

and reduce the risks of patients organising an HIV test without pretest counselling. If a positive result had occurred in case 1, the GP's professional and ethical role would have become more complex. The duty of care would expand to cover both the patient and their partner.⁹ Failure to notify the partner of the patient's HIV status can represent a breach in duty of care.^{1,7,9}

Kaposi's sarcoma can occur spontaneously in the elderly, however, in younger men it is usually a sign of AIDS.¹ General practitioners need to be very alert to the possibility of HIV infection. Acute HIV seroconversion and HIV infection can mimic conditions commonly seen in general practice including lymphadenopathy, fever, myalgia, cough, diarrhoea, candidiasis, and seborrhoeic dermatitis. Incorporating sexual and drug histories into routine clinical care can identify patients at increased risk of HIV. Case 2 demonstrates that the general practitioner needs to consider the possibility of HIV in association with the patient's risk factors. Suggesting a possibility of HIV where it is unexpected and the risk is low, can in itself cause anxiety and distress. A valid argument to defer raising the possibility of an HIV diagnosis was made and supported by the subsequent histology in case 2.

This case series demonstrates bioethical dilemmas which can arise in HIV medicine in general practice. The GP plays an

important role in assessing patient risks factors, facilitating early detection of HIV, and ensuring that testing occurs with informed consent. At times, these duties can compete with each other and GPs need to balance the rights of their patients and partners to optimise care.

REFERENCES

- 1 Australasian Society for HIV Medicine. *HIV/viral hepatitis: a guide for primary care*. Canberra: National Capital Printing, 2001.
- 2 Bhagwanjee D, Muckart D, Jeena P, et al. Does HIV status influence the outcome of patients admitted to a surgical intensive care unit? A prospective double blind study. *BMJ* 1997;**314**:1077-81.
- 3 Newton P, Newsholme W, Brink N, et al. Acute meningoencephalitis and meningitis due to primary HIV infection. *BMJ* 2002;**325**:1225-6.
- 4 Kale R. Commentary: Failing to seek patients' consent to research is always wrong. *BMJ* 1997;**314**:1081-2.
- 5 Malin A, Lockwood D. Informed consent: study in which patients had HIV tests could be designed differently. *BMJ* 1997;**315**:251-2.
- 6 Sommerville A. Commentary: Is testing for HIV without consent justifiable? *BMJ* 2002;**325**:1226-7.
- 7 General Medical Council. *Serious communicable diseases*. London: General Medical Council, 1997.
- 8 Royal Australian College of General Practitioners. *Training program curriculum* [2nd ed]. Melbourne: Royal Australian College of General Practitioners, 1999.
- 9 Hirsch D. Doctor's duty of care to a patient's sexual partners. *Australian Health Law Bulletin* 1999;**8**:53-6.

HIV testing

HIV testing and informed consent

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People should be allowed to decide how and where they wish to be tested for HIV without there being a formal requirement for pretest counselling

In his paper, *Ethics of HIV testing in general practice without informed consent*, Fraser argues that pretest counselling and informed consent are pillars of the ethical conduct of HIV testing. In my response I want to look critically at these contentions. While I will agree with Fraser that it is always necessary to get informed consent from a patient for an HIV test I will argue that an emphasis on pretest counselling as a prerequisite for testing can actually undermine a patient's autonomy, the very principle that informed consent seeks to promote.

This response will start with an analysis of Case Two as this highlights the fundamental importance of informed consent. It will then go on to look at Case One and show how the special application of informed consent in the field of HIV testing can, in certain circumstances, lead to a reduction in patient autonomy.

CASE TWO

In Fraser's second case a 43 year old married clergyman presented with a

recurrent infection of his little toe and the preliminary lab reports queried Kaposi's sarcoma. The general practitioner (GP) thought that because of the patient's lifestyle there was little risk of HIV infection, "suggesting the possibility of HIV, when it is unexpected and the risk low, can in itself cause anxiety and distress". On these grounds the GP did not call the patient in for an HIV test.

Some might argue that the GP should have tested the clergyman. This could have been done in one of two ways: by seeking his explicit consent for an HIV test, or by getting blanket consent for a range of tests, including HIV, without HIV being explicitly mentioned.

The first option, while possibly causing the patient some distress, would, had HIV been confirmed, have been seen by many to be the correct course of action. There are clearly important benefits, which would outweigh the anxiety caused by the test itself, to both the patient and his immediate contacts to knowing his positive HIV status. In this situation a risk assessment was

made that it was unlikely the clergyman would be HIV positive, because of his lifestyle, and this proved to be correct.

Some practitioners, however, would argue that in instances such as Case Two a more effective course of action would have been to simply get blanket consent for an unspecified range of tests that would have included HIV.

This argument has been put forward in a recent *BMJ* editorial. According to this editorial it is time to, "lower the threshold for HIV testing", enabling doctors, in certain circumstances, to test for HIV without obtaining a specific consent for the HIV test. "We propose that if a patient freely consents to be investigated, a doctor can initiate tests aimed at excluding serious diseases without an in depth discussion of all possible results, provided the test result, positive or negative, should benefit the patient".¹ To support their case Manavi and Welsby make an analogy with the case of tuberculosis testing. Often patients do not explicitly consent to the taking of a sputum sample for acid fast bacillus to exclude or confirm tuberculosis, as it is seen as just one of many tests performed to make an accurate diagnosis. They infer from this that HIV should be treated in a similar fashion and be included in a range of non-specified diagnostic tests to which a patient would give blanket consent.

Arguments in favour of such an approach to HIV testing are broadly consequentialist in nature.² It would improve the diagnostic capabilities of doctors if they could, on suspecting HIV infection, simply include it in a battery of tests without having to obtain specific consent. As demonstrated by Case Two,

doctors are wary of suggesting the possibility of HIV to patients and such a reluctance to test may result in a delayed diagnosis and compromised care for the patient.³ It could also be argued that this blanket consent to HIV testing would reduce the “unnecessary” distress of patients—that is, if the test eliminated HIV—and increase the levels of HIV testing in general medicine—a desirable outcome.

Such blanket testing, although arguably having some benefits, clearly goes against current notions of good practice. Although there may be good arguments to suggest that HIV should be treated like any other disease it is another matter to suggest that HIV testing should embrace what is increasingly seen as bad practice in other areas. Current GMC guidelines state: “You must obtain consent from patients before testing for a serious communicable disease”.⁴

Although the GP in Case Two did not go ahead with an HIV test the principle of informed consent was at the centre of his decision and he acted in accordance with current guidelines. Had the GP decided to test, wishing to uphold the principle of informed consent, he would have been obliged to tell the patient about the HIV test. It was the possible anxiety to the patient created by raising the possibility of a test that was felt to outweigh the risks of not testing.

I want to show how the special practices that have grown up around obtaining informed consent for HIV testing can, paradoxically, sometimes have the effect of undermining a patient’s autonomy—the very principle which underpins informed consent. It is to this specific problem, exemplified in Fraser’s first case, to which I will turn.

CASE ONE

In Fraser’s first case a patient refused consent for an HIV test when requesting life insurance. Subsequently, the patient authorised a test on the request form without the GP’s knowledge. For Fraser, the ethical difficulty presented by this case was that the minimal standard of care, providing pretest counselling, was not given and after reflecting on this incident he changed his practice to, “reduce the risk of patient initiated HIV testing”.

Inherent in Fraser seeing “patient initiated testing” as morally problematic is the view that HIV is somehow different from other diseases and therefore “special” ethical considerations pertain to the conduct of testing.⁵ The major factor that has often distinguished HIV testing from other medical tests is that people have had to have counselling as a prerequisite for having a test. Whereas with other diseases

counselling might be offered or made available if requested, with HIV a patient has had to undergo counselling in order to have a test. This is one aspect of what has been called “HIV/AIDS exceptionalism”—treating HIV differently from other diseases.^{6,7}

The question we have to ask is should HIV be treated differently. Should there always be, as Fraser suggests, obligatory pretest counselling or should HIV be treated the same as other conditions of a similar severity?

Fraser says the reason for pretest counselling for an HIV test is to promote and safeguard patient autonomy. I would argue that such counselling may promote autonomy in one way, in that it provides information to patients so they can make a fully informed decision. However, it can undermine patient autonomy in another way, by forcing patients to receive face to face counselling, which, given the nature of how the disease is transmitted, they may not want to have.⁸ An insistence on pretest counselling can be seen as a paternalistic response that actually reduces, rather than fosters, a person’s autonomy. Thus, I would disagree with Fraser and argue that making pretest counselling a requirement for having an HIV test should no longer be seen as an ethical necessity. This is not to say that if people want counselling it should not be available but, that if they do not, their decision should be respected.

A further element of Case One that Fraser sees as morally problematic is that the patient had initiated the test himself. On this basis, Fraser would be against home or self testing for HIV. Such opposition clearly raises important ethical considerations. The recent trend in health care, stimulated by an emphasis on patient autonomy, has been for greater self diagnosis and screening. As it has become more widely recognised that patients can make informed decisions without the direct intervention of healthcare professionals, individuals have been encouraged to take responsibility for their own health. Self breast examination and pregnancy testing are all routinely carried out at home and there is—for example, a self test available for occult blood in stools, to screen for colorectal cancer.

If it is accepted that people should be allowed to make informed decisions as to how they are to be tested then there is clearly a very strong ethical case for saying that patients should be able to self or home test for HIV. This is already the case in the USA where a Federal Drug Agency (FDA) approved home test has been available since 1996.⁹ While recognising that there are many issues raised by self or home tests,¹⁰ I would argue, nevertheless, that where the possibility

of accurate testing exists we should allow people to choose where and how they have an HIV test. It is possible that a substantial number of people would prefer to conduct the test at home.^{8,10} As an editorial in the *Canadian Medical Association Journal* says: “Where the technology exists, why should the public not have autonomy and privacy in obtaining important health information [on their HIV status]?”¹¹

CONCLUSION

Fraser’s cases raise some interesting dilemmas faced by practitioners over the conduct of HIV testing. I have agreed with Fraser that it is always necessary to get informed consent from a patient for an HIV test and, indeed, this is now part of standard medical practice for any serious disease. However, his support for obligatory pretest counselling as a means of obtaining informed consent can be questioned. I have argued that such a requirement can, paradoxically, sometimes have the effect of undermining a patient’s autonomy—the very principle that informed consent seeks to promote. Hence, I would support the removal of the requirement for pretest counselling, something that is already happening in the UK, and let people decide how and where they wish to be tested for HIV.

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REFERENCES

- 1 **Manavi K**, Welsby P. HIV Testing should no longer be accorded special status. *BMJ* 2005;**330**:492–3.
- 2 **Parker M**. Consent to HIV testing and consequentialism in healthcare ethics. *HEC Forum* 2004;**16**:45–52.
- 3 **Newton P**, Newsholme N, Brink N, *et al*. Acute meningoencephalitis and meningitis due to primary HIV infection. *BMJ* 2002;**325**:1225–6.
- 4 **General Medical Council**. *Serious communicable diseases*. London: General Medical Council, 1997.
- 5 **Pinching A**, Higgs R, Boyd K. The impact of AIDS on medical ethics. *JME* 2000;**26**:3–8.
- 6 **DeCock K**, Johnson A. From exceptionalism to normalisation: a reappraisal of attitudes and practice surrounding HIV testing. *BMJ* 1998;**316**:290–3.
- 7 **Rosenbrock R**, Dubois-Arber F, Moers M, *et al*. The normalization of AIDS in western European countries. *Soc Sci Med* 2000;**50**:1607–29.
- 8 **Merson H**, Feldman E, Bayer R, *et al*. Rapid self testing for HIV infection. *Lancet* 1997;**349**:352–3.
- 9 www.fda.gov/cber/products/testkits.htm (accessed 1 May 2005).
- 10 **Speilberg F**, Levine R, Weaver M. Self testing for HIV: a new option for HIV prevention? *Lancet Infect Dis* 2004;**4**:640–6.
- 11 **Anon**. Home HIV testing: why not in Canada? *CMAJ* 2000;**162**:1545.