

Mandatory HIV Notification: Bioethical Concerns vs. Public Health Concerns, Health and Medical Dilemmas

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Abstract: The topic of mandatory HIV notification is controversial and conflicting for counselors and public health workers. Counselors may seek to maintain patient confidentiality and public health workers are concerned with combating the spread of sexually transmitted infections. Embedded between bioethical priorities and public health concern is the HIV positive patient. Thus, there exists a convoluted dichotomy between privacy and prevention; as it pertains to HIV notification for the patient, counselor and public health advocate. [The Journal of American Science. 2006;2(1):42-45].

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In understanding the complexities of HIV notification, it is imperative to understand and evaluate the critical public health laws regarding HIV/AIDS notification. Currently, all 50 states require mandatory HIV/AIDS reporting to state or local health officials, this policy is viewed as the first major statute. However, there is some variance among the states concerning different statutes mandated by state legislatures. According to Stephen J. Paskey and Karen H. Rothenberg, the privilege to disclose statute, which authorizes physicians to notify needle-sharing or sexual partners directly, without consent or previous knowledge of the positive HIV patient, varies the most among states (1995, p.1573). Physicians who adhere to the 'privilege to disclose' statute are immune from civil liabilities, which would ordinarily ensue from a patient breach of confidentiality; however, "in some states, including California, New York, and Pennsylvania, the privilege is restricted by carefully worded legal conditions" (1995, p.1573). The privilege to disclose statute is often synonymous to the duty to warn concept faced by counselors. The Tarasoff decision is the predecessor of the duty to warn concept. Essentially, *Tarasoff v. Regents of University of California*, 1976 stipulated that a "therapist who knew, or according to professional standards should have known, that a client posed a threat to another individual, has a duty to warn the intended victim" (Hazler & Stanard, 1995, p.397). Thus, the duty to warn is often viewed as a limitation of the confidentiality code.

Overall, it is not unreasonable to suggest that such statutes appear to be in conflict with patient autonomy and patient confidentiality. With respect to HIV notification, confidentiality is a particularly important notion. Beauchamp and Childress illustrate the importance of confidentiality by examining the ethical ideas of deontology and consequentialism (Bayer & Tooney, 1992, p. 1163). For the most part, the

deontological belief highlights the importance of the patient's trust in the counselor. The consequentialists advocate that confidentiality is important to uphold because it encourages patients to divulge information that would not be given otherwise, in the absence of confidentiality. Although counselors value the importance of confidentiality, they understand that confidentiality is not absolute, or without limitations (Bayer & Tooney, 1992, p.1163). For example, counselors recognize the need for communicating confidential patient information with other health care workers as parts of the client's care. However, the communication of confidential information to a third party that is not responsible for the treatment or care of the HIV positive patient is problematic for many ethicists. However, the divulgence of such confidential patient information may be significant for public health workers.

The practice of public health workers overriding patient rights is not a new concept. However, according to Carmody, the notion of individual liberties is a relatively new concept and was not widely recognized during the birth of aggressive public health measures (Carmody, 1999, p.112). For example, the practice of quarantining, isolation, and mandatory immunization were widely practiced without objection. Furthermore, according to Carmody, with the advent of sexually transmitted infections such as: Chlamydia, syphilis, hepatitis B, and gonorrhea, national contact tracing programs were firmly implemented during the late 1940s (1999, p.110). Thus, the practice of contact tracing, or partner notification is not a recent phenomenon. But there is objection to the practice because: "These strategies [such as, mandatory partner notification] remove control from the individuals' life and place it in the hands of government" (Carmody, 1999, p.113). Also, there was little objection to contact tracing because it provided the benefit of treatment and

decreased the prevalence of syphilis by the late 1950s (Carmody, 110). Despite many of the perceived benefits of mandatory HIV notification and its parallels to other sexually transmitted infections, the virus is unique in that there is no cure for HIV. The newfound presence of the bioethical perspective is also partially responsible for the controversy and inherent conflicts between the goals of the counselor and the goals of the public health worker.

As a result, there is a profound importance for public health laws and efficacy regarding mandatory HIV/ AIDS notification. The 1905 case of *Jacobson v. Massachusetts*, in which the statute for mandatory vaccination was challenged, is recognized as the foremost court decision regarding the limits and authority of mandatory public health measures (Carmody, 1999, p.127). The decision of the landmark case was that public health measures supercedes infringement of individual rights because “the police power of a state must be held to embrace, at least, such reasonable regulations... as will protect the public health and the public safety” (Carmody, 1999, p. 127). Consequently, in most states, physicians are legally responsible for reporting all new HIV infections and, to some extent, responsible for partner notification. Notwithstanding, disagreements certainly arise out of this practice, because of the unique nature of HIV. As Carmody points out, the practice of mandatory partner notification may adversely affect the scope of public health goals: “...mandatory partner notification may deter people from getting tested for HIV in the first place...[thus,] this necessity may actually be more of a liability in the state’s effort to protect the health of its citizenry” (1999, p.128).

Still, there is a concern over a patient’s breach of confidentiality and a counselors’ duty to warn the partners of positive HIV patients. There appears to be a direct conflict of interest. Rebecca Stanard and Richard Hazler address the conflict of confidentiality versus the duty to warn and assert, “[that] confidentiality is an essential component of counseling practice whose original intent was to promote full client disclosure and protect clients from stigmatization” (1995, p. 397). Stanard and Hazler, like many other bioethicists, maintain this view despite the 1976 benchmark case of *Tarasoff v. Regents of University of California*. Essentially, the *Tarasoff* decision held that therapists had a duty to warn third parties (such as, sexual partners of HIV positive patients) of inherent danger and victimization. The *Tarasoff* decision presented limits to the notion of confidentiality; perhaps, even, a complete breach of patient confidentiality. Regardless of its flaws, it is important to note that the *Tarasoff* decision has limitations and ethical benefits. Eliot D. Cohen advocates the significance of the *Tarasoff* decision from a utilitarian stance (1990, p. 283). However, because of

its foreseeable conflict of interest, application of the *Tarasoff* decision dictates strict caution from the clinician and that the decision be used only as a last resort, after all other possibilities have been exhausted. *Tarasoff* mandates three conditions before its application: “(a) a special relationship, (b) a reasonable prediction of conduct that constituted danger; and (c) a foreseeable victim (Gehring, 1982)” (Hazler & Stanard, 1995, p. 398).

Overall, it is imperative that HIV counselors and physicians be mindful of ethical principles as guidelines for their decision making. There are two major ethical theories that concern confidentiality and a counselors’ code of ethics: utilitarianism and Kantian ethics. Utilitarianism consists of the questions “how much good will the performance do?” and “how likely is it to produce this value” (Cohen, 1990, p. 282). Similarly, Kantian ethics upholds the strict belief that persons never be treated as objects and that persons must “be willing to accept the logical implications of the reasons for their actions when these reasons are applied to all relevantly similar cases (Hazler & Stanard, 1995, p. 399). The two major ethical theories set the framework for rudimentary ethical principles, established by Kitchner, which include autonomy, non-maleficence, beneficence, justice and fidelity.

However, because HIV and AIDS are classified as highly infectious and without a cure, positive patients have a limited scope of confidentiality protection (Curran & Gostin, 1987, p. 364). Much of the debate concerning prominent ethical principles and the duty to warn centers around the question posed by Posey: “who is responsible for whom?” (Hazler & Stanard, 1995, p. 398), and to what extent should that responsibility be exercised by counselors and public health officials. There are countless proposed answers to Posey’s question, whom herself viewed the *Tarasoff* as a last resort. Conversely, Gray and Harding strongly advocated breach of confidentiality, by direct informing of sexual partners if the client does not take the action him or herself, because of the fatality of HIV and its lack of an existing cure. Ultimately, the decision to breach confidentiality should be made in conjunction with the ethical principles defined by Kitchner, and with the unique judgment of the counselor and the physician.

The judgments of the counselor and physician are not absolute, or always ethically correct. Norton et al, concluded that there is a pattern of decision among physicians who breach the confidentiality of HIV positive patients. A stratified random sample of 628 primary physicians, practicing in Tennessee during 1986, indicated that a patient’s sex, race, sexual preference and socioeconomic status were taking into consideration before a physician decided to breach or uphold patient confidentiality (Norton et al., 1990, p.829). The study concluded that “Black heterosexual

women and homosexual men were less likely to have their confidentiality maintained,” which was of little surprise because of the “stigmatization of Blacks, more specifically of Black men, by Whites” (Norton et al., 1990, p. 833).

The Tennessee study illustrates some of the flaws, which result from confidentiality breaches and mandatory HIV notifications. Sadly, the practice of overt breaching of confidentiality, which can sometimes be inconsistent and biased, for HIV positive patients can cause serious ramifications for already suffering patients who must cope with their HIV positive status (Carmody, 1999, p.108). Adverse risks of HIV positive persons include: stigmatization, isolation, domestic violence, depression, and suicide. The risk for domestic violence and depression is of particular significance for females.

Rothenberg and Paskey stress the importance of specialized intervention and partner notification procedures for women, which must be responsible for placing the safety of women as paramount (1995, p.1574). Mandatory partner notification and confidentiality breaches create a second problem; in that it may discourage HIV testing. In such cases, persons who are infected with HIV will forgo treatment and counseling for the sake of maintaining privacy and autonomy. Although such a stance would be highly counterproductive for public health workers, it is a rationale decision from the psychological view of a person who seeks to maintain his or her privacy. Furthermore, people who refuse HIV testing are more prone to late diagnosis and susceptibility of spreading the fatal infection. Clearly, the benefits and harms of mandatory HIV notification must be further analyzed because, “Mandatory HIV partner notification weighs the value of public health over the individual personal liberties of HIV infected persons” (Carmody, 1999, p. 135). And, such a stance is in direct contrast to autonomy and justice. In the aspect of patient isolation, depression, and suicide, mandatory HIV notification can be reasonably viewed as an action that conflicts with the principles of nonmaleficence and fidelity too.

Above all, breaches of patient confidentiality poses profound problems for the traditional relationship of trust between a patient and a counselor. A patient is less likely to speak freely with his or her counselor when confronted with the issue of trust and breach of his or her confidentiality. Such an action would prevent proper treatment and counseling in all capacities. Thus, “Counseling should be sensitive to the cultural, historical traditions and prevailing public health practices, social values and political differences in attitude toward the importance of treating someone as a private individual” (Lie & Sauka, 2000, p. 737). In other words, it is important to maintain the perspective of treating and counseling the HIV positive patient as an

individual and not merely as another case. Since, a paucity of physician trust and confidentiality can have negative implications the quality of patient care. Such practices of trust and confidentiality must be demonstrated to the patient ensure treatment.

Mandatory HIV notification has not been proven effective at lowering transmission, it “is really only effective in slowing transmission in situations where the notified partner is unaware that the behavior he has been engaging is risky, and is willing to discontinue that behavior” (Carmody, 1999, p. 109). Therefore, there are some benefits of HIV notification for sexual partners. Also, epidemiological studies have shown mandatory HIV notification to be successful with people who are not readily exposed to HIV counseling and HIV notification, such as in rural communities (Carmody, 1999, p. 109).

Similarly, mandatory HIV notification to U.S. Departments of Health does present countless benefits for the public health spectrum. For example, Andrew Bindman and Grant Coflax indicate that HIV notification enables public health departments to link HIV positive patients with “medical referrals, risk reduction counseling, and partner notification programs” (1998, p.1158) and to monitor long-term counseling and treatment. However, one has to question if such practices are truly in the best interest of the HIV positive individual. In other words, an HIV positive person may feel that such programs, despite their perceived benefits by public health advocates, are intrusive and insensitive to their autonomy and privacy. But, public health advocates would assert that HIV notification presents rewards for the patient and the general public; it helps prevent the spread and control of an infectious disease that is currently without a cure. From the standpoint of the partner of the HIV positive patient, some ethicists would argue in favor of mandatory partner notification. One who may have been infected has a moral right to know such information, so that he or she may get tested, seek treatment, or take preventive measures for their own autonomy.

There is a fragile balance that must be maintained in the dilemma between HIV notification and HIV prevention for public health workers, bioethicists, counselors and the HIV positive patient. Despite the delicate issue of HIV notification and confidentiality, it is clear that confidentiality has a binary aspect of not being absolute yet of great importance for counselors (Hayter, 1997, p.1163). The twofold position of confidentiality exists because of the responsibility to protect the public health and the greatest number. However, “some mantras of bioethics...are not necessarily congruent with the greatest benefit to the greatest number” (Lachman, 1998, p.302). And, the principles of bioethics should not be a function of merely the greatest number, but also the individual.

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