

Clinical Cases

Please Don't Say Anything: Partner Notification and the Patient-Physician Relationship

When a public health risk exists, a physician's obligations to warn those in potential danger overrides rules of patient confidentiality.

Commentary by Ronald Epstein, MD, James C. Thomas, PhD, MPH, and Gregory W. Rutecki, MD

On Dr. Singh's recommendation, one of her patients, Mr. Henry Roland, consented to be tested for HIV and had a positive test result, which he feared but suspected. Mr. Roland has a longtime girlfriend, Lisa, whom he sometimes mentions to Dr. Singh. When talking to Mr. Roland about his positive test result, Dr. Singh brought up the topic of notifying Mr. Roland's past and present partners so they could be tested themselves. Mr. Roland refused to agree to tell Lisa, or even allow Dr. Singh to notify the health department so they could call her to suggest that she be tested.

"If she's positive, she'll know it was me. Please don't say anything or she'll know I gave it to her."

Mr. Roland told Dr. Singh that he intended to continue having sexual relations with Lisa, otherwise she would suspect that something was wrong with him. He insisted he would use protection consistently. Dr. Singh explained to Mr. Roland that Lisa may already be HIV-positive and if she is, she should seek treatment.

"She'll leave me if she knows. I can't deal with this without her, Dr. Singh, I just can't."

Commentary 1

by Ronald Epstein, MD

While there might be general agreement that the ideal outcome of this difficult situation would involve disclosure to the partner as soon as possible, the pragmatics are not so obvious. The case description gives us little help, because the tools we need are embedded not in the facts of the case but in the patient-physician relationship [1,2]. We know little about the prior relationship between Dr. Singh and Mr. Roland or between the physician and Lisa. We don't know much about the beliefs that may underlie each person's actions. But, for argument's sake, let's assume that there is a patient-physician relationship predating the HIV test, but, perhaps, they have not had any situations that tested the relationship (as is usually the case with otherwise young, and presumably healthy, men). Let's also assume that Mr. Roland is no longer an adolescent, has no other current sexual partners, and is not actively using intravenous drugs. And, for argument's sake, let's consider that Dr. Singh did a good job of pretest counseling. She informed Mr. Roland about the medical implications—that HIV is a treatable but very serious illness, and that treatment is often delayed until the immune system shows signs of malfunction—and the psychosocial implications—that partner notification and family support would both be important.

Now that the patient has returned and received the test result, Dr. Singh tries to follow through by bringing up partner notification. If this is the same visit in which bad news has been delivered (no matter how gently and empathically), the patient is likely struggling to make sense of his own future, much less anyone else's [3-6]. When Dr. Singh brings up the issue of partner notification, Mr. Roland cannot face the stark choice that appears to have no viable answer: either betraying his lover or losing her.

Dr. Singh knows that scolding, threatening, and berating occasionally motivate humans to act responsibly, but these are not reliable tools [7]. Even if partner notification is mandated by law (as it is in New York State), the physician faces the dilemma of timing. Is this the time to persist? Would it be responsible to ask the patient to come back in a few days or in a week to discuss this further? After all, Mr. Roland could infect Lisa between now and then. Should Dr. Singh warn Lisa herself? Or how about contacting the public health authorities? They would likely send an officer to Lisa's home to advise her to be tested. The physician is in a dilemma similar to Mr. Roland's: she can insist and run the risk that the patient will never return or wait and run the risk that Lisa will become infected.

This may call for an imperfect temporary solution to preserve any possibility of long-term success. It may have to suffice to say, "I know that this has been too much bad news for one day. Maybe we should talk more next time. How about next week? But between now and then, please protect the one you love. And, is there someone with whom you can share this news who will help you through this week?" This way, Dr. Singh expresses empathy rather than disdain [8-9]. She expresses concern for both the patient and his partner, and introduces the idea that the patient, similarly, might be able to find a way to care for himself and also Lisa at the same time. And, finally, Dr. Singh makes a suggestion for a short-term plan with an implied agenda. The patient is anxious, but knows that he will be understood [10].

If we have gained the patient's trust, he returns. As often as not, he may have found a way to tell his partner. She may have threatened to leave him, but, as often as not, she may display unexpected support. But, what if she still does not know? To help Mr. Roland, Dr. Singh has to try harder and overcome any awkwardness she might feel [11]. She is careful not to coerce or threaten; she tries to understand the patient and to find some aspect of this patient with which she can work to create a stronger therapeutic bond [12]. Dr. Singh might ask, "What is the most frightening thing about telling her?" Normalizing, coupled with an offer to work together may be useful: "Anyone would find this an incredibly difficult situation, but I think that we can find a way to deal with it." Sometimes anticipating a different outcome can be helpful, "I don't know Lisa that well, but a large percentage of partners end up being very supportive."

When trust is stronger, the patient can be helped to examine his values and the schism between values and actions. Using a conditional (if...then) or third person grammatical construction can distance the patient from the frightening immediacy of the situation while helping him to brainstorm: "What if you somehow found the courage to tell her. What might you say?" Or, "If it were a friend of yours who just tested positive, what would you say to him?" Offering options can motivate the patient to disclose: "You know that this has to happen, but the question is how. Would it be better for you to tell her or to have the health department tell her? There are advantages to both." Self-confidence and self-efficacy can be reinforced through gentle cajoling: "I know that you can." Role reversal can add another perspective: "What would you want her to do if she were you? Would you be able to still love her?"

These solutions are not perfect. Sometimes conflict is unavoidable. The ante may need to be raised. The physician might say, "I will not be able to live with myself unless I know that Lisa is adequately informed." Or, the law can be invoked, "State law requires me to make sure that Lisa knows. But, I would strongly prefer to do it in a way that we can both find acceptable." Rarely, the patient-physician relationship may be severed to protect a third party. The worst outcome, though, would be if the patient did not disclose, and did not return for follow-up. Desperation might lead him to jeopardize his own life as well as his partner's.

It is not known how often patients inform partners and what percentage of sexual partners have been informed. Even untreated patients with HIV may be asymptomatic for over 10 years, so sometimes there are many partners who should be informed. How hard should the patient and physician try? What about the 1-night encounter 14 years ago with someone who has since moved away? Some standard of reasonableness should be applied, but there are no rules to dictate those standards.

Partner notification requires knowledge of relevant options, laws and ethical standards, skills to communicate effectively, and the practical wisdom to know when and how to put that knowledge and those skills into action. Although it is often framed as a conflict, it can and should be done in a way that supports that part of the patient that wants to do the right thing. Most importantly, the physician should have sufficient self-awareness to recognize and adjust for prejudicial attitudes [13-14]; we all have these biases; it is how we handle them that can build or destroy a relationship.

References

1. Epstein RM. A biopsychosocial approach to HIV. In: von Uexkull T, Adler R, eds. *Psychosomatic Medicine*. Munich: Urban & Schwarzenberg; 1997:623-674.
[Google Scholar](#)
2. Epstein RM. The patient-physician relationship. In: Mengel MB, Holleman WL, Fields SA, eds. *Fundamentals of Clinical Practice*. 2nd ed. New York; Plenum. In Press.
[Google Scholar](#)
3. Baile WF, Lenzi R, Kudelka AP, et al. Improving physician-patient communication in cancer care: outcome of a workshop for oncologists. *J Cancer Educ*. 1997;12:166-173.
[View Article](#) [PubMed](#) [Google Scholar](#)
4. Eggly S, Afonso N, Rojas G, Baker M, Cardozo L, Robertson S. An assessment of residents' competence in the delivery of bad news to patients. *Acad.Med*. 1997;72:397-399.
[View Article](#) [PubMed](#) [Google Scholar](#)
5. Fallowfield LJ, Lipkin M Jr. Delivering sad or bad news. In: Lipkin M Jr, Putnam SM, Lazare A, eds. *The Medical Interview*. New York; Springer-Verlag: 1995:316-323.
[Google Scholar](#)
6. Quill TE, Townsend P. Bad news: delivery, dialogue, and dilemmas. *Arch Intern Med*. 1991;151:463-8.
[View Article](#) [PubMed](#) [Google Scholar](#)
7. Deci EL, Ryan RM. *Intrinsic Motivation and Self-Determination in Human Behavior*. New York; Plenum Press: 1985.
[Google Scholar](#)
8. Platt FW, Keller VF. Empathic communication: a teachable and learnable skill. *J Gen Intern Med*. 1994;9:222-226.
[View Article](#) [PubMed](#) [Google Scholar](#)
9. Suchman AL, Markakis K, Beckman HB, Frankel R. A model of empathic communication in the medical interview. *JAMA*. 1997;277:678-682.
[View Article](#) [PubMed](#) [Google Scholar](#)
10. Epstein RM, Morse DS, Williams GC, LeRoux P, Suchman AL, Quill TE. Clinical practice and the biopsychosocial model. In: Quill TE, Frankel RM, McDaniel SH, eds. *The Biopsychosocial Model*. Rochester, NY; University of Rochester Press. In Press.
11. Epstein RM, Morse DS, Frankel RM, Frarey L, Anderson K, Beckman HB. Awkward moments in patient-physician communication about HIV risk. *Ann Intern Med*. 1998;128:435-442.
[View Article](#) [PubMed](#) [Google Scholar](#)
12. Epstein RM, Frarey L, Beckman HB. Talking about AIDS. *AIDS Patient Care STDs*. 1999;13:545-553.
[View Article](#) [PubMed](#) [Google Scholar](#)
13. Novack DH, Suchman AL, Clark W, Epstein RM, Najberg E, Kaplan C. Calibrating the physician: personal awareness and effective patient care. *JAMA*. 1997;278:502-509.
[View Article](#) [PubMed](#) [Google Scholar](#)
14. Epstein RM. Mindful practice. *JAMA*. 1999;282:833-839.
[View Article](#) [PubMed](#) [Google Scholar](#)

Ronald Epstein, MD, is a professor of family medicine and psychiatry at the University of Rochester School of Medicine and Dentistry.

Commentary 2

by James C. Thomas, MPH, PhD

There are at least 3 ethical threads running through this case: partner notification, disease reporting for surveillance purposes, and Mr. Roland's dishonesty and self-interest in his relationship with Lisa. Each of these highlights some aspect of public health ethics.

Whereas medical ethics is defined in large part by the interactions between a clinician and a patient, public health ethics is defined by the interactions between an agency, such as the health department, and a population of people. The agency is concerned about the well-being of the whole population, including the risk that one member can bring to the other members of the community. For this reason, public health ethics views the world through the lens of interdependence rather than the lens of autonomy [1]. We are interdependent in that one person's risk depends on another person's infection.

Mr. Roland illustrates for us how an infected person will not always act in the best interest of the uninfected person. He is willing to put his girlfriend's life at stake so he won't have to confront the reality of their relationship. (Deception is evidently part of their reality since he assumes he did not get his infection from Lisa, but from a person that Lisa doesn't know about.) Unfortunately, such self-interest and denial are common.

Out of an awareness that individuals with sexually transmitted diseases (STDs) are often hesitant to name their sexual partners and that clinicians may yield to the self-interest of the patient and also not report an infection to those who will notify sexual partners of their risk, state governments legally require that certain STDs be reported to the health department. Thus, when a clinician diagnoses syphilis, for example, reporting the infection to the health department is neither at the patient's nor the clinician's discretion. Once reported, a disease intervention specialist contacts the infected person and elicits the names and contact information of people with whom the infected person has had sex within the infectious period. Once found, the sexual partner is tested for infection and, if found to be infected, is treated. By shortening the duration of infection, the harm to the infected partner is minimized, as is the chance for transmission to still others.

The benefit of reporting HIV infection is not as clear cut as it is for syphilis. When syphilis is found, the infection can be cured. But that is not the case with HIV infection. In part because this benefit is not available for HIV, not all states require that HIV infections be reported. Current treatments reduce the viral load and thus decrease infectiousness, reduce perinatal transmission in pregnant women, and generally postpone AIDS and death. These benefits are enough that the Centers for Disease Control and Prevention (CDC) now recommend that all states require HIV reporting. CDC also argues that HIV reporting is necessary to monitor the epidemic and thus to better respond to it [2].

We don't know where Dr. Singh practices, so we don't know if she is required to report Mr. Roland's infection under state law. If there is significant risk of transmission, it is unlikely that Dr. Singh would be legally liable if she were to report the infection when she is not legally required to do so. The ethical duty to protect others from an HIV-infected man who intends to have sex without telling his partner(s) of his infection would compel Dr. Singh to report the infection to the health department. Some argue that a reporting requirement causes fewer HIV-infected individuals to get tested because they fear what will happen if their infection becomes known. If many people do this, testing and reporting will have the unintended consequence of leading to *more* undiagnosed infections and thus more transmission. For this reason some states offer anonymous testing, in which the name or contact information of the person being tested is not known to the clinician. The situation we are dealing with in this case, however, is a known infection in a known person.

It *is* clear that Mr. Roland would be legally liable if he were to have sex while knowingly infected with HIV and not informing his sexual partner, as he intends to do with Lisa. This is often treated as a felony offense which can result in a prison sentence. Moreover, a strict reading of the law does not allow use of a condom as an excuse for not informing [3].

Viewed from a public health perspective, Mr. Roland has an ethical duty to inform Lisa and his other sexual partners of his infection. He can do this himself or he can let the health department do it for him. If he has sex again he also has a legal requirement to inform his partners. Dr. Singh has the ethical duty, and likely the legal mandate, to report Mr. Roland's infection to the health department. The importance given by public health to the protection of the community leads to this course of action.

References

1. Thomas JC, Sage M, Dillenberg J, Guillory VJ. A code of ethics for public health. *Am J Public Health*. 2002;92:1057-9.
[View Article](#) [PubMed](#) [Google Scholar](#)
 2. Centers for Disease Control. Guidelines for national human immunodeficiency virus case surveillance, including monitoring for human immunodeficiency virus infection and acquired immunodeficiency syndrome. *MMWR*. December 10,1999;48.
[PubMed](#)
 3. Gostin LO. *Public Health Law*. Berkeley, CA: University of California Press; 2000.
-

James C. Thomas, MPH, PhD, is an associate professor of epidemiology and director of the program of public health ethics at the University of North Carolina School of Public Health in Chapel Hill, NC.

Commentary 3

Notification of HIV status: Are There Limits to Patient-Doctor Confidentiality?

by Gregory W. Rutecki, MD

"Client-provider" confidentiality has been essential to the integrity of the learned professions for centuries, in fact dating back to a time long before the common era (BCE). Privileged communication is critical to the intimate conversations that characterize medicine, law, and religion. The earliest explicit codification of confidentiality in this context is contained in the Oath of Hippocrates (circa 400 BCE). "Whatsoever in the course of practice I see or hear, or even outside my practice in social intercourse, that ought never to be published abroad, I will not divulge, but consider such things to be holy secrets" [1]. Other medical oaths, written throughout recorded history, are characterized by rich cultural diversity—emanating from Islamic, Hebrew, Hindu, and Daoist sources, for example—and agree substantively with the tenets of the Hippocratic Oath and Corpus, including agreement on the issue of confidentiality.

The confidentiality mandate has been so important that other professions have followed medicine's lead. The durability of confidentiality in patient-physician, advocate-client, and priest-penitent interactions speaks to an almost universal penetration through eastern and western culture.

Although the professional's obligation (confidentiality) to keep the secrets of the other party (their right to privacy) can be agreed upon as a common good, are there any limits? The answer to this question is the crux of any ethical discussion related to Dr. Singh and Mr. Henry Roland. Would Dr. Singh breach any of the accepted precepts of the patient-physician relationship if she contacts Lisa with the news of her intimate partner's HIV status? Let's try to answer that question.

Hippocrates' Oath adumbrated the principle of professional privacy and influenced cultures separated widely by time and worldview perspective thinking. However, it seems that one statement in the Oath regarding privacy, namely, "Whatsoever (of what is seen or heard) ... that ought never to be published abroad," implies that there are times or contents of intimate conversation that should, by their very nature, be "published abroad." If this remains true today, it suggests that a "relative" rather than absolute value be applied to the "good" of keeping confidences that arise during medical encounters. What would specifically qualify as more important than the protection of privileged information? How about the protection of life itself as a higher good? If keeping the secret endangers life, limited sharing, to those who have a valid "need to know," is an ethical imperative.

Earlier attempts to provide limits to privacy included the scholarly physician Moses Maimonides. In his Mishneh Torah, preserving life took precedence over many other "goods," even one as strict as Sabbath keeping. But for

contemporary audiences, represented by many individuals who rely on legal precedent, the rationale justifying dissemination of privileged information has to be developed in more detail.

In 1969, Tatiana Tarasoff was stabbed to death by her boyfriend. Prior to her murder, the boyfriend confided to his therapist that he intended to kill Ms Tarasoff. The courts ruled that the therapist had a legal duty to warn Ms Tarasoff despite the fact the relevant information in question was considered protected by client-therapist privilege. As precedent, the judges quoted prior case law that determined that contagious diseases were to be reported if innocent parties outside the protected relationship were placed at risk.

More specifically, the courts have ruled similarly related to HIV positivity. Jennifer Lawson, a 12-year-old, was transfused with blood in 1985 [2]. One day later, her physician discovered that the transfused blood was HIV-positive. The physician did not tell Jennifer or her parents about the tainted transfusion. Three years later, Jennifer became intimate with Daniel Reisner. Two more years later, Jennifer developed AIDS and told Daniel. One month after that, Jennifer died of her disease. Daniel sued Jennifer's physician. The judges ruled in favor of Daniel and against the physician in question. The court's opinion was recorded thusly, "When the avoidance of foreseeable harm to a third person requires a defendant to control the conduct of a person with whom the defendant has a special relationship (such as physician and patient) or to warn the person of the risks involved in certain conduct, the defendant's duty extends to a third person with whom the defendant does not have a special relationship." *People v Jensen* [3] likewise decided that "HIV carriers must notify sexual partners." The duty to warn has been similarly applied in *DiMarco v Lynch Homes-Chester County* [4] concerning the sexual transmission of hepatitis-B virus to a third party.

From a strictly legal perspective, Dr. Singh is obligated to notify Mr. Roland's sexual contacts. Therefore, the Hippocratic Oath, other medical oaths from a diverse cultural sampling, Moses, Maimonides, and the courts as far back as the "Typhoid Mary" era have understood professional confidentiality as a good but a relative good. The preservation of human life is a far greater good, even if the life in question is outside the immediate context of a specific patient-physician relationship.

From a professional and logistic perspective, Dr. Singh could soften the blow a number of ways. She should encourage Mr. Roland to tell his partner because it is the loving thing to do, she has a right to know, and harm could ensue if she isn't informed. She could apprise Mr. Roland of the legal implications, for both the physician and patient, if sexual partners are not notified. She can reassure her patient that the confidence will only be shared with those who need to know, excluding all others. She could also educate Mr. Roland that "safe sex" with a condom is not a fail-safe guarantee that he will not transmit the virus to his partner. Some of the emotional stress of these particular encounters could be obviated in the future if physicians would inform their patients about the relativity of privileged sharing prior to intimate conversations. In fact, sharing diversity and worldview perspectives before contentious issues arise is good for the patient-physician relationship. To many patients, the physician's primary commitment to the protection of life should be viewed as a wonderful attribute.

References

1. Cameron NM. *The New Medicine: The Revolution in Technology and Ethics*. London, England: Hodder and Stoughton; 1991.
[Google Scholar](#)
2. *Reisner v Regents of University of California*, 31 Cal. App 4th 1195, 37 Cal. Rptr 2d 518. Accessed October 24, 2003.
3. *People v Jensen*, 231 Mich App 439, 586 NW2d 748 (Aug 28, 1998). Accessed October 24, 2003.
4. *DiMarco v Lynch Homes—Chester County*, 583 A 2d 422 (Pa 1990).

Gregory W. Rutecki, MD, is the E. Stephen Kurtides Chair of Medical Education at Evanston Northwestern Healthcare and an associate professor of medicine at the Feinberg School of Medicine Northwestern University in Chicago, Illinois. He is a fellow at the Center for Bioethics and Human Dignity. Available at: <http://www.CBHD.org>.

The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.

© 2003 American Medical Association. All Rights Reserved.