ETHICAL ISSUES IN AIDS SCREENING
INTRODUCTION: WHY SCREEN?

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AIDS poses a number of ethical problems. It is recognised that AIDS is a devastating disease and that to be tested and found positive for HIV infection can have serious consequences for an individual. By implication, therefore, it would seem that we are ethically and legally bound to seek consent before we take an HIV test from a patient. Ethical problems also exist however in relation to public health, clinical care and confidentiality (Watson, 1990).

The hospital staff, particularly surgeons, obstetricians, midwives, and operating theatre-I.T.U. nursing staff are at risk when treating HIV-positive patients, and they have every right to minimize that risk. The question remains as whose rights will prevail - The rights of the individual or those of the community. One way to minimize the risk is to be forewarned, so that adequate protective measures can be undertaken. While the disease is at present generally restricted to high risk groups like homosexuals, drug users and haemophilics, there is increasing evidence that the infection is spreading to the heterosexual population, thus widening the population at risk criteria (Sim, 1988; Bradbeer, 1986; IPPF, 1990).

Like other countries in Europe, the incidence of AIDS infection in the Maltese Islands has increased over the last years (Figure 1). The rate of increase in infection rate apparently corresponds to the increase reported in the weighted European average (Central Office of Statistics, 1991). The majority of AIDS cases (86.7%) have been in the high list category, though at least one individual is known to have been married to a woman of childbearing age, while another death included a female individual. The incidence of Hepatitis in the Maltese Islands in much lower when compared to the weighted European averages, and the reported incidences for the last years appears to show a downward trend (Figure 2).

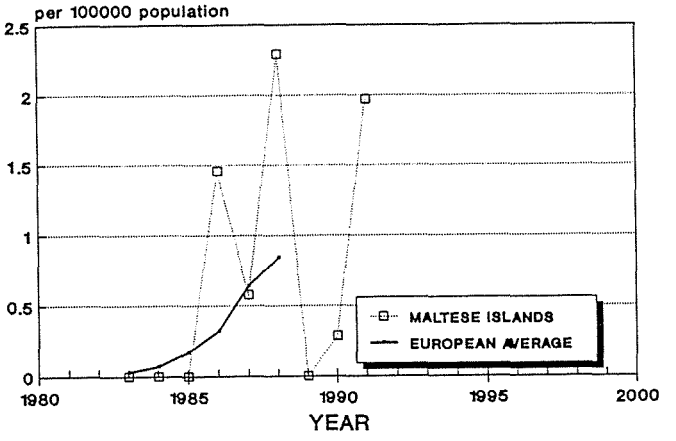

FIGURE 1: TRENDS IN AIDS INFECTION: MALTESE ISLANDS & EUROPEAN MEAN

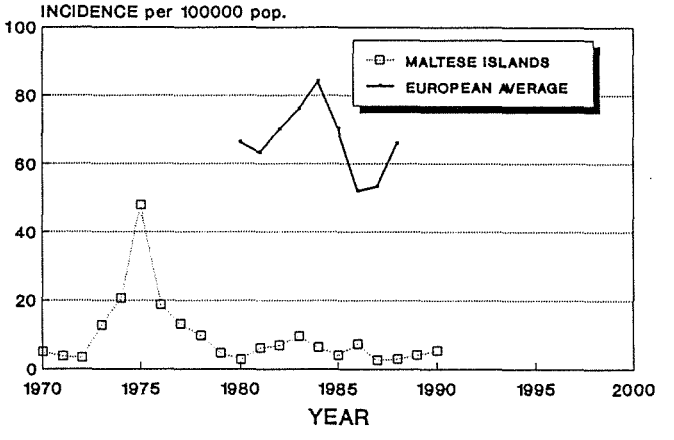

FIGURE 2: TRENDS IN HEPATITIS INFECTION: MALTESE ISLANDS & EUROPEAN MEAN

The reported figures are however only the tip of the iceberg. Whereas the reported incidence of Hepatitis B in 1990 was only 2.8 per 100000 population (Table 1), testing of blood donors in 1986 has shown a positive HBsAg in 3.45% of donors, giving an estimate of 2.9% HBsAg carriers (Farrugia, 1987). The situation is similar with HIV infection. Up to October 26, 1991 there were

only twenty AIDS related deaths all in the 13-49 years age range, but there were 50-100 people who were seropositive (ToM, 1991).

HEPATITIS INFECTION	no.	%	incidence per 100000 pop
Hepatitis A	6	31.6	1.70
Hepatitis B	10	52.6	2.84
Hepatitis non-A non-B	3	15.8	0.85
TOTAL	19	100.0	5.39

TABLE 1: HEPATITIS INCIDENCE: MALTESE ISLANDS - 1990 (Source: Health Service Information Unit)

It would seem therefore that a health professional is entitled to ask a patient to have an HIV test before commencing treatment - definately if there is a relevant history of high-risk activity (Gillett, 1991). In the light of the changing epidemiology of the disease, this request may be made to all patients presenting for "high-risk treatment". The patient may or may not accept to be tested. Confidentiality during testing needs to be maintained. It is ironical that whereas patient consent and confidentiality are rightly continuously respected and maintained, the same cannot be said for health personnel. A US appeals court has recently ruled that a hospital can warn patients treated by a doctor who is HIV positive. The judges in this case stated that although the risk was small, "it is no consolation to the one or two individuals who become infected....that they were part of a rare statistic". The risk of infection to the medical and paramedical personnel appears to be small (HEU, 1988), however this serves as no consolation. Accidental injury at the time of surgery occurs in as many as 15% of operations, while surgical gloves are punctured in as many as 30% of operations. Labour, delivery, and the puerperium are special risk situations where potentially infected body fluids are shed in large

amounts. The precautions required to prevent inadvertent infection during surgery and in obstetrics have been defined (Sim, 1988; RCOG, 1987). An HIV-positive tested patient ought to be counselled about the implications of the infection to him/herself and to the community. Should the patient declines testing, then it is widely agreed that a doctor or nurse should not refuse to treat the patient (Gillett, 1991), but reasonable precautions should be taken as though the patient was HIV positive (Figure 3). An obvious alternative form of management is to treat every patient as if infected, but this is impractical and involes added expense.

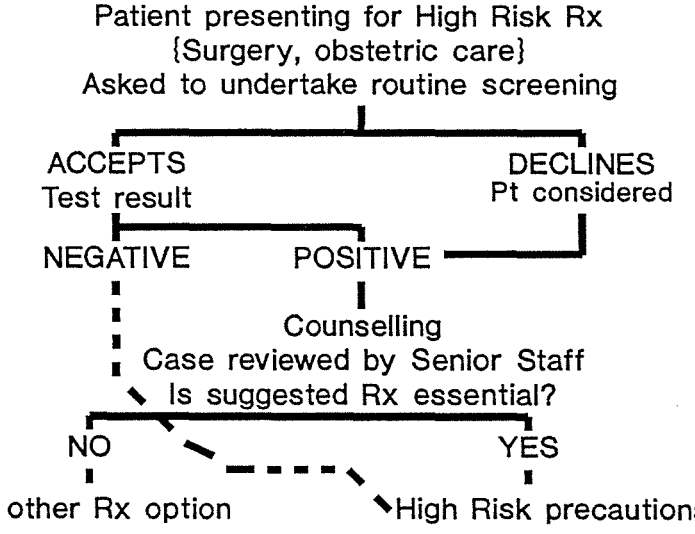

FIGURE 3: PROPOSED SCHEME FOR MANAGEMENT

The situation with regards Hepatitis, especially in obstetrics, is different since the ethical rights of the neonate come into play. Hepatitis vaccine is availiable and known to be protective to the infant. Routine sceening should identify the Hepatitis carriers so that vacination is initiated to the benefit of the infant. The situation is similar to routine screening for syphilis, where prenatal treatment can prevent congenital infection. If zidourdine or a similar drug is developed to the extent that it offers a reasonable prospect of cure or control of the HIV virus, then the ethical issues regarding HIV screening would have to be reconsidered.

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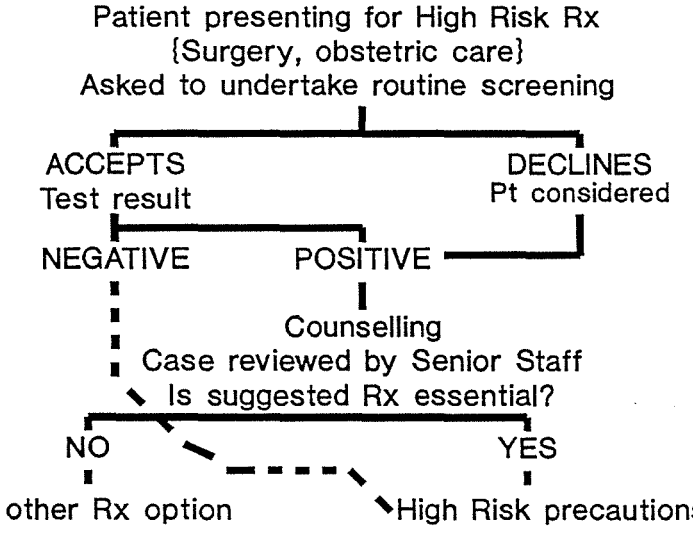

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