Globally, the Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) pandemic presents as the most challenging matter of modern times, and in the health care arena, it has brought to home the reality that health practice is more than ever, a social pursuit rather than a strictly individual activity. A Dhai: MBChB(Natal), FCOG (SA), LLM (Natal), PGDipIntResEthics (UCT), Director - Steve Biko Centre for Bioethics, Adjunct Professor and Head - Bioethics, University of the Witwatersrand Medical School, 7 York Road, Parktown 2193, Tel: (011) 7172718, Fax (011) 7172558, Email: Amaboo.Dhai@wits.ac.za

**HIV and AIDS: Ethical and Legal Challenges**

**INTRODUCTION**

Globally, the Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) pandemic presents as the most challenging matter of modern times, and in the health care arena, it has brought to home the reality that health practice is more than ever, a social pursuit rather than a strictly individual activity. In the practice of dentistry, it has posed very many controversial dilemmas, resulting in intense debate and discussion encompassing a range of ethical issues from autonomy, justice and resource allocation, to prejudice and discrimination, to name a few. Never before in the history of health care have society and health care practitioners been compelled to reconsider important values relating to justice, public health and human rights.

Moreover, vast amounts of funding and immense scientific commitment dedicated to both prevention and treatment have resulted in remarkable advances transforming the lethal nature of the disease into that of one with chronic status – readily manageable with both reduction in morbidity and mortality.

**HIV and AIDS – Historical and Sociopolitical context**

It is imperative that practitioners in South Africa, in their holistic approach towards managing patients with HIV or AIDS, have an understanding of the historical and sociopolitical context of the disease.
When the first cases of AIDS were discovered among gay men in the United States of America, there was the initial misunderstanding that AIDS was a disease that only affected gay people.

As a consequence, there was a new wave of prejudice and discrimination against gay people. In South Africa as well, AIDS was first linked to gay men. Subsequently, when a study in 1987 revealed a relatively high level of infection among Malawian gold miners, the blame for the disease shifted to people from other African countries. Later, it was thought that AIDS was a “white” disease, and today, the perception has shifted to AIDS being a “black” disease. In addition, prior to 1994, the government blamed AIDS on “terrorists” coming in from other African countries. As a consequence, the response to the disease with regard to education and programs to halt its spread was very sluggish. This resulted in very rapid spread of HIV amongst all South Africans and between 1990 and 2000, the prevalence of HIV infection among pregnant women rose from less than 1% to over 20%. Moreover, after 1994, repeatedly confusing messages from government have resulted in there being a great deal of fear and ignorance about HIV/AIDS. People have thus acted in ways that are irrational, with a reluctance to change the way they think and behave and, even now they are afraid to talk about HIV and AIDS.

Prejudice, Discrimination and Responsibilities

The health care practitioner, as the patient’s fiduciary, has a primary responsibility to his / her patient. His / her true ethics is exposed in the way he / she balances his / her own interests against that of the patient’s. Within the sociopolitical context of the disease, there has been a very strong emphasis on human rights issues, especially in relation to discrimination. However, discrimination against individuals with HIV or AIDS remains pervasive, even within the scientific community, where the risk of infection has resulted in a reluctance to treat them. Besides moral arguments, scientific evidence has not been able to support such a position. Section 9 of the Bill of Rights of the South African Constitution, affirms that everyone is equal before the law, have the right to equal protection and benefit of the law, and that there should be no unfair discrimination, directly or indirectly against anyone. Hence, Constitutional safeguards for patients against prejudicial and discriminatory practices from health care practitioners. Furthermore, the Employment Equity Act censures unfair discrimination on the basis of HIV Status. Therefore, health care workers, especially those in private practice, cannot use HIV status as a determining factor when making decisions on whether or not to employ or retain staff.

Nevertheless, dentists, like surgeons, are among health practitioners most exposed to blood and other bodily fluids that potentially could transmit HIV. Whether there is a duty to treat a patient in need, when to do so could mean an effacement of the practitioner’s interests is a question that health practitioners have faced since the plagues of the Middle Ages. This dilemma is further intensified, with renewed urgency for dentists and other health practitioners in the era of AIDS.
Those who defend refusals to care for patients infected with HIV offer the following arguments based on a fear of being infected: "AIDS was not in the social contract when they entered medicine, obligations to self and family override obligations to patients, physicians who contract AIDS are permanently lost to society and their patients, treating patients when one is fearful or hostile only compromise their care, ... ". Scientifically, though, the risk of contagion is disproportionate to the fear expressed. The Health Professions Council of South Africa (HPCSA), in its Ethical Guidelines for Good Practice with Regard to HIV, calls attention to practitioners that it is against all ethical and professional rules for a health care practitioner to refuse to treat a patient solely on the ground of the patient's perceived or actual HIV status. Furthermore, treatment should not be suboptimal because of a perceived potential HIV risk to the health care practitioner. It underscores that unilateral decisions not to treat or resuscitate patients with HIV would be a violation of fundamental human rights.

In addition, the guidelines state that it is the responsibility of the practitioner to obtain an informed consent before testing the patient for HIV. A diagnosis of HIV without further examination and investigation provides only the most basic information about a patient's prognosis or actual state of health. Hence, the HPCSA places a responsibility on the practitioner to continue counseling and conduct further investigations as indicated. In addition, the guidelines state that in the management of these patients, due consideration should be given to other health care workers who are also involved in their management, e.g. where necessary informing them of the patient's HIV status. Moreover, it emphasizes that practitioner responsibility extends to supporting all measures aimed at preventing HIV infection. These would include appropriate education, improved management of predisposing and aggravating factors, mobilizing support from the community and disseminating information regarding preventative measures.

Informed consent – patient and practitioner autonomy

Unlike testing for any other medical condition, special conditions apply to HIV testing. This is recognized by the South African law and the Constitution. Consequent to a high index of suspicion for HIV infection based on oral lesions, dental practitioners are not infrequently confronted with having to test patients for HIV. The HPCSA's guidelines point out that HIV testing must only take place with the voluntary informed consent of the patient. The patient is to be given information regarding the purpose of the test, advantages and disadvantages of the test, why this information is necessary, how the results will influence the treatment and the psychosocial impact of a positive result. Even if posters are displayed in an attempt to inform patients about HIV testing, this must be supplemented by verbal pretest counseling carried out by the practitioner. Moreover, communication should be in a language understandable to the patient. An informed consent requirement for HIV testing is that post-test counseling will follow if the patient is found to be HIV-positive. A positive
obligation is imposed on the practitioner, therefore, to ensure that the patient is directed to appropriate facilities that will oversee their further care and where appropriate, counsel the family and sexual partners. Children 12 years and over are now in a position to consent to HIV testing without the need for parent or guardian permission provided they are of sufficient maturity to do so8. A highly contentious issue at present with regard to informed consent and patient autonomy is whether it would be necessary to inform the patient of the practitioner’s HIV status where the latter is HIV-positive. Does the patient have a right to know the practitioner’s HIV status? If so, what about the practitioner’s rights to autonomy and confidentiality? While the initial focus regarding risk in the health care setting was protective of the practitioner, awareness of the emergence of the HIV-positive practitioner has broadened the scope of such concerns to include patient safety3. Since the beginning of the AIDS crisis, there have been 5 possible cases of transmission from dentist to patient in the much-publicized Florida (USA) case9. This seminal case shifted concerns towards practitioner-patient transmission. However, analysis of the case reveals problems with infection control and universal precautions rather than practitioner-patient transmission. Following these initial reports, the Centers for Disease Control (CDC) issued guidelines with recommendations 10 that there be adherence to universal precautions, that health practitioners performing exposure-prone procedures know their HIV status, that HIV-infected workers not perform exposure-prone procedures unless they had consulted an expert review panel which would advise on performing procedures and that patients should be informed of the practitioner’s HIV status before performing such procedures. Mandatory testing was not recommended because it was felt that the guidelines as set out would lead to practitioners avoiding HIV testing and concealing their status3,10. Estimates of the chance of a patient contracting HIV from invasive procedures have been determined by the CDC as 1: 263 000 to 2.6 million from dental surgery in the decade before 1991, without universal precautions being applied11. Moreover, if the CDC guidelines were implemented, the AIDS epidemic would only be reduced by 0.0006%3.

Further, research into transmission rates from known HIV-positive practitioners to patients established a zero transmission rate both in the case of surgeons and dental workers10. Besides, with effective antiretroviral treatment now available, the perceived risks to patients would be further reduced12. It is not surprising, therefore, that this data has led to the value of the guidelines being questioned. The guidelines have also been criticized for promoting discrimination, impinging on practitioner privacy and confidentiality and jeopardizing careers of health practitioners3. The HPCSA’s guidelines have adopted the CDC recommendations. In a developing world country where the need for health services far outstrip supply (including human resources), the usefulness of adopting the CDC recommendations, including the need to inform one’s patients of his / her HIV-positive status is most certainly dubious.

Disclosures of HIV status
Patients have both ethical and legal protections to privacy and confidentiality. However, these safeguards may be infringed under certain circumstances only. In Jansen van Vuuren and Another v Kruger (1993), the Appellate Division of the Supreme Court determined that a doctor could not disclose the HIV status of a patient to other doctors without the consent of the patient unless there was a clear legal duty to do so. The facts of the case, (better known as the McGeary case) are as follows:

Mr McGeary requested his doctor to do an HIV test for him as he was in the process of applying for a life assurance policy. He was informed by the doctor that the result was positive. The following day, the doctor, while playing golf with another doctor and a dentist, informed them that Mr McGeary had tested positive for HIV. Within days, this information spread through the community. McGeary brought a civil claim against the doctor for breaching his ethical and legal rights to confidentiality.

The court found that Dr Kruger had not respected his patient’s right to confidentiality and ordered him to pay R5000 compensation to McGeary’s estate (McGeary had died during the trial but his estate continued with the case on his behalf). The HPCSA guidelines state that practitioners should encourage their patients to disclose their status to their sexual partners who are at risk of contracting the virus. Where the patient refuses to do so, and after counseling, the practitioner should inform the patient of the latter’s ethical obligation to inform the partner, and go ahead and do so.

With regard to ICD codes, patients must give an informed consent for such information to be placed on the account. Confidentiality regarding the patient’s HIV status extends to other health practitioners as well. Information regarding the patient’s HIV status should not be divulged to other health practitioners without the explicit consent of the patient, except where clinically indicated. The guidelines state that confidentiality regarding test results is likely to be breached in a ward, hospital or health practitioner’s reception area. Hence, clear policies as to how laboratory results are to be communicated and how confidentiality is to be maintained should be formulated.

Management of a risk-bearing incident

Where the practitioner sustains a risk-bearing incident, immediate post-exposure prophylaxis may be beneficial and therefore information regarding the patient’s HIV status should be obtained. The HPCSA’s guidelines recommend that any existing blood specimen from the source patient should be tested, ideally with the patient’s consent. However, if this consent is withheld, the specimen should nevertheless be tested, but only after informing the patient that the test will be done and providing for protection of privacy. Where there is no existing specimen, and the patient refuses to have an HIV test, it is recommended that the patient should be treated as HIV-positive and post-exposure prophylaxis to the practitioner be initiated. If the patient is unable to consent, and is unlikely to do so for a significant length of time, appropriate proxy consent should be obtained where possible. Proxy consent means consent by a person legally able to...
give such consent in terms of the National Health Act 13 – i.e. in order of precedence, a spouse or partner, parent, grandparent, adult child, brother or sister, or in terms of the Children’s Act, the clinical manager in the absence of such persons in the case of a child.

CONCLUSION

The impact of HIV and AIDS has far reaching implications in health and health care both for the patient and the practitioner. Becoming infected, in the main, is a non-event, with the majority of people infected with the virus only becoming aware of their status by voluntarily choosing to have an HIV test. In the management of these patients, its is imperative that health practitioners respect their rights to autonomy, confidentiality and non-discrimination. It is also important that the rights of HIV – positive health practitioners are equally respected and any decision to censure their activities be based on scientific fact rather than emotion and prejudice.

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