# HIV/AIDS and ethics: responses of medical practitioners

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*A married woman was tested for HIV in a medical check-up prior to tubectomy. She tested positive The result was conveyed to the aunt who accompanied her, and the operation was cancelled. The aunt spread the news that the woman had 'AIDS' to relatives and neighbours. People stopped coming to their house, and those who did refused to drink even water there. When the husband confronted the aunt about this changed behaviour, she said, "Your wife has AIDS, that devil (the wife) will die and also take you along with her." Timely support from a neighbour, who knew of services for HIV, helped them to recover from the shock and to seek support.*

*A pregnant woman believed to be from a neighbouring country tested HIV positive on a routine medical check up. The doctor not only denied her further treatment but also revealed her HIV status to a leader of the slum community, where she lived. Community leaders got together and forced all the men and women from that linguistic group to leave their slum. The leaders claimed that these people were 'illegal migrants' engaging in 'prostitution' and 'spreading AIDS' in the area.*

Over the last 20 years, HIV/AIDS has tested society in general and health care providers in particular. It has exposed fears, prejudices, double standards and failures in the social and medical response to the needs of people living with HIV/AIDS (PLWHs). Doctors have been criticised for their apathy, discrimination and unethical practices to a medical problem which requires support from the health sector. Countless reports, from the denial of basic medical services to the merciless exploitation of PLWHs at the hands of health professionals, call into question the level of awareness about this disease as well as the very values and ethics guiding the medical profession. This article is based on the experiences shared by PLWHs and attempts to highlight some of the ethical issues around current practices in HIV/AIDS treatment and care. However, it is not intended to ignore the good work being done by many medical practitioners across the country.

## Refusal to treat

Legally, doctors in public hospitals may not refuse treatment to any patient, while doctors in the private sector are not obliged to provide treatment except in an emergency. However, experience suggests that the majority of doctors in both sectors refuse to treat people with HIV, mostly due to baseless fear and ignorance about the disease. There are countless instances in which patients are denied admission, not provided proper attention and care, and discharged without surgery and treatment. In public hospitals, patients with HIV have been discharged in critical condition; they have been denied services and even told to go back to their villages. Private hospitals explain their refusal to treat by citing the risk of infection to health care providers, non co-operation of staff, fear of losing other patients, inadequate infrastructure (like separate delivery tables) and the high cost of universal precautions. These arguments are made even though it is well known that the risk of other infections such as Hepatitis B and the risk of HIV infection during the window period necessitate the practice of universal precautions.

Private hospitals often refer PLWHs to government hospitals saying that they will get special treatment and medicines there. These referrals are often incomplete, as patients are not directed to the right department or given information on what services they can get from there. In private health care centres, many PLWHs find doctors conducting even non-invasive examinations with gloves and masks, when there is no need for this practice. Some limit the medical examination to listening to the patient and prescribing medication, and charge double for this service. Though it is usually doctors who are held responsible for discriminatory practices, patients experience such responses from nurses, ward boys and 'aayahs'.

## Unethical testing for HIV

Guidelines for HIV testing state the need for pre- and post-test counseling, and also require that the person's informed consent be taken before testing. These requirements are made because of the emotional, psychological and social aspects of HIV/AIDS. However, in most cases HIV testing is done without the consent of the patient and the results are disclosed without any sensitivity. This sends people into shock and denial, and sometimes even triggers attempts at suicide. Even healthy people with an HIV positive result are told that they have 'AIDS' and 'will live only six months' or 'two years'. Results are often disclosed not to the patients, but to their relatives or friends. No thought is given to the implications this could have on the lives of the individuals and families concerned.

Health care providers have a right to break confidentiality only in certain, specific, circumstances like – when disclosure is for the patient's benefit (to another doctor treating the patient), to protect partners/spouses or under legal requirements. In reality, most disclosures violate ethical guidelines and patients' rights. HIV test results are available to health care workers at all levels. Disclosure of a positive result is often made not to the person infected but to the parents, friends and relatives.

## Other troubling practices

Even now health practitioners give people incorrect or incomplete information about HIV/AIDS. Unfortunately, the profession does not give serious attention to the need to update one's scientific knowledge and skills.

Patients are not assessed for the appropriateness of anti-retroviral therapy. They are not counselled on its duration,

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costs, side effects and the monitoring requirements. Patients are asked to undergo expensive tests without ascertaining whether they can afford them, or the drugs. When anti-retroviral drugs are prescribed without taking patients' financial position into consideration, patients are forced to stop the drugs when their savings are exhausted. This leads to their pauperisation – and the development of new resistant strains of the virus.

PLWHs are used for medical research often without their knowledge and consent. There are instances in which PLWHs were admitted to the hospitals and discharged after the research was completed.

High fees are charged (almost three to five times more) from PLWHs for conducting deliveries and surgeries. Some practitioners offer 'magic cures' claimed to be based on Ayurvedic and herbal medicines – and charge exorbitant amounts for these.

In short, despite our improved knowledge of HIV/AIDS, and the introduction of anti-retroviral therapy, the PLWHs continue to experience such unethical medical practices.

One cannot expect drastic changes in the existing scenario, but hope is offered by the fact that an increasing number of doctors are coming forward to provide services. Experience suggests that Continuing Medical Education (CME) programmes focusing on HIV/AIDS will result in provision of better services to PLWHs, based on patients' needs and rights.

## Continuning medical education

Center for Development Initiatives is a non-governmental organisation working on sexual and reproductive health issues, with under privileged communities in the outskirts of Mumbai. As part of this work, it organised a series of CME sessions among doctors in the project area, involving expert medical practitioners and consultants from public hospitals in Mumbai. The topics covered included HIV/AIDS basic science, universal precautions, opportunistic infections, anti retroviral therapy, counseling, human rights and ethical issues. Participants reported that the programmes improved their ability to deal with patients. They could provide appropriate counseling, they were more confident when treating patients, their attitude towards PLWHs had changed, and they made conscious efforts to take universal precautions irrespective of the patient's HIV status. The programmes gave an opportunity for them to interact with experts, clarify their doubts, and learn new skills in communicating with and treating patients. At the request of doctor participants, the programme was later extended to cover nurses in private health care settings.

## Conclusion

Majority of PLWHs will require medical services at various points in the course of the disease. Medical practitioners need to recognise their role in providing services to PLWHs adhering to the profession's ethical guidelines. Considering that more than 60 per cent of the population seeks medical help in private health care centres, the responsibility of treating PLWHs cannot be relegated to public hospitals alone. It must be accepted that HIV is often diagnosed first by a private medical practitioner.

HIV/AIDS provides health professionals another opportunity to look at their attitudes to patients and to change them to suit the profession's noble aim. At the same time medical associations and agencies working for HIV/AIDS must invest in involving more medical practitioners in the treatment and care of PLWHs.

E Rajarethinam (globalcitizens@vsnl.net) cites press reports of a man who went to a government hospital for an HIV test and was informed of the positive results so casually that he took his own life. Despite the existence of anti-retroviral drugs, government hospitals give only nominal treatment for opportunistic infections, and for a maximum of 10 days. So a positive result means an early death.

Such stories do not end with the person's death. When a government hospital patient died after testing positive for HIV, doctors refused to perform a post-mortem (*Indian Express*, June 1, 2002).

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"Patients with HIV are desperate for a cure; many of them have spent their life savings on various 'cures' advertised in the press," writes Ruth Kattumuri, who has worked with various development projects in South India (r_katts@yahoo.com). The medical profession cannot ignore such alternative treatments, but their efficacy should be tested "without using patients as guinea pigs," she adds. Unfortunately, the medical profession is not seen as caring. "Patients with HIV are routinely abused publicly by doctors. It is important that doctors be trained adequately to deal maturely and sensitively with such patients."

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Dr Ashok Kumar Agarwal from Kolkata (drakagarwal@vsnl.net) describes the plight of a nurse from a private nursing home who received a finger prick while injecting a patient suffering from meningitis. The patient's CSF report identified the infecting agent as cryptococcus fungi. The patient's blood was sent for HIV testing and turned out to be positive. Later, when she had herpes, the nursing home doctor suspected HIV and repeated the test which was positive. HAART would cost Rs 3,000 a month – her entire salary for a job which is now in jeopardy. Dr Agarwal asks, "How many health workers would feel safe and comfortable in handling patients after knowing this story? Would it have been different in a government set-up? No insurance company provides cover for HIV."