ETHICAL ASPECTS OF THE PHYSICIAN/HIV PATIENT RELATIONSHIP

A SEMINAR FOR RESIDENTS

APPENDICES

David H. Smith, Ph.D.

The University of South Florida
August 1, 1988
APPENDIX 1

ETHICAL ASPECTS OF THE PHYSICIAN/HIV PATIENT RELATIONSHIP

READINGS FOR SEMINAR FACULTY

A. ANNOTATIONS (taken from an Annotated Bibliography on Ethical Aspects of the Physician/HIV Patient Relationship by Chessa and Smith

B. ARTICLES

Seminar Faculty should also read the material for participants in Appendix 2
Emanuel, Ezekiel J., MD
Do Physicians Have an Obligation to Treat Patients with AIDS?
The New England Journal of Medicine, vol. 318 no. 25 (June 23, 1988)

The author treats the question of a physician's duty to treat HIV patients. A physician's obligation to treat arises from his/her participation in the profession of medicine. Medicine is an essentially moral enterprise. However, the obligation to treat is not absolute. It is limited by several factors, including: 1) the benefit (or lack of benefit) such treatments would secure for the patient, 2) the risk to the physician. The risk of treating HIV patients, however, is not great enough to outweigh the physician's professional responsibility to treat.

Beauchamp, Dan E.
Morality and the Health of the Body Politic
Hastings Center Report, vol. 16 no. 6 (Dec. 1986) pp. 30-36

The author discusses the role of legal moralism in the AIDS epidemic. Legal moralism is the view that laws and regulations should be used to promote society's moral aims. The author argues that this approach is counterproductive. Laws against homosexuality fuel societal prejudice, prevent public health agencies from conducting education campaigns for safer homosexual sex, and discourage gays from seeking early medical attention. While it may be necessary to legislate against some activities, a clear distinction should be drawn between doing so in order to promote public morality and doing so to protect public health.

Dannemeyer, William E., U.S. Representative
AIDS: The Case for Routine Testing

The questions relating to liability for health care providers when dealing with victims of the AIDS epidemic are not unique. Health care providers have been faced with legal and ethical dilemmas throughout the centuries
and have always found humane and compassionate means of dealing with the most difficult of problems. Like any other illness, AIDS should be handled with each state's pre-existing statutory scheme for dealing with deadly, communicable disease. Although AIDS raises some particularly difficult questions for civil libertarians, if this disease is treated in a purely public health context the issues become a great deal clearer.*

U.S. Representative Dannemeyer's article is largely written in support of legislation he introduced. His bill (H.R. 2273) would require states to institute mandatory testing for certain groups. These include: persons seeking a marriage license; persons convicted of prostitution; persons convicted of IV drug use; persons between the ages of 15 and 49 who are admitted to hospitals; and persons being treated for venereal disease. Representative Dannemeyer argues that voluntary testing and AIDS education programs have failed to slow the epidemic and, thus, that widespread testing is warranted. He also argues that safeguards meant to protect the HIV patient from discrimination may place health care workers at significant risk for infection. Hence, no new safeguards regarding confidentiality and discrimination of HIV patients should be legislated.

Brown, Mary L.
AIDS an Ethics: Concerns and Considerations

The AIDS epidemic and public confusion about the disease pose many challenges to nurses in all areas of practice. As with other epidemics and uncertain diagnoses, the questions exceed available answers. Nurses providing direct patient care as well as nurses involved with policy making and planning, need guidelines to assist in the decision making process and in providing care for AIDS patients. A framework for decision making is suggested. Knowledge of theoretical concepts about the ethical issues will provide the nurse with the necessary tools to make clear clinical and administrative judgements about how to deal with these very ill patients and this troubling epidemic.

Henry, Keith, MD; Myra Maki, RN; Kent Crossley, MD;
Analysis of the Use of HIV Antibody Testing in a Minnesota Hospital
The authors studied the use of the HIV antibody test in a Minnesota hospital. They utilized three factors to determine the "appropriateness" of administering an HIV test. These were 1) that the test is medically indicated (either because of risk factors or clinical manifestation of symptoms), 2) that consent is obtained prior to the test and 3) that counseling and risk reduction information were provided. The authors noted several disturbing trends. (1) In 42 percent of those tested for HIV virus, there was no rationale for the test noted in the patient's records. (2) In 79 percent of the cases of those tested for the HIV virus, there was no notation in the patient's records that the test was discussed with the patient. (3) In 91 percent of the cases there was no indication of pre- or post test counseling. (4) In 44 percent of the cases, the patients had no recognized risk factor for HIV infection. In addition to these trends, the authors found several other disturbing features concerning the use of the test. In several instances, a positive ELISA was interpreted by physicians as a positive test, even in light of a negative Western Blot analysis. In other instances, asymptomatic seropositive patients were recorded as having AIDS.

Zuger, Abigail
AIDS on the Wards: A Residency in Medical Ethics
Hastings Center Report, vol. 17 no. 3 (June 1987) pp. 16-20

The author discusses her experiences with AIDS as a resident at Bellevue Hospital in New York City. She discusses how a variety of "physician oriented" ethical issues affect the medical resident. These include caring for the terminally ill and the refusal to treat. She notes that the refusal to treat among residents is often "covert" and suggests that this may hinder the provision of compassionate care for HIV patients.

DeSimone, Philip A; Janet I. Pisaschesi; Harold W. Jaffe; Joseph Engleberg; and Madhira D. Ram
AIDS: Medical Ethics Grand Rounds
Hospital Practice, vol. 21 (Dec. 15, 1986) pp. 121-51

The article is a transcript of a conference in which the ethical problems underlying clinical decisions were discussed. The case involved an AIDS patient who wished to be sent home, but who also requested that his
sister, with whom he was living, not be informed of the diagnosis of AIDS. The respondents discuss breaching confidentiality, modes of transmission, risk to health care workers, etiology and treatment.

Wachter, Robert M., MD; Molly Cooke, MD; Philip C. Hopewell, MD; John M. Luce, MD, San Francisco
Attitudes of Medical Residents Regarding Intensive Care for Patients with the Acquired Immunodeficiency Syndrome
Archives of Internal Medicine, vol. 148 (Jan. 1988) pp. 149-52

We recently surveyed the medical house staff at the University of California, San Francisco, and found that residents had a good understanding of the poor prognosis of patients with the acquired Immunodeficiency (AIDS) and Pneumocystis carinii pneumonia who require intensive care of respiratory failure, and tended to favor early discussions with patients regarding resuscitation and intensive care. We used the same questionnaire to survey the staffs of four other programs varying in geography and exposure to patients with AIDS. We found a striking correlation between the number of patients with AIDS cared for by the residents, the assessment of the prognosis of patients with AIDS with Pcarinii pneumonia and house-staff attitudes toward discussions about resuscitation and intensive care. The results of this study suggests that the intensity of exposure of patients with AIDS determines the assessment of prognosis, and that one or both of these factors strongly influences attitudes toward intensive care. Regardless of these attitudes, early discussion of resuscitation and intensive care between physicians and patients with AIDS and P carinii pneumonia seems warranted.*

*annotation written by the author(s) of the article
APPENDIX 2

ETHICAL ASPECTS OF THE PHYSICIAN / HIV PATIENT RELATIONSHIP

READINGS FOR SEMINAR PARTICIPANTS

A. ANNOTATIONS

B. ARTICLES
This section contains readings that will help you think about the ethical and social issues which are raised in your contact with HIV patients. The issues have been organized under six headings.

1. Deciding to Treat HIV Patients
2. Deciding to Test for HIV Status
3. Maintaining Confidentiality
4. Caring for the Terminally Ill
5. Providing for Compassionate Care
6. Resident Physicians and the HIV Epidemic

Summaries of the articles are provided on the next several pages. They are taken from, An Annotated Bibliography on Ethical Aspects of the Physician/HIV Patient Relationship by Chessa and Smith.
Deciding to Treat HIV Patients

Allen, James R.
Health Care Workers and the Risk of HIV Transmission
*Hastings Center Report*, vol. 18 no. 22 (April/May 1988) pp. 2-5

The author is a physician with the CDC AIDS Program. The article 1) summarizes the current studies regarding the risk of HIV transmission in the health care setting and 2) describes the results of a CDC multihospital study regarding HIV transmission in the workplace. The author concludes that the risk of HIV transmission is low, and can be further reduced by strict adherence to precautions against needlesticks.

Arras, John D.
The Fragile Web of Responsibility: AIDS and the Duty to Treat
*Hastings Center Report*, vol. 18 no. 2 (April/May 1988) p. 10

The author examines how several bioethical theories relate to a physician’s obligation to treat HIV patients. He concludes that the duty to treat is best grounded in a "virtue based" ethic. That is, physicians feel a duty to treat because they attempt to "live up" to their image of the "ideal" physician. He argues that this image originates in society's conception of a "good" physician. The author notes that this feeling of duty is "fragile." It can be quickly eroded by society's changing conception of the good. He warns that the public's shunning of AIDS patients, and the public's support of physician's who refuse to treat, may erode the ethic to treat.

Deciding Whether to Test for HIV Status

Childress, James F.
An Ethical Framework for Assessing Policies to Screen Antibodies to HIV

Neither the moral imperative to control AIDS, nor the principle of respect for persons, can be considered absolute. However, the principle of respect
of persons, and three derivative principles, liberty, privacy and confidentiality, are recognized as prima facie binding. That is, the principles are normally binding, and any departure from them must be justified. The author suggests four conditions that must be met when overriding the principles.

1. The probable benefits of infringing the principles must outweigh the probable harms.

2. The benefits of infringing the principles must not be attainable by a less restrictive alternative.

3. When the principles must be infringed, society should choose the policies that are least disruptive.

4. Society may have to provide compensatory measures for individuals for whom the principles are infringed.

In light of the above considerations, the author discusses the merit of screening programs which range from compulsory/universal to voluntary/selective.

Gostin, Larry, JD: William J. Curran, JD, LLM, SMHG
AIDS Screening, Confidentiality, and the Duty to Warn

We oppose mandatory screening for antibodies to the human immunodeficiency virus (HIV) because it is unlikely to lead to changes in behavior necessary to impede the spread of AIDS, and because of the potential for invasion of privacy and discrimination.

In this column we put forward general criteria for assessing compulsory screening of persons with antibodies to the human immunodeficiency virus. We then (sic) apply these criteria to three paradigmatic proposals for programs currently being suggested across the country: premarital screening, screening in drug treatment, and general screening in prisons. Finally we bring into focus the public health official's sharpest legal and ethical conflict in the systematic collection of test results—the duty of confidentiality versus the duty to protect third parties against foreseeable transmission of HIV.*
Maintaining Confidentiality

Belitsky, Richard, MD: Robert A. Solomon
Doctors and Patients: Responsibilities in a Confidential Relationship
Project (New Haven: Yale University Press, 1987)

The problem of confidentiality and HIV disease is discussed from a legal perspective. There are two purposes for breaching confidentiality: 1) to protect the public health, 2) to protect specifiable third parties at risk. The authors concentrate on the latter issue. Case law recognizes a physician's responsibility to warn third parties about a patient's dangerously contagious disease when the patient does not do so. Delicate questions about informing an HIV patient's spouse or lover arise in this context. Under what circumstances should a lover be informed? How far can one trust the HIV patient's statement that he/she has done so? What procedures should be used to inform the partner?

Gillon, Raanan
AIDS and Medical Confidentiality

The public health strategy for combating AIDS depends upon the voluntary testing of at risk persons. In order to facilitate voluntary testing among high risk groups, public authorities must allay the fear of discrimination. This requires the strict maintenance of confidentiality. Many argue that confidentiality should be routinely breached in the interest of controlling the epidemic. This would be counter productive, dissuading many high risk individuals from being tested. Thus, the method of arresting the epidemic that is recommended on consequentialist grounds conforms to deontological principles of medical confidentiality.

Sherer, Renslow, MD:
Physician Use of the HIV Antibody Test: The Need for Consent, Counseling, Confidentiality and Caution
In this commentary, the author discusses the disturbing features about the use of HIV test which were cataloged by Henry et. al. (JAMA, vol. 259, no. 2; pp. 229-232). He concludes that the HIV test should not be considered routine because of the potentially devastating effects of discrimination and the likelihood of false positive results in a low risk population. HIV testing should follow three guidelines. 1) The test should be administered only when it is medically indicated, or for individuals from high risk groups. 2) The test should be accompanied by pre- and post-test counseling. 3) Strict standards of confidentiality should be maintained.

Caring for the Terminally Ill


A psychologically competent patient dying of Pneumocytis declines medical treatment that has a fair chance of success. What actions should be taken in this situation? The authors discuss means of communicating with the patient, his family and his lover. They present opposing opinions on the correct course of action in the event the patient does not rescind his decision.


AIDS presents ethical dilemmas about intensive care. Even with intensive care the outcome for patients with AIDS is poor. Care givers have no ethical or medical obligation to provide futile care. Decisions concerning competent patients should be made jointly by physicians and the informed patients themselves. For incompetent patients decisions should be made jointly by physicians and appropriate patient-surrogates in light of the previously expressed wishes of the patients. Care givers should encourage patients with AIDS to express their preferences about life sustaining treatment in order to avoid dilemmas should these patients later become Incompetent. The AIDS epidemic may force more explicit discussions
about the allocation of limited health-care resources, such as intensive care. Such allocation decisions should not discriminate against patients with AIDS.

Providing for Compassionate Care

Thompson, Leslie M., PhD
Dealing with AIDS and Fear: Would You Accept Cookies From an AIDS Patient?

Acquired immunodeficiency syndrome (AIDS) has engendered a crisis of fear among the public and health professionals alike. In addition to the myriad anxieties that generally accompany dying and death, AIDS patients must deal with numerous additional fears. In rushing to treat the physiologic aspects of AIDS, health professionals have generally failed to provide adequate support systems to deal with the emotional needs of dying AIDS patients. Health professionals now must move rapidly to develop support systems based on a realistic understanding of the fears and the other powerful emotions confronted by AIDS victims. Such systems must permit AIDS patients to give meaning to their adversity. *

Kelly, Jeffrey A., PhD; Janet S. St. Lawrence, PhD; Steve Smith, Jr., BS; Harold V. Hood, BA; Donna J. Cook, MS
Stigmatization of AIDS Patients by Physicians
American Journal of Public Health, vol. 77 no. 7 (July 1987)

A randomly selected sample of physicians in three large cities was asked to read one of four vignettes describing a patient. They then completed a set of objective attitude measures eliciting their reactions to the patient described in the vignette. The vignettes were identical except that the patient's illness was identified as either acquired immunodeficiency syndrome (AIDS) or leukemia and the patient's sexual preference as either heterosexual or homosexual. Harsh attitude judgments were associated with the AIDS portrayals, as well as much less willingness to interact even in routine conversation when the patient's illness was identified as AIDS. Increasing numbers of AIDS patients will be seeking medical attention from physicians in all areas of the country and it will be
Important for health care professionals to develop programs which counter the unreasonable stigma and prejudicial attitudes that may be associated with the illness.*

Resident Physicians and the HIV Epidemic

Wachter, Robert M., MD
The Impact of AIDS on Medical Residency Training
The New England Journal of Medicine, vol. 314 no. 3 (Jan. 16, 1986)

An entire generation of medical residents has been (and continues to be) profoundly affected by the AIDS epidemic. The labor intensive care of HIV patients falls largely on residents. Residents are more likely to be familiar with the opportunistic diseases of AIDS patients than with other previously common diseases. Medical students' choice of residency programs may be affected by the desire to avoid the tertiary care centers to which HIV patients gravitate. The intensely emotional decisions and fears associated with AIDS impact residents just as they are beginning their professional careers. From his perspective as a resident at San Francisco General Hospital, the author discusses the practical and emotional problems in the care if HIV patients, and offers suggestions about how such problems may be minimized.