CONCLUSION

In the final analysis, we may well agree with Smith and Martin about how the psychiatrist should handle this case. In this article we have tried to criticize not the answer, but the process by which the answer was reached. We urge ethicists who are dealing with a challenging case to use the process of case comparison in their analysis, examining a variety of analogous cases; to seek sufficient information to be able to identify all the moral issues in a case and situate the case in its proper taxonomic family; to attempt to develop creative, “least-restrictive” alternatives to ethical dilemmas; and to determine if there are ways that the ethical problem can be prevented in the future. Close attention to these points is likely to improve ethical decision making in the clinical setting and ethical analyses of cases presented in the bioethics literature.

ACKNOWLEDGMENTS

We would like to thank our friends and colleagues for their helpful comments on this paper: Lisa Parker, PhD; Joel Frader, MD; Peter Ubel, MD; and Shawn Wright, JD, MPH.

NOTES

4. Ibid.
5. N. Whitman, Creative Medical Teaching (Salt Lake City: University of Utah School of Medicine, 1990).

The Legal Dilemma of Partner Notification during the HIV Epidemic

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THE ISSUE

Law is a tempting treat. Who can doubt the allure of so dispositive a statement as: “That’s just the way it is.” Or more in a common-law manner: “That’s simply the way we have always done it.” To be spared the task and toil of reason, experience, and risk of personal error, each of us may willingly be tempted into panacean solutions, especially if any blame can be charged to America’s favorite scapegoats: lawyers.

In the midst of the HIV (human immunodeficiency virus) epidemic, a facile solution to the dilemma of partner notification is tempting. Assume the facts presented by Martin L. Smith and Kevin P. Martin. Seth, the HIV-positive adult, with knowledge of his status—even though he is at diminished capacity—entered into an intimate relationship with Maxwell, another adult, for at least two months. Maxwell ends his relationship with Seth and returns to a former lover. Some form of sexual activity is presumed. A psychiatrist, with societal obligations assumed through the Hippocratic Oath and civil and criminal enforcement requirements, learns of the relationship and is faced with the dilemma of informing Maxwell of Seth’s HIV status.

The dilemma is whether to promote Maxwell’s health and safeguard the health of others, or to maintain the confidentiality of his medical relationship with Seth. If Maxwell is told, he could be tested and—depending on the results—begin medical treatment immediately, thereby increasing his chances of survival. And, of course, he may be more likely to take precautions that could prevent the transmission of the disease to others. On the other hand, by violating confidentiality and disclosing
Seth’s HIV status to Maxwell, the psychiatrist risks exposing his patient to social and economic discrimination. And others, upon hearing about the psychiatrist’s breach of confidentiality, may avoid testing or even treatment. What to do? The psychiatrist’s duty to maintain doctor-patient confidentiality conflicts with his duty as a physician to warn third parties at risk.

A ONE-HANDED LAWYER

Law is not a talisman, but a present resolution of conflicting claims and passions. In the heat of conflict, amidst the oft-cited adage, “On the one hand . . . but then again on the other,” this wish is often heard: “My kingdom for a one-handed lawyer!” Dilemmas such as that of the psychiatrist are not easily resolved, and those who wish for the one-handed lawyer to make it so, misapprehend the function of law. “Reason is the life of the law; nay, the common law itself is nothing but reason.” There is no panacea, no facile solution, even though using the law as such is a tempting treat. Common law and statutory formulation should—must—result from the initial dilemma and the struggle through reason to a present resolution. Only a present resolution can be expected; reason abounds with experience and experience shifts, surprises, and—above all—progresses. Such an observation prompted U.S. Supreme Court Justice Oliver Wendell Holmes, Jr., to write: “The life of law has not been logic; it has been experience.” Reason and experience are the tools with which to construct an approach to the psychiatrist’s dilemma of partner notification.

Experience first tells us that partner notification is not something new with AIDS (acquired immunodeficiency syndrome). Communicable diseases such as tuberculosis, cholera, and venereal diseases prompted authorities in the past to locate the source of the infection; trace epidemics; and identify individuals who might be subject to cure, treatment, and quarantine. Little objection was raised against the state’s authority to provide for the health and safety of its citizens by requiring notification and treatment. This was due partly to less of an emphasis on privacy and the more casual nature of transmission for non-HIV diseases. Prior to AIDS, partner notification was axiomatic. The fact is that the law took a much stronger approach to containing health threats in the past. Laws “provided a warrant for mandating compulsory examination and screening, breaching the confidentiality of the clinical relationship by reporting to public health registries the names of those with diagnoses of dangerous diseases,” imposing treatment, and in the extreme cases, confining persons through the power of quarantine. Almost from the start, “HIV exceptionalism” exempted HIV from this forceful approach. Perhaps this is because of the virulent discrimination associated with AIDS; and perhaps it is because of HIV prevalence among homosexuals, intravenous (IV) drug users, and increasing numbers of racial and ethnic minorities. Also, the increased militancy of gays and lesbians in advocating both statutory and case-law reform should not be overlooked.

But note that the dilemma of partner notification is restricted to HIV-seropositive status—a condition that can be identified because of the HIV-antibody test. AIDS itself, the later condition characterized by opportunistic infections, has been considered a “reportable condition” in every state since 1983. And in 1990, the Centers for Disease Control (CDC) advocated reporting HIV status: “By using measures to maintain confidentiality, the implementation of a standardized system for HIV reporting to state health departments can enhance the ability of local, state, and national agencies to project the levels of required resources.” Subsequently, this standardized system was to provide “for partner notification and treatment services.” Partner notification has been recommended by both the American Bar Association and the American Medical Association; some states have even passed legislation granting physicians immunity from confidentiality if they warn sexual or needle-sharing partners of seropositive persons. But an essential element within the past context of partner notification was the anonymity of the infected person, so as to protect against discrimination and provide a climate of trust that would facilitate more testing and treatment.

Experience suggests that HIV was—and perhaps still is—enraged within an HIV-exceptionalism that rejects the forceful methods with which disease was controlled in the past. Exceptionalism today takes the form of greater concern for security of information and protection of confidentiality so as to promote testing within at-risk populations. There is a fine balance between notification and confidentiality. But experience is shifting, in that the disease is affecting a less affluent community and the context of individual liberty is less demanding.

The political forces that restrained government containment of disease within the stricture of individual liberty are produced by the burgeoning strength of the gay and lesbian community. But today HIV prevalence is shifting from homosexuals to poor, black, and Hispanic IV-drug users, and the concern is whether there will be a concomitant shift from HIV exceptionalism in legal response. Also, studies have demonstrated that treatment provides longer and healthier life if started earlier. Both of these experiences affect the legislative process and
result in greater efforts directed toward removing HIV from its exceptional status. Some regard exceptionalism as moribund: "The effort to sustain a set of policies treating HIV infection as fundamentally different from all other public health threats will be increasingly difficult. Inevitably, HIV exceptionalism will be viewed as a relic of the epidemic’s first years."27

Experience, however, does not command a return to a punitive past. A more balanced approach is possible, one that would combine the lessons learned from individual liberty with the societal benefits to be gained from identification and notification. Balance would result from lessons learned—"about mobilizing an effective campaign of public health education, about the central importance of involving . . . those who speak on behalf of those most at risk, and about the very limited and potentially counterproductive consequences of recourse to coercion in seeking to effect a radical modification of private behavior."28

Experience is teaching that punitive measures do not assist in meeting the health-care crisis. The Lambda Legal Defense and Education Fund reports: "Mandatory name reporting continues to discourage persons at risk from being tested for HIV antibodies, endangering such persons’ health and thwarting the stated objectives of public health authorities."29 At a 30 September 1992 meeting, attended by state health officials and senior officials at the CDC, mandatory name reporting was discussed. In recent years, 26 states have enacted mandatory name reporting.30 AIDS community activists admitted at the meeting that the goals of the name-reporting program may be to improve surveillance, target prevention efforts, facilitate voluntary partner notification, and enable treatment, but "closer analysis of actual experience with name reporting indicates that few of its purported benefits are ever realized."31 Yet, it seems that there are some benefits, and the degree of advantage depends upon the features of each state’s reporting scheme. Colorado, for instance, relies on a system of direct reporting of test results by laboratories to public health departments and then sends inquiries to each person testing positive. If requested, the state will assist with partner notification, and as a result of notification, "the State has identified hundreds of cases of previously-unknown HIV-infection."32 Since 1986, South Carolina has reported HIV infection by name and has provided medical referrals and voluntary partner-notification services to those desiring them. The CDC closely scrutinizes these data and offers them as an incentive for other states. They report, for instance:

In Missouri, approximately 25% of persons infected with HIV who were reported to the health department had been enrolled in a state-funded cases-management plan that offers CD4 testing, a medical evaluation, and zidovudine and other medications. Patients reported by personal physicians are offered care-coordination services and, for those who are eligible, provided insurance co-payments. In Minnesota, all persons reported with HIV-infection are offered counseling and partner-notification assistance by the health department; in addition, funding for education and prevention services targeted to adolescents has resulted directly from HIV-report data that demonstrated the need for intervention among this age group. Similarly, in Arizona, services available through the health department to HIV-infected persons include counseling, psychosocial and physician referrals, and zidovudine treatment.33

The services recounted by the CDC are impressive and incontestable. Nonetheless, AIDS activists continue to criticize mandatory name reporting because of one or all of the following: (1) it encourages persons at risk to avoid the health-care system; (2) it encourages persons to be tested anonymously out of state; (3) it is possible for sexual and drug-using partners to be notified without revealing the name of the original partner; (4) it is very expensive to notify partners (on average, more than $3,000 is spent to locate each case of previously undiagnosed HIV infection34); (5) harassment can occur when there is an intentional or inadvertent breach of confidentiality.35 And yet, even in light of the antagonism of mandatory reporting critics, there is much to be said of a system that intervenes and initiates treatment while seeking to provide for maximum confidentiality. Is this the preferred course today?

The record of experience suggests that allowing HIV-infected persons to notify sexual or drug-using partners voluntarily of possible infection has had limited success. In North Carolina, where law requires all HIV-positive persons to contact their partners, either themselves or through a counselor employed by the state, only 7 percent of partners were notified when notification was left to the infected person.36 Other parts of the country also indicate voluntary partner notification is ineffective: in Los Angeles, 52 percent of infected men kept their infection secret from one or more of their sexual partners, and demand for HIV testing increased 50 percent overall and 125 percent among gay men when anonymous testing was made available.37 In Oregon, from 1988 through 1991, public testing centers providing anonymous testing recorded increases in the number of persons requesting to be tested.38 Thus, evidence suggests that voluntary individual anonymity may promote more testing. But, on the other hand, those tested often do not return for the results, often fail to warn at-risk partners, and almost certainly avoid treatment.
that would prolong life. For example, since 1990, almost 70 percent of the 416 people who tested positive for HIV in the District of Columbia never returned to find out the test results. And, until recently, public health workers did not try to find those testing positive to deliver the news.35

Should the law exert pressure to help people help themselves and others? Pressure in this context consists of names, recorded and identified, and when this is available, the threat to confidentiality is clear and present. If anonymity is offered through the use of a fictitious name or the last four digits of a social security number, there is little evidence that partners at risk will be notified. If complete anonymity is offered, evidence suggests that the test taker himself or herself may never be notified. This dilemma was not present in past epidemics, since the factors suggesting HIV exceptionalism were not present.

If a health official were to poll persons at risk for HIV with the question, “Would you be willing to allow us to keep you and those you know alive?” the answer would be overwhelmingly positive. Nonetheless, actions speak louder than words, and evidence confirms that persons at risk are crossing state lines to utilize anonymous-testing centers, failing to notify partners of the possibility of infection, and neglecting to return for the test results after being tested themselves in an anonymous setting.36 Why is this? The human factor needs to be experienced. For instance, David Feinberg writes in Eighty-Sixed, a novel about life in the pre-AIDS and post-AIDS gay world, about secrecy and disease that has nothing to do with law, ethics, or health policy. He writes:

Philip Moscowitz has a neighbor in Jersey City who is ill but does not want him to tell anyone about it. He doesn’t want the pity of his friends; he doesn’t want them to treat him differently. He drops over and makes him dinner a couple of nights a week: a barbecued chicken from the deli, a green health-salad, and rice pudding for dessert. “Some days I wish I could tell someone else who knows him. It’s really hard, the burden of secrecy.”37

Many such tales are recited in other fictional and autobiographical stories, but the point is the same: people are afraid to know, they are afraid to tell someone else of disease and sexual preference, perhaps, and they are afraid to lose control over themselves. It is this human factor that must be experienced to understand the political, social, and legal issues inherent in the AIDS crisis.38 And it is this human factor that continues to rebel against a government entity—no matter how beneficial—knowing something so intimate as sexual preference, drug usage, or a sentence of death. Is it any surprise that the law seems so impotent when confronted with the dilemma of the psychiatrist who struggles between the burden of confidentiality and the benefits of care—albeit government interference. What to do? My kingdom for a one-handed lawyer.

THE STRAW THAT BROKE THE CAMEL’S BACK

If the law is to proceed with reason and to act upon experience, is there some factor that tips the balance one way or the other? The conclusion accepted by Smith and Martin in their analysis suggests that there is. Regarding the psychiatrist revealing the seropositivity of Seth to Maxwell:

There is support for the physician to warn [Maxwell, but] . . . there is greater support for upholding confidentiality in this case. The individual risk of discriminatory harm from disclosure is possible, although admittedly small. Further, it is reasonable to presume the third party’s awareness of his risk and of the risk to his sexual partner(s) of carrying the HIV virus, and thus, his awareness of the need for appropriate precautions.

The straw, so to speak, that makes the difference, is that it is reasonable to assume that “a gay or bisexual male is already aware of his risk and that of his sexual partner(s) for carrying the HIV virus. Warning a probably knowable third party about the HIV-positive status of a previous sexual partner may be of little benefit to the third party, while it risks the greater individual, societal, and professional harms.” The balance tips in favor of confidentiality when evidence suggests that the person at risk knows of both the probability of harm and the necessity of precaution. This seems reasonable based upon experience.

Implied consent, assumption of risk, and perhaps careless disregard can be cited as factors in deciding that the psychiatrist was not under either a legal or ethical duty to inform a third party of risk from HIV. But implicit within this is the probable knowledge of the at-risk person. Is this the true crucial factor applicable in all of our experiences? Do all medical blood recipients have probable knowledge? Consider the following classes of persons: organ recipients; homeless and IV-drug users; wives, husbands or lovers; the infant who is breast-feeding. Is it possible for the law to fashion a duty of care that would be applicable to all experiences requiring warning? It is no more than a tempting treat to suggest that any federal or state statute could resolve the myriad of situations—unless, of course, the law were to require notification for everyone at all times and in any circumstances. To do so would eliminate confidentiality in ethics, constitutionality in law,39 and treatment in medicine. Experience in all three disciplines supports this thesis. Thus, while the
ethical decision in the case presented by Smith and Martin was legally justifiable, there is something more that law may utilize as an experiential factor to be used within reason to offer better legal formulations. It is possible to suggest a legal formula that will utilize experience and present a method by which to resolve the dilemma presented by the psychiatrist.

The crucial factor—the true straw that breaks the camel’s back—is local involvement that will continue to balance the individual rights of the person with the community’s concern over health and safety. Partner notification from the perspective of the rights and duties of confidentiality between doctor and patient, or from the rights and duties owed to persons at risk, or even the rights and duties owed to persons who may eventually become infected or directly suffer the economic costs of the epidemic, may all be addressed in the paradigm of local control.

CONCLUSION

Medical treatment at the community level for those affected with HIV is consistently recognized as superior to national or even state efforts. This local involvement was the deciding factor in awarding grants under the Ryan White Comprehensive AIDS Resources Emergency Act of 1990. There, the federal legislation sought to support local health-care initiatives that had been proven effective by providing grants to continue services or to initiate others likely to be effective. Even in regard to legal issues such as partner notification, the sense of the legislation was to leave to the states “the complex decision as to whether to require identifying information based on the State’s assessment of whether gathering such information will discourage individuals from volunteering for counseling, testing, and early intervention services.”

The same pattern should be followed in addressing the legal dilemma of confidentiality versus disclosure.

Localities are far more likely to be sensitive to electorate pressures, and judicial decision making is likely to be better informed about local issues. Thus, the exigencies of San Francisco will not be entangled with those of Salt Lake City. Some may find that partner notification is effective and appreciated, as is suggested in South Carolina. Other states, such as New York, view such schemes as far too intrusive upon the privacy of the individual. The vast majority of states fall between the two. But the fact that New York is different from Los Angeles, which is different from Dallas, is not a weakness but a strength and, in the case of law, a federalist foundation implicit within the Constitution.

The facts contained within the dilemma of the psychiatrist are relatively easy in retrospect; confidentiality issues arise in far more situations and with complex parameters. The spectrum of persons affected encompass patients, children, lovers, spouses, blood recipients, and mother and child. The information is obtained through voluntary or involuntary testing, at public and private clinics, and with consent that is “borderline” informed. And the notification of test results can be by name or anonymously; notification should be accompanied by counseling, but this—like the medical attention that will prolong life—is often lacking. All of these factors compel the conclusion that the issue of partner notification is best left to local initiative. Law should not provide a tempting treat of a remedy to address each and every situation on all levels when law cannot possibly experience all of the parameters. Law is best utilized at the local level, perhaps most of all, because that is where the people affected are.

NOTES

1. See, for example, Landeros v. Flood, 17 Cal. 3d 399, 131 Cal. Rptr. 69, 551 P. 2d 389 (Cal. 1976), which permitted a complaint of malpractice against a physician and a hospital for failing to report serious injuries to a child that allowed for the child to be returned to a parent who subsequently abused the child again, Tarasoff v. Regents of the University of California, 17 Cal. 3d 425, 551 P. 2d 334 (1976), where a physician was civilly liable for failing to report a child victim of physical abuse. But see Mavroudis v. Superior Ct., 102 Cal. App. 3d 594, 600-1, 162 Cal. Rptr. 724, 729 (1980), where the court limited Tarasoff to cases where victims are readily identifiable; In re Estate of Voteler, 327 N.W. 2d 759 (Iowa 1982), which found no liability when the victim already knew of danger; Gammill v. United States, 727 F. 2d 950 (10th Cir. 1984), where the court of appeals for the 10th Circuit held that an Army physician had no duty under Colorado law or the Federal Tort Claims Act to warn the neighbors of a hepatitis victim. In Stroh v. Silverman, 186 Cal. App. 3d 671, 231 Cal. Rptr. 27 (1986), the court found that the state reporting statute conferred absolute immunity upon any physician deciding to report under reporting requirements.

incidence of opportunistic infections in patients with symptomatic HIV infection.

3. Evidence suggests that the homosexual community is taking such precautions.

4. Specifically in the epicenters of the AIDS epidemic, the high prevalence of infection estimated to exist among homosexually active men, combined with the increased infectivity believed to be associated with later stages of infection, confers a substantial risk of disease transmission by any single homosexual contact” (pp. 83-84).


5. Extensive findings concerning the risks of breach of confidentiality, and the public distrust of testing appear in Presidential Commission on the Human Immunodeficiency Virus Epidemic, Report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic (Washington, D.C.: U.S. Government Printing Office, 1988): As long as discrimination occurs, and no strong national policy with rapid and effective remedies against discrimination is established, individuals who are infected with HIV will be reluctant to come forward for testing, counseling, and care” (p. 119).

Indeed, to protect against deliberate or inadvertent disclosure, many professional groups recommend that anonymous HIV-antibody testing be available on a voluntary basis for anyone desiring it. See National Research Council, AIDS: Sexual Behavior and Intravenous Drug Use (Washington, D.C.: National Academy Press, 1989).

Recently, the New York Court of Appeals ruled that the New York health commissioner has discretion to withhold HIV infection from the state’s list of communicable and sexually transmissible diseases. The court found that the decision was rational because attendant reporting and contact tracing would be detrimental to the public health because it would discourage voluntary testing. New York State Society of Surgeons v. Axelrod, 72 N.Y. 2d 677, 569 N.Y.S. 2d 922, 572 N.E. 2d 605 (N.Y. 1991).


7. O.W. Holmes, Jr., The Common Law, quoted in Bartlett, Familiar Quotations, 643. The shifting and progressive nature of law is well described in another of Justice Holmes’s sayings: “The law embodies the story of a nation’s development through many centuries, and it cannot be dealt with as if it contained only the axioms and corollaries of a book of mathematics” (p. 643). With the patient-referral method, infected persons are asked to notify their partners of their disease and refer them to the health department for counseling and evaluation. When provider referral is used, trained public health counselors on the staff of the health department locate partners on the basis of the names, descriptions, and addresses provided by the patient, who may also notify partners and tell them of their risk of infection. During the notification process, counselors always preserve the anonymity of the [primary] patient.


9. For examples of the heightened awareness of privacy issues, see Illinois v. Adams, 149 Ill. 2d 331, 597 N.E. 2d 574 (Ill. 1992), which found that a statute requiring defendants convicted of prostitution-related crimes and other sexual misconduct to be tested for HIV does not violate the Fourth Amendment or its state counterpart, see also Watson v. Red Cross, 974 F. 2d 482 (4th Cir. 1992), which found that the federal district court did not violate a blood donor’s privacy rights in allowing the tort plaintiff, whose infant received HIV-infected blood, to propound court-approved interrogatories to the donor, whose identity would be divulged only to that donor’s lawyer, concerning the donor’s medical and blood-donation history and screening process; Most v. Tulane Medical Center, 576 So. 2d 1387 (La. 1991), which ruled that an HIV seropositive patient’s need to discover the blood donor’s identity outweighed the privacy interests of the donor and any public policy considerations favoring nondisclosure; Application of M.S. Hershey Medical Center, 595 A. 2d 1290 (Pa. Super. 1991), which permitted two hospitals to disclose a physician’s identity and his HIV-positive status to certain of his colleagues and to disclose to certain of his patients that...
the resident physician who participated in their surgical procedure or obstetrical care was HIV positive; Government of Virgin Islands v. Roberts, 758 F. 2d 898 (D.V.I. 1981), which ruled that the district court has authority, subject to constitutional limitations, to require extraction of blood for purposes of testing for HIV; Love v. Superior Court, 226 Cal. App. 3d 736, 276 Cal. Rptr. 660 (December 1980), which ruled that persons convicted of soliciting an act of prostitution could be ordered to undergo AIDS testing and counseling without denial of equal protection, due process, or protection under search and seizure.

10. There is a recent surge in the number of cases of tuberculosis, especially in large urban areas, see CDC, "Meeting the Challenge of Multidrug-Resistant Tuberculosis: Summary of a Conference," Morbidity and Mortality Weekly Report 41(1992): 51. Tuberculosis spreads on airborne droplets, and anyone sharing a poorly ventilated space with a sick person can contract the disease. According to CDC statistics, "The tuberculosis incidence rate for 1991 was 10.4 per 100,000 population, compared to 10.3 per 100,000 in 1990;" see CDC, "Tuberculosis Morbidity--United States, 1991," Morbidity and Mortality Weekly Report 41 (1992): 240. Cholera, recently appeared in Peru and quickly spread to other Latin American countries; see CDC, "Surveillance for Epidemic Cholera in the Americas: An Assessment," Morbidity and Mortality Weekly Report 41 (1992): 27, which emphasizes the effectiveness of a simple, widely accepted, well-described surveillance system as the best means of controlling cholera. Measles, another expanding disease in the United States, recently became an epidemic in New Zealand. Study of the disease thwarted public health productivity and prompted the authorities to propose making "measles a legally notifiable disease so that future outbreaks can be recognized early, thereby avoiding the delays in initiating interventions that were experienced during the most recent epidemic;" see CDC, "Surveillance for Measles--New Zealand, 1991," Morbidity and Mortality Weekly Report 41 (1992): 13, 17.

11. See O'Brien, "Discrimination: The Difference with AIDS.


15. Ibid.


17. Ibid.

18. For example, since 1973, the Lambda Legal Defense and Education Fund has pursued litigation to counter discrimination against gay men and lesbians, as well as educational projects to raise public awareness of gay legal rights. The shift in HIV prevalence from homosexual men to black and Hispanic men, women, and children cannot be overstated. "The Centers for Disease Control report that 29 percent of all reported AIDS patients in 1989 were African American and 16.5 were Hispanic. This represented an increase of 13 percent and 5 percent, respectively, from the previous year." See W. El-Sadr and L. Capps, "The Challenge of Minority Recruitment in Clinical Trials for AIDS," Journal of the American Medical Association 267 (1992): 954.


27. Ibid.


29. Lambda reports that: "At one test site in Augusta, Georgia, more than one-half of all persons tested reside in South Carolina, and 90 percent of all people testing positive live in South Carolina." Lambda, "Name Reporting," 17.
30. Ibid.

31. In Illinois, public health authorities can use AIDS surveillance lists to identify and monitor infected health-care workers; in Colorado, authorities can use surveillance information to inform emergency personnel of possible exposure to HIV. Ibid., 18.

32. Landsis, et al., “Results of a Randomized Trial of Partner Notification,” 741-104. The subjects were predominantly black, male homosexuals or bisexuals; 42 percent of the subjects reported previous treatment for syphilis and thus, presumably, had some history of contact tracing.


34. CDC, “Testing for HIV in the Public and Private Sectors—Oregon, 1988-1991” Morbidity and Mortality Weekly Report 41 (1992): 581, 583. Oregon law requires that all blood samples to be tested for HIV be accompanied by certification of informed consent. The certification form, completed by the health-care provider, includes general demographic information about the patient tested, reason for testing, previous HIV results, and the specimen collection date. Of significance is the fact that the patient’s name is not reported. Because demographics are provided, health officials may target particular groups; the lack of a mandatory name-reporting requirement prohibits voluntary or involuntary partner notification.


43. See J.L. Jones, R.F. Wykoff, S.J. Holitsa, et al., “Partner Acceptance of Health Department Notification of HIV Exposure, South Carolina,” Journal of the American Medical Association 264 (1990): 1284. Of the 202 partners notified, 132 (65 percent) were located and completed the survey satisfactorily. Only 12 (9 percent) thought they may have been exposed to HIV before the health department’s notification. When the 132 partners were asked if they thought the health department did the right thing in notifying them, 87 percent said yes; when asked if the health department should continue to notify people, 92 percent said yes.

44. See Lambda, “Name Reporting Still Stings.” The New York State health commissioner was successful in resisting efforts by several medical groups to classify HIV as a reportable communicable disease.


Erratum

In Carol Nash’s “Interpreting Cultural Differences in Medical Intervention” (volume 4, number 2), the last sentence on page 189 should have read as follows: “Unlike Anglo Americans, Costa Ricans consider cooking as an activity that defines the bond between mothers and daughters. There is a particular way that food must be prepared, and this almost always requires palm oil.”

We regret any confusion that may have been caused by this error.