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CASE AND COMMENTARY
Please Don't Say Anything: Partner Notification and the Patient-Physician Relationship, Commentary 1

Commentary by Ronald Epstein, MD

Case

On Dr. Singh's recommendation, one of her patients, Mr. Henry Roland, consented to be tested for HIV and had a positive test result, which he feared but suspected. Mr. Roland has a longtime girlfriend, Lisa, whom he sometimes mentions to Dr. Singh. When talking to Mr. Roland about his positive test result, Dr. Singh brought up the topic of notifying Mr. Roland's past and present partners so they could be tested themselves. Mr. Roland refused to agree to tell Lisa, or even allow Dr. Singh to notify the health department so they could call her to suggest that she be tested.

"If she's positive, she'll know it was me. Please don't say anything or she'll know I gave it to her."

Mr. Roland told Dr. Singh that he intended to continue having sexual relations with Lisa, otherwise she would suspect that something was wrong with him. He insisted he would use protection consistently. Dr. Singh explained to Mr. Roland that Lisa may already be HIV-positive and if she is, she should seek treatment.

"She'll leave me if she knows. I can't deal with this without her, Dr. Singh, I just can't."

Commentary 1

While there might be general agreement that the ideal outcome of this difficult situation would involve disclosure to the partner as soon as possible, the pragmatics are not so obvious. The case description gives us little help, because the tools we need are embedded not in the facts of the case but in the patient-physician relationship.[1, 2] We know little about the prior relationship between Dr. Singh and Mr. Roland or between the physician and Lisa. We don't know much about the beliefs that may underlie each person's actions. But, for argument's sake, let's assume that there is a patient-physician relationship predating the HIV test, but, perhaps, they have not had any situations that tested the relationship (as is usually the case with otherwise young, and presumably healthy, men). Let's also assume that Mr. Roland is no longer an adolescent, has no other current sexual partners, and is not actively using intravenous drugs. And, for argument's sake, let's consider that Dr. Singh did a good job of pretest counseling. She informed Mr. Roland about the medical implications—that HIV is a treatable but very serious illness, and that

treatment is often delayed until the immune system shows signs of malfunction—and the psychosocial implications—that partner notification and family support would both be important.

Now that the patient has returned and received the test result, Dr. Singh tries to follow through by bringing up partner notification. If this is the same visit in which bad news has been delivered (no matter how gently and empathically), the patient is likely struggling to make sense of his own future, much less anyone else's.[3-6] When Dr. Singh brings up the issue of partner notification, Mr. Roland cannot face the stark choice that appears to have no viable answer: either betraying his lover or losing her.

Dr. Singh knows that scolding, threatening, and berating occasionally motivate humans to act responsibly, but these are not reliable tools.[7] Even if partner notification is mandated by law (as it is in New York State), the physician faces the dilemma of timing. Is this the time to persist? Would it be responsible to ask the patient to come back in a few days or in a week to discuss this further? After all, Mr. Roland could infect Lisa between now and then. Should Dr. Singh warn Lisa herself? Or how about contacting the public health authorities? They would likely send an officer to Lisa's home to advise her to be tested. The physician is in a dilemma similar to Mr. Roland's: she can insist and run the risk that the patient will never return or wait and run the risk that Lisa will become infected.

This may call for an imperfect temporary solution to preserve any possibility of long-term success. It may have to suffice to say, "I know that this has been too much bad news for one day. Maybe we should talk more next time. How about next week? But between now and then, please protect the one you love. And, is there someone with whom you can share this news who will help you through this week?" This way, Dr. Singh expresses empathy rather than disdain.[8, 9] She expresses concern for both the patient and his partner, and introduces the idea that the patient, similarly, might be able to find a way to care for himself and also Lisa at the same time. And, finally, Dr. Singh makes a suggestion for a short-term plan with an implied agenda. The patient is anxious, but knows that he will be understood.[10]

If we have gained the patient's trust, he returns. As often as not, he may have found a way to tell his partner. She may have threatened to leave him, but, as often as not, she may display unexpected support. But, what if she still does not know? To help Mr. Roland, Dr. Singh has to try harder and overcome any awkwardness she might feel.[11] She is careful not to coerce or threaten; she tries to understand the patient and to find some aspect of this patient with which she can work to create a stronger therapeutic bond.[12] Dr. Singh might ask, "What is the most frightening thing about telling her?" Normalizing, coupled with an offer to work together may be useful: "Anyone would find this an incredibly difficult situation, but I think that we can find a way to deal with it." Sometimes anticipating a different outcome can be

helpful, "I don't know Lisa that well, but a large percentage of partners end up being very supportive."

When trust is stronger, the patient can be helped to examine his values and the schism between values and actions. Using a conditional (if...then) or third person grammatical construction can distance the patient from the frightening immediacy of the situation while helping him to brainstorm: "What if you somehow found the courage to tell her. What might you say?" Or, "If it were a friend of yours who just tested positive, what would you say to him?" Offering options can motivate the patient to disclose: "You know that this has to happen, but the question is how. Would it be better for you to tell her or to have the health department tell her? There are advantages to both." Self-confidence and self-efficacy can be reinforced through gentle cajoling: "I know that you can." Role reversal can add another perspective: "What would you want her to do if she were you? Would you be able to still love her?"

These solutions are not perfect. Sometimes conflict is unavoidable. The ante may need to be raised. The physician might say, "I will not be able to live with myself unless I know that Lisa is adequately informed." Or, the law can be invoked, "State law requires me to make sure that Lisa knows. But, I would strongly prefer to do it in a way that we can both find acceptable." Rarely, the patient-physician relationship may be severed to protect a third party. The worst outcome, though, would be if the patient did not disclose, and did not return for follow-up. Desperation might lead him to jeopardize his own life as well as his partner's.

It is not known how often patients inform partners and what percentage of sexual partners have been informed. Even untreated patients with HIV may be asymptomatic for over 10 years, so sometimes there are many partners who should be informed. How hard should the patient and physician try? What about the 1-night encounter 14 years ago with someone who has since moved away? Some standard of reasonableness should be applied, but there are no rules to dictate those standards.

Partner notification requires knowledge of relevant options, laws and ethical standards, skills to communicate effectively, and the practical wisdom to know when and how to put that knowledge and those skills into action. Although it is often framed as a conflict, it can and should be done in a way that supports that part of the patient that wants to do the right thing. Most importantly, the physician should have sufficient self-awareness to recognize and adjust for prejudicial attitudes;[13, 14] we all have these biases; it is how we handle them that can build or destroy a relationship.

References

1. Epstein RM. A biopsychosocial approach to HIV. In: von Uexkull T, Adler R, eds. *Psychosomatic Medicine*. Munich: Urban & Schwartzenberg; 1997:623-674.

2. Epstein RM. The patient-physician relationship. In: Mengel MB, Holleman WL, Fields SA, eds. *Fundamentals of Clinical Practice*. 2nd ed. New York; Plenum. In Press.
3. Baile WF, Lenzi R, Kudelka AP, et al. Improving physician-patient communication in cancer care: outcome of a workshop for oncologists. *J Cancer Educ* 1997;12(3):166-173.
4. Eggly S, Afonso N, Rojas G, Baker M, Cardozo L, Robertson S. An assessment of residents' competence in the delivery of bad news to patients. *Acad Med* 1997;72(5):397-399.
5. Fallowfield LJ, Lipkin M Jr. Delivering sad or bad news. In: Lipkin M Jr, Putnam SM, Lazare A, eds. *The Medical Interview*. New York; Springer-Verlag: 1995:316-323.
6. Quill TE, Townsend P. Bad news: delivery, dialogue, and dilemmas. *Arch Intern Med* 1991;151(3):463-468.
7. Deci EL, Ryan RM. *Intrinsic Motivation and Self-Determination in Human Behavior*. New York; Plenum Press: 1985.
8. Platt FW, Keller VF. Empathic communication: a teachable and learnable skill. *J Gen Intern Med* 1994;9(4):222-226.
9. Suchman AL, Markakis K, Beckman HB, Frankel R. A model of empathic communication in the medical interview. *JAMA* 1997;277(8):678-682.
10. Epstein RM, Morse DS, Williams GC, LeRoux P, Suchman AL, Quill TE. Clinical practice and the biopsychosocial model. In: Quill TE, Frankel RM, McDaniel SH, eds. *The Biopsychosocial Model*. Rochester, NY; University of Rochester Press. In Press.
11. Epstein RM, Morse DS, Frankel RM, Frarey L, Anderson K, Beckman HB. Awkward moments in patient-physician communication about HIV risk. *Ann Intern Med* 1998;128(6):435-442.
12. Epstein RM, Frarey L, Beckman HB. Talking about AIDS. *AIDS Patient Care STDs* 1999;13(9):545-553.
13. Novack DH, Suchman AL, Clark W, Epstein RM, Najberg E, Kaplan C. Calibrating the physician: personal awareness and effective patient care. *JAMA* 1997;278(6):502-509.
14. Epstein RM. Mindful practice. *JAMA* 1999;282(9):833-839.

Ronald Epstein, MD is a professor of family medicine and psychiatry at the University of Rochester School of Medicine and Dentistry.

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