AIDS and Issues of Partner Notification

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As part of a comprehensive plan to control syphilis and other venereal diseases in the 1930s, health departments in the United States instituted widespread contact tracing, a form of partner notification, to identify and treat the sexual contacts of people known to be infected with the microorganisms that caused these diseases. Public health officials interviewed infected patients to obtain the names and locations of their sexual contacts, notified these individuals, informed them of their health risks, and gathered information about people whom they might have unwittingly infected. This effort was important in slowing the spread of syphilis and in getting treatment to people with venereal diseases.

As early as 1986, the Centers for Disease Control (CDC) publicly espoused a similar approach to deal with the AIDS epidemic and notifying the partners of people infected with HIV, whether by public health officials employing traditional methods of contact tracing, by HIV-infected individuals themselves or by their health care providers. Several presentations at the Fifth International AIDS Conference in June 1989 advocated partner notification and are indicative of the growing support for partner notification as a way to help people take steps either to avoid becoming infected or, if already infected, to avoid infecting others and to seek appropriate medical care.

Partner notification, however, raises legal, ethical, and psychological issues about privacy and discrimination, as well as concerns about the effectiveness of this method to control the epidemic. Some of these concerns are satisfied by devising reasonable procedures for partner notification; others require broader public policy discussion and resolution; still others require health practitioners to make personal decisions. This article explores some of these factors and ways to deal with them.

Appropriate Use of Contact Tracing

Unlike other venereal diseases to which public health officials have applied contact tracing methods, HIV infection is typically asymptomatic for five to seven years, and possibly up to 16 years or more. Infected people may be unaware of their infection until symptoms develop, and, as a result, may have exposed sexual and needle-sharing partners over an extended period. These contacts may be forgotten or difficult to locate after the passage of time. In addition, contact tracing for HIV infection acts primarily to interrupt the chain of transmission rather than to provide people with a cure, as penicillin was a cure for syphilis.

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According to CDC officials and other health educators, contact tracing by public health authorities is of limited benefit to individuals in cities that already have been the focus of successful general education efforts. For example, contact tracing is not an efficient or cost-effective intervention for gay partners of infected persons in San Francisco, since such partners are likely to have already responded to the local education efforts. In these circumstances, notification of partners by the infected person is the most efficient method of ending the transmission chain.

On the other hand, public health partner notification programs that include provider referral (notification by a health care provider) and encourage patient referral (notification by the patient) are beneficial for contacts who may perceive themselves as being at little or no risk for HIV infection, for example, gay men in small, isolated communities and heterosexuals. (See Recent Reports below for a discussion of a cost-effective contact tracing program in a rural community.) Heterosexual women of childbearing age, in particular, who may be unaware of HIV-related risks, are often targeted by public health officials for notification about possible HIV exposure in order to prevent perinatal transmission of the virus.

Partner Notification Procedures

Applicable state law and policy regarding the reporting of HIV infection to public health authorities will influence the partner notification activities of practitioners treating HIV-infected clients. Arizona, Colorado, Idaho, and South Carolina require reporting to public health officials the names of all people with positive HIV antibody tests and encourage all infected people to participate in provider referral. In these states, a health care practitioner may choose to defer counseling of both patients and contacts to the partner notification expertise of local health authorities. In addition, since public health officials generally do not disclose the identity of an individual when counseling that person's contacts, clients may prefer this method to protect their anonymity. In states that do not require such reporting or that prohibit such disclosures without a client's written authorization, practitioners should encourage clients either to notify contacts personally or to authorize practitioners or public health officials to do so.

Recent guidelines from the California Department of Health Services (DHS) recommend that the practitioner and the client assess the following: the HIV-infected person's attitude about HIV disease and willingness to inform partners; the infected person's comfort in informing partners about exposure; the infected person's and exposed partner's living situations, and personal and cultural beliefs; and the content of the notification message and its delivery to exposed partners. In terms of the message, the practitioner should demonstrate to the client various ways to inform partners, and should assist the client in developing a plan of action for the notification. Practitioners should note that I.V. drug users, many of whom distrust the "system" in general, may refuse to divulge the names of others who are engaging in drug use, despite the fact that this information is to be used for public health and not law enforcement purposes.

DHS recommends that practitioners arrange a follow-up appointment with the client for no longer than three weeks later. If at that time the client has been unable or is unwilling to notify the exposed partners, the practitioner should offer health department assistance in carrying out the notification. As of July 1988, 48 states offered provider referral upon request by a client. The other two states, Georgia and Nebraska, authorize notification by health department personnel only when female partners, who may not
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continued from cover

have been aware of a risk factor, are involved, or in cases of rape or sexual abuse.

A multidisciplinary approach may be the best route to effective partner notification, particularly among clients who themselves wish to notify their partners. In a recently published case, Mr. Y, a 56-year-old bisexual with HIV infection and neurological problems, had not yet informed his wife of his infection at the time of his hospital admission for evaluation and further diagnosis.

After discussions among the hospital social worker, hospital bioethicist, the primary care physician and a psychiatrist, these individuals met with Mr. Y and advised him of his responsibility to inform his wife. Following his acknowledgement of that responsibility and further psychiatric consultation, Mr. Y disclosed his HIV infection to Mrs. Y during a meeting that included the participation and support of four professionals. This case illustrates the desirability of a multidisciplinary approach to partner notification whenever resources are available.

Legal and Ethical Issues for Providers

At some point, a practitioner might be confronted by an HIV-infected client who refuses to notify sexual and needle-sharing partners. Although the recommended course in such cases is unclear, knowledge of the relevant legal and ethical standards can facilitate a practitioner's informed decision whether to notify the endangered partner.

The conflict between the practitioner's obligation to keep a patient's private information confidential and society's duty to protect an identifiable third party from foreseeable harm was weighed and resolved in favor of the third party by the California Supreme Court in the case of Tarasoff v. Regents of the University of California. This decision has since been codified in California law and has become a standard for courts around the country and for other states writing similar legislation. In Tarasoff, the court decided that a psychotherapist, who determines or should have determined that a client presents a serious danger of violence to an identifiable third person, must use "reasonable care" to protect the intended victim, and stated that such reasonable care might include warning the intended victim.

Many commentators have suggested that Tarasoff creates a duty to warn the identifiable sexual or needle-sharing partners of an HIV-infected client who refuses to inform partners of their past or present risk. Under this interpretation of the case, a practitioner could be liable for failing to warn people who might be exposed to HIV through sexual or needle-sharing activities with the practitioner's client, whether local health policy requires or allows practitioners to undertake partner notification. However, until a court decides this question or a legislature passes a law creating this duty, it remains unclear whether the failure to disclose HIV infection to a sexual or needle-sharing partner is tantamount to the unexpected physical violence of the murder involved in Tarasoff.

Long and intensive public education efforts have tried to create a social standard that makes each individual responsible for his or her own sexual behavior. Courts may be influenced by this standard when asked to rule against a practitioner who failed to warn a person who acquired HIV infection through high-risk behavior with the practitioner's infected client. Whether or not this occurs, it is likely that the court will award damages against a health practitioner who fails to warn a third party who is not knowingly engaging in high-risk activity, for example, a long-time monogamous spouse, such as Mrs. Y.

A practitioner who warns a third party and thus violates the professional duty to hold the client's private information confidential is also at risk for liability. The California statute based on Tarasoff protects from liability a psychotherapist who warns an intended victim of a client's threat of physical violence. However, California also has established a strong public policy against disclosing a person's HIV antibody test results without the written consent of the person or the person's legal representative, with fines, civil liability and imprisonment for violations. A narrowly drawn exception to the policy allows physicians to disclose their patient's HIV infection to the patient's sexual or needle-sharing partner, under specified circumstances, but only after counseling the patient and attempting to obtain his or her consent to the warning. The statute also explicitly forbids the disclosure of "any identifying information" about the infected person.

The conflicts in California law illustrate the tensions, which may exist in other states, regarding the balance between protecting a client's privacy and protecting third parties from danger. Many other states, including Washington, Oregon and Vermont, have adopted Tarasoff-like standards, both in case law and statute. Practitioners who are faced with this dilemma should consult local and state laws and regulatory policies, which may demonstrate a clearer preference for either confidentiality or disclosure, and practitioners should consider from a personal perspective the ethical issues involved.

In the case of Mr. Y, the practitioners were keenly aware of their legal and ethical obligations to guard Mr. Y's private information, but had decided to inform Mrs. Y of her husband's HIV infection if he refused to do so. By approaching Mr. Y in a manner designed to win his cooperation and by offering him extensive support in making his disclosure, the conflict was avoided.

Conclusion

Clearly, partner notification may prevent transmission of HIV and thus save lives and resources. It is not, however, the only approach that may be taken to slow transmission. Mass media education, personalized health education and counseling have been effective in changing behavior in dramatic ways.

Those involved in determining public policy regarding partner notification should consider the costs and benefits of partner notification and compare the efficacy of the various forms of partner notification with other methods of preventing HIV transmission. Policy makers as well as individual practitioners need to be aware of the hidden costs of partner notification, such as the sacrifice of the client's trust and willingness to seek necessary treatment and counseling, and the risks to clients and their contacts arising from lost confidentiality.

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References


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HIV Infection and Sexual Assault

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One out of three women and one out of seven men in the United States will be victims of sexual violence during their lifetimes. Acts of sexual violence, known generally as rape, are terrifying and unexpected. In addition to physical and emotional trauma, victims are increasingly concerned about HIV infection, as well as other sexually transmitted diseases and pregnancy.

As legislatures throughout the country consider laws requiring perpetrators and victims of sexual violence to be tested for HIV antibody, the issue of rape and AIDS has gained prominence. Medical and mental health practitioners who work with victims of sexual violence must be aware of how rape and HIV infection interrelate in order to counsel these individuals more effectively about HIV transmission, antibody testing and treatment.

Psychological Response to Rape

Post-assault responses are survival reactions to the experience of sexual violation, particularly the loss of control over one's body and the overwhelming feeling, at some point during the assault, that one may be killed or mutilated. The process of recovery from sexual violence involves both immediate and deferred responses. Immediate responses may include shock, fear, disbelief, anxiety and feelings of vulnerability. Victims' moods may vary from emotive to controlled, and it is not unusual to see a wide range of reactions among people who are raped.

The second stage of the recovery process begins as the shock of the event subsides. During this period, victims may continue to experience fear and anxiety, intrusive flashbacks of the event, sleep and appetite disturbances, and an overall sense of helplessness. It is not unusual for victims to become depressed and to withdraw from friends and support systems. Second stage symptoms can last for weeks, months and even years, particularly if there is no therapeutic intervention.

When fears and concerns about HIV infection emerge, either immediately following the sexual assault or a period of time after it, they intensify a victim's usual reactions. The victim's feelings of vulnerability, evoked during the assault, merge with the fears of possible HIV infection, particularly if the survivor has not in the past considered the risk of HIV infection. Some victims, overwhelmed by fears of AIDS, may minimize the assault itself.

HIV Transmission during Rape

The FBI estimates that each year in the United States there are at least 87,000 cases of vaginal rape of women 16 years or older. Non-vaginal sexual assaults of men and women add significantly to this number. The Centers for Disease Control (CDC), however, reports that there are to date no cases of AIDS attributable to sexual assault, although it is reasonable to assume that the CDC will eventually document such cases.

Only sexual assaults that involve contact with HIV-infected semen and blood can put an individual at risk for HIV infection. There are no data which show sex offenders as being at greater risk for HIV infection than others in the general population. In addition, sex offenders are known to exhibit a high incidence of sexual dysfunction during assault. As many as 40 percent of assailants have ejaculation problems, further reducing the chance of semen coming in contact with the victim's blood.

Survivors need to be aware that vaginal or rectal assaults with ejaculation could increase the risk of HIV transmission. Any information known about the assailant can help determine risk status. Obviously, assailants known to use intravenous drugs or to engage in unprotected anal intercourse, particularly with other men, would be at increased risk of being infected. Some states require the testing of assailants. Ultimately, however, since a variety of factors are involved in HIV transmission, victims of sexual assault can best rely on monitoring their own health and antibody status for signs of HIV infection.

Prophylactic treatment with a spermicide after sexual assault may hinder transmission and may allow assault survivors to take an active approach toward HIV prevention. Prophylactic treatment with antiviral drugs, such as AZT, is not as yet recommended by organizations such as the CDC as standard post-assault care.

Antibody Testing

 Victims of rape might seek HIV antibody testing for two reasons: to use in legal and financial proceedings stemming from the assault, and to use to make HIV-related treatment decisions. Sexual assault victims may be eligible to collect reimbursement for medical expenses from government agencies in many states, and may sue their attackers. According to anecdotal reports, victims applying for such reimbursement have been asked to provide evidence that they were seronegative prior to the assault.

Unlike follow-up testing, which can be done at anonymous test sites, records of such baseline testing must be accessible to courts and government agencies. In some states, hospitals do baseline testing of rape victims as a matter of course. Thus, survivors face or are forced to face the conflict between their rights to privacy and their rights to legal access and medical coverage.

When the fear of and concern about HIV infection emerge, they usually intensify the reactions of victims to sexual assault.

A seropositive result given at the time a victim is being treated for the assault may add alarm to an already emotionally-devastating situation. Providers may discuss the possibility of baseline testing with recent survivors but should defer pretest counseling and actual testing for 24 to 48 hours after the assault. A recently-assaulted individual may be unable to give informed consent because of emotional trauma immediately after an assault. Baseline testing, however, must be done within one week of the assault in order to determine accurately a victim's serostatus prior to the assault.

Survivors may also want to be tested to reassure themselves that they have not been exposed during the assault or, if they have been exposed, to help them make decisions about early treatment. These individuals should take the test at least three months after the assault to allow antibodies to form. Recommendations for testing of rape victims are based on CDC recommendations for health care workers exposed to HIV during their work.

Conclusion

To provide sensitive and appropriate care to victims of rape, health care professionals must educate themselves about sexual assault and the natural responses to sexual violence. They should be prepared to offer survivors information about HIV infection, making decisions and coping with the trauma of rape. At the same time, rape crisis workers and counselors need to be more knowledgeable about HIV risk, transmission and antibody testing, as victims become more vocal about these issues. Sensitivity among all professionals will enable survivors to gain greater control over their health, emotional well-being, and legal and social status.

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References


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Recent Reports


Representatives from 20 countries attending the WHO Consultation on Partner Notification developed guidelines for national and local governments considering contact tracing as a response to the AIDS epidemic. Partner notification programs for HIV infection should be considered, but should be undertaken only if they are voluntary, confidential, accompanied by pre-and post-test counseling, and coordinated with access to appropriate health and social services.

The decision to begin such a program must consider local and national variables such as HIV seroprevalence and patterns of incidence, financial and technological resources, cultural beliefs, and the social and political environment. In a discussion of methods, the report stresses that the only information that should be given to partners is notification that they may be infected with HIV.

Contact Tracing in a Rural Community. South Carolina Department of Health and Environmental Control (Journal of the American Medical Association, June 24, 1988; and Fifth International Conference on AIDS abstract, Montreal, June 1989).

A study of a rural South Carolina program demonstrated that contact tracing leads to the identification of a high percentage of asymptomatic people with HIV infection, leads to a decrease in high-risk behaviors and is cost effective. Researchers, who reported initial data in JAMA and later data in Montreal, attribute the success of their program to the guarantee of confidentiality and assurance of health services to notified individuals. They qualified their results by stating that programs in urban areas or other regions of the United States may be more costly and more difficult to administer.

The JAMA study began by tracing the route of sexual transmission from one index patient and compiled a list of 82 male contacts and one female contact. Of these, researchers tested 63 men and one woman for HIV antibody. Later data reported in Montreal included 316 sex and needle-sharing partners of HIV-infected individuals; 202 of these agreed to be tested, 36 (18 percent) of whom tested HIV antibody positive. (Editor's note: The number of subjects in the study changed as the study grew, and these changes are reflected in the results reported.)

Partner notification seemed to be effective in reducing high-risk sexual activity. In a group of 69 men, none reported using condoms during sex. Six months later, 29 of 41 men reported using condoms at least some of the time.

The study offered insights into the contact tracing process. The probability that a named sex contact was seropositive increased directly with the number of times that the contact was named. In the initial group of 63 individuals, sex contacts named more than once had a 38 percent likelihood of being antibody positive, compared to a 7 percent chance for those named only once. Most of the study participants had not been tested prior to the study. In a follow-up group of 70 subjects, only four had previously been tested for HIV antibody, two of whom were seropositive. A second Montreal presentation, studying 79 contacts of seropositive subjects, found that 70 (89 percent) of these contacts believed the health department should continue notifying individuals who have been exposed to HIV.

The average cost of the program for the first 63 individuals tested was $100 each, which included the costs of a physician, a nurse, a sexually transmitted disease investigator and an antibody test. The cost per seropositive individual in this group was about $810, compared with an average cost of about $500 for each seropositive individual identified through the state's alternate test sites.


In a report that has received a great deal of attention in the popular press, two men, subjects of the ongoing San Francisco City Clinic Cohort Study, who reported their only high-risk activity as being receptive oral sex with ejaculation, tested HIV antibody positive. These are the first such cases in the study of 6,697 gay and bisexual men and two of only a handful of documented cases in the world in which oral sex is the probable route of HIV transmission.

While the researchers did not quantify the risk of HIV transmission through oral sex, they stated that their findings were consistent with current health recommendations that receptive oral sex with ejaculation does pose a risk of transmission. They concluded that anal sex, with or without ejaculation, continues to be the riskiest sexual activity for transmitting HIV.

Both men, who tested antibody positive during a recent testing, reported they had not had anal sex during the past two years, but had participated in multiple episodes of oral sex with ejaculation. Both men also had gum disease. Researchers say it is unlikely that the men had been previously infected without developing antibodies. To support this conclusion, both men had negative results to polymerase chain reaction (PCR) assays taken at the time of their last negative antibody tests. PCR is designed to detect HIV even if antibodies have not been produced.

Next Month

HIV infection, which only recently has shown signs of responding in major ways to medical treatments, has long implicated the involvement of co-factors both in the disease mechanism and the healing process. The connection between nutrition and the immune system is crucial to the well-being of people with HIV infection and may be important in terms of the prevention of infection. In the December issue of FOCUS, Richard Beach, MD, PhD, Clinical Assistant Professor of Epidemiology and Public Health at the University of Miami School of Medicine, discusses the effects of nutrition on HIV infection. Also in the November issue, Marcy Fenton, MS, RD, a nutrition consultant who does work with the AIDS Project Los Angeles, offers practitioners advice on how to counsel their clients about the range of alternative nutritional therapies available to people with HIV infection.