

Reducing the Risk of Domestic Violence against HIV-Positive Women: The Application and Efficacy of New York's Partner Notification Deferral Mandate

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INTRODUCTION

Domestic violence is a distressingly common problem among women living with HIV. Women with HIV are more likely to experience domestic violence, and women who experience domestic violence are at greater risk of HIV transmission.¹ HIV diagnoses interact with domestic violence in a complicated way, offering abusive partners new ways to commit acts of violence and exert control, whether by threatening to disclose their victims' status to others if they try to leave or by preventing patients from taking their medication. Partner notification, although purportedly voluntary, presents unique risks for patients who are trapped in violent relationships. Although estimates of the prevalence of post-disclosure violence vary, women's stories suggest that post-disclosure violence is experienced and perceived as a real threat to safety. In querying what states can do to address the concerns of women living with HIV who are also victims of domestic violence when conducting partner notification, one possible solution is to implement a domestic violence screening and deferral policy, as enacted in New York.

This article addresses New York's attempted solution and considers various modifications to that state's particular policy. Although this article mainly focuses on New York, many of the referenced statistics and studies examine other geographic locations, and the analysis could apply to any state with some partner notification program that is not completely voluntary for all patients. This article also focuses on heterosexual relationships, with the male as the abusive partner and the female as the abused partner. The focus results not from a lack of concern for domestic violence in same-sex relationships, but due to the fact that much of the available literature focuses on opposite-sex relationships. The New York policy is not gendered, however, and much of the analysis could still apply to same-sex relationships.

In Part II, I present background information on partner notification programs and their justifications, domestic violence, and the interrelationship

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1. Centers for Disease Control and Prevention, *Intersection of Intimate Partner Violence and HIV in Women* 2 (2014), http://www.cdc.gov/violenceprevention/pdf/ipv/13_243567_green_aag-a.pdf (noting that the rate of domestic violence among women with HIV is double the national average and that women in abusive relationships are four times as likely to contract sexually transmitted infections, including HIV).

between HIV and domestic violence. The purpose of this section is not to make any judgment about the necessity or wisdom of partner notification programs in general. Partner notification programs have been widely adopted by states, and have been encouraged by the Centers for Disease Control and Prevention, as a public health measure; legislators and administrators clearly believe that they are effective (and cost-effective) in preventing the spread of HIV. In Part III, I conduct an interests analysis of partner notification, focusing on patients and partners in abusive relationships. I also review New York's policy of screening patients for domestic violence and granting deferrals to some of those patients and present criticisms of some aspects of the program's execution. I consider the noncompliance of many physicians and the availability of anonymous testing as alternatives to the codified deferral program. In Part IV, I recommend certain changes to New York's policy, including increased physician training and a more comprehensive "script" for domestic violence screenings. Even with these changes in place, New York's solution might not be ideal. However, absent the elimination of (involuntary) partner notification programs entirely, individuals concerned about the impact of involuntary notification on abused patients must find some way to identify and protect those patients most at risk of disclosure-related violence.

I. BACKGROUND: PARTNER NOTIFICATION, DOMESTIC VIOLENCE, AND HIV

Partner notification, also known as "contact tracing," and, more recently, as partner "services,"² has been defined by the Centers for Disease Control and Prevention as "a process through which infected persons are interviewed to elicit information about their partners, who can then be confidentially notified of their possible exposure or potential risk."³ This definition obscures a number of the nuances of partner notification as practiced by providers, community health agencies, and individuals who have tested positive for HIV or other sexually transmitted infections. Some aspects of partner notification not captured in the definition include who interviews infected persons, who is responsible for notifying the named partners, whether infected persons are obligated, or told they are obligated, to comply with this process,⁴ and how confidentiality is

2. *Recommendations for Partner Services Programs for HIV Infection, Syphilis, Gonorrhea, and Chlamydial Infection*, 57 MORBIDITY & MORTALITY WKLY. REP. 1, 3 (Ctr. for Disease Control & Prevention, Atl., Ga.), Nov. 7, 2008, available at <http://www.cdc.gov/mmwr/PDF/rr/rr5709.pdf> [hereinafter *CDC Recommendations*] (using the term "partner services" rather than "partner notification" or "contact tracing" "to describe the type and range of public health services recommended for sex and drug-injection partners of HIV-infected persons"); Lawrence O. Gostin & James G. Hodge, Jr., *Piercing the Veil of Secrecy in HIV/AIDS and Other Sexually Transmitted Diseases: Theories of Privacy and Disclosure in Partner Notification*, 5 DUKE J. GENDER L. & POL'Y 9, 12 (1998) (describing "partner notification support services" as the "preferred terminology").

3. *CDC Recommendations*, *supra* note 2, at 4.

4. Naming partners should be optional for index patients, according to federal guidelines. *CDC Recommendations*, *supra* note 2, at 6 (listing "voluntary and noncoercive" as one principle of partner services). However, some states require public health officials to notify already-known partners of the index patient's HIV infection. See, e.g., N.Y. COMP. CODES R. & REGS. Tit. 10, § 63.4 (2012) (requiring providers to report known contacts to the health department, who may then be notified by public health officials); 10A N.C. ADMIN. CODE 41A.0202(2)(b) (2007) (requiring attending

maintained for both infected persons and their partners.⁵ The three primary models of partner notification are patient referral, provider referral, and conditional referral. Patient referral makes infected persons (or “index patients”) responsible for notifying their sexual (or needle-sharing) partners of their HIV status, although public health officials may assist in the process. The confidentiality of the index patient cannot be guaranteed.⁶ Provider referral, by contrast, makes public health officials responsible for locating and notifying index patients’ partners of the HIV risk; confidentiality is at least superficially guaranteed.⁷ Conditional referral allows patients to notify their partners directly; if they fail to do so, public health officials will notify the partners.⁸

Some of the justifications, as well as criticisms, of partner notification are apparent, and likely do not rely on any objective, statistical analysis to be maintained. Partners of index patients may be seen as having the right to know that they may be at risk of HIV infection. On the other hand, infected persons have a strong privacy interest, even if some index patients choose to participate in partner notification programs.⁹

Partner notification has also been justified on public health grounds. If the partners of index patients can be notified of their risk, they can be tested; if they test positive, they can receive treatment, change their behavior, and, given the

physician to report a known spouse to the Division of Public Health if the spouse has not already been notified with the patient’s consent). No state criminalizes the failure to comply with a partner notification program. The Ryan White Care Act does not provide grants for partner services programs unless “[t]here is no criminal or civil penalty on, or civil liability for, an infected individual if the individual chooses not to identify the partners of the individual.” 42 U.S.C. § 300ff-38(b)(3)(G) (2009). *But see* MICH. COMP. LAWS § 333.5114a(3) (2014) (“A local health department . . . shall inform the individual that he or she has a legal obligation to inform each of his or her sexual partners of the individual’s HIV infection before engaging in sexual relations with that sexual partner, and that the individual may be subject to criminal sanctions for failure to so inform a sexual partner.”). Although this statute does not require index patients to inform sexual partners of their HIV infection if they no longer engage in sexual relations, the mention of criminal sanctions in a discussion of partner notification could have a coercive effect on infected persons, even if no future sexual relations are planned. *See id.*

5. Although confidentiality is practically a universally-shared goal of partner notification programs (or at least of provider or conditional referral programs), such programs may unintentionally breach the confidentiality of both index patients and referred partners. Partners will often correctly guess the identity of the index patient, particularly if the index patient is their only recent sexual partner or if they reside with the index patient, and public health officials may inadvertently reveal the purpose of their visit when they attempt to notify partners. *See* Gostin & Hodge, *supra* note 2, at 64 (“The maintenance of patient confidentiality through contact tracing is a factual myth” due to the knowledge of the index patient’s identity on the part of public health officials, as well as the likelihood that the informed partner will deduce the index patient’s identity and tell others).

6. *Id.* at 26-27.

7. *Id.* at 27.

8. *Id.*

9. For a particularly thorough example of such an analysis, including the interests of the government, infected persons, and their partners, *see id.* at 51-68. The interest of partners is not necessarily in eliminating future transmission, but in being notified of possible past transmission in order to facilitate testing and treatment. *See also* Leah H. Wissow, *Public Health vs. Privacy: Rebalancing the Government Interest in Involuntary Partner-Notification Following Advancements in HIV Treatment*, 21 AM. U. J. GENDER SOC. POL’Y & L. 481 (2012) (analyzing the privacy interest in a hypothetical case).

effectiveness of current treatments,¹⁰ be prevented from passing on the virus. If they test negative, they might still change their behavior and avoid transmission of the virus. Twenty-one percent of individuals with HIV are unaware of their status,¹¹ and one study estimated that “unrecognized HIV infection is the source of more than half of new HIV infections.”¹² This suggests that lack of awareness of HIV infection is still a major driver of the epidemic. In addition, there is some evidence that patients are less likely to engage in risky behaviors following an HIV diagnosis.¹³ However, there is little evidence that partner notification is effective as a public health strategy.¹⁴ A review of available literature conducted by the Task Force on Community Preventive Services found that, for HIV, “a range of one to eight partners was identified per index patient,” a mean of 63% of notified partners were tested, and 20% of those newly tested were diagnosed with HIV.¹⁵ Other studies cast further doubt on the effectiveness of partner notification, finding lack of compliance and high costs.¹⁶

One of the justifications individuals often cite for lack of compliance with partner notification programs is the fear of domestic violence, particularly for women in abusive relationships who have tested positive for HIV.¹⁷ Domestic violence, or “intimate partner violence,” “refers to any behavior within an intimate relationship that causes physical, psychological or sexual harm to those

10. Myron S. Cohen, M.D., et al., *Prevention of HIV-1 Infection with Early Antiretroviral Therapy*, 365 NEW ENG. J. MED. 493 (2011) (noting that a study indicated that “early initiation of antiretroviral therapy reduced rates of sexual transmission of HIV-1”).

11. Comm. on HIV Screening and Access to Care & Bd. on Population Health and Pub. Health Practice, Inst. of Med. of the Nat'l Academies, *HIV SCREENING AND ACCESS TO CARE: EXPLORING BARRIERS AND FACILITATORS TO EXPANDED HIV TESTING* 5 (2010), available at http://www.nap.edu/openbook.php?record_id=12932&page=5 [hereinafter *HIV SCREENING*] (citing Michael L. Campsmith et al., *Undiagnosed HIV Prevalence Among Adults and Adolescents in the United States at the End of 2006*, J. ACQUIR. IMMUNE D. SYNDR. 53(5), 619-24 (2010)).

12. *Id.* at 4 (citing Gary Marks et al., *Estimating Sexual Transmission of HIV from Persons Aware and Unaware that they are Infected with the Virus in the USA*, AIDS 20(10), 1447-50 (2006)).

13. Lisa A. Eaton & Seth C. Kalichman, *Changes in Transmission Risk Behaviors Across Stages of HIV Disease Among People Living With HIV*, 20 J. OF THE ASSOC. OF NURSES IN AIDS CARE 39, 41 (2009) (“Following HIV diagnosis, regardless of stage of disease or risk group, significant numbers of HIV-infected men and women reduce their sexual risk behaviors.”). They also note, however, that “many” individuals with HIV continue to engage in high-risk sexual behaviors, and might “revert” back to such behaviors after initially changing their behavior following diagnosis. *Id.* at 41, 44. A significant percentage of men who have sex with men, in particular, seem to continue engaging in high-risk behavior following diagnosis. *Id.* at 44.

14. CDC *Recommendations*, *supra* note 2, at 2 (“Published, scientific, evidence-based information on partner services is limited.”).

15. *Id.* at 4, 6 (citing Task Force on Cmty Preventive Servs., *Recommendations to Increase Testing and Identification of HIV-Positive Individuals Through Partner Counseling and Referral Services*, 33 AM. J. PREVENTIVE MED. 588 (Supp. II 2007)).

16. Mary D. Fan, *Sex, Privacy, and Public Health in a Casual Encounters Culture*, 45 U.C. DAVIS L. REV. 531, 565-66 (2011) (citing a syphilis study in Florida and New Jersey that only yielded less than 20% of potentially-exposed partners, concluding that “partner notification programs have low yield rates”).

17. Karen H. Rothenberg & Stephen J. Paskey, *The Risk of Domestic Violence and Women with HIV Infection: Implications for Partner Notification, Public Policy, and the Law*, 85 AM. J. PUB. HEALTH 1569, 1571 (1995) (citing data from the authors’ Baltimore study that “more than half” of providers reported that one or more female patients resisted participating in partner notification and listed fear of abandonment, physical violence, and emotional abuse as the main reasons for the resistance).

in the relationship,” and can include acts of physical violence (like beating), sexual violence, and emotional abuse (like intimidation and threats of future harm).¹⁸ These behaviors are distressingly prevalent in the United States.¹⁹

Domestic violence is prevalent among women with HIV; however, studies suggest that violence is not brought on by an HIV diagnosis alone, but rather that, for women, the risk factors for HIV transmission overlap with the risk factors for domestic violence.²⁰ Women in violent relationships are less likely to try to negotiate condom use,²¹ are more likely to have multiple sexual partners,²² and are more likely to have partners with multiple sexual partners.²³ Whatever the nature of the relationship between HIV infection and domestic violence,²⁴ domestic violence is a real concern in the lives of many women living with HIV: one study has shown that 66% of HIV-positive women experienced physical abuse.²⁵

Women with HIV in violent relationships are often afraid to disclose their diagnoses to their partners, a rational fear given the quantitative and qualitative evidence of abuse (or escalation of abuse) following disclosure. The percentage of HIV-positive women who are known to experience violence after disclosure is small, ranging from 0.5-4%, depending on the study.²⁶ However, the fear of

18. World Health Organization, *Understanding and Addressing Violence Against Women: Intimate Partner Violence* 1 (2012), http://apps.who.int/iris/bitstream/10665/77432/1/WHO_RHR_12.36.eng.pdf.

19. 18.3% of women have been raped at some point in their lives, 51.1% of which were raped by an intimate partner, and at least 24.3% of women have experienced some kind of “severe physical violence” by a partner. NAT’L CTR. FOR INJURY PREVENTION & CONTROL, CTR. FOR DISEASE CONTROL & PREVENTION, NATIONAL INTIMATE PARTNER AND SEXUAL VIOLENCE SURVEY, 2010 SUMMARY REPORT, EXECUTIVE SUMMARY 1-2 (2011), available at http://www.cdc.gov/violenceprevention/pdf/nisvs_executive_summary-a.pdf (including statistics on female, as well as male, victims of intimate partner violence).

20. Linda J. Koenig & Jan Moore, *Women, Violence, and HIV: A Critical Evaluation with Implications for HIV Services*, 4 MATERNAL & CHILD HEALTH J. 103, 104 (2000) (“[T]he risk of violence is not statistically increased among women with prevalent HIV infection compared with demographically and behaviorally similar women.”). “[E]nvironmental and behavioral risk contexts” that correlate with both HIV infection and domestic violence include poverty, unemployment, and alcohol and drug abuse. *Id.*

21. *Id.* at 106 (“Researchers and advocates have argued that women in violent relationships may not even attempt to negotiate condom use either because they feel helpless or powerless to change the partner’s behavior or because they are afraid of [her partner’s] response.”). Studies suggest that 4-5% of women experience abuse as a result of asking partners to use condoms. *Id.*

22. *Id.*

23. *Id.*

24. One study of HIV-positive women at domestic violence agencies found that 58.1% of the women studied had a steady partner with more than one sexual partner, another 16.3% of women did not know if their partner had more than one partner, and 32.6% of the women had more than one partner themselves, supporting the theory that women in violent relationships are more likely to engage in certain risk behaviors for HIV. Mona Mittal et al., *HIV Risk Among Women From Domestic Violence Agencies: Prevalence and Correlates*, 24 J. OF THE ASSOC. OF NURSES IN AIDS CARE 322, 326 (2013).

25. David Vlahov et al., *Violence Among Women with or at Risk for HIV Infection*, 2 AIDS & BEHAV. 53 (1998).

26. Koenig & Moore, *supra* note 20, at 104. But see Sally Zierler et al., *Violence Victimization After HIV Infection in a US Probability Sample of Adult Patients in Primary Care*, 90 AM. J. PUB. HEALTH 208, 211 (2000) (survey showing that 20.5% of women reported physical violence after an HIV diagnosis,

disclosure-triggered violence may prevent some women from telling their partners at all.²⁷ In addition, some women who have disclosed their diagnoses have reported extremely violent responses:

One woman described her partner's reaction: 'One day, he kicked the TV . . . and knocked up all the furniture, and took soap and wrote 'AIDS bitch' on the mirror.' Another woman explained the increased violence she experienced: 'He was abusive before I told him I was HIV-positive, and afterwards, well, the beatings got worse and more . . . they happened more regularly. I say that because I remember him making the statement, 'I should kill you since you are trying to kill me.' Other reports confirm that '[w]omen have been shot, physically and verbally abused, rejected, and abandoned after revealing their HIV status.'²⁸

The risk of domestic violence after disclosure, then, seems to be less common than one might expect, but severe when it does occur. This has led many researchers to recommend some type of screening and adjustment to partner notification programs for those who may be at risk of such post-disclosure violence.²⁹

Beyond disclosure-related violence, HIV infection can offer abusers new ways to exert violence and control over their partners, including using knowledge of a partner's HIV status to control that partner, trapping them in the relationship, and interfering with medical care.³⁰

A positive HIV status is not necessarily a result of a violent relationship, although some of the behaviors associated with such relationships increase the risk of HIV transmission (including having sex without condoms and having multiple partners). Similarly, a positive HIV status does not necessarily result in a violent relationship, although it can be used as a weapon by an abusive partner. It is, perhaps, useful to think of HIV not as a cause or effect of domestic violence, but as a series of risks embedded in such relationships where they already exist. The risk of HIV transmission to a woman in a violent relationship likely exists before she even contemplates taking an HIV test, and, once she learns that she is HIV-positive, her status creates or exacerbates risks of various violent behaviors on the part of her partner. Such violent relationships increase

with half listing the diagnosis as "a trigger for violent episodes"); Andrea C. Gielen et al., *Women's Lives After an HIV-Positive Diagnosis: Disclosure and Violence*, 4 *MATERNAL & CHILD HEALTH J.* 111, 118 (2000) ("The finding that only 4% of women experienced abuse they attributed directly to a disclosure event should be balanced against our finding that 13% of women reported emotional, physical, or sexual abuse that occurred only after they learned they were HIV-positive and an additional 32% of women experienced such abuse both before and after learning they were positive.").

27. *Id.* ("We do not know if some of these women would have been assaulted if they had disclosed their status and the extent to which this reaction would change our estimates of the proportion of women at risk for disclosure-related violence.").

28. Jane K. Stoever, *Stories Absent from the Courtroom: Responding to Domestic Violence in the Context of HIV and AIDS*, 87 *N.C. L. REV.* 1157, 1170 (2009).

29. *See id.* at 1171 ("Partner notification is important because a woman's delay in disclosure, combined with her hesitation or inability to insist on condom use, could lead to unprotected sex and increase the risk of transmission to an uninfected partner; however, precautions need to be taken to protect a survivor's safety during disclosure."); Koenig & Moore, *supra* note 20, at 105 (describing screening for risk of domestic violence as an ethical obligation).

30. Stoever, *supra* note 28, at 1171-74.

the risk *of* and the risks *from* HIV, and preventing or ending domestic violence would eliminate one of the more fertile environments for HIV transmission.

However, given the very immediate risk of domestic violence to some women newly-diagnosed with HIV, what can public health agencies do now to protect those women from violent reactions (immediate or forestalled) to HIV disclosure, without impairing the operation of potentially useful³¹ partner notification programs?

II. A WORKABLE SOLUTION: NEW YORK'S DOMESTIC VIOLENCE SCREENING AND DEFERRAL MANDATE

A. Interests Analysis

Partner notification programs can affect the interests of the government, index patients, and their partners in a number of different ways. Both index patients and their partners have privacy interests; however, their interests are not aligned. Partners have an interest in avoiding transmission of the virus, while the government has an interest not only in preventing the spread of the virus from the index patient to his or her partners, but in encouraging testing and treatment, particularly among at-risk populations. Domestic violence might tip the balance of the scales on which an interests analysis is conducted.

An index patient who is also an abuse victim has an immediate interest in maintaining privacy and avoiding disclosure. She will likely fear violent retaliation when she discloses her HIV status to her partner. Provider referrals' assurances of confidentiality may not help, since her partner might correctly guess her status – and, even if he is unsure, might nevertheless blame her. She will also have an interest in being treated with antiretroviral drugs; if her partner does not know her status, she might have difficulty in concealing her treatment from him or in finding excuses to travel to a clinic. On the other hand, if her partner does know of her status – and her treatment – he might use that information as a weapon against her.³² Determining the effect of partner notification on her ability to receive treatment might not be a straightforward inquiry. It would require weighing the control her partner exerts over her actions and movements in the present and the risk from the (perhaps furtive) measures she will need to enact to take antiretroviral drugs against the likelihood that her partner would use his knowledge of her status and treatment to control and abuse her in the future.

An index patient who is also an abuse victim may have an interest in being referred to domestic violence agencies or other support services. This interest,

31. Conceptually, at least, partner notification could present an opportunity for intervention in violent relationships, allowing medical personnel or public health officials to screen women for domestic violence and refer women to domestic violence agencies or other services. It is also important to remember that the risk to women from HIV disclosure does not end with the immediate reactions of their partners; their partners could still attempt to use the knowledge of their status to exert control, for example, even if they react well to disclosure.

32. Stoeber, *supra* note 28, at 1173 (“An abusive partner may prevent the HIV-positive partner from obtaining medical care and from following a doctor’s prescribed medical regimen. It is common to hear that a batterer destroyed medication to control a partner’s health and keep her sick.”).

however, would not require her partner to be notified to be upheld. Post-test screening and counseling, in- or outside the context of a partner notification program, could be used to identify patients who would qualify for and benefit from certain domestic violence intervention services.³³

A partner, whether abusive or not, has an interest in learning that he might have contracted HIV.³⁴ Although he might already know, in the abstract, that he is at risk of HIV infection and choose to be tested, knowing that he has had sexual contact with someone with HIV would establish a more compelling reason to be tested. If the partner does have HIV, he may receive treatment or change his behavior, which would likely prevent the spread of the virus. His interest in avoiding future reception of the virus is not as compelling, in relation to the need for partner notification, both because of the near-total effectiveness of antiretroviral treatment in preventing transmission³⁵ and because that interest is arguably protected by requirements that the infected persons disclose their status or face criminal sanctions prior to engaging in sexual intercourse.³⁶

If the index patient's partner engages in sexual relationships with individuals other than the index patient, those "third parties" have an interest in learning that they might have contracted HIV. If the index patient's partner is HIV-positive, he will likely participate in partner notification, and might stop engaging in risky sexual behavior. This interest could be perceived as stronger in the domestic violence context, where the index patient's partner is more likely to engage in risk behaviors like having sex without condoms and having multiple partners.³⁷

The government has one primary interest – stopping the HIV epidemic – but that interest is not necessarily best served by partner notification. Although partner notification could prevent an HIV-positive partner from unknowingly spreading the virus, it could also discourage individuals from being tested, particularly if they fear disclosure-related violence.³⁸

It is not clear that index patients' interests are outweighed by the interests of partners, third parties, and the government. If partner notification programs can be carefully tailored to meet the needs of individuals affected by domestic

33. At least one study of domestic violence screening in health care settings has cast doubt on the effectiveness of such screenings. Harriet L. MacMillan et al., *Screening for Intimate Partner Violence in Health Care Settings: A Randomized Trial*, 302 JAMA 493 (2009).

34. The probability of female-to-male sexual transmission is 4 per 10,000 exposures, as compared to male-to-female transmission through penile-vaginal intercourse (8 per 10,000 exposures). Ctr. for Disease Control & Prevention, *HIV Transmission Risk*, <http://www.cdc.gov/hiv/policies/law/risk.html> (last updated July 1, 2014).

35. Cohen, *supra* note 10.

36. *See supra* note 4.

37. *See supra* notes 21-24 and accompanying text.

38. *See* HIV SCREENING, *supra* note 11, at 14 (citing James M. Tesoriero et al., *The Effect of Name-Based Reporting and Partner Notification on HIV Testing in New York State*, 98 AM. J. PUB. HEALTH 728 (2008)) ("Studies conducted in the late 1980s and early 1990s suggested a deterrent effect of HIV reporting, while more recent studies have found fewer or no deterrent effects."). The study cited shows that only 48.5% of the women surveyed in New York knew that naming partners was voluntary; unfortunately, the study authors did not give the percentage of women for whom partner notification would be a deterrent. Only 8.6% of women agreed that name-based reporting (to the government) was a deterrent. Tesoriero, *supra* note 38, at 731.

violence, it might be possible to respect the interests of index patients, which generally disfavor disclosure, while respecting the numerous interests that favor disclosure. This would require an individualized analysis of the various aforementioned interests. The analysis would need to consider not only the immediate risk of violence following disclosure, but also the continuing risk of violence related to the partner's knowledge of the index patient's HIV status.³⁹ Given the relatively low likelihood that a partner (who does not already have HIV) would have contracted it from the female index patient and the possibility that partner notification acts as a deterrent in seeking testing, if after screening it is apparent that there is a risk that disclosure will cause or exacerbate domestic violence, no partners should be notified without the completely non-coerced consent of the index patient.⁴⁰

B. New York's Domestic Violence Screening and Partner Notification Deferral Policy

New York's provision for partner notification is found in the state's regulatory code.⁴¹ Physicians must report all initial HIV diagnoses as soon as possible but no later than twenty-one days after diagnosis, and include the "names and addresses, if available, of contacts, including spouses, known to the physician. . . or provided to them by the protected person⁴²...and information, in relation to each reported contact, required by an approved domestic violence screening protocol."⁴³ When making the mandated report, physicians must indicate "whether they have conducted post-test counseling and an assessment of the risk of domestic violence in conformance with a domestic violence screening protocol developed by the commissioner."⁴⁴ Physicians can choose to conduct contact notification, which they then must report, or they can request "partner notification assistance" from public health officials.⁴⁵ Public health officials "shall make a good faith effort" to obtain the index patient's assistance in naming and notifying contacts. "No information about the protected individual will be released to any person in this process."⁴⁶

The screening for risk of domestic violence is used to determine whether a deferral from contact notification is warranted:

39. This is particularly important given the quantitative and qualitative evidence showing that many of the risks domestic violence victims face regarding their HIV status are not the immediate result of disclosure. See Gielen, *supra* note 26, at 117-18; Stoever, *supra* note 28, at 1171-74.

40. Index patients can, of course, be referred to domestic violence agencies, and, if the intervention is successful, the interests analysis might suggest that partner notification could be revisited.

41. N.Y. COMP. CODES R. & REGS. Tit. 10, § 63.8.

42. The index patient is referred to as the "protected person" in the context of the regulation's focus on confidentiality of information. *Id.* § 63.1(g). The choice of that term might suggest that the interests of the index patient are seen as predominant, or at least might suggest that the privacy interest is seen as worth protecting.

43. Although the partner notification program is supposedly voluntary, contacts known to the physician must be reported, whether the index patient agrees or not. *Id.* § 63.4.

44. *Id.* § 63.8(a)(1).

45. *Id.*

46. *Id.* § 63.8(a)(3).

In cases which merit contact notification, if an indication of risk of domestic violence has been identified... the authorized public health official, in consultation with the reporting physician, must be satisfied in his/her professional judgment that reasonable arrangements, efforts or referrals to address the safety of affected persons have been made if and when the notification is to proceed. Such consultation shall also consider information, if available, requested from the protected person, or from a domestic violence service provider pursuant to a signed release.⁴⁷ Physicians may notify contacts under certain conditions, but they still must apply the mandated domestic violence screening.⁴⁸

Based on this regulation alone, the safety of the index patient relies on the professional judgment of the public health official,⁴⁹ or of the physician, if she chooses to notify the partners herself. This standard is somewhat indeterminate; it seems likely to rely on the official's or physician's accumulated experience. In addition, the "remedy" to a risk of domestic violence is that "reasonable arrangements, efforts or referrals to address the safety of affected persons" be made, which does not directly specify that those arrangements, efforts, or referrals must be *successful* or even likely to succeed in order to proceed with the notification. The provision that the consultation consider (and, impliedly, request) information from the index patient (or domestic violence service provider) is encouraging, insofar as it suggests that the determination should be based on facts, rather than speculation.

More information on the intended operation of the domestic violence screening requirement can be found in the protocol issued by the New York State Department of Health. The protocol acknowledges that "screening takes place within an overall context which recognizes the intersection between risk of domestic violence and risk of HIV/AIDS."⁵⁰ After establishing that domestic violence screening should be a standard of care in all health settings, the "guidelines" offer samples of questions to ask patients, including, "Do you ever feel unsafe at home?" and "Are you in a relationship in which you have been physically hurt or felt threatened?"⁵¹ Although questions should be tailored to each individual,⁵² the protocol sets up a sort of script for physicians to follow.⁵³

47. *Id.* § 63.8(c).

48. *Id.* § 63.8(l)(1).

49. Which public health official will notify the contacts is determined by the county in which the index patient resides. *Id.* § 63.8(a)(2). This might be a concern for index patients who reside in counties with more stigma towards, and perhaps less knowledge and understanding of, HIV or domestic violence.

50. N.Y. State Dep't of Health, *NYSDOH Protocol – Domestic Violence Screening in Relation to HIV Counseling, Testing, Referral & Partner Notification*, <https://www.health.ny.gov/diseases/aids/providers/regulations/domesticviolence/protocol.htm> (last updated June 2013) [hereinafter *NYSDOH Protocol*].

51. N.Y. State Dep't of Health, *Guidelines for Integrating Domestic Violence Screening into HIV Counseling, Testing, Referral & Partner Notification*, <https://www.health.ny.gov/diseases/aids/providers/regulations/domesticviolence/guide.htm> (last updated Nov. 2013) [hereinafter *NYSDOH Guidelines*].

52. *Id.*

53. Under "Step #2," "Assess domestic violence risk to the HIV-infected individual," the "Suggested script" includes the following questions:

"What response would you anticipate from this partner if he/she were notified

Physicians are then directed to refer their patients who are at risk of domestic violence to a domestic violence service provider. After screening patients and referring them to domestic violence services, physicians must step back and think about the safety of their patients should their partners be notified of their HIV infection; they are instructed to:

Defer partner notification any time a risk of behavior toward the HIV-infected individual may have a severe negative effect on the physical⁵⁴ health and safety of the HIV-infected individual, his/her children, or someone who is close to them, or to a contact if identified. In all other cases partner notification should go forward.⁵⁵

If partner notification is deferred, public health officials may contact the physician and the patient may be asked to sign a release form “to enable future follow-up,” determining whether the risk of domestic violence has been eliminated. All of the relevant parties must then communicate, and the public health official must make the decision, in accordance with the regulation, whether to proceed with partner notification.⁵⁶ There is no clear end-point to the deferral – no point at which physicians and public health officials are instructed to “give up.”⁵⁷

In comparison to the regulation, the protocol suggests that domestic violence concerns must be “resolved” before partner notification can proceed; making an effort to address domestic violence concerns, without that effort actually minimizing those concerns, is not enough.⁵⁸ However, the protocol also narrows the range of cases in which a risk of domestic violence might be found

of possible exposure to HIV?”

“Has a partner or ex-partner currently or ever: Pushed, grabbed, slapped, choked or kicked you?”

“Based on what you just told me, do you think that the notification of this partner will have a severe negative effect on your physical health and safety, or that of your children or someone close to you?”

NYSDOH *Protocol*, *supra* note 50.

54. The protocol specifies that the violence must have an effect on the physical health and safety of the index patient, but this standard is likely broader than it appears. The “guidelines” specify that outcomes of domestic violence “that can affect physical health and well-being of individuals with HIV . . . include loss of housing, withdrawal of financial support, isolation or loss of contact with and support from family and friends, custody retaliation and withholding access to health care or medications.” NYSDOH *Guidelines*, *supra* note 51. Whether physicians and public health officials can properly screen for these risks and see them as true threats to the physical health and safety of index patients is an open question.

55. NYSDOH *Protocol*, *supra* note 50.

56. *See id.*; N.Y. COMP. CODES R. & REGS. Tit. 10, § 63.8(c); *supra* text accompanying note 47.

57. Instead, physicians are instructed to “[r]evisit partner notification and domestic violence risk throughout the continuum of care.” Physicians are advised to refer patients to “HIV case management services” that ensure continuing discussion of partner notification and to engage in the partner notification process when the domestic violence problem is “resolved.” NYSDOH *Protocol*, *supra* note 50.

58. The protocol is clear—through the instruction to the physician that deferral be granted whenever a serious risk exists (as it still would, if the situation were not truly resolved) and more results-focused language like “concerns . . . are sufficiently allayed” and “resolved”—that the intervention must be successful, and not merely attempted, in order for partner notification to proceed. *See id.*; *supra* text accompanying note 49.

by conditioning deferrals on abuse that might have a severe negative effect on the index patient's physical health and safety, which would likely be more extreme in nature. Although nothing in the standard requires the violence to be immediate or physical in nature (as opposed to interference with medical care, for example), the questions physicians are instructed to ask, while broad, focus more on the results of the partner notification itself than on the ways the HIV diagnosis might affect the index patient's experience of domestic violence in the future.⁵⁹

New York's partner notification program and domestic violence deferral policy are rather sensitive in responding to the needs of domestic violence victims, considering not only the risk of violence to the index patient but also the risk of violence to their partners (from other partners), the intersection of economic and physical well-being, and the difficulties of maintaining confidentiality when the index patient interacts with physicians and public health officials.⁶⁰ However, the central role of physicians who administer HIV tests in domestic violence screening and the failure of the guidelines to respond to some of the more common, if not obvious, risks for index patients might be cause for some concern.

Physicians might seem like the best people to screen patients for the risk of domestic violence, particularly if they have an ongoing clinical relationship with the patient. However, physicians do not necessarily receive adequate training in understanding and identifying domestic violence, and are often uncomfortable with screening patients for domestic violence.⁶¹ More physicians have formally learned about domestic violence in recent years,⁶² but training is not extensive.⁶³ Physicians have reported that they are reluctant to "intervene with victims" for a number of reasons, including the "lack of time," "lack of education in domestic violence," "lack of knowledge of legal issues," and "cultural barriers."⁶⁴ Surveys have also shown that physicians perceive their patients' hesitancy to discuss domestic violence as a barrier to productive conversation, and that patients are reluctant to disclose their experiences of domestic violence because of "fear of their partner's retaliation, shame, humiliation, denial, and a belief that health

59. Questions like, "Are you afraid of what might happen to you or someone close to you, for example your children, if this partner were notified?" do not exclude responses that focus on less immediate risks, but they will not necessarily elicit such responses. See NYSDOH *Protocol*, *supra* note 50.

60. All discussions related to domestic violence screening should be held in private. In no instance should HIV counseling and testing or domestic violence discussions occur in the presence of a parent, guardian, adult or child who accompanies the individual seeking testing. Any individual escorting the person seeking testing may be the perpetrator of domestic violence or may be an individual whose presence inhibits the person seeking testing from discussing domestic violence with the provider. NYSDOH *Guidelines*, *supra* note 51.

61. See Carole Warshaw, *Domestic Violence: Changing Theory, Changing Practice*, in HEALTH CARE ETHICS: CRITICAL ISSUES FOR THE 21ST CENTURY 327 (Eileen E. Morrison & Beth Furlong, eds., 2013) (noting that domestic violence uniquely challenges physicians to go beyond the "traditional medical paradigm" in treating patients).

62. *Id.* (noting that over 60% of medical schools have incorporated domestic violence training into their curricula).

63. *Id.* at 328.

64. Barbara Gerbert et al., *Simplifying Physicians' Response to Domestic Violence*, 172 WEST. J. OF MED. 329, 330 (2000).

care professionals cannot do much to help them.”⁶⁵ Physicians have compared discussing domestic violence with their patients to “opening Pandora’s box,”⁶⁶ an attitude that, if present, is unlikely to be helpful when screening patients for the risk of domestic violence in the HIV context.

In *Domestic Violence: Changing Theory, Changing Practice*, Carole Warshaw identifies a number of institutional and structural barriers to effective acknowledgment of domestic violence by physicians. These include the process of medical training and professional socialization, which can diminish physicians’ capacities to “deal with difficult social and personal issues,”⁶⁷ the attempt to reduce social problems like domestic violence into simple diagnoses,⁶⁸ and the “micromanagement” of physicians’ time and reimbursement system, which do not incentivize the individualized type of conversation necessary for effective domestic violence screening.⁶⁹

Some of these concerns might not apply to New York’s domestic violence screening mandate. Physicians are given guidelines for the conversation, which might reduce their uneasiness or mitigate the impact of their lack of training, and the procedure is essentially required, which would encourage them to allocate at least some time to the conversation. Certain concerns still apply, though, the foremost being patients’ reluctance to disclose experiences of domestic violence. Although patients might have more of a reason in this context to disclose, since the failure to disclose might lead to partner notification-related violence, the screening protocol should be designed to elicit the most helpful responses from patients.

First, physicians should make an effort to adequately inform patients of the nature and limits of their obligation to report contacts. One study of the effects of New York’s name-based reporting and partner notification law and regulations found that, alarmingly, those surveyed after the current law went into effect were *less* likely to know that naming partners is voluntary than were those surveyed before the current law went into effect, suggesting that pre- and post-test counseling is confusing to patients. Even more alarming is the fact that “one third of HIV counseling and testing providers were unaware that naming partners was not mandatory for those testing positive for HIV.”⁷⁰ If patients know that their physicians will have to report the contacts they already know about, but that they will not have to name any other contacts, they might be more likely to disclose domestic violence (at least regarding any partners the physician already knows of) and to trust that the physician will not coerce them into naming other partners. Second, the scripted questions in the protocol

65. *Id.* at 330-31.

66. Nancy Kathleen Sugg & Thomas Innui, *Primary Care Physicians’ Response to Domestic Violence: Opening Pandora’s Box*, 267 JAMA 3157 (1992).

67. Warshaw, *supra* note 61, at 329.

68. *Id.* at 330 (using the interrelation of HIV and domestic violence as an illustration “of the need to shift from a standard problem-oriented framework to a more comprehensive model;” “[R]ecognitions of these connections has led a number of comprehensive HIV programs to integrate screening and counseling for domestic violence into the preventive as well as treatment services they provide.”).

69. *Id.* at 333.

70. Tesoriero, *supra* note 38, at 732.

should be designed to correspond as closely as possible to the experiences of index patients who are also abuse victims. Since physicians may not receive specific training in identifying and discussing domestic violence, they might over-rely on the protocol, which would make its suggestions even more important.

The suggested initial question, "What response would you anticipate from this partner if he/she were notified of possible exposure to HIV?" is very open-ended, but the suggested follow-up questions narrow the field of inquiry. The protocol recommends that physicians ask their patients about whether their partners have engaged in certain behaviors: physical violence, like pushing, grabbing, choking, and hitting; sexual violence; making threats to hurt the index patient or others; and stalking.⁷¹ Although this might seem like a fairly comprehensive list, it might not elicit disclosure of threats of harm to patients' economic well-being (threats to "kick out" the patient, for example, if the patient will not comply with certain demands), severe emotional abuse, or efforts to control patients by limiting whom they can associate with, where they can go, or what they can buy or possess. All of these mechanisms of abuse are relevant in the context of HIV, and could result in physical harm to patients. Patients with HIV who rely on an abusive partner for economic survival might not have a robust social support network to sustain them if that partner abandons them,⁷² particularly if they live in communities that stigmatize people with HIV. Patients will need to be able to see physicians regularly and take antiretroviral drugs daily; patients' past experiences might suggest that abusive partners would try to interfere with their medical care.⁷³ If physicians do not learn about these risks to their patients, they will not have enough information to determine whether partner notification will put their patients in danger of immediate or future physical harm, and thereby to determine whether deferral is necessary.

A study of the actual operation of New York's partner notification program examined the attitudes of survey participants toward disclosure-related domestic violence (here termed "intimate partner violence"):

Participants indicated that IPV was a very real consequence of notifying partners. They described specific acts that had been committed both against them and by themselves when they were told of their own exposure risk. Even those who did not experience violence discussed how real the threat was. Importantly, participants did not feel that the HIVRPN law increased the risk of IPV. Participants reported little awareness of any formal screening mechanism regarding their risk for IPV when undergoing HIV testing or beginning PN.⁷⁴ Survey participants also reported that they preferred to notify current partners

71. NYSDOH Protocol, *supra* note 50.

72. See Sally Zierler & Nancy Krieger, *Reframing Women's Risk: Social Inequalities and HIV Infection*, 18 ANN. REV. OF PUB. HEALTH 401, 413 (1997) (citing a study of inner-city Los Angeles neighborhoods showing that "[m]ost of the women received their primary economic support from male sex partners . . . [and] reported a monthly income of less than \$1000").

73. See *supra* notes 30 and 32 and accompanying text.

74. OFFICE OF PROGRAM EVALUATION & RESEARCH, N.Y. STATE DEP'T OF HEALTH AIDS INST., THE IMPACT OF NEW YORK'S HIV REPORTING AND PARTNER NOTIFICATION (HIVRPN) LAW: GENERAL FINDINGS REPORT 41 (2006), available at http://www.health.ny.gov/diseases/aids/regulations/reporting_and_notification/docs/impactreport.pdf [hereinafter NYSDOH REPORT].

themselves.⁷⁵

The survey also examined the responses of physicians (or health care providers) to the domestic violence screening requirement:

There was a strong consensus among providers that they always screen their clients for the risk of IPV and defer notification when indicated. However, providers noted that IPV in relation to PN is complex and they expressed the need for additional training. For example, many providers in these groups indicated that if there is an IPV risk, they do not report that partner's name to the Department of Health, because they do not want to risk the safety of their client in any way (i.e., by PNAP staff inadvertently notifying these partners).

This practice, if widespread, may be contributing to IPV deferrals being underreported in the HIVRPN system. At the other extreme, a minority of providers expressed a belief that partners possess a universal right to be made aware of their exposure risk, notwithstanding a positive screen for IPV. It is important to note that even these providers reported a universal application of the required IPV screening process, including deferrals when warranted.⁷⁶

The study also found that only 3.1% of partners were not notified due to domestic violence deferrals; this can, perhaps, be explained by physicians' stated reluctance to report their clients' known contacts.⁷⁷

These results confirm that disclosure-related domestic violence is a real problem, but they are surprising insofar as they show that HIV-positive patients do not see any additional risk from the state-run reporting and partner notification program. This could be explained by the fact that most women – even those in abusive relationships – choose to disclose their diagnosis to their sexual partners.⁷⁸ Physicians, unsurprisingly, would like more training in domestic violence screening; however, once they determine that there is a risk of domestic violence to their patients, they seem reluctant to work with public health officials to further assess the risk of domestic violence or monitor the success of interventions.

C. Alternatives to a Formalized Screening and Deferral Process

New York's formal, codified domestic violence screening and deferral process, although carefully designed, does not represent the only solution to disclosure-related domestic violence. Alternatives that preserve the basic state-run partner notification program include leaving the decision to exempt individuals from partner notification entirely to physicians and encouraging the use of anonymous testing.

Physicians could be seen in at least some instances as having a duty to protect their patients from disclosure-related domestic violence by neglecting to report known partners to public health officials, even if the letter of the law

75. *Id.*

76. *Id.* at 42.

77. *Id.* at iii.

78. Gielen, *supra* note 26, at 112 (reviewing various studies finding 78-87% disclosure rates following an HIV diagnosis, noting that "disclosure rates were no different for women with or without a history of abuse").

suggests that they should.⁷⁹ Indeed, the reluctance of many physicians in New York to report known partners of their patients to public health officials out of the fear that the partners might be inadvertently notified suggests that many physicians already consider this their duty.⁸⁰ There is no suggestion in the survey results that physicians methodically weigh the potential harm to their patients from domestic violence against the potential harm to the partners from lack of disclosure; although physicians could complete such an analysis, certain factors might often tip the scales in the patients' favor.⁸¹

Allowing physicians to exercise their professional judgment in this matter, while according with everyday practice, would likely protect a number of patients at the expense of a few. The New York survey identified a minority of doctors who believe that partners should be notified, whatever the risk to patients. The survey authors noted, however, that these doctors put aside that personal belief to complete the domestic violence screening and recommend deferral, if warranted.⁸² If screening out patients with domestic violence risks were entirely left to physicians, who would neglect to report the partners of patients at risk of violence to public health officials, some physicians would report these partners to public health officials, and those officials would have no procedure to screen the patients for domestic violence. In addition, not all physicians have sufficient training in identifying domestic violence; some might benefit from the guidance provided by the health department.⁸³

Anonymous testing is available in New York and in many other states, although it is often restricted to certain designated sites.⁸⁴ Anonymous testing is described on the AIDS.gov website as meaning that "nothing ties your test results to you. When you take an anonymous HIV test, you get a unique identifier that allows you to get your test results." The results of anonymous tests will not be placed in patients' medical records.⁸⁵ It is possible to conduct limited partner notification programs at anonymous testing sites,⁸⁶ and there is

79. See Richard L. North & Karen H. Rothenberg, *Partner Notification and the Threat of Domestic Violence Against Women with HIV Infection*, 329 NEW ENG. J. MED. 1194, 1195 (1993) ("How can the physician reconcile the public health strategy of notifying all partners with the duty to do no harm to the patient, especially when the patient reports a strong possibility of violence should her partner learn of her HIV infection?").

80. See *supra* text accompanying note 76.

81. Potential factors to be considered are the likelihood and severity of a violent response to notification, the doctor's duty of confidentiality, and the risk of transmission, which is relatively low female-to-male and could be irrelevant if the partner already has HIV. North & Rothenberg, *supra* note 79, at 1195-96. Since this analysis was conducted, the preventive effect of antiretroviral treatment has made post-treatment transmission even less likely.

82. See *supra* note 76.

83. See *supra* notes 61-66 and accompanying text.

84. E.g., N.Y. PUB. HEALTH LAW § 2781(4) (McKinney 2010); LA. REV. STAT. ANN. § 1300.13(C) (2007); N.J. STAT. ANN. § 26:5C-6 (1990) (only allowing up to six anonymous testing sites in the state and requires reporting of HIV diagnoses without identifying information); MD. CODE ANN., HEALTH-GEN. § 18-207 (2008) (restricting anonymous testing to sites approved by the Department of Health and Mental Hygiene).

85. *Confidential & Anonymous Testing*, AIDS.GOV, <http://www.aids.gov/hiv-aids-basics/prevention/hiv-testing/confidential-anonymous-testing/> (last updated June 8, 2010).

86. See MICH. COMP. LAWS ANN. § 333.5133(8) (2011) (requiring personnel at anonymous testing sites to "proceed with partner notification" when an individual anonymously tests positive for HIV);

some evidence that many partners of anonymously-tested patients are eventually notified, even without the assistance of partner notification programs.⁸⁷

Anonymous testing is typically not available in “hospitals, medical clinics, and physician-owned organizations.”⁸⁸ Patients who are tested anonymously may be less likely to receive medical treatment than those who are tested confidentially;⁸⁹ one of the reasons for this might be the difficulty of “following up” with anonymous clients.⁹⁰ Despite these drawbacks, interviews with HIV test counselors reveal that anonymous testing is seen as something of a cure for fears surrounding partner notification. One counselor said of those who fear partner notification, “Most of them prefer anonymous. . .because the County will get this and the next thing you know, if you test positive, they’re gonna detect all the other partners.”⁹¹

Anonymous testing is one possible way to reduce the risk of disclosure-related violence to HIV-positive women, since involuntary partner notification cannot coexist with true anonymity. However, the difficulty in encouraging access to subsequent medical treatment, which might already be more difficult for women in violent relationships to access, makes anonymous testing an unsatisfying solution.

III. RECOMMENDATIONS

HIV-positive women are commonly, and uniquely, affected by domestic violence. Many HIV-positive women are also victims of domestic abuse, and that abuse is sometimes intensified by their HIV status, which can be used like a weapon against them. Many women experience, or at least perceive, the risk of disclosure-related violence.⁹² Nevertheless, most women, including those at risk of domestic violence, disclose their diagnoses to their sexual partners.⁹³

CDC *Recommendations*, *supra* note 2, at 14 (“[P]rogram managers who are responsible for HIV partner services should work with providers who offer anonymous HIV testing to develop strategies for offering and providing partner services to persons who test positive anonymously and elect not to enter a confidential system.”).

87. See CDC *Recommendations*, *supra* note 2, at 14 (reviewing studies that mostly find that “two to three times more partners are notified when persons are tested confidentially,” but noting that one study found no difference between confidential and anonymous testing).

88. Oscar Grusky et al., *Anonymous versus Confidential HIV Testing: Client and Provider Decision Making Under Uncertainty*, 19 AIDS PATIENT CARE & STDs 157, 160 (2005).

89. *Id.* at 158.

90. See *id.* at 162 (noting that confidential testing is preferred by testing sites because anonymous testing does not provide a way for sites to contact individuals who fail to pick up their results or to encourage positive individuals to seek treatment). In addition, anonymous test results are not forwarded to physicians, other medical care providers, or government or private insurers, making it impossible to both remain anonymous and pay for and receive medical care. Patients can convert their anonymous test to a confidential test if they want help with receiving medical care. N.Y. State Dep’t of Health, *HIV Reporting and Partner Notification Questions and Answers*, http://www.health.ny.gov/diseases/aids/providers/regulations/reporting_and_notification/question_answer.htm (last updated Nov. 2013).

91. Grusky, *supra* note 88, at 163-64.

92. See *supra* notes 26-29, 74 and accompanying text for discussion of quantitative and qualitative studies of disclosure-related violence, as well as indications of widespread perception of violent reactions.

93. Gielen, *supra* note 26, at 112 (reviewing various studies finding 78-87% disclosure rates

Involuntary partner notification, which can occur even in systems like New York's because of its requirement that doctors report known partners, poses a risk for many women, even those not at immediate risk of a physically violent response. These women might face the consequences of HIV-related abuse later in the relationship, when a partner uses his knowledge of her status to control her. For these women, the discussion with their physicians about partner notification and the risk of disclosure-related violence after they receive their test results might be the first and only time anyone acknowledges a relationship between HIV and domestic violence. Although the focus of that discussion would likely be on the immediate risk to patients from their partners, the discussion could be used as a locus for intervention in the relationship. This intervention would occur too late to remedy many of the connections between HIV and domestic violence, which exist before transmission in the form of domestic violence-linked high risk behaviors, but it could reduce the new risks that HIV brings to abuse victims.

A. Implement a Broader Domestic Violence Screening and Deferral System

In order to protect the interests of index patients who are also victims of abuse, policies like New York's domestic violence screening and deferral from partner notification should be designed to take into account HIV-related emotional, economic, and other forms of abuse that occur not only immediately after notification but throughout the course of the relationship. Although states might still require severe effects on health and safety to grant deferrals (since they need to implement some standard for granting deferrals if they intend to maintain mandatory reporting and occasionally involuntary partner notification programs), the interests analysis of involuntary partner notification for index patients who suffer abuse, their partners, and third parties suggests that involuntary partner notification is frequently unwarranted when index patients are also abuse victims.⁹⁴

The domestic violence screening should be conducted by physicians with adequate training in the interrelation between HIV and domestic violence and should include questions intended to identify less obvious forms of abuse. Some physicians report that they lack adequate training to understand the relationship between domestic violence and partner notification,⁹⁵ and studies have shown that many physicians are uncomfortable with initiating any discussion of domestic violence with their patients.⁹⁶ The training physicians receive should prepare them for difficult discussions of sensitive topics. This might require physicians to reexamine their own beliefs and attitudes about domestic violence, as the lack of formal training has previously left many physicians to rely on their own internal resources when engaging in discussions about domestic violence.⁹⁷

following an HIV diagnosis; "disclosure rates were no different for women with or without a history of abuse").

94. See *supra* Part III.a.

95. See *supra* text accompanying note 76.

96. See *supra* notes 61-66 and accompanying text.

97. Warshaw, *supra* note 61, at 328 ("[C]linical responses often are shaped by an interplay of the physician's own personal experiences and social, cultural, and religious beliefs" due to the lack of

The suggested script for the domestic violence screening should include questions tailored to the experiences of HIV-positive abuse victims, including concerns regarding stigma and interference with medical care. The following sample script, with some questions retained from the current protocol, would potentially identify more women at risk of HIV-related domestic violence:

“What response would you anticipate from this partner if he/she were notified of possible exposure to HIV?”

“Have you ever felt afraid of your partner?” Why?

“Has a partner or ex-partner currently or ever” hit you, “forced you to have sex,” or “threatened to hurt you?” Has he ever hurt your children?⁹⁸

Does your partner support you financially? Does he ever try to tell you what to do or what not to do with your money? Has he ever told you that he would cut you off if you didn’t do what he wanted you to do?

Do you live with your partner? When your partner is angry, has he ever told you he would kick you out? Do you know what you would do if he did?

Do you think your partner would still support you if he knew you had HIV? Do you think he might cut you off or kick you out if he knew?

Has he ever threatened you with trying to take custody of your children? Do you think he would try to do this if he knew you had HIV?

Has he ever stopped you from taking any medication you needed or took it himself, instead? Do you think he would do this if he knew you had HIV?

How do you get to the hospital, doctor’s office, or clinic? Has your partner ever tried to stop you from going somewhere you needed to go?

Do you think your partner might tell other people about your HIV status to punish you, to get back at you, or for some other reason? Do you think he might threaten to tell other people if you don’t do what he wants you to do?

These are obviously very difficult questions, and might offend some patients. Physicians will need to be sensitive to and respect the verbal and nonverbal cues of their patients signaling discomfort, and will need to tailor the conversation to each patient, in order to gain the trust of their patients, which is necessary for the domestic violence screening to be successful.

Physicians can then, alone or in conjunction with public health officials, determine whether a risk of disclosure-related domestic violence exists to a particular patient. The analysis should consider all of the potential risks elicited from the patient through the screening, including risks to the patient’s economic security and the likelihood of interference with medical treatment. Although an interests analysis might suggest that partner notification should be deferred only where the risk of domestic violence outweighs the threat of harm to the partner and third parties,⁹⁹ weighing these interests might be difficult for physicians and

domestic violence training). The author also notes that medical training may deplete some of the resources physicians already have in dealing with “difficult social and personal issues:” *Id.* at 329. “Pain, anger, frustration, and sadness are common responses to hearing about abuse. Without specific training and support, many clinicians find themselves dealing with these situations through a variety of techniques designed to protect and distance themselves from potentially distressing encounters.” *Id.*

98. These quoted questions come from NYSDOH Protocol, *supra* note 50.

99. A very slight risk of domestic violence could be outweighed, for example, if a patient reveals

potentially incompatible with their duties to their patients. The interests of partners and third parties would likely be sufficiently protected where public health officials require a severe negative effect on physical health and safety to grant deferral, as in New York.

After domestic violence screening is completed, physicians should refer patients to domestic violence service providers. Physicians should also use the results of the domestic violence screening to understand the unique treatment needs of their patients. Knowing that a patient fears interference with medical care, for example, might help physicians understand why a patient is noncompliant with her treatment regimen. Understanding the problem, the physician can then consult with or refer the patient to a service that can help the patient find transportation to the clinic or conceal her medication, if necessary.

Domestic violence screening that is tailored to the experiences of HIV-positive patients and partner notification deferrals based not only on immediate physical harm but on other common risks could protect the small but important contingent of women who have no current intention to disclose their HIV diagnosis to their partners but who would be forced, under a mandatory reporting and notification scheme with no protection or more limited protection for domestic violence victims, to disclose. Such screening could also help physicians refer their patients to the domestic violence service providers that might meet their particularized needs. Although screening at this stage will not reduce the risk of HIV transmission to which domestic violence likely contributes, it will reduce the risks of violent behavior caused or exacerbated by an HIV diagnosis.

B. Allow Physicians a Safety Valve

In New York, many physicians ignore mandatory reporting requirements if they believe that providing information about patients' partners would lead to involuntary, harmful disclosure.¹⁰⁰ These physicians do not work with public health officials, for reasons that signal some degree of distrust,¹⁰¹ which makes the impact of disclosure-related domestic violence (or fears of such violence) and the success of a deferral program more difficult to measure. Instead of trying to secure physician compliance in naming partners, states could give physicians the option of either complying with the domestic violence screening and deferral protocol or determining, on their own and without revealing partner information to public health officials, that there is a sufficient risk of domestic violence to the index patient to warrant withholding the information.

This might seem redundant, since many physicians will find both a risk of domestic violence under the current screening procedure and in their own professional opinion, but this "safety valve" would allow the current protocol to act as a "floor" while preventing it from being used as a "ceiling." For the minority of physicians who believe that partners should be notified regardless of the risk of domestic violence, the current protocol would prevent them from

that her partner shows some symptoms of illness and has unprotected sex with many other partners.

100. See *supra* text accompanying note 76.

101. *Id.* It seems from the survey responses as though physicians lack trust in public health officials' competence, if not in their intentions.

acting on that belief. Similarly, for physicians who might have narrow ideas of domestic violence, a revised version of the current protocol would prevent them from ignoring risks outside their personal experience. However, for the majority of physicians, who are vigilant in protecting their patients' safety, the safety valve will allow the exercise of professional judgment in determining the individualized (and perhaps not covered under even a revised protocol) risks to their patients *and* forthrightness with public health officials.

CONCLUSION

New York's domestic violence screening and deferral policy might not identify and protect every index patient at risk of disclosure-related domestic violence. It attempts to consider a broad range of abusive behaviors, including withdrawal of economic support, but the protocol does not clearly instruct physicians to ask about these behaviors and does not clearly specify how to categorize and weigh these behaviors, particularly in relation to the severe negative effect on physical health standard for deferral.¹⁰² However, New York has attempted a solution to the problem of disclosure-related violence, while only a few other states have.

Although involuntary partner notification puts some women at risk of disclosure-related domestic violence, it is important to remember that most women tell their partners of their HIV diagnosis. HIV-positive individuals, while recognizing that disclosure-related violence is a real threat, seem to agree that partner notification does not have a negative effect on most women's situations, perhaps because women cannot (or will not) conceal their diagnosis forever.¹⁰³ For these women, the value of domestic violence screening and deferral might reside mostly in the opportunity for intervention. Referral to domestic violence service providers could help some women either mitigate their risks in violent relationships or leave these relationships altogether.

Intervening after women receive positive HIV test results will not change the fact that partners in abusive relationships are more likely to engage in risk behaviors for the transmission of HIV; nor will exempting women from mandatory notification. However, these efforts acknowledge the unique risks that HIV poses to women in abusive relationships, allowing states, when designing programs to protect the public health, to advance the modest goal of not making the situation of HIV-positive women in abusive relationships any more perilous.

102. See *supra* note 54 and accompanying text.

103. See *supra* text accompanying note 74.