*For Debate . . .*

# Refusal to treat AIDS and HIV positive patients

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"I . . . reserve the right to decline to operate on those in whom recent or continuing infection with HIV is likely other than in lifethreatening circumstances."[1] Few doctors have been as bold as to say so in print. It seems clear, however, that the author of this assertion is by no means alone, and I have heard several anecdotal reports of doctors who have refused to see or treat human immunodeficiency virus (HIV) positive patients and of a general practitioner who removed a patient from his list after learning that the patient was HIV positive. As against such a stance a *BMJ* editorial suggested that the General Medical Council should take a leaf out of the Royal College of Nursing's book[2] and discipline any doctor who refuses to care for a patient infected with HIV.[3]

What are the proposed justifications for withdrawal of medical care from HIV positive patients? The surgeon who reserves "the right to decline to operate" implies that four types of risk and, in addition, the "voluntary sexual perversion or mainline drug abuse" of most HIV positive patients justify withdrawal of medical care. The risks he refers to are those to other patients, to the doctors and to their staff and their families "of contracting this terrible disease."

## Empirical evidence

Part of the assessment of these justifications obviously depends on the empirical facts—just what are the risks to health care workers (and thus to their families) and to other patients if HIV positive patients are treated? In terms of the nature of the harm risked clearly it is indeed a "terrible disease" which is risked. However, the probability of that harm occurring as a result of health care workers treating HIV positive patients is very low according to the consensus of expert opinion.[4-10]

According to Miller *et al*, for example, there is a substantial body of evidence that the risk of occupational transmission "is negligible provided that basic standards appropriate for the care of all patients are applied" and "even in 'needlestick' injury the risk appears to be extremely small. . . ."[5] Volberding and Abrams, acquired immune deficiency syndrome (AIDS) physicians in San Francisco, "consider the risk of contracting AIDS from patients to be negligible,"[9] and the San Francisco task force on infection control in the care of HIV patients state that "the risk of nosocomial transmission of HIV is extremely low even after accidental parenteral inoculations."[10]

Among the postulated reasons for this low probability of occupational infection are the notions that the HIV virus is a "pathogenetic weakling that is truly difficult to transmit except by sexual routes"[11] and the relatively low concentration of HIV virus particles in infected blood compared with, for example, blood infected with hepatitis B.[4] Nor does ordinary social contact present a risk of infection according to the official advice from the Department of Health and Social Security to surgeons and other doctors dealing with AIDS patients,[8] and Friedland *et al* found no transmission to 101 household contacts of 39 AIDS patients studied for between three and 48 months (median 22 months) and report that: "Except for sexual partners and children born to infected mothers none of the family members in more than 12 000 cases reported to the Centers for Disease Control (CDC) are known to have contracted AIDS (CDC, unpublished data)."[12] Sande concluded "that caring for AIDS patients, even when there is intensive exposure to contaminated secretions, is not a high risk activity."[13]

It must be said that occasional expert medical doubt is cast on this consensus. Seale, for example, in the *Guardian*[14] and at a recent London Medical Group conference on AIDS, suggested that there is a risk of salivary spread of HIV by kissing—a worry about saliva which was perhaps reflected in the ticket collector's concern about collecting chewed rail tickets reported in the *London Evening Standard*.[15] Smith's reply to Seale, from the Public Health Laboratory Service,[7] seems convincing and most of the empirical evidence indicates that the risk to doctors and other health care workers (and thus to their families) of occupational acquisition of AIDS virus infection is very low probability; and extrapolating the information available it seems even less likely that other patients will contract the infection as a result of AIDS patients being treated in the same operating theatres or wards, etc.

None the less, someone might argue that it is not just the nature of the harm and its probability that is important in risk assessment; it is also its perception. If a health care worker perceives the risk of acquiring AIDS as being very frightening, even if there is in fact only a low probability that this will actually happen, then ("in a free world") there is no obligation on him or her to participate in the infected patient's care. An appeal to the principle of respect for autonomy might be offered in support of such a claim—respect, that is, of the health care worker's autonomy rather than the patient's. Undoubtedly, the factor of risk perception is important,[16,17] and it is also true that a plausible case can be made for the claim that in a free society people in general should not be forced to do what they perceive to be dangerous to themselves to benefit others even if their perceptions of danger seem greatly inflated.

## A moral obligation to help our patients

We come now to what seems to me the crux of this argument, for while it may be hard to justify the imposition of such perceived risk taking on all and sundry does the same apply to members of the medical and other health care professions? The counterargument is that as health care professionals we accept obligations to treat our patients even when this entails what might be called real risks, let alone when the risks, though fatal if they occur, are in fact very unlikely to happen. I have argued previously that this medical obligation to benefit our patients is not absolute (nor is any obligation).[18] It is, however, surely an important component of being a health care professional that one takes on a special and supererogatory obligation to benefit one's patients—an obligation, that is, which is greater than the ordinary obligations we all have to benefit each other.[19,20] Such a claim is by no means universally accepted. Downie, for example, argues that doctors have no greater moral obligations to their patients than anyone has to anyone else.[21,22]

If he is right then there would seem to be no particular moral obligation for doctors and nurses to treat their AIDS patients if they feel the risk is too great—no more at any rate than there is on any one else with appropriate skills to help an AIDS patient despite feeling threatened by the risk. But for those of us who believe that both corporately as a profession and individually as members of that profession we still commit ourselves to the characteristic medical obligation to benefit our patients that is referred to in the Hippocratic Oath and its modern successors,[23-25] there can be little doubt that Dr Smith is right[3] and that it is indeed part of a doctor's duty to treat his HIV infected patients even when his perception of the risks makes these risks more alarming to him than they are to the profession as a whole.

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### Disease resulting from voluntary activities

Is there, however, some additional moral weight to be given to the last part of the argument purportedly justifying the withholding of treatment—the argument that since the infection "is likely to have been acquired during the course of some voluntary sexual perversion or mainline drug abuse" this somehow cancels the normal obligation of a doctor to treat his patient? Note that even if this argument were sound it would still leave the treatment of those who had acquired HIV through other routes unclear. After all, such patients will be no less risky to their doctors and other carers than the homosexual and drug addicted carriers. If the risk is found acceptable in the case of these other categories but not with the homosexuals and drug addicts it suggests that the risk to others is not the real reason for withholding treatment so much as the "voluntary sexual perversion or mainline drug abuse."

The implicit argument is by no means clear but is open to at least two interpretations. It might mean that doctors need not feel obliged to treat *any* patient whose illness results from a voluntary activity. Alternatively, it might mean that doctors need not feel obliged to treat any patient whose illness results from a voluntary activity of which the doctor disapproves. The former claim is obviously absurd and can be ignored. (It would, for example, allow doctors to opt out of treating voluntarily pregnant women—or car crash victims, even if they *had* put on their seat belts, let alone those who hadn't.)

### Disapproval and the withdrawal of treatment

What about the second interpretation? May doctors withdraw from their normal obligations to treat their patients (assuming of course that we do have such obligations) if the patient's illness has resulted from some voluntary action of which the doctor disapproves? This, like so many of the medicomoral dilemmas of AIDS, is not a novel idea. Doctors are occasionally to be heard arguing that drink-drivers should not be treated, and that smokers should not be treated, and that attempted suicides should be left to die. Perhaps one of the simplest ways of seeing the unacceptability of such proposals is to imagine oneself in the role of the patient with the doctor disapproving of one's own actions or lifestyle, or both. Suppose, for example, a surgeon who reserves "the right to decline to operate" contracts syphilis and in the venereal disease clinic encounters a bigoted gay doctor who disapproves of heterosexual intercourse. Would the latter be justified in withholding medical treatment for syphilis on the grounds that it resulted from a voluntary activity of which he or she disapproved?

The norms for withholding medical treatment simply do not include moral disapproval by the doctor of his patient's lifestyle or actions. Patients, society, and the medical profession would, it seems uncontentious to assert, be far the worse off if this was changed. Meanwhile the principles of professional conduct laid down by the General Medical Council, and representing the profession's and the public's agreement about how doctors in Britain should behave, seem explicit and unambiguous on such matters. Under the heading: "Neglect or disregard of personal responsibilities to patients for their care and treatment" the GMC's "little blue book" states: "In pursuance of its primary duty to protect the public the Council may institute disciplinary proceedings when a doctor appears *seriously* to have disregarded or neglected his professional duties, for example by failing to visit or to provide or arrange treatment for a patient when necessary."[26] Thus there seems little doubt that a patient would have at least a legitimate prima facie case for complaint to the GMC about any doctor who failed to operate or provide or arrange other necessary treatment solely on the grounds that the patient was HIV positive or had AIDS. If the facts of the case were as hypothesised it is difficult to see how any such doctor could justly escape being found guilty of serious professional misconduct.

### References


1 Guy PJ. AIDS: a doctor's duty. *Br Med J* 1987;**294**:445.
2 Royal College of Nursing Working Party on AIDS. *Nursing guidelines on the management of patients in hospital and the community suffering from AIDS*. London: Royal College of Nursing, 1986. (Second report.)
3 Smith T. AIDS: a doctor's duty [Editorial]. *Br Med J* 1987;**294**:6.
4 Geddes AM. Risk of AIDS to health care workers. *Br Med J* 1986;**292**:711-2.
5 Miller D, Jeffries DJ, Green J, Willie Harris JR, Pinching AJ. HTLV-III: should testing ever be routine? *Br Med J* 1986;**292**:941-3.
6 Wells N. *The AIDS virus—forecasting its impact*. London: Office of Health Economics, 1986.
7 Smith JWG. HIV transmitted by sexual intercourse but not by kissing. *Br Med J* 1987;**294**:446.
8 Department of Health and Social Security. *Acquired immune deficiency syndrome (AIDS). Booklet 3. Guidance for surgeons, anaesthetists, dentists and their teams in dealing with patients infected with HTLV III*. DHSS. London, 1986.
9 Volberding P, Abrams D. Clinical care and research in AIDS. *Hastings Center Report* 1985;**15**: 16-8.
10 Gerberding JL, and University of California, San Francisco Task Force on AIDS. Recommended infection control policies for patients with human immunodeficiency virus infection—an update. *N Engl J Med* 1986;**315**:1562-4.
11 Osborn JE. The AIDS epidemic: multidisciplinary trouble. *N Engl J Med* 1986;**314**:779-82.
12 Friedland GH, Saltzman BR, Rogers MF, *et al*. Lack of transmission of HTLV III/LAV infection to household contacts of patients with AIDS or AIDS related complex with oral candidiasis. *N Engl J Med* 1986;**314**:344-9.
13 Sande MA. Transmission of AIDS. The case against casual contagion. *N Engl J Med* 1986;**314**:380-2.
14 Seale J. An AIDS challenge on the dangers of kissing. *Guardian* 1987 Jan 20:12.
15 Anonymous. "AIDS" ticket scare. *London Evening Standard* 1987 Mar 2:13.
16 Anonymous. Risk [Editorial]. *J Med Ethics* 1982;**8**:171-2.
17 Nelkin D, Hilgartner S. Disputed dimensions of risk: a public school controversy over AIDS. *Milbank Mem Fund* 1986;**64**:(suppl 1):118-42.
18 Gillon R. *Philosophical medical ethics*. Chichester: Wiley, 1986:73-9.
19 Gillon R. More on professional ethics. *J Med Ethics* 1986;**12**:59-60.
20 Gillon R. Do doctors owe a special duty of beneficence to their patients? *J Med Ethics* 1986;**12**:171-3.
21 Downie R. Professional ethics. *J Med Ethics* 1986;**12**:64-5.
22 Downie R. Professional ethics: further comments. *J Med Ethics* 1986;**12**:195-6.
23 British Medical Association. Hippocratic Oath. *The handbook of medical ethics*. London: BMA, 1984:69-70.
24 World Medical Association Declaration of Geneva. In: Duncan AS, Dunstan GR, Welbourn RB, eds. *Dictionary of medical ethics*. London: Darton, Longman and Todd, 1981:132.
25 British Medical Association. World Medical Association International code of medical ethics. *The handbook of medical ethics*. London: BMA, 1984:700-2.
26 General Medical Council. Professional conduct and discipline: fitness to practise. London: GMC, 1985:10.


*Is there any justification for using phenazone in a local application prescribed for the treatment of acute otitis media?*

Phenazone is a rather impotent non-steroidal anti-inflammatory derivative of pyrazolone. Taken by mouth it is less effective than aspirin and considerably more toxic than other non-steroidal anti-inflammatory drugs and is therefore no longer in use. Phenazone does not penetrate intact skin, has no proved local activity, and is not known to be ototoxic. Presumably it is included in many ear drops because it is believed to have a local anti-inflammatory and therefore analgesic action in acute otitis media. The pain of acute otitis media, however, is due primarily to the stretching and distension of the intact skin covered tympanic membrane by pus under pressure in the middle ear. This is borne out by the fact that this pain rapidly disappears the moment the tympanic membrane ruptures and the pus is discharged. So it would seem unlikely that phenazone would have any action on the skin of the intact tympanic membrane though it might be mildly inflamed and distended. Support for this view is contained in a paper comparing the symptomatic effect of another non-steroidal anti-inflammatory drug, suprofen (5-7·5 mg/kg by mouth) with that of ear drops containing lidocaine and phenazone on children between the ages of 3 months and 3 years with acute otitis media.[1] The children showed a significant symptomatic improvement when taking suprofen but deterioration occurred after using the ear drops. Neither treatment group was compared with a no treatment group. There seems, therefore, to be no justification for the inclusion of phenazone in local preparations used in treating acute otitis media. Indeed, there is little justification for the use of any local preparation in treating this condition and growing experimental evidence that the routine use of antibiotics or myringotomy, or both, does not relieve symptoms in the short term or reduce the likelihood of long term sequelae.[2] Treatment should therefore be confined to analgesics only, probably paracetamol as the safest and debatably the most effective oral analgesic in children.—W V CARLIN, consultant ear, nose, and throat surgeon, Stoke on Trent.


1 Weippl G, Michos N, Stocker H. Assessment of pain in babies and infants/analgesic effect of suprofen syrup in acute otitis media. *Arzneimittelforschung* 1985;35:1732-4.
2 Browning GG. *Clinical otology and audiology*. Sevenoaks: Butterworths of Borough Green, 1985:158-9.