Benjamin Freedman, PhD

Is There a Duty to Provide Medical Care to HIV-Infectious Patients? Facts, Fallacies, Fairness, and the Future

SUMMARY

The author examines and rejects two common types of argument in support of the duty to care for persons infected with HIV, namely, the view that exposure to this contagion has been accepted (individually or communally) by physicians, and the view that physicians can be held to a high standard of moral conduct that encompasses a substantial degree of self-sacrifice. He suggests rather that the duty to care for the HIV-infectious patient is grounded in the harm that would ensue were discrimination to be permitted, and in fairness to those members of the medical profession who refuse to discriminate. (*Can Fam Physician* 1990; 36:479–482.)

RÉSUMÉ

L'auteur examine et rejette deux types courants d'arguments en faveur de l'obligation de soigner les personnes infectées par le HIV, à savoir l'opinion que les médecins ont accepté (individuellement ou collectivement) l'exposition à cette contagion, et l'opinion à l'effet que les médecins sont appelés à faire preuve d'une conduite morale impliquant un degré substantiel d'esprit de sacrifice. Il suggère plutôt que le devoir de soigner les patients infectés par le HIV repose sur le tort qu'engendrerait la discrimination si elle était permise, et en guise de solidarité aussi envers les membres de la profession médicale qui refusent toute forme de discrimination.

Key words: AIDS, family medicine, infectious diseases, medical ethics, occupational risks

Dr. Freedman, a philosopher by training, is an Associate Professor at the McGill Centre for Medicine, Ethics and Law, and is Clinical Ethicist at the Sir Mortimer B. Davis Jewish General Hospital of Montreal. Requests for reprints to: Prof. Benjamin Freedman, McGill Centre for Medicine, Ethics and Law, 2020 University, Montreal, Que. H3A 264

THE HUMAN immunodeficiency viros (HIV) is more than a pathogen; it is a complicated bundle of paradox and contradiction. It is a leading public health problem, caused by the most private of activities. It brings plague, the ancient scourge of humanity, into a modern era that thought itself, in the privileged West, free of epidemic.

The rapid spread of HIV infection is facilitated by intravenous drug abuse and the complicated technological achievement of world-wide integration through transportation. It wreaks its damage by appropriating to its own deadly use the body's basic defence mechanism against disease.

The ethical paradoxes associated with HIV are no less notable. In this article, I concentrate upon one issue: the physician's obligation to treat patients infected with HIV. (I shall speak of "HIV-infectious" patients, rather than of those who are "HIV-infected" or "HIV-positive," to emphasize the doctor's concern with contagion. Patients need not be HIV-positive to be contagious; before seroconversion, the infected person is clearly contagious.[1] In addition, growing experience with the disease suggests that infected patients vary in infectiousness as the disease runs its course.)[2,3]

The paradoxes are numerous: for example, a profession instituted to care for the ill ponders whether it has a duty to care for the desperately ill person with AIDS. A response is mounted by several authors, who have reached the right conclusion—there is a duty to treat—for what seem to me the wrong reasons. It is important to explore this paradox, for it has implications for our understanding of medicine's past traditions, present practices, and future challenges.

Health care workers' risk of occupational acquisition of HIV infection has been reviewed in detail[4] and is the subject of ongoing prospective and retrospective study in Canada and elsewhere.[4,5] Several salient points emerge.

1. The risk can be delineated and is largely confined to those exposed to HIV-infectious blood by needlestick injury or by a splash onto an open wound or a mucous membrane.
2. The risk can be reduced by the use of barrier precautions limiting exposure.[6]
3. The risk is small. Even those exposed are very unlikely to become infected; perhaps one in 200 needlestick exposures from known HIV carriers will result in seroconversion.[5]
4. The risk is real. Even presuming effective use of blood and body fluid barrier precautions, some exposures will occur, and a few of those exposed will seroconvert and go on to develop AIDS.

Fallacies

When a perception of occupational AIDS risk first developed in North America, a number of physicians and some medical organizations declared that this new threat modified and limited the physician's obligation to his or her patients. Such public statements quickly grew scarce in the face of an opposing stance adopted by bodies including state licensing boards, human rights commissions, and, ultimately, the American Medical Association (AMA).[7]

The public consensus that there is an enforceable professional duty on the part of doctors to treat HIV-infectious patients was bolstered by several articles I shall discuss below describing the ethical underpinnings of this duty. Yet some of the arguments most often used to establish the duty are demonstrably weak, and ethicists above all should concern themselves with the validity of the arguments employed as well as their conclusion.

"This Was Part of the Deal."

Within our fragmented ethical world, the most common form of duty that we understand is self-imposed: the duty to keep promises, to fulfill contracts and commitments.[8] It is therefore not surprising to hear that doctors have a duty to treat the infectious patient because that risk is an unwelcome but unavoidable part of the deal. The argument appears in several versions, each one problematic in its own way.

Gillon argues that individual physicians have accepted this risk: "As health care professionals we accept obligations to treat our patients even when this entails what might be called real risks."[9] This argument makes sense when addressed to students of medicine and nursing today, for it is now established that there is an occupational risk associated with HIV that trainees and practitioners may not contract out of. But this cannot be said of those who chose a profession, who were trained, and who established a practice without knowing that this risk loomed over the horizon. Would they have chosen medicine, knowing that this risk would occur? It is impossible to say, although the current severe drop in medical school applications in the United States is suggestive. At any rate, what doctors would have done had they known is irrelevant. They did not in fact know, and so did not in fact agree to undergo this risk.

While HIV occupational risk was not an explicit part of the undertaking, however, some will suggest it is implicitly incorporated within the broad category of risk to which persons have agreed. Health care workers run a 6% to 30% risk of acquiring hepatitis B virus (HBV) infection after parenteral exposure to the blood of HBV-infected patients. Thus, the risk of dying from occupationally induced hepatitis B remains much greater than HIV risk.[10]

If individuals accept equivalent or greater risks as part of the implied contract of employment as physicians, why not subsume HIV risk in this way? By way of illustration, Sheldon Landesman has described a question posed by a surgeon in an AIDS symposium. The questioner, a volunteer fireman in a suburban community north of New York City, asked about potential infection by providing mouth-to-mouth resuscitation at the scene to a burn victim. Even while responding to the question, Landesman expressed bemusement at concern over a small risk of contagion on the part of someone who voluntarily spends his spare time racing into burning buildings (personal communication from Landesman S 1987 Oct 28).

But this last example demonstrates a problem with the argument. Individuals are entitled to choose the form and level of risk they will undergo. No definitive, rational response to risk[11] can be imposed, as when someone who has already accepted the risk of hepatitis B is told that it is irrational for him to reject the increment of HIV risk. Clearly, too, the manner of death by AIDS bears with it, for both medical and social reasons, a particular dread that does not necessarily apply to other occupational risks.

The AMA has adopted still a third version of the argument that "this risk was part of the deal." In its view, a duty to treat the HIV-infectious patient flows from an historically accepted principle of medical ethics: "When an epidemic prevails, a physician must continue his own labors without regard to the risk to his own health."[12] By this account, while the duty to treat need not have been an explicit or implicit individual undertaking, it is a long-standing communal undertaking on the part of the profession, which can be imputed to individual members as well.

To its credit, the AMA has maintained this stance from its very beginnings; the above-quoted statement was first employed in the AMA's original code of ethics, adopted in 1847. Yet it did not then, nor does it now, have a power of attorney on behalf of every physician that allows it to bind him or her to a contract the AMA signs. The AMA could claim to be expressing, rather than establishing, a professional obligation. That is, it can claim that the duty to stand by patients at times of epidemic has always been acknowledged by physicians and that its statement merely codified this obligation. But recent historical study into physicians' behaviour during epidemics, undertaken specifically in a search for guidance by precedent, reveals a very mixed picture.[13] While many physicians stayed to treat patients, many others, including prominent and respected members of the profession, fled.

Some accounts criticize those who fled for unethical conduct, but other accounts find those who stayed guilty of the same charge—because, for example, they placed their other patients at risk of infection. To ground a professional obligation within a practice, that practice needs to be widespread, if not actually uniform, and should be self-consciously adopted with specifically ethical motivation. The historical record of physicians faced with epidemic disease fills neither requirement.

"We Expect More from Physicians."

A second set of arguments frequently offered to support an obligation to treat the infectious revolves around a form of noblesse oblige. By this account, physicians can justifiably be held to a higher standard of moral conduct than others, a higher standard that includes a degree of self-sacrifice on behalf of the welfare of patients.

Zuger and Miles argue, for example, that the duty to care for the infectious patient is neither a result of contract nor of a patient's right to be treated, but is rather an expression of professional virtue.[14] Ethics measures character as well as conduct, and the good physician can be expected to adhere to high standards of courage, integrity, and loyalty to the patient. These virtues are tested, and gain correspondingly in importance, during epidemics.

Gillon makes a similar point when he writes to and of his fellow physicians, "We still commit ourselves to the characteristic medical obligation to benefit our patients."[9] And Pellegrino, who has been prominent among those writing of the unique ethical features of medicine, argues that a duty to treat HIV-infectious

patients follows from the medical practitioner's effacement of self-interest, a stance based upon the nature of professional commitment to the ill person; the public, non-proprietary character of medical knowledge; and the public avowal of professional responsibility expressed in the oath taken by those entering the profession.[15]

I have considerable sympathy for this stance.[16] Unlike the previous argument, which maintained that HIV risk was already accepted by professionals, this view holds that special ethical standards uniquely appropriate to and incumbent upon the medical profession include a duty to undergo the risk in treating infectious patients. Ultimately, I believe there is a special—and, in some respects, higher—ethical standard to which medical practitioners must be held. Nonetheless, I find these arguments unconvincing in the specific context of a duty to treat the infectious patient.

First, in response to Miles and Zuger, it can be said that patients themselves have insisted upon respecting rights and contract in medical practice, most notably through consumer demands for patient autonomy and the right to consent, and (notoriously) in malpractice litigation. A physician can be excused for believing that the insistence by laypeople on rights has poisoned the warm, trusting soil within which an ethic of virtue must grow. I repeat: I do not agree with this view; but I have sympathy for the practitioner who feels caught in a catch-22, within which the ethical rules are always employed to the physician's detriment. Connected to this view is the perception by physicians that there are ever fewer privileges granted to the profession: "If we are so 'oblige,' where is the 'noblesse'?"

These views are inadequate for another reason: they are not comprehensive. Occupational risk of HIV is shared across professional lines, by dentists, nurses, and blood technicians, as well as by physicians and surgeons. They all bear the risk, and, I believe, they all bear the same ethical duty. Yet if that is true, the ethical duty surely cannot be based on an ethic unique to the medical profession.

Indeed, some physicians could state that, although they are willing to accept the risk on their own behalf, they cannot expose their spouse to it, in the event of infection from an unnoticed occupational exposure. The claim would probably be disingenuous, but it is not necessarily so. Can another approach to this issue avoid these problems while providing a comprehensive basis for the duty to treat the infectious patient?

Fairness and Equity

A mental exercise will clarify the proper basis for this duty to treat the infectious. Imagine that the profession decides to the contrary, that there is no such duty. Every practitioner is left free to refuse to care for HIV-infectious patients, and this exclusionary decision is no cause for professional discipline or even for adverse comment from the leaders of the profession. What would be the predictable results of this policy?

Obviously, a number of practitioners would be tempted to establish an "AIDS-free" practice. It is impossible to estimate what proportion of practitioners would succumb to this temptation. Even under present circumstances, some have stated publicly that they exclude HIV-infectious patients, and many more have said this *sotto voce*. To these would be added, within our hypothetical scenario, those deterred to date solely by fear of professional discipline (e.g., loss of hospital privileges) or the more informal sanction of adverse public comment and moral criticism. For that matter, there is, presumably, a cohort that does not discriminate against the HIV-infectious patient for reasons of conscience, and some of these, within our scenario, would find that—contrary to what they had believed—there was no moral necessity to continue to subject themselves to this unwanted risk.

My guess, for what it is worth, is that initially a significant, but not overwhelming, proportion of non-hospital-based practitioners would choose an "AIDS-free" practice and that this proportion might rise over time. I would guess further that the distribution of those who refuse to treat would not be geographically uniform, so that there would be some regions of low population density where most local practitioners would refuse to treat the HIV-infectious patient. They could exclude the HIV-infectious patient primarily through serum screening of all patients or of patients who seem likely to be at risk of infection.

What then would follow? Fear within the community at large would be bolstered and legitimized. The facts are, as we have seen, that the risk of transmission of HIV in health care occupations is small and controllable. But permitting physicians to exclude the HIV-infectious patient would send the opposite signals: that anyone dealing with a person with AIDS is at risk; that HIV risk is unavoidable; that those who know the most about infection—doctors themselves—are worried. An important moral message would also be sent: HIV status is an acceptable basis for depriving someone of rights and services.

These messages of panic and discrimination are in themselves deeply worrying, but worse is to come. The refusing practitioner is worried about infection, but his or her only reliable evidence for that will be serum-negative status. Yet as we know, there is an HIV "window period" between a person's acquiring the infection and seroconverting. The window period is commonly two to three months, but can be as long as a year.[17] Throughout that period, the person is at least as infectious as one who has seroconverted.

It is for this reason that I have referred to the "AIDS-free" practice in quotation marks. Even with universal and regularly repeated screening of all of the patient population, no practitioner could honestly make that claim. There is one way of ensuring that a person with negative serum status is not infected: by ascertaining that he or she has not engaged in any HIV-risky behaviour for the previous 12 months. This path is unfortunately not available to the refuser. Those who are at risk will, predictably, lie to their physician about their behaviour in order to retain medical services. Without justifying the lie, I must admit that under these circumstances I would find it hard to criticize the liar.

Two further circumstances will ensue. The practitioner who believes that he or she has excluded the risk of occupational HIV infection could be lulled into a false sense of security and could omit onerous and expensive adherence to uniform barrier precautions, thus incurring a higher risk of infection. And practitioners who claim—falsely—to have an "AIDS-free" practice will reap the benefit of this falsehood by adding to their practice credulous and panicked patients, to the detriment of their more scrupulous colleagues.

I have saved for the last those consequences that are, in my judgement, the most worrisome and ethically troubling. Physicians excluding patients known or thought to be HIV-infectious would externalize their risk to those colleagues

who do not practise this discrimination, resulting in an unjustified concentration of risk. This would be deeply unfair.

Finally, legitimate efforts to test patients for HIV status and to exchange this information in health care settings would be hampered. In its day, syphilis was known as the "great impostor," a disease in which the effects could mimic the symptoms of a myriad ailments, confounding differential diagnosis. Clearly, HIV disease is taking on that grim role today, and an exclusion of HIV could become the first step of diagnosis for a large proportion of patients.[18] In the interests of the responsible provision of health care, it will become absolutely essential that information on HIV status be shared among providers, as it is with any other systemic disease.

At some point, discussions of AIDS and confidentiality will need to come to terms with this medical and ethical imperative. A policy that permitted physicians to refuse with impunity to care for the HIV-infectious patient would make it impossible to elicit and share this information honestly. Patients who know they are or might be infected will have a powerful motivation for concealment, the fear of losing access to health care. Many such patients will be aided in their efforts to conceal or evade discovery by practitioners who know of their HIV status, but do not want to see their patients lose access to the services of others.

If a practitioner can refuse to treat someone who is HIV-infectious, doctors may refuse to tell dentists, pulmonary specialists may refuse to tell surgeons, house staff may refuse to tell nurses. Discrimination breeds concealment; and the free exchange of information is essential to the modern team approach to health care delivery. That approach requires discretion and confidentiality of the patient-team relationship, not simply of the traditional patient-doctor dyad.[19]

Conclusion

A few more paradoxes—this time, of my own manufacture—can be added to the above litany. I have argued that the professional duty to treat the HIV-infectious patient is not grounded upon a prior agreement to undergo this risk—although from this point on, it clearly is. Anyone entering a health care profession must now realize that "this is part of the deal."

The duty is not based upon any extraordinary moral obligations incumbent upon physicians, even though I believe such obligations do indeed exist. It is, rather, based upon a realistic appreciation of how harmful the results would be were such discrimination to be permitted, as well as an elementary concern for fairness: that discriminators not reap the rewards of their fear and dissimulation and that non-discriminators not be subjected to added risk in picking up the slack left by their colleagues.

Sooner or later in discussions of ethics and AIDS, someone is bound to argue against a supposed privilege or right of AIDS patients by asking why this disease is so special. Why establish a duty to treat persons infectious with HIV, for example, when in general a physician is an autonomous professional, free to limit practice however he or she chooses? Therein lies the final paradox.

In principle I agree that HIV should be treated exactly like any relevantly similar pathogen; yet it is only in relation to AIDS patients that the question of discrimination arises. We search the current literature in vain for discussions of the right to refuse to treat those infectious with hepatitis, those terminally ill with disseminated cancer, those who are ungrateful or distasteful. The acquired immune deficiency syndrome belongs within the ordinary continuum of human ailments, but it will take extraordinary attention on the part of society in general and the health care community in particular before we are prepared to admit that. ■

References

1. Ward JW, Holmberg SD, Allen JR, et al. Transmission of human immunodeficiency virus (HIV) by blood transfusions screened as negative for HIV antibody. *N Engl J Med* 1988; 318(8):473–8.

2. Anderson RM, May RM. Epidemiological parameters of HIV transmission. *Nature* 1988; 333:514–8.

3. Albert J, Pehrson PO, Schulman S, et al. HIV isolation and antigen detection in infected individuals and their seronegative sexual partners. *AIDS* 1988; 2:107–11.

4. Anonymous. Occupational exposure to the human immunodeficiency virus among health care workers in Canada. *Can Med Assoc J* 1989; 140(5):503–5.

5. Marcus R and the CDC Cooperative Needlestick Surveillance Group. Surveillance of health care workers exposed to blood from patients infected with the human immunodeficiency virus. *N Engl J Med* 1988; 319(17):1118–22.

6. Federal Centre for AIDS. Recommendations for prevention of HIV transmission in health-care settings. *Can Dis Wkly Rep* 1987; 13:53.

7. Freedman B. Health professions, codes, and the right to refuse to treat HIV-infectious patients. In: *AIDS: the responsibilities of health professionals*. Special supplement to *Hastings Center Report*. 1988; 8(2):20–5.

8. Sandel M. *Liberalism and the limits of justice*. New York: Cambridge University Press, 1982.

9. Gillon R. Refusal to treat AIDS and HIV positive patients. *Br Med J* 1987; 294:1332.

10. Allen JR. Health care workers and the risk of HIV transmission. In: *AIDS: the responsibilities of health professionals*. Special supplement to *Hastings Center Report* 1988; 18(2):2–5.

11. Kahneman D, Tversky A. The psychology of preferences. *Sci Am* 1982; 246(1):162.

12. Council on Ethical and Judicial Affairs. *Ethical issues involved in the growing AIDS crisis*. Washington, DC: American Medical Association, 1987.

13. Fox DM. The politics of physicians' responsibility in epidemics: a note on history. In: *AIDS: the responsibilities of health professionals*. Special supplement to *Hastings Center Report* 1988; 18(2):5–10.

14. Zuger A, Miles SH. Physicians, AIDS, and occupational risk. *JAMA* 1987; 258(14):1924–8.

15. Pellegrino E. Altruism, self-interest, and medical ethics [Editorial]. *JAMA* 1987; 258(14):1939–40.

16. Freedman B. A meta-ethics for professional morality. *Ethics* 1978; 89(1):1–19.

17. Pedersen C, Nielsen CM, Vestergaard BF, et al. Temporal relation of antigenaemia and loss of antibodies to core antigens to development of clinical disease in HIV infection. *Br Med J* 1987; 295:576–9.

18. Gilmore N. Patient care for AIDS. *Transplant/Implant Today* 1988; 5:47–50.

19. Gilmore N. Protection of sensitive health information in an epidemic situation: from the doctor-patient dialogue to the computer. Read before the World Health Organization Consultation on Health Legislation and Ethics in AIDS and HIV Infection, Oslo, 26 April 1988.