HIV Prevention and the Two Faces of Partner Notification

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ABSTRACT

In the cases of medical patients with sexually transmitted diseases (particularly those with the human immunodeficiency virus), two distinct approaches exist to notifying sexual and/or needle-sharing partners of possible risk. Each approach has its own history (including unique practical problems of implementation) and provokes its own ethical dilemmas. The first approach—the moral "duty to warn"—arose out of clinical situations in which a physician knew the identity of a person deemed to be at risk. The second approach—that of contact tracing—emerged from sexually transmitted disease control programs in which the clinician typically did not know the identity of those who might have been exposed. Confusion between the two approaches has led many to mistake processes that are fundamentally voluntary as mandatory and those that respect confidentiality as invasive of privacy. In the context of the AIDS epidemic and the vicissitudes of the two approaches, we describe the complex problems of partner notification and underscore the ethical and political contexts within which policy decisions have been made. (*Am Public Health* 1992;82: 1158–1164)

As public health officials confronted the acquired immunodeficiency syndrome (AIDS) epidemic in the early 1980s they came to recognize the crucial importance of confidentiality. Only if those at risk for human immunodeficiency virus (HIV) infection could be convinced that their clinical encounters would not be disclosed without their consent could they be encouraged to undergo counseling and testing. Thus, the Centers for Disease Control (CDC),[1] the Surgeon General,[2] the Institute of Medicine and the National Academy of Sciences,[3] and the Presidential Commission on the HIV Epidemic[4] all came to stress a common point: that the protection of the public's health was not compromised by the protection of confidentiality. On the contrary, the protection of confidentiality was a precondition for the achievement of public health goals.

Although the protection of confidentiality was supported by public health officials, gay rights organizations, and civil liberties groups, the best strategy for reaching those unknowingly placed at risk for infection or those who might inadvertently place others at risk was the subject of profound disagreement. Thus did deep and sometimes bitter disputes arise over partner notification in the epidemic's first decade.

Disagreements over the scope and limits of the principle of confidentiality, deep distrust over the motives of public health officials, doubts about the relevance and potential efficacy of traditional public health approaches to sexually transmitted diseases in dealing with AIDS, and the enduring suspicions of those who viewed government agencies as a source of endangerment rather than protection were all involved in the controversy. Each of these factors helped to shape the context within which a profound confusion emerged between two very different approaches to informing unsuspecting third parties about their potential exposure to medical risk.

Each approach has its own history, including a unique set of practical problems in its implementation, and provokes its own ethical dilemmas. The first approach, involving the moral "duty to warn," arose out of the clinical setting in which the physician knew the identity of the person deemed to be at risk. This approach provided a warrant for disclosure to endangered persons without the consent of the patient and could involve the revelation of the identity of the "threatening" party (the index patient). The second approach—that of contact tracing—emerged from sexually transmitted disease (STD) control programs in which the clinician typically did not know the identity of those who might have been exposed. This approach was formally predicated upon the voluntary cooperation of the patient in providing the names of contacts, never involved the disclosure of the identity of the index patient, and entailed the protection of the absolute confidentiality of the entire process of notification.

Confusion between the two approaches has led many to mischaracterize processes that are fundamentally voluntary as mandatory, and processes that respect confidentiality as invasive of privacy. As late as 1988, the *Washington Post* described the "inherent" conflict in contact tracing between "two fundamen-

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tal principles rooted in law and ethics: the individual's right to privacy and the duty of health officials to warn those they suspect or know are in danger."[5] Such misapprehensions were, however, not limited to the popular media. They extended to groups and individuals more familiar with public health practices. In writing about the counterproductive consequences of mandatory measures for the control of the HIV epidemic, June Osborn, dean of the School of Public Health at the University of Michigan and currently chair of the National Commission on AIDS, said, "As to mandatory tracing of the sexual partners of persons with AIDS, the justification offered is that it is a tried and true method of controlling STD, but in fact it has never worked well."[6]

What can account for the misunderstandings that fed the political controversy? In part, the conceptual confusion can be traced to the tendency to use the same terms—"contacting," "notifying," "protecting," "informing"—to describe the goals of both approaches to informing those placed at risk for HIV infection. The confusion may have been compounded inadvertently by the adoption of the term "partner notification" by the United States Public Health Service (PHS) and the Association of State and Territorial Health Officials in 1988, and by the Global Programme on AIDS of the World Health Organization in 1989, to describe the full scope of outreach efforts that range from individuals informing their own partners to contact tracing by public health workers, and even disclosure by physicians without the consent of their patients.

In this article, we describe the complex problems provoked by attempts in the past decade to implement partner notification. We examine the vicissitudes of the two approaches, underscoring the ethical and political context within which policy decisions have been made. Finally, we argue that in a rapidly changing clinical context in which the early identification of those with HIV infection has become important, and in the context of the changing epidemiology of the epidemic, efforts at partner notification—especially those based on the contact tracing tradition—will play an important public health role.

The Tradition of Contact Tracing

In 1936 Thomas Parran, the architect of the federal anti–venereal disease program, told the National Conference on Venereal Disease Control, "Every case must be located, reported, its source ascertained and all contacts then informed about the possibility of infection, provided with a Wasserman test, and if infected treated" (Centers for Disease Control [CDC], unpublished document, April 30, 1987). Only such an effort, he believed, could break the "chain of disease transmission." In the 1940s, when effective treatments for syphilis were developed, contact tracing became a central feature of all STD programs. These efforts were labor intensive and dependent on resources available to public health departments, but on each occasion when concern about STDs intensified, contact tracing was viewed as a cornerstone of the control strategy. This was the case with syphilis in 1961, gonorrhea in 1972, and chlamydia in 1985 (CDC, unpublished document, April 30, 1987).

Clinicians in STD control programs often did not have knowledge of a patient's background or family relationships. To elicit the names of sexual contacts, it was therefore necessary to obtain the cooperation of the index patient. Although considerable pressure might be applied, and indeed there are undocumented reports that on some occasions STD workers threatened to withhold treatment from those who would not provide the names of contacts, typically the patient's willingness to cooperate dictated the ultimate success of the partner-locating effort. To facilitate such cooperation, STD programs promised that the identity of the index patient would never be made available to contacts who were named. The index patient maintained ultimate control over the process, retaining the ability to withhold or provide names. Thus, the tradition of contact tracing was predicated on the voluntary cooperation of index patients and on a striking commitment to the protection of their anonymity. There were, quite obviously, circumstances when the identity of the index patient could be deduced even if he or she was not named, the paradigmatic case being the monogamous partner who was informed that he or she had been exposed to an STD. Yet even in such situations the two central principles of contact tracing remained uncompromised. The public health worker would not confirm the identity of the obvious source of exposure. Even when the index patients themselves requested that their identity be revealed to contacts, no exceptions were to be made.[7]

Despite the four decades of experience with contact tracing, all efforts to undertake such public health interventions in the context of AIDS met with fierce resistance in the first years of the epidemic.[8] Opposition by gay leaders and civil liberties groups had a profound impact on the response of public health officials, especially in states with relatively large numbers of AIDS cases. In San Francisco, a proposal that health department staff offer contact tracing services to bisexual men whose female partners might unknowingly have been placed at risk was denounced as Orwellian because of the prospect of creating lists of bisexual men and their partners.[9] Even greater antagonism greeted the possibility of creating lists of the homosexual contacts of gay men, because of fears of discrimination. Homosexual behavior, it was argued in the early and mid 1980s, was still a crime in 24 states, and the Supreme Court had declared in *Bowers v Hartwick* that sodomy laws represented a constitutional exercise of state authority. Thus, in the course of an especially bitter controversy sparked by the Minnesota Department of Health's effort to launch an aggressive contact tracing program in 1986, one opponent declared that "the road to the gas chamber began with lists in Weimar Germany."[9]

Underlying this debate was the fact that in the first years of the AIDS epidemic, no therapy could be offered to asymptomatic infected individuals. Thus, the role of contact tracing in the context of HIV infection differed radically from its role in the context of other STDs. In the latter case, effective treatments could be offered to notified partners. Once cured, such individuals would no longer pose a threat of transmission. In the case of HIV, nothing could be offered other than information about possible exposure to HIV. For public health officials, who saw in such information an opportunity to target efforts to foster behavioral changes among individuals still engaging in high-risk behavior—behavior that could place both the individual contacted and future partners at risk—that was reason enough to undertake the process. For opponents of contact tracing, the very effort to reach out to such individuals represented a profound intrusion on privacy with little or no compensating benefit. The task of behavioral change, they asserted, could be achieved more effectively and efficiently through general education.

Although by 1988 all 50 states were establishing the capacity to offer contact tracing services at the request of the index patient, only 22 states emphasized such an approach. With the exception of Florida, these tended to be states with relatively low numbers of AIDS cases.[10] Doubts about effectiveness and about the costs of so labor-intensive an approach to AIDS prevention partially explain the resistance to emphasizing contact tracing, but more important was the political opposition to such efforts, opposition that was most visible and effective in the states that had borne the brunt of the epidemic.

Local resistance to contact tracing also shaped the efforts of the CDC to encourage the states to make available some form of partner notification. In the *Federal Register* announcement of the HIV/AIDS prevention cooperative agreements supported through the Division of STD/HIV Prevention at the CDC for the fiscal year 1988, grant recipients were asked to "encourage seropositive patients to refer their sex or needle-sharing partners and offer them guidance in making referrals when feasible; and provide assistance by notifying their partners and counseling them . . . if they prefer."[11] By the following year, the grant announcement required recipients to "establish standards and implement procedures for confidential notification of sex and needle-sharing partners of AIDS cases and HIV seropositive individuals."[12] For fiscal year 1990, the agency went further and specified that grant recipients should, "where appropriate, offer health department assistance in confidentially notifying partners."[13] The definition of appropriate circumstances was left to the individual states. Despite the belief of those responsible for STD control programs that the traditional model of contact tracing—now called the "provider referral" model of partner notification—would be more effective, emphasis continued to be placed on the importance of having patients notify their own partners.

By the late 1980s, the debate over contact tracing had shifted from one centered on the ethical issues of privacy to one focused on efficacy. The debate was fueled by questions that had begun to surface about the utility of contact tracing in the control of syphilis in populations where individuals had large numbers of sexual partners, many of whom were anonymous.[14–16] This transformation reflected a maturing of the discussion. Early misapprehensions about the extent to which public health officials typically relied on overt coercion in the process, and the degree to which confidentiality might be compromised, had by decade's end all but vanished. With such political concerns allayed, many gay leaders had come to recognize that partner notification, in fact, could be a "useful tool" in efforts to control AIDS.[17]

But as opposition to the tradition of contact tracing on the part of those committed to privacy all but vanished, a quite different source of opposition emerged, one that challenged the two central principles of the contact tracing tradition—voluntarism and index-patient anonymity.

The failure to reveal the name of the index patient to those who were notified could, some critics asserted, result in an inadequate warning regarding the source of potential ongoing exposure. These claims were embedded in a much broader political challenge to AIDS policies in the United States that viewed the concern for the protection of the rights of those with HIV infection as a capitulation by public health officials to those with a libertarian agenda. Conservative critics of AIDS policy in California proposed a state law that would have required those who were infected with HIV to reveal the names of all their partners.[18] With an almost willful disregard for the complexity of efforts to encourage those with STDs in general, and HIV more specifically, to reveal the names of their partners—Just how could someone be compelled to reveal names?—the challenge to voluntarism and index-patient anonymity embodied in such legislative efforts entailed a rejection of the lessons of four decades of contact tracing, lessons that were rooted in the pragmatics of STD control.

Alarmed by such efforts to undermine the integrity of the contact tracing model and by the havoc that might ensue if the long-standing commitments to voluntarism and confidentiality were reversed, officials at the CDC wrote of the damage that could follow a change in programmatic course. Citing data that indicated that an end to index-patient anonymity could result in a dramatic decline in the willingness of individuals to collaborate with public health officials, Willard Cates and his colleagues concluded that

> guarding confidentiality as part of partner notification is a long-standing public health activity and is critical to the control of bacterial STD. Even though viral STDs are different because of their persistence, the public health principle of confidential partner notification is still valid.[19]

Efforts to subvert the process of contact tracing by imposing compulsory features, and the debates about the ethical justification and wisdom of such efforts, must be understood in light of the concern over the extent to which clinicians who knew that their HIV-infected patients would not inform their partners were obligated to breach confidentiality to notify those at risk.

The Duty to Warn

As physicians were called upon to treat patients with infectious diseases, it was inevitable that they would be confronted by the question of whether the duty to protect the privileged communications within the clinical relationship took priority over the obligation to protect others from their patients' communicable conditions.

A misreading of a number of early 20th century cases has led some commentators to conclude that state courts had established an affirmative duty to breach confidentiality to protect known third parties.[20] Indeed, it was such a misreading that permitted the California Supreme Court to claim the authority of precedent when in 1974 it crafted a doctrine that represented the most striking judicial challenge to the professional discretion of physicians when faced with patients who might endanger third parties. The "protective privilege ends where the public peril begins," wrote the majority in Tarasoff *v* Regents of California.[21] In this 1974 case the court held that a psychotherapist could be held liable for failing to take adequate steps to protect the known intended victim of his patient, in this instance a patient who had threatened to murder his former girlfriend.

The decision drew a great deal of attention and provoked sharp debate. What had been a matter of professional discretion had been transformed by the court into a legal obligation. It was thus with *Tarasoff* that the contemporary legal conception of a duty to warn or protect was created. The precise nature of the required action on the part of the physician was dependent on the unique circumstances involved. The court stated that efforts to protect or warn must be undertaken "discretely [*sic*] and in a fashion that would preserve the privacy of the patient to the fullest extent compatible with the prevention of the threatened danger."[22] For the American Psychiatric Association, *Tarasoff* represented a grave threat to the therapeutic relationship founded on patient candor and involved unacceptable assumptions regarding the capacity of psychiatrists to predict dangerous behavior.[23]

At the root of the *Tarasoff* decision was an ethical judgment that, although confidentiality was crucial for individual patients' autonomy, the protection of third parties vulnerable to potentially serious harm must be given priority. As a matter of moral principle, that determination provoked widespread support. What remained a matter of great controversy, however, was the question of whether such a determination represented wise public policy. Would the recognition of a legal duty to warn or protect so subvert the trust necessary to the therapeutic relationship that patients with violent fantasies would be constrained from talking about them with their therapists? Would the reduction in candor ultimately harm the public good by limiting the capacity of therapists to help their patients control their dangerous behaviors?

The *Tarasoff* doctrine and its ethical underpinnings provided the backdrop to the disputes that would surface as physicians confronted the dilemma of how to respond to HIV-infected patients who refused to inform their needle-sharing or sexual partners of their exposure[24–27] when the clinician knew the identity of the endangered party. For some the dilemma arose solely in the context of partners who quite obviously had no reason to suspect that they had been placed at risk, the paradigmatic case being the female partner of a bisexual man. Other physicians extended their concern to those who might have reason to know but might nevertheless be ignorant of the risk to which they had been exposed, for example, the gay male partner in a long-standing, apparently monogamous relationship. The choices to be made would be all the more difficult given the extraordinary efforts that had been made to protect the confidentiality and rights of those infected with HIV. In fact, many early state statutes enacted to guard the privacy of HIV-related records precluded the exercise of professional judgment about whether confidentiality should ever be breached. This was the case in California, the home of the contemporary legal doctrine of the duty to warn or protect.

As legal scholars and ethicists confronted this issue, they often concluded that breaches of confidentiality could be justified. Writing in the *American Journal of Public Health,* Larry Gostin and William Curran concluded, "When there are strong clinical grounds for believing that a specific contact has not been informed who is in serious danger from exposure to HIV, the prudent course for the physician is to notify the contact of the positive serological status of the patient."[28] Grant Gillett made the strongest moral argument for breaking the prima facie duty to protect confidentiality in the case of an HIV-infected patient who refuses to modify his or her behavior or inform sexual partners:

> In asking that his affairs be concealed from others, a person is demanding *either* the right to preserve himself from the horrors that might befall him if the facts about his life were generally known *or* that his sensitivity as an individual be respected and protected. On either count it is inconsistent for him to claim some moral justification for that demand when it is made solely with the aim of allowing him to inflict comparable disregard or harm upon another.[29]

Margaret Somerville and her colleagues echoed this perspective when they stated, "The objective of medical confidentiality is perverted if it is used to facilitate the intentional transmission of disease."[30] The controversy continued, however, over the questions of whether such disclosures should be viewed as morally obligatory or discretionary; whether the morally obligatory should be made a legal duty; and whether, in warning contacts, the identity of the index patient should ever be revealed.[31]

Although the American College of Obstetrics and Gynecology maintained in a set of ethical guidelines that the wishes of the patient took precedence over any other concern, even in the case of STDs,[32] the American Psychiatric Association, the American Academy of Family Physicians, and the American Medical Association have all supported the warning of unsuspecting partners by physicians as a matter of professional ethics. Although such support is far from the endorsement of legislative efforts to mandate warnings as a matter of law, the enunciation of such moral principles may encourage those who believe that a fully enforceable duty to warn should be created.

Despite its opposition to the *Tarasoff* decision, the board of trustees of the American Psychiatric Association declared in 1987 that if a patient refused to change his or her behavior or to notify a party at risk known to the psychiatrist, it was "ethically *permissible* for the physician to notify [the person] who the physician believes to be endangered"[33] (emphasis ours).

The American Academy of Family Physicians went further and declared in 1990 that if a physician failed to convince a patient to inform a partner at risk about his or her HIV infection, the imperative that these persons be informed "supersedes the patient's right to confidentiality" (American Academy of Family Physicians, board meeting minutes, April 18–20, 1990). Under such circumstances, the academy said, the physician is ethically obligated to warn partners at risk.

The Council on Ethical and Judicial Affairs of the American Medical Association (AMA) promulgated a more elaborate position, declaring that if a physician failed to get a patient to notify an endangered partner, efforts should be made to enlist the assistance of local public health departments to undertake the necessary warning. If such efforts were unsuccessful, then the physician should take whatever steps were necessary to inform the unsuspecting partner. This position was endorsed in mid-1988 by the AMA's House of Delegates. In commenting on the significance of this decision, the newly elected president of the AMA, James E. Davis, declared:

> This is a landmark in the history of medical ethics. We are saying for the first time that, because of the danger to the public health and the danger to unknowing partners who may be contaminated with this lethal disease, the physician may be required to violate patient confidentiality. . . . The physician has a responsibility to inform the spouse. This is more than an option. This is a professional responsibility.[34]

These moves by the medical establishment alarmed defenders of civil liberties and gay rights advocates. To those who had devoted themselves so assiduously to the effort to win the support of public health officials for ironclad protections of confidentiality, and who had been so successful in achieving support for strict confidentiality enactments in many state legislatures (most notably in those states most affected by the AIDS epidemic), these professional assertions represented a dire turn of events. The enunciation of a professional duty to warn also provoked frequent warnings about the potentially counterproductive consequences of such a position—that individuals would be discouraged from seeking voluntary HIV testing and counseling. Thomas Stoddard, Executive Director of the Lambda Legal Defense and Education Fund, declared that "this would undermine to its root the physician-patient relationship and undermine the effort to control the epidemic. If patients feel doctors are going to rat on them," they would simply refuse to consult doctors.[34] Here the challenge was not only to the professional duty to disclose but to the older standard that accorded physicians the option to warn when they deemed it necessary.

As public health officials began to consider the issues posed by the warning of third parties discovered during the clinical work of physicians to be at risk, they sought to chart a response that was cognizant of both the centrality of confidentiality in the effort to control the spread of HIV infection and the importance of ensuring that known parties were informed of their possible exposure to HIV. In September 1988, mandatory notification was rejected in a report adopted by the Association of State and Territorial Health Officials, the National Association of County Health Officials, and the US Conference of Local Health Officials.[35] Instead of mandatory notification, these public health officials argued for a "privilege to disclose," thus freeing physicians from liability for either breaching confidentiality or not warning those who were at risk. In so arguing, these officials were reasserting the principle that had guided public policy in the era before *Tarasoff* and that historically had guided physician behavior.

The doctrine of the privilege to disclose was a political compromise designed to meet the concerns of a number of constituencies, not all of whom shared assumptions about the appropriate role of physicians in protecting vulnerable third parties from HIV infection. For all clinicians, the doctrine offered the freedom to make complex ethical judgments without the imposition of state mandates. For clinicians committed to warning as many unsuspecting partners as possible, it offered the opportunity to act on their professional obligations without being burdened by the dictates of the state. For those who believed that breaches of confidentiality were acceptable only in the rarest of circumstances, the privilege to disclose permitted a principled recognition that disclosure could be justified without the dangers associated with an overbroad commitment to notification.

Not only did the *Guide to Public Health Practice: HIV Partner Notification Strategies*[35] reject mandatory notification, it explicitly warned against ever revealing the identity of the infected individual, thus imposing on the process the standard of anonymity rooted in the practice of contact tracing: "The partner should be notified in the same way as if the index patient had asked for assistance in notifying the partner; that is, the identity of the index partner is not revealed." Finally, reflecting a belief that public health officials were best positioned to meet the challenge that originated in clinical practice, the report urged physicians to rely on public health departments to undertake the process of notification.

Between 1987 and 1989, 21 states adopted legislation explicitly confronting the issue of how and when physicians could warn unsuspecting partners. In all but two cases—North Dakota and South Carolina—mandatory notification was rejected. Five states explicitly prohibited the revelation of the identity of the infected party to the individual being notified (George Washington University Intergovernmental Health Policy Project, unpublished files, 1987–1989).

New York State's 1988 confidentiality law,[36] enacted after a complex process of political bargaining, carefully circumscribed the conditions under which notification might occur while prohibiting the revelation of the identity of the index case. Under the law, physicians may disclose the possibility of risk only when each of the following conditions has been satisfied: (1) the physician reasonably believes that notification is medically appropriate and that there is a significant risk of infection; (2) the patient has been counseled regarding the need to notify partners; (3) the physician has reason to believe that the patient will not notify partners; and (4) the patient has been informed of the physician's intent to notify partners and has been given the opportunity to express a preference as to whether the partners should be notified by the physician directly or by a public health officer. Although considerable latitude was thus provided for clinical judgment, the New York law clearly sought to avoid a situation of unbridled discretion, the kind of discretion that was of concern to Harold Edgar and Hazel Sandomire when they wrote, "What most surprises us is that so many legislatures are prepared to leave responsibility for the choice of whether contacts are made in the hands of physicians without . . . indicating the basis on which they are to make their choices."[37]

But the political compromise represented by the privilege to disclose was ultimately vulnerable to charges that in granting physicians broad discretion there was no way to ensure that individuals at risk would, in fact, be notified. Thus Stephen Joseph, then commissioner of health in New York City, challenged the privilege-to-disclose doctrine that only a year earlier he had helped to fashion when he testified before the New York State legislature that the state's physicians were failing to make use of their privilege to warn. He urged a statutory revision, making the notification of endangered, unsuspecting third parties known to the physician a legal duty.[38]

In some states the "duty to warn" perspective influenced practice even in publicly operated STD clinics. In Florida, for example, partners named by an index patient in a syphilis investigation are notified about their potential exposure to HIV if the index patient is subsequently diagnosed with HIV, even if that patient does not provide their names. Although the identity of the index patient is never revealed, this practice does represent a departure from the norm of voluntariness that is so central to the contact tracing tradition.

Although federal health officials have clearly supported efforts on the part of the states to fashion policy in this realm, the PHS could most directly set policy for the clinical services directly provided by agencies such as the Indian Health Service, the National Institutes of Health, or the Health Resources and Services Administration. And here federal officials opted for required notification of known partners when treating physicians believed that their patients with newly detected HIV infection would not undertake the process themselves. At the same time, the PHS rejected the opinion of some officials as well as pressure from conservative political leaders to mandate the revelation of the identity of the index patient (R. Windom, assistant secretary for health, memorandum, August 16, 1988). Following the model of partner notification derived from the tradition of contact tracing in STD control programs, anonymity of the index patient was to be maintained. To ensure that this policy was implemented, all PHS agencies were required to submit formal partner notification procedures to the assistant secretary of health for approval.

The commitment to index-patient anonymity was further underscored by the response of James Mason, assistant secretary of health, to an American Bar Association (ABA) recommendation asserting that in some circumstances the effective warning of third parties under the privilege to disclose doctrine might require the revelation of the identity of the index patient. The ABA group had reasoned that there were circumstances in which a partner in an ongoing relationship would have no reason to suspect that a particular individual was the potential source of infection, and that in these cases a failure to disclose such information would be tantamount to no warning at all.[39] In a letter to Walter H. Beckham, Jr, secretary of the ABA, on June 20, 1990, Mason responded by arguing that any support for a breach of confidentiality—even within the very limited clinical context dealt with by the ABA—might be construed by some as justifying such breaches in STD clinics where the contact tracing tradition held sway. As a result, the willingness of individuals to participate in programs where cooperation was predicated on strict adherence to the principle of confidentiality could be affected. Rather than risk confusion, the PHS chose to support patient confidentiality under all circumstances, even those in which the "duty to warn" tradition was being invoked. In so doing, the PHS determined that the ethical obligation of clinicians to unsuspecting third parties could be fulfilled through confidential notification, the standard that was central to the practice of contact tracing.

Conclusions

Early identification of HIV infection in asymptomatic individuals will become increasingly beneficial in the changed clinical climate produced by the availability of antiviral therapy, prophylactic antimicrobials, and other therapeutic interventions. The case for partner notification becomes especially important as the incidence of HIV infection shifts from gay middle-class men to other populations, in which the level of awareness is lower and the capacity to act on whatever awareness exists may be limited; the needs of poor Black and Hispanic women will bear special consideration.

As increasing numbers of individuals with HIV-related conditions come under the care of physicians in settings other than STD clinics, the question of the circumstances under which it is appropriate to breach confidentiality to warn unsuspecting partners will be faced repeatedly. Available evidence reveals that many persons who know themselves to be infected fail to inform their sexual partners of this fact.[40] Policy makers and clinicians will need to consider whether the process of notifying partners under such circumstances should be discretionary, as it now is under the doctrine of the privilege to disclose, or made mandatory. They will also have to consider whether identification of the index patient will be required if notification is to serve its protective function. Finally, they will have to determine whether clinicians themselves should undertake the process of notification when they know the identity of unsuspecting partners or whether that responsibility should be given to public health officials.

From the perspective of the ethics of the clinical relationship, those who may have been placed at risk unknowingly have a moral right to such information. They are entitled to such information so that they may take steps to protect themselves, so that they can seek HIV testing and clinical evaluation, so that they may commence treatment if necessary, and so that they may avoid the inadvertent transmission of HIV. The moral claim of those who have unknowingly been placed at risk entails the correlative moral duty of the clinician to ensure that the unsuspecting party is informed. Neither the principle of confidentiality nor the value attached to professional autonomy is an absolute.

Yet what seems so straightforward given the ethics of the clinical relationship is not so simple from the perspective of public health. As commentators have noted ever since the *Tarasoff* decision, it is possible that widespread awareness of the unconsented notification of third parties placed at risk (even when such notification is undertaken as a matter of professional obligation rather than legal duty) could discourage individuals from seeking care or from speaking candidly to their caregivers. Policy makers simply do not have sufficient data to resolve the question of whether unconsented disclosure would have this adverse impact. Thus policy will have to be made in the face of uncertainty. It will therefore be crucial to undertake carefully designed investigations to study the impact of physician disclosures to third parties so that public policy can be adjusted in the light of new evidence as it becomes available. Finally, since it is clear that private physicians are reluctant to undertake the process of notification—either because they believe it is beyond their professional responsibility and training or because the time involved is viewed as prohibitive—it will be necessary for public health departments to undertake the task of notification at the request of clinicians who know the identities of third parties who have been placed at risk. Despite its limitations, such an approach has the advantage of utilizing the skills of those who have been trained in partner notification and who are aware of how crucial confidentiality is to the process of informing contacts.

If the duty to warn poses difficult ethical questions, contact tracing does not. Contact tracing typically entails neither disclosure without the consent of the infected patient nor breaches of confidentiality. In fact, it can be argued that public health departments have a moral responsibility to undertake efforts modeled on the tradition of contact tracing programs that can inform individuals at risk about matters crucial to their lives and to the lives of their sexual and needle-sharing partners without recourse to mandatory measures.

But such a moral injunction may create difficult choices for policymakers, who must try to balance these activities with other moral claims on limited resources. Whatever the strengths of contact tracing, it is but one element in a much broader array of educational and programmatic efforts to limit the spread of HIV infection.[41] What proportions of the overall prevention efforts should be devoted to this labor-intensive and inevitably costly strategy? How are limited resources to be allocated among alternative strategies for achieving behavioral change? To these questions there can be no universal response, one that is applicable to all locales with their differing patterns of HIV infection. Targeted programmatic reviews based on the local epidemiological conditions and resource availability will be required. But what an advance it will represent to face the question of partner notification without the misconceptions that bedeviled discussions during the first decade of the AIDS epidemic. □

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