable disease reporting requirements apply;

(4) Serious imminent harm to identified third parties exists;

(5) Data protection laws require disclosure; or

(6) A criminal activity investigation requires information.

CHAPTER 4 - NATIONAL MEDICAL COMMISSION(NMC) 2023 REGULATIONS; PROFESSIONAL STANDARDS FOR CONFIDENTIALITY

1) REGULATION 24 - CONFIDENTIALITY AS CORNERSTONE DUTY

The NMC Professional Conduct, Etiquette, and Ethics Regulations 2023 (effective August 2, 2023) address all physician requirements, including confidentiality. Compliance with Regulation 24 requires: "An RMP shall not disclose any information obtained from the patient and necessary for treatment, diagnosis, research or education, except with the explicit/implicit consent of the patient, or when required to do so by law." The regulation acknowledges that secrecy serves core purposes: patient trust, enabling honest communication important for diagnosis and treatment; autonomy, allowing patients to control personal information; privacy, etc. Exceptions: disclosure required by court order, disclosure mandated by legal requirements (notifiable disease reporting, statutory investigations), disclosure necessary to protect seriously endangered third parties, and disclosure required for ethical and medical purposes when patient cooperation is not obtained despite counseling.

2) REGULATION 22 - MEDICAL RECORDS & DATA SECURITY

Regulation 22 addresses medical record management by mandating physicians to keep records for at least three years and digitize them within three years while conforming to privacy rules. This section mandates the

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[1744] Anjali Rai, World AIDS Day 2025, ddnews, (Dec 1, 2025) implementation of security measures to secure sensitive information in HIV records. The rule implicitly contains requirements under data protection frameworks (the proposed Digital Personal Data Protection Bill 2023, which has not yet been adopted as of late 2025, focuses on data minimization, security, and purpose limitation in HIV record handling).

3) REGULATION 23 - BOUNDARY VIOLATIONS

Regulation 23 focuses on broader boundary violations in which physicians exploit patients. This section addresses not just sexual exploitation, but also financial, social, and informational exploitation. A physician who exploits HIV status information (for example, extortion, discriminatory treatment, or illegal disclosure) may face Regulation 23 violations as well as Regulation 24 confidentiality breaches.

CHAPTER 5 - CONCLUSION

Protecting HIV confidentiality appears to conflict with public health but actually advances both individual rights and disease control. Strong confidentiality protections facilitate voluntary testing, treatment engagement, partner communication, and prevention. Conversely, weak confidentiality drives infection underground, deters treatment-seeking and worsens epidemic control. The HIV/AIDS Act of 2017, the NMC 2023 Regulations, constitutional safeguards, and court precedent in India provide a solid foundation for strict confidentiality. However, implementation remains weak. Healthcare facilities lack the necessary infrastructure, training, and accountability systems to ensure protection. Reformed standards that incorporate disclosure constraints, procedural safeguards, data security requirements , ethics monitoring, training and community participation might provide long-term confidentiality protection while accommodating valid exceptions to protect vulnerable third parties. The balance can be achieved through transparent, accountable institutional systems that consider both individual autonomy and public health imperatives. Prioritizing this reform implies an investment in both human rights protection and epidemiological control, which are critical for India's expanding healthcare system.