Where the third party at risk is not under the care of the same doctor, some would argue that the doctor's responsibility to that third party should also override the doctor's duty of confidentiality to the index patient. In the UK, the General Medical Council (GMC) advises that a doctor 'may disclose information to a known sexual partner of a patient with HIV' if the doctor has 'reason to think that the patient has not informed that person, and cannot be persuaded to do so'. However the GMC does not say that the doctor should disclose the information and cautions that the doctor must be prepared to justify such a decision. It is for individual doctors to decide when they are convinced that the patient cannot be persuaded to tell and whether they should then breach confidentiality.

However, disclosure by a patient to their partner can be terrifying – for some initially impossible – and the time required before a patient feels able to disclose may vary considerably. While the patient might initially feel unable to divulge a positive result to others at risk, the first step would be to encourage behaviour modification to prevent ongoing risk and to continue to work with the patient towards disclosure at a later date if possible. This is preferable to concluding simply that the patient cannot be persuaded to tell.

The GMC also points out that a doctor cannot disclose to others – including relatives – who are not at risk. It is therefore interesting that in this case history the man's diagnosis was first told to the patient's brother. It is not clear whether the patient had requested this or had given consent for this, or whether this is an accepted practice in India. Under UK guidelines, however, the disclosure to the brother, if not with the patient's consent, would constitute clear breach of confidentiality.

The GMC points out that if the doctor intends to disclose, the patient should be informed beforehand. However a patient is entitled to assume that the doctor will observe confidentiality. Hence, if a doctor considers it his/her duty to divulge such information to a third party who is at risk of infection, this should be made clear to the patient before the HIV test is carried out – to enable the patient to decline the test and to go elsewhere for the test on either a named or anonymous basis.

Concluding comment

Mary Hepburn and Anne Scoular

There is potential for conflict between different aspects of a doctor's duties, and there are different interpretations of the boundaries of these duties, particularly with regard to the duty of confidentiality, as demonstrated by the differing comments above, from two colleagues working in the same hospital. While the different views expressed might seem irreconcilable, in practice they do not interfere with effective collaboration in the management of HIV positive patients. Mutual recognition of and respect for the right to individual interpretation is essential. However the vital factor is to ensure that patients are fully informed about all aspects and implications of any proposed management (including HIV testing) before it is commenced, with prior exchange of views between doctor and patient and/or between doctors. In other words in a case such as the one described, adequate pre-test counselling with effective communication between colleagues will ensure good patient management.

A Sad Story, Filled With Misunderstandings and Unfortunate Behaviours

Catherine Hankins

The case history of a woman who unknowingly acquired HIV infection from her husband, who was aware of his own HIV status, is a sad story, filled with misunderstandings and unfortunate behaviours on the part of the husband, his brother, the two physicians involved and the hospital.

It brings to mind the Tarasoff legal case in California, USA, in which a psychiatrist was successfully sued for several million dollars by the family of a murder victim because a psychiatric patient had indicated to the psychiatrist his intention to kill the eventual murder victim. This case created legal precedent for breaking patient confidentiality when the life and security of an unknowing third party is at stake.[1]

As a consequence, medical licensing and disciplinary bodies across Canada have informed physicians that, although they are not obligated to do so, they may break patient confidentiality to

inform sexual partners who are unknowingly at ongoing risk of being exposed to HIV infection. In practice, this rarely occurs now for two reasons. The first is that the issue of who would need to be informed is discussed up front with patients during the pre-test counselling session, so that patients can anticipate this responsibility and their need for assistance with disclosure. Second, patients are offered several options in the post-test counselling session, including self-disclosure, disclosure in a couple session with the physician, and physician notification of the spouse or other ongoing sexual partner.

Nonetheless, there have been cases of physicians being taken to court for not having followed through to ensure that sexual partners at ongoing risk were informed.

Despite this, there are situations that can take time and sensitivity to resolve because disclosure can run the risk of provoking domestic violence, particularly when the woman is the first to be detected as being HIV positive, a situation that is increasing with the advent of a universal offer of HIV testing to women during pregnancy. This issue was raised during meetings addressing issues of disclosure held in 1999 in Windhoek, Namibia and at the World Health Organization in Geneva. The consensus view was that counsellors must help women to balance the responsibility to disclose against the risk of personal injury, particularly in situations in which the ongoing partner is the likely source of the woman's HIV infection.[2]

This case history presents the opposite situation: an ill husband who finds out that he has HIV infection and not only decides not to disclose his status to his wife but also forges ahead with his desire to beget a child. The two physicians' behaviours are also questionable. The man's physician tests him without his consent, and presumably without pre-test counselling, and then proceeds to break patient confidentiality to inform the younger brother before he has even discussed the result with the patient. The woman's physician also tests the woman without her informed consent and then she finds herself in the dilemma of having to inform the woman of a positive result when the woman did not even know that she had been tested. In Canada this would be grounds for an assault case.

The husband's behaviour concerning his wife's pregnancy is perplexing. If he so wanted to have a child, why does he not allow his wife to seek antenatal care and increase her chances of having a healthy baby? Why did he not reveal his status after she became pregnant so that they could use condoms to reduce her risk of acquiring HIV infection during pregnancy, which is believed to result in an increased risk of transmission to the infant?

Health care workers at the hospital where the woman delivered her baby were ill-informed about HIV in the context of obstetrical care, since they needlessly isolated the woman. This may have revealed her status to others who had no reason to know of her HIV infection. As well, the baby may have been deemed HIV-infected when it was too early to know this, since an HIV test at birth is automatically HIV positive due to transplacentally acquired HIV antibodies from the mother, which can persist for up to 18 months of age. Only where PCR (polymerase chain reaction) or antigen testing are available to detect the actual presence of the virus itself, can the infant's own HIV status, independent from the mother's, be determined earlier.

The Supreme Court of India, when asked recently to rule on a case of involuntary disclosure, ruled that HIV-positive persons do not have the right to marry.[3] This ruling is being contested by a group of lawyers advocating that the right to marry is a constitutionally protected right and that no restrictions should be placed on the marriage of HIV-positive individuals, with the informed consent of the prospective spouse.[4] Unopposed, the Supreme Court ruling would do nothing to reduce the stigma and discrimination associated with HIV infection, which have been present since the start of the epidemic in India.

Surely the critical issue is one of the responsibility to disclose in the interests of protecting potential marriage partners or current loved ones. Until this is understood by physicians, patients and the general public in India and other countries around the world, HIV transmission to unknowing sexual partners, who have no reason to think that protective condoms should be used, will continue. At the same time, those who are infected will be denied the care and the support that would assist them in responsibly reducing the risk that they pose for their sexual partners. One solution is pre-marital and pre-conception voluntary counselling and HIV testing of both partners together, so that results are learned

together and mutual decisions can be made about marriage and pregnancy.

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1. Tarasoff versus Regints, 17Cal3d 425, 551 P 2d 334, 131 Cal Rptr 14 (1976).
2. World Health Organisation/ Joint United Nations Programme on AIDS. Questions and answers on reporting, partner notification and disclosure of HIV serostatus and/or AIDS. Public health and human rights implications. Geneva. June 1999.
3. Mr. X versus Hospital Z (1998) 8 SCC 296.
4. Lawyers Collective HIV/AIDS Unit. Full text of the Supreme Court decision and comment by the Lawyers Collective: www.hri.ca/partners/lc

The Fear of Disclosure is Costing the Lives of Precious Men and Women

Carmen D Zorrilla

During the past 14 years, I've seen more than 800 women living with HIV, the larger proportion at some point during a pregnancy. I started a antenatal screening programme in Puerto Rico in 1987 when there were no treatments available, and many women felt hopeless. Even then, I believed that there was something to gain from the knowledge of one's HIV serostatus. A range of options, including decisions for termination or continuation of the pregnancy, lifestyle changes during pregnancy, learning about safer sex practices, and post-partum family planning methods (both temporary or permanent) should have been available to all patients.

Today, there are a range of options for women living with HIV in developed countries, we are still debating some of the early issues within the context of resource-poor countries. The issues now have a different perspective because they make more evident the inequalities of access to care, the lack of public concern and outrage with some discriminatory practices, and the prevailing misconceptions that arise from fear.

This case illustrates the many issues related to partner notification and the lack of quality antenatal services. These include universal HIV counselling and testing and options for medical management of HIV infection beyond risk reduction of perinatal HIV transmission. It also makes evident the social pressures for having children, the power inequalities between the partners in a marriage, and the strong presence and roles of the extended family in the reproductive and health care decisions of a couple.

In this larger context of cultural and societal values and mores, it is not appropriate to assign personal or legal responsibilities to individuals when their actions just reflect the society's values. In my opinion, the language used for presenting this case reflects too much concern with the individual actions, without considering the larger context: 'Our objective in presenting this report is to look at the human rights violation of a wife who had to become pregnant without being aware of the fact that her husband was an AIDS patient.'

The fear of disclosure of an HIV diagnosis is part of the reaction that every person living with HIV has to confront. This fear is based precisely on the society's misperceptions, and biases against HIV/AIDS. This fear has taken a large toll in terms of human lives because many people, and in particular, many women have not sought care for fear of being identified. Many women are afraid of disclosing their diagnosis to a partner for the fear of violence, abuse and abandonment. This fear is also present in men. It is a major killer. This silence is costing us the lives of precious men and women.

I don't believe in forcing disclosure upon individuals, but I believe that we as health care professionals should work with our patients to facilitate this disclosure while providing a safe environment. Certain assurances need to be in place to facilitate such disclosure, such as laws to protect individuals from discrimination, physical abuse and abandonment, to mention a few. To the extent that the perception of the negative consequences of the disclosure overshadows the gains and hopes, we will continue to witness such cases. In this particular situation, there is much work to do in terms of modifying the reasons for this fear. If there is no treatment and no hope, and disgrace will fall onto their family, I can understand why a person would not disclose their diagnosis.

On the other hand, I cannot accept that a health care provider (in this case a physician) discloses an HIV diagnosis first to a relative instead of to the patient. I cannot accept that it is the relative who provides the patient with the diagnosis. A relative, even with the best of intentions, is not the appropriate messenger. A relative, in this case the brother, was as ignorant as