

Domestic Violence and Partner Notification: Implications for Treatment and Counseling of Women with HIV

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Current public health policy encourages partner notification to protect those at risk of HIV infection. Provider experiences with partner notification, domestic violence, and women with HIV compel a reassessment of this strategy. In a survey of 136 health care providers in Baltimore, substantial numbers reported knowledge of their HIV-infected patients' experiences with domestic violence before and after partner notification. Providers believed that fear of physical abuse, emotional abuse, and abandonment are important reasons why many female patients resist partner notification. Provider opposition to partner notification was strong in cases where female patients faced a risk of domestic violence. The realization that HIV-infected women fear and experience domestic violence has broad implications for health care practice. The authors recommend changes in provider practices to insure that the risk of domestic violence is identified and addressed, and that partner notification strategies do not threaten the safety of HIV-infected women. They also highlight areas for further research on the connections among partner notification, domestic violence, and women with HIV.

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Each year, approximately three to four million women in the United States are severely abused by male partners.¹ Pregnant women are particularly vulnerable to physical violence, which may include blows to the abdomen and injuries to the breasts or genitals.^{2,3} A recent study of poor urban women receiving care in public prenatal clinics found that 22% of teenage women and 16% of adult women were abused during pregnancy.⁴ Research has also demonstrated a correlation between domestic violence and the use of illicit drugs by women or their partners.^{5,6} There is every reason to believe that the problem of domestic violence is no less severe among women infected with human immunodeficiency virus (HIV).⁷ Many women first learn they are HIV positive during prenatal care, and intravenous drug use by women or their partners represents the most significant source of risk for women.⁸ Despite the fact that women now constitute the fastest growing group of people infected with HIV,⁹ there is little or no published research on the impact of domestic violence in their lives.

The growing use of partner notification underscores the need for such research. Medical commentators have generally concluded that physicians have a professional duty to warn the known but unsuspecting partners of HIV-infected patients—even in cases where the patient does not consent^{10,11}—and legal commentators have extensively discussed the possibility that physicians may have a legal duty to warn.¹²⁻¹⁴ The “privilege to disclose” doctrine, endorsed by public health officials and the American Medical Association, would grant physicians immunity from civil liability whether they warn a known partner or not.¹⁵ As of November 1994, at least 31 states had adopted legislation addressing partner notification (unpublished data, AIDS Policy Center, Intergovernmental Health Policy Project, The George Washington University, 1994). The trend has been toward the adoption of statutes that per-

mit, but do not require, physicians to notify known partners without the patient's consent. Approximately 15 states have expressly declared that physicians do not have a duty to warn. Among the remaining states, a physician's legal duty to unsuspecting partners remains uncertain. It bears noting, however, that partner notification statutes have focused almost exclusively on disclosure by physicians or public health personnel. Few state legislatures have considered whether nurses, social workers, and other care providers should also be permitted or required to notify partners.

The possibility that HIV-infected women may experience domestic violence when their partners are notified requires a careful reassessment of partner notification strategies.¹⁶ For more than a decade, researchers, clinicians, and professional organizations have urged that medical practitioners take a more active role in responding to the epidemic of domestic violence.^{1,17-20} Medical commentators²¹ as well as the AMA's Council on Ethical and Judicial Affairs²² have concluded that physicians have an ethical obligation to diagnose and treat domestic violence. For providers engaged in the treatment of HIV-infected women, the obligation to diagnose for domestic abuse must be balanced with public health goals and the provider's legal or ethical duties to known partners.²³

The present study was designed to explore some of the issues that may arise when partner notification is considered in the context of domestic violence against HIV-infected women. In the fall of 1993, we conducted a survey of providers who care for, treat, or counsel HIV-infected women in Baltimore, Maryland. We chose to survey providers rather than HIV-infected women for both practical and substantive reasons. The partner notification strategies employed in a given case and the means by which they are carried out are largely within the discretion of providers, subject to the protocols of their practices.

Understanding the relationship between domestic violence and partner notification requires, in part, that we examine the knowledge, perceptions, attitudes, and practices of these providers.

The survey was designed to gather data in the following five areas: 1) provider knowledge about patient experiences with domestic violence; 2) the extent to which providers assessed and intervened in cases involving domestic violence; 3) provider perceptions of resistance to partner notification by female patients, and the role that fears of domestic violence may play in that resistance; 4) partner notification strategies actually used by providers; and 5) provider attitudes about partner notification efforts, both generally and in the context of domestic violence. In addition, differences by provider group (ie, social worker, nurse, physician) and gender were examined.

Methods

Sample. The survey sample was designed to target both medical and mental health care providers in Baltimore who are primarily involved in the care, treatment, and counseling of female patients infected with HIV. Public health personnel were excluded. To derive this sample, a snowball sampling procedure was used.²⁴ Snowball samples are achieved through a series of purposive sampling rounds. In the first round, a group of participants who meet the requirements for the study sample is identified. These people are then used as informants to identify the second round of respondents, who in turn provide more respondent names.

For the first round of sampling in this project, local experts in acquired immune deficiency syndrome (AIDS) treatment and education were identified with the assistance of staff from the Maryland AIDS Professional Education Center (MAPEC), the statewide program providing continuing AIDS education and training to health care professionals. The second round included health care providers and mental health professionals who care for, treat, or counsel HIV-infected women. The list generated from the first two rounds of sampling was reviewed for accuracy and completeness by staff from MAPEC, and additional providers were identified.

A survey was mailed to 267 providers employed in more than a dozen different

treatment settings, including university-based hospitals, outpatient clinics, drug treatment programs, and private medical practice. In some cases, a central person in an organization took responsibility for distributing surveys to co-workers. Returns were tracked by a research assistant. Nonrespondents received a reminder postcard and a second copy of the survey.

Measure. A self-administered survey instrument was developed to measure provider attitudes and practices as well as provider knowledge about patient experiences with domestic violence. The instrument was refined after discussions with two focus groups. The six participants in the first focus group included physicians, a nurse, a social worker, and an expert in domestic violence. The second focus group consisted of a dozen representatives from state and local health departments in Maryland, including administrators, physicians, and epidemiologists. The survey instrument was pilot tested by several health care providers, and further refinements were made.

To provide a standardized frame of reference, questions on provider knowledge of patient fears and experiences were limited to patients treated within the last 12 months. Responses to attitude questions were measured on a Likert-like scale. For questions that asked about patient experiences with domestic violence, subjects were asked to provide descriptive examples to better characterize the nature of the findings.

Providers were questioned about their knowledge of patient experiences with "physical violence," defined as hitting, slapping, shoving or grabbing, and "emotional abuse," including threats of violence or intimidation. Providers were also asked about patient experiences with "abandonment," defined as withdrawal of financial support, shelter, or access to family members or belongings. All questions about patients were limited to *female* patients of any age. Partner notification was defined to include four distinct strategies: 1) provider encouragement of disclosure by the infected patient ("patient referral"); 2) provider assistance with disclosure to the partner; 3) provider disclosure directly to the partner at risk ("provider referral"); and 4) provider disclosure of the partner's identity to public health departments for the purpose of

Demographic Profile of Providers Treating HIV-Infected Women in Baltimore (N=136)

	N	%
Gender		
Female	87	64
Male	49	36
Professional Group		
Social Worker/Psychologist	58	43
Nurse/Physician Assistant	39	29
Physician	31	23
Other	8	5
Race/Ethnicity		
White	98	72
African-American	30	22
Asian	5	4
Latino/a	3	2
Professional Setting		
Hospital/Hospital Clinic	60	44
Substance Abuse Facility	23	17
Community Health Center	21	16
Community Service	20	15
Private Medical Office	7	5
Group Practice/HMO	3	2
Other	2	1

contact tracing.

Analysis. Data were tabulated to derive percentages and frequencies. Potential differences by professional group and gender were assessed using nonparametric tests such as chi-square and Wilcoxon Signed-Ranks tests. Nonparametric statistics were used because of concern that the response rate may have skewed distribution of results. For those questions where providers were asked about fears and experiences reported by their female patients, results are presented as follows. First, we present the percentage of providers who had at least one female patient reporting the experience under question. Second, for those providers only, we present the percentage of their female patients reporting the experience.

Results

Characteristics of Respondents. Completed surveys were received from 136 (51%) respondents. Providers were an average of 40 years old, predominantly female (64%) and white (72%), with an average of six years experience treating patients with HIV. There was good variation across both professional group and professional setting. The sample included social workers and psychologists (43%), nurses and physician assistants (29%), physicians (23%) and other professionals (5%). In large part, the providers treated patients in either a hospital-based (44%) or a community-based health care facility (48%), includ-

ing both community outreach centers and drug treatment programs (see table). On average, providers cared for patient populations that were 47% female. A majority (54%) of providers cared for fewer than 25 female patients within the past year, while 20% cared for 26 to 50 female patients. Due to the nature of the sampling procedures, demographic data are not available on nonrespondents. In general, however, response rates were higher among providers working in university-based clinical settings, where, historically, a large proportion of HIV-infected women in Baltimore have been treated.

Provider Knowledge of Patient Experiences with Domestic Violence. In the last year, 63% of providers had *at least one* female patient who reported living in a situation involving violence or emotional abuse; 23% of the female patients of these providers reported living in this situation. In many cases, the living situations of female patients were unknown, and providers could not state whether these patients were living in situations involving abuse. A majority (63%) of providers had at least one female patient whose living situation was unknown; these providers were unaware of that information for almost half (45%) of their female patients.

Nearly half (45%) of all providers had at least one female patient who expressed fear of physical violence resulting from disclosure of her diagnosis to a partner; 56% of providers encountered patients who expressed fear of emotional abuse, and 66% of providers encountered patients who expressed fear of abandonment. Among providers who encountered these fears, the fears were expressed by 18%, 29%, and 35% of their female patients, respectively.

Twenty-four percent of providers had at least one female patient who experienced physical violence following disclosure to a partner. More than one-third of all providers (38% and 37% respectively) had at least one female patient who experienced emotional abuse and abandonment following disclosure. Eight percent of the female patients of these providers experienced physical violence soon after disclosure to partners, 23% experienced emotional abuse, and 19% experienced abandonment. There were no significant differences in provider

knowledge or the prevalence of reported domestic violence by professional group or gender.

Providers reported incidents of violence, emotional abuse, and abandonment, including the following. Incidents of violence: patients were hit, kicked, beaten, punched, or raped by partners; one woman was shot, one jumped from a third-floor window to escape being shot, and one received a knife wound to the face. "One male became angry, throwing things in the hospital room and had to be removed by security." Incidents of emotional abuse: patients were yelled at, harassed, intimidated, spit on, and called names such as "sluts, no good, and bitches." Both women and their children were threatened, "If I am infected, I will kill you." One woman had "AIDS bitch" written on her door. Incidents of abandonment: women found their partners withdrawing physical, emotional, and financial support; two were left homeless; many lost their children, family, and friends. "One woman came home to find the garbagemen loading what was left of her possessions into the back of a truck." "Most partners left within 72 hours and all left by three to four months."

Protocols for Assessment and Intervention. Only 23% of all providers reported the existence of a procedure to assess for the risk of domestic violence. A larger proportion (38%) reported having a protocol to follow when violence or abuse was suspected. In most cases, assessment for abuse was done by social workers or case managers as part of an intake procedure. Protocols for intervention in cases where abuse was indicated typically involved referral to either in-house social

workers or battered women's shelters.

Resistance to Partner Notification by Female Patients. More than half (55%) of all providers had at least one female patient who resisted disclosure of her HIV status to a partner during the previous year; an average of 26% of the female patients of these providers resisted. Knowledge of resistance did not differ by professional group or gender.

Providers who had at least one patient resist disclosure ranked ten factors thought to be related to this resistance. Fear of abandonment, fear of physical violence, and fear of emotional abuse were ranked first, third, and fourth, respectively. When asked how important they thought these fears were to women who had resisted, the majority of providers indicated they thought fears of abandonment (92%), emotional abuse (75%), or physical violence (60%) were either "important" or "very important." The factor ranked second was loss of emotional support. The remaining six factors, in rank order, were: fear of stigmatization, loss of sexual activity, loss of custody of children, loss of drug activity, loss of health insurance, and loss of employment.

Use of Partner Notification Strategies. The majority of providers encouraged patients to inform their partners (85%), but only for an average of 66% of their female caseload. A lesser number (34%) assisted women in informing their partners, but only for an average of 18% of their female patients. An even smaller percentage (13% and 4% respectively) of providers had *ever* notified the health department or informed a partner directly; they did so for fewer than one-quarter of their female patients.

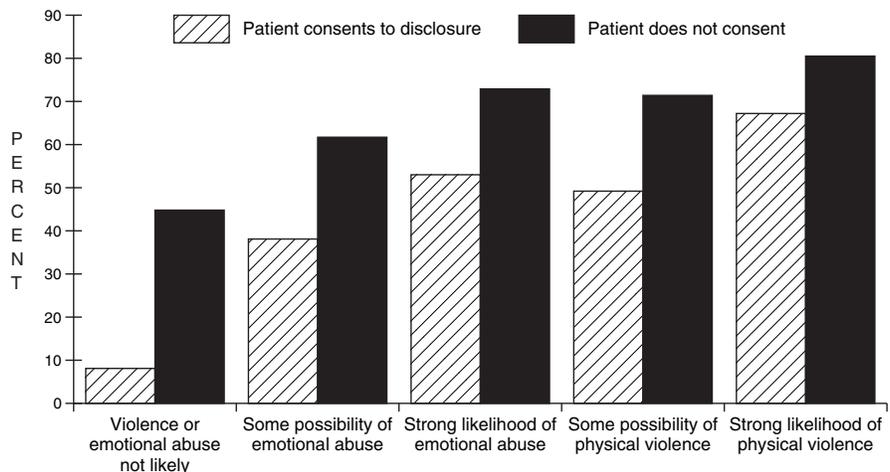


Figure 1. Percent of providers opposed to partner notification with and without patient consent.

Provider Attitudes about Partner Notification Efforts. Overall, between 72% and 80% of providers felt that partner notification was at least “somewhat effective” in achieving three stated public health goals: 1) reducing the spread of HIV infection, 2) providing testing and counseling to people at risk for infection, and 3) providing treatment to infected people. A sizable minority of providers (20% to 28%) thought that notification was “somewhat ineffective” or “very ineffective” in achieving these goals. For each goal, 10% to 17% of providers thought partner notification was “very effective.”

Attitudes toward partner notification were also assessed in the context of patient consent and the risk of domestic violence. Providers were questioned about their attitudes toward notification in the following five scenarios: when there is “no likelihood” of violence or abuse, “some possibility” or a “strong likelihood” of emotional abuse, and “some possibility” or a “strong likelihood” of physical violence. For each scenario, providers were asked to state their attitude toward notification when the patient consented or did not consent to disclosure.

Figure 1 shows the percent of providers who opposed disclosure for each scenario. As the likelihood of violence or abuse became more certain, opposition to disclosure increased. For example, with a consenting patient, 67% of providers opposed disclosure when there was a strong likelihood of violence as compared to only 8% who opposed disclosure when there was no possibility of abuse. Figure 1 also reveals that patient consent played a role in the degree of opposition. Even when violence or emotional abuse were not likely, nearly half (45%) of providers opposed disclosure in the absence of patient consent. When the lack of consent was coupled with a strong likelihood of physical violence, the proportion of providers who opposed disclosure increased to 80%. In all five scenarios, Wilcoxon Signed-Ranks tests revealed that providers were significantly more likely to oppose disclosure if the patient did not consent ($p < .001$).

Figures 2 and 3 separate these data by professional group. When the patient consented to disclosure, chi-square analysis revealed that social workers and nurses were significantly more likely than physicians to oppose disclosure if there was

some possibility of physical violence ($p < .05$) or emotional abuse ($p < .01$). When the patient did not consent, social workers and nurses were significantly more likely than physicians to oppose disclosure in all situations of physical violence or emotional abuse ($p < .05$). There were no significant differences between professional groups when violence and abuse were not at issue. There were no significant differences by gender when patient consent was present. However, when the patient did not consent and there was a strong likelihood of physical violence, female providers were significantly more likely than male providers to oppose disclosure ($p < .01$).

Discussion

Over the past several years, we have encountered anecdotal reports of HIV-infected women who experienced domestic violence after partners were notified, including two cases in which women were shot by partners. This small, exploratory study was designed to assess whether the magnitude of the problem required further research and a reassessment of public health policy. We originally intended to survey a random sample of public health personnel and other providers selected from a mailing list including more than 2,000 professionals who have attended MAPEC educational programs. Due to concerns about privacy, we were not permitted to use the list and were unable to distribute the survey among public health personnel. Therefore, we had to rely on the snowball sampling scheme described above.

The lack of a rigorous sampling frame

is a limitation of the study. We do not have complete demographic data on non-respondents and cannot assess whether the sample is representative of AIDS care providers in Baltimore. Moreover, the response rate (51%) suggests that a response bias may be likely. It is reasonable to assume that the providers who responded to the survey were more likely to be concerned about the problem of domestic violence than those who did not. Nonetheless, the data strongly support the need for rigorous research among both HIV-infected women and the providers who treat or counsel them.

With regard to HIV-infected women, future research should assess the frequency and severity of domestic violence, both before and after partner notification. Researchers should also attempt to determine whether partner notification acts as a “trigger” for episodes of domestic abuse. In the present study, the majority of providers had at least one female patient who reported experiencing domestic violence (63%) or who expressed fears that physical violence (45%) or emotional abuse (56%) might result from partner notification. The link between partner notification and fear of domestic violence was also evident for the one-quarter of providers who reported that patient fears were realized. There is reason to believe that provider awareness of abuse may be low; a recent study, conducted in three internal medicine clinics, found that two-thirds of abused women who sought medical care unrelated to their abuse did not discuss the abuse with a health care provider.²⁵ The low response rate, however, suggests the pos-

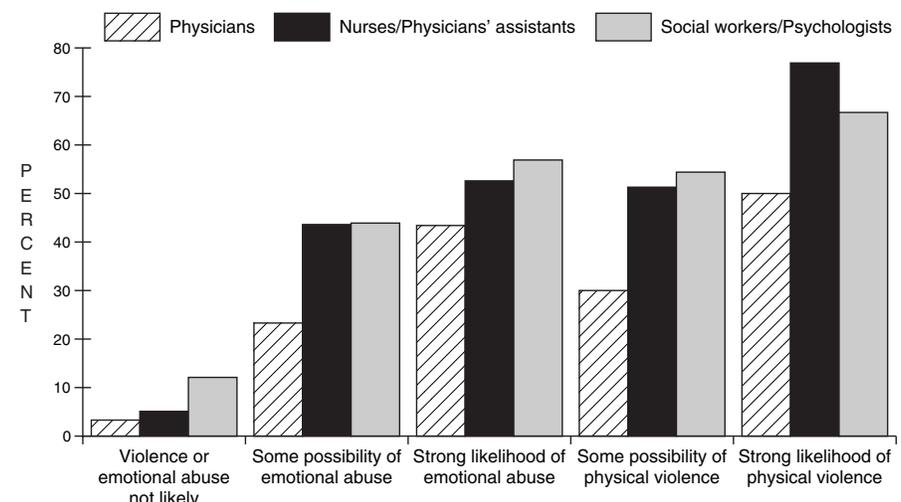


Figure 2. Provider opposition to partner notification by profession with patient consent.

sibility that respondents to our survey may represent an especially sensitive, well-informed cohort of providers. These factors, as well as the inherent limitations of surveying providers rather than patients, indicate that our data do not warrant precise conclusions regarding the prevalence of domestic violence among HIV-infected women.

Future research should also assess the possibility that fears of domestic violence, emotional abuse, and abandonment may act as barriers to patient cooperation with partner notification efforts. Commentators and public health officials have long recognized that the success of partner notification depends heavily on the voluntary cooperation of the infected patient.¹⁵ In general, high levels of resistance to partner notification are well documented for patient populations that consist primarily of gay or bisexual men.²⁶⁻²⁸ Despite that evidence, researchers have not attempted to isolate the specific sources of patient resistance or assess their relative importance, particularly for HIV-infected women.

Between 45% and 66% of survey respondents reported patient resistance to partner notification, and these figures are likely to be an underestimate. For example, in some cases, patients may have chosen not to voice their resistance; in others, providers may have been unaware of patient resistance because they saw the patient only after notification had occurred. Findings suggest that fears of violence, abuse, and abandonment are important factors in resistance by female patients. In the view of survey respondents, concerns about discrimination ("loss of employment" and "loss of health insurance") were the least important of the ten fears listed. Fears of physical violence and emotional abuse were rated as important or very important by 60% and 75% of providers respectively. Those two factors, together with fear of abandonment and loss of emotional support, were ranked as the four most important factors related to resistance to disclose. To the extent that the success of partner notification depends on patient cooperation, improving the efficacy of those efforts requires that providers identify the sources of patient resistance and provide appropriate support.

Although research among HIV-infected women presents the most pressing need,

additional research on the providers who care for these women is also important. To the best of our knowledge, assessment and intervention in cases involving domestic abuse have not been formally recognized as the appropriate standard of care for HIV-infected women. Thus, the decision to assess and intervene lies largely within the discretion of health care providers, subject only to the protocols of the treatment settings in which they practice. In addition, decisions about when and how to notify partners are also left to provider discretion. The development of public health policies that fully address the concerns of women requires a deeper understanding of the ways in which providers exercise that discretion. Further research, therefore, should focus on both the attitudes and practices of health care providers.

The balance between patient confidentiality and public health goals has been a central concern in the partner notification debate. To our knowledge, no prior research has assessed the weight that providers give to patient consent and the possibility of domestic violence when considering partner notification strategies. Despite the emphasis on duty to warn issues in both the academic literature and at professional seminars, the overwhelming majority of providers relied on patient referral as their primary partner notification strategy: only 4% of providers had informed a partner directly within the past 12 months, while 13% reported one or more cases to the health department for the purpose of contact tracing.

Within the present study, the more revealing findings are those concerning

provider opposition to disclosure in cases where the patient does not consent to the disclosure or faces risk of abuse. For many providers, the patient's consent to disclosure was a matter of great importance, even in cases where violence and emotional abuse were not likely. In each scenario where the lack of consent was compounded by the possibility of abuse, opposition to partner notification was sharply higher. Likewise, the possibility of abuse mattered to many providers, even in cases where the patient consented to disclosure. Because of the discretion exercised by providers, these attitudes are likely to play a critical role in provider practices.

Finally, there were significant differences based on both the profession and gender of the provider. Physicians and men were more likely to favor disclosure. The confounding nature of profession and gender (ie, three-quarters of the physicians were men) makes it difficult to evaluate whether the differences are based on profession, gender, or both. Physicians may have been more likely than other professionals to support notification because only physicians have immunity for that disclosure under Maryland law.²⁹ The professional background of providers may also be influential. Recent research has found that different professional groups have differing perceptions of their role in the treatment of domestic violence.³⁰ The differences observed in our data may be based on provider perceptions, differences in training, gender socialization, or some combination of these factors. Future research should be better able to distinguish the

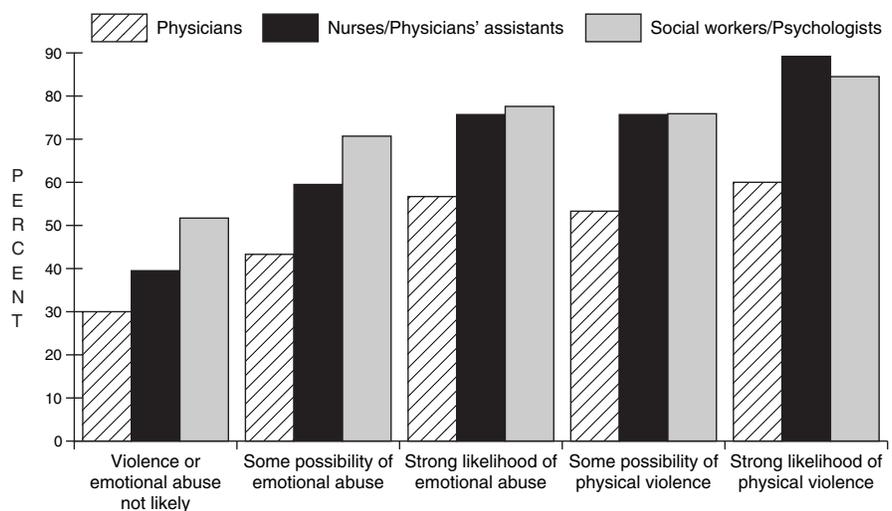


Figure 3. Provider opposition to partner notification by profession without patient consent.

professional and gender differences among providers by using random sampling procedures, achieving higher response rates and larger sample sizes.

Practice Recommendations. The possibility of abuse against HIV-infected women underscores the importance of assessment and intervention as a preventive measure. The consequences of failing to assess and intervene are clear: abuse is likely to continue and in many cases may escalate. A study of battered women in emergency departments found that one woman in five had sought medical care more than ten times previously, while an additional 23% sought care six to ten times.³¹ Among women who have been battered once, 75% will be battered again by the same partner.¹⁸ A study that followed a cohort of women for five years found that previously battered women were, on average, admitted to hospitals four times more often than a control group, and that severe depression, suicide, and substance use were all strongly associated with prior abuse.³²

Until further research is completed, it is reasonable to assume that the problem of domestic violence is at least as severe among HIV-infected women as it is among women in general. Indeed, the need for assessment and intervention may be greatest among those populations of women most likely to be diagnosed with AIDS or HIV infection. The women at highest risk of infection—those who use intravenous drugs—may also face an increased risk of domestic violence. Many women first learn of their HIV infection during prenatal care, when they also are particularly vulnerable to abuse. To the extent that testing of all pregnant women may become a reality, the need for assessment and intervention will be correspondingly greater.

In light of the documented reality of domestic violence and the literature addressing the problem, we propose the following recommendations. First, we advocate that all HIV-infected women should be screened for the risk of domestic violence. In no case should providers notify a partner over the objection of a female patient without making a thorough assessment of those risks. For most patients, the necessary assessment can be done quickly and accurately using a three-question abuse assessment screen.^{2,4} In cases where abuse is indicated, a more

comprehensive assessment should be conducted,³³⁻³⁶ including assessment for risk of homicide.³⁷

Second, where assessment indicates a risk of domestic violence, providers should insure that counseling and a referral strategy are available. Essential community resources include a crisis hot line, shelters for battered women, support groups for victims of family violence, mental health services, general social services, law enforcement agencies, emergency medical care, and providers of legal assistance.^{35,38} Counseling and compassion from health care providers themselves is also appropriate; a provider who does nothing more than make a referral may reinforce feelings of isolation, discourage efforts to leave, and compound damage already done to the patient's sense of self-worth.^{21,39}

Third, in cases where there is a risk of domestic violence, the provider should assure that an adequate safety plan is in place before counseling the patient to notify her partner(s). If the patient still refuses to notify her partner *and* the risk of abuse to the patient has been eliminated, then the provider may consider other forms of partner notification with the patient's consent. In all events, the provider must give the patient advance warning and an opportunity to implement her safety plan before attempting to notify a partner.

We recognize that state law, clinical protocols, or other considerations may sometimes mandate that partners be notified without the patient's consent. Under these circumstances, providers should carefully balance the potential harm to patient and partner before ever choosing to breach confidentiality against the wishes of the patient. For example, providers should consider the possibility that the partner is already infected, and the likelihood that the risk of female-to-male HIV transmission is substantially lower than the risk of male-to-female transmission.^{40,41} Providers should also consider the potential impact of involuntary notification on the provider-patient relationship. If notification is done without the patient's consent, will she avoid further treatment, and continue to engage in risky behaviors with other contacts? These concerns weigh heavily against involuntary notification.⁴²

Despite the extensive literature urging

health care providers to intervene in cases involving domestic violence, the great majority of providers surveyed by this project do not routinely assess their HIV-infected female patients for the risk of domestic violence. Nonetheless, most providers were aware that HIV-infected female patients sometimes experience violence or abuse. The majority also recognized that there are important connections between domestic violence and partner notification efforts.

The spread of HIV infection among women continues to pose new challenges for researchers and clinicians. To meet these challenges, future research and treatment strategies must address the risks faced by HIV-infected women, including the threat of violence, emotional abuse, and abandonment. To do otherwise would threaten both the safety of HIV-infected women and the effectiveness of AIDS control efforts. ■

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