The medical and legal ramifications of women with AIDS

The World Health Organization designated Dec 1, 1990 as "Women and AIDS" Day. This third annual World AIDS Day featured special events designed to emphasize the impact of AIDS on women. Of the 8 million persons with AIDS, one third are women. Intravenous drug use, particularly needle-sharing among users, continues to be a major route for HIV transmission in women. The Centers for Disease Control (CDC) reports that diagnosed AIDS cases increased 29% in women from 1988 to 1989. During that same period, the incidence of AIDS in men rose 18%. If the current trend continues, AIDS will be among the five leading causes of death in women aged 15 to 44 years this year, according to CDC estimates.

Of all AIDS cases in women, 85% occur among women in their childbearing years, namely between the ages of 15 and 44 years. Thus, AIDS poses not only a health threat to women, but also to their unborn children. For example, in a recent Florida study, 1 out of every 220 mothers giving birth tested positive for the HIV. Thus, potentially 1 out of every 220 infants in Florida alone may be infected with the HIV. Even if the number of HIV-infected mothers is lower in the other 49 states, the potential health implications are enormous. Coupled with these sheer numbers is the estimated median 11-year HIV incubation period.

With such a large pool of women—and their children—at risk for HIV infection, what role do physicians play in this scenario? We must first realize that many sexually active women are unaware of their risk of contracting the HIV. Our advice and counseling with respect to sexual matters are critical. Other than in a long-term, monogamous relationship, sexual activity is potentially hazardous. We physicians have an obligation to inform and counsel patients accordingly.

But what responsibility do we have to notify the sexual or needle-sharing partners of our HIV-infected patients? Beginning on page 46, Scott H. Isaacman, DO, JD, and Michael L. Closen, JD, write that physicians who care for HIV-infected patients have a duty to assure that at-risk third parties are notified of their respective risks of infection. The authors write that the CDC guidelines recommend the following: "If [HIV-infected persons] are unwilling to notify their partners or if it cannot be assured that their partners will seek counseling, physicians or health department personnel should use confidential procedures to assure that the partners are notified."

The authors conclude, "A physician who fails to disclose a patient's HIV infection to identified or reasonably identifiable sexual or needle-sharing partners (or both) may become embroiled in a negligence claim based on failure to warn."

Certainly we have a legal obligation to warn third parties of their partners' infection. However, we have a medical and perhaps even a moral obligation to not only counsel our patients but their partners as well.

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An example of putting our assumptions to the test

Much of what we assume to be true in medicine has not been tested; objective evidence of cause and effect is often lacking. Case in point is the relationship between unlevelness of the sacral base, scoliosis, and back pain. Osteopathic physicians have long assumed a cause-and-effect relationship. However, as Robert E.

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