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# After HIV Testing:



## What's Next ?

Josie Lu O'Quinn and Polly Hulme

**N**urses and other health care providers involved in HIV testing are required to provide pre- and post-test counseling in accordance with guidelines from the Center for Disease Control (CDC, 1992). Clients who test positive are extensively counseled and educated on the nature of the virus, its modes of transmission, the need to practice "safer sex," and the obligation to advise sexual (and needle) partners (Preston, 1989). Some individuals do not inform their partners and this presents an urgent dilemma: Is a nurse bound by a client's right to privacy not to advise that client's partner of his or her HIV infection? Or does the duty to warn, and thus prevent possible harm to others, supersede confidentiality in this case?

This situation involves two competing societal values: the rights of the individual and the rights of the public as a whole. Individual rights, such as liberty and privacy, are the foundation of our society. At the same time, the public's health and safety, which constitute state interests, need to be secured (Northrop, 1988). Yet it is unclear just how much that state may control individual behavior to protect the public. At this point, there is no statute that requires health care providers to warn exposed third parties of the risks associ-

ated with their partners' infections (Melroe, 1990). California passed a law effective January 1, 1988 that allows doctors to directly inform spouses, but notification is not mandatory; a few other states have similar laws (Killian, 1990; Melroe, 1990).

### Standard public health measures seen as counterproductive

Public health measures seem to favor the privacy of the infected individual over the rights of informing the third party. The CDC recommends a policy of voluntary self-disclosure by the infected person (Reisman, 1988). Education and voluntary testing have been established as the only acceptable method of controlling the spread of the virus (Brown, 1987). These policies are due in large part to the nature of the disease. Such epidemic control measures as mandatory testing, contact tracing, and quarantines that have been used in the past are considered counterproductive with the HIV virus (Lindell, 1987).

What, then, is the obligation of the nurse who performs HIV testing—or cares for infected persons in the community—in regard to partner notification when education fails? Are the protocols set by the nurse's employing facility morally and socially respon-

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sible to all parties involved, or is this indeed possible? As with all dilemmas, there are no satisfactory answers. However, because both individuals and whole societies are affected by decisions of autonomy and confidentiality, such issues need to be thoughtfully clarified and considered, preferably before the need for a decision presents itself (Donovan, 1991).

Confidentiality is the cornerstone of the nurse-client relationship. Because it instills trust, promotes autonomy, enables human relationships, and insures fidelity, it is an inherent and respected ethical duty (Haddad, 1989). Confidentiality allows clients to seek assistance without fear of public disclosure, preserves the client's right to self-determination, and facilitates free disclosure of information (Brown, 1987). A nurse who discloses privileged information violates the client's rights to privacy and autonomy, and jeopardizes the nurse-client relationship, threatening the quality and effectiveness of further nursing care (Reisman, 1988).

### **Breaking confidentiality can result in ostracism**

Confidentiality is particularly crucial for HIV positive clients. Breaking confidentiality can result in loss of employment, eviction from housing, denial of medical insurance, ostracism from the community, and disownment by family and friends for the seropositive client (Preston, 1989). People at risk for HIV are often already members of groups subject to prejudice and discrimination (Gostin & Curran, 1987).

Knowing that partners could be notified if test results came back positive could cause a lack of trust in the health profession as a whole, and could cripple the voluntary testing program (Melroe, 1990). Many at-risk persons may not voluntarily get tested, knowing that confidentiality could be broken. This would seriously impede the overall public health goal of decreasing the spread of the virus, because more people would be ignorant of their infectiousness, as would be their sexual partners (Melroe, 1990). Further, it is conceivable that this practice would encourage more anonymous sexual behavior, to avoid being named and traced (Reisman, 1988).

The ANA's *Code for Nurses* (1987) maintains that the nurse safeguards the client's right to privacy by protecting confidential information. The right to privacy and the right to autonomy mandate personal control over information about oneself, and control of access to that information. This is extremely important for HIV-infected clients, who are definitely at risk of harm from disclosure of this information (Reisman, 1988).

### **The exceptions to safeguarding confidentiality**

The role of the health care provider is to maintain and promote health. If information exists that will directly harm another individual's health, then the duty to warn concept supports the health care provider in warning the third party, despite ethical and moral imperatives of confidentiality (Melroe, 1990). According to the ANA's

*Code for Nurses* (1987), there may be exceptions to safeguarding confidentiality when innocent parties are in direct jeopardy.

Legally, the health care provider is not bound to report a person who may be transmitting a communicable disease. However, court cases have set precedent that place liability on health care providers to warn persons at risk. The California Supreme Court's *Tarasoff v. The Regents of the University of California*, in 1976, found a psychologist liable for failure to warn a third party of his patient's intention to murder her (*Tarasoff v. The Regents of the University of California*, 1976). In regard to communicable diseases, courts have recognized the need for public safety by repeatedly ruling that a physician has the duty to warn others of their risk of infection (Gostin & Curran, 1987; Melroe, 1990).

### **Is the duty of confidentiality unconditional?**

The immediate function of the duty to warn is to protect the health of those at risk. The second reason to warn is to protect the public from the spread of a deadly, devastating disease. When the rights or interests of the public come into conflict with the individual's right to confidentiality, society takes precedence over the client (Northrop, 1988; Reisman, 1988). According to this argument, withholding information subjects the general public to greater risk of contracting the disease. Persons unaware that they have been infected have the potential to expose many others before they themselves have symptoms, perpetuating the spread of the disease (Kirkman & Bell, 1989). Also, providing for the confi-

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deniality of seropositive clients will not protect them from the devastation of the disease anyway (Kirkman & Bell, 1989). Since mandatory testing and strict quarantine of infected persons has been rejected as a method of slowing the disease, partner notification, whether by the client or the health care provider, is the only way to directly reach persons who may be spreading the disease unknowingly.

Although where the nurse lives and works mandates the required action, the question remains: What is the moral obligation of the nurse to the seropositive client who refuses to tell test results, and to the third parties involved, and at the same time protect the public from the spread of this fatal disease?



One of the main considerations of this dilemma is whether the duty of confidentiality is unconditional. Ethically, there *are* circumstances under which a health care provider is obligated to violate patient confidentiality. These depend on the client, disease, moral obligation, and rights of the moral agents (the client, health care provider, and third party) involved (DeSimone, Piscaneschi, Jaffe, & Engelberg, 1986).

In the case of HIV infection, despite educative efforts, the *client* does not want to reveal his/her disease and perhaps socially unacceptable life-style to a third party who is at risk of contracting this same disease. The motive for this reluctance would have to be stronger than the logic presented by education—perhaps revenge or fear of revenge, fear of abandonment, fear that others such as employers or insurance companies would find out, or mental incapacity. If confidentiality were broken in order to warn the third party, the health care provider would have to be particularly careful not to mention the seropositive client's name, although to some this would not protect their identity. Further, the seropositive client would need to be advised in writing before the disclosure took place.

**I**n terms of the *disease*, AIDS is almost always fatal with no cure. The virus thought to be responsible, HIV, is often transmitted by apparently healthy people engaged in intimate acts that public health measures cannot directly control nor prevent. Mass education may well be the only answer to controlling the epidemic, but until all people know how to protect themselves or are monogamous, there are always going to be third parties who have been unknowingly exposed. Without knowing their test status, infected third parties may not know they are infecting others. Additionally, such individuals can usually benefit from early treatment.

Some feel that the health care provider's sole *moral obligation* is to the infected client (Laufman, 1989). I believe the health care provider's moral obligation is to all parties who may have been exposed since there is no way to know if one is infected unless one is tested. Withholding this information to protect client confidentiality, particularly for clients who are refusing *their* moral obligation, is a misuse of professional power. The third party must, however, be well educated on the need for testing as well as all the other components of pre- and posttest counseling.

So far, this discussion has been limited to two moral agents: the seropositive client, who for justified or unjustified reasons refuses to notify his or her contacts, and the health care provider, caught between the bind of duty to confidentiality and duty to warn others who may be at risk. The third moral agent, the third party, requires some examination. First, who are the third parties? In some cases they may be wives of bisexual men. Others may be short- or long-time homosexual partners. And others may be the multiple nameless clients of an infected male or female prostitute. Ironically, the third parties hardest to trace, clients of prostitutes, are the ones posing the greatest public health

risk, while the most accessible third parties are the wives and lovers of infected individuals, and whose contacts are more limited.

## Reconcile conflicting rights on case-by-case basis

Whether a professional policy of partner notification will decrease voluntary testing can only be answered with time, perhaps in such states as California and New York that protect physicians who warn spouses. If partner notifications are only done when there is strong evidence that a third party is in danger of being unknowingly infected, and carried out in a way that protects the seropositive client's rights and privacy as much as possible, voluntary testing will probably not be significantly affected. The challenge to nurses is to assure continued social and legal protection of the professional ethic of confidentiality and the seropositive client's right to privacy, as well as the right of third parties to be warned of possible harm. Only in this way can ethical choices be compassionately made on a case by case basis. 🌐

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