The use of ‘A personal view’ as a sub-title carries an implication and also an obligation. The implication is obvious—that no official organisation is involved; the responsibility for what is said rests with myself alone. The obligation, perhaps less obvious, is that when writing on an ethical topic I should disclose, at least in outline, my own general ethical position. It is that of ‘situation ethics’, whose nature and grounds I have set out more fully elsewhere [1,2]. But the essence of the matter is that, while respecting general guidelines and the like, I attach a still higher priority to the particular circumstances of the case in point. One consequence of this standpoint, relevant to the present discussion, is that I am reluctant to give too much weight to the distinction often made between ‘science’ (considered to be a matter of fact) and ‘ethics’ (considered to be a matter of conviction); in the actual concrete situation both these elements are present, neither of them can be neglected, and indeed they influence each other. Bad science is not likely to be good ethics, and conversely.

In a statement [3] approved in May 1988, the General Medical Council (GMC) recognised, in relation to AIDS and related states, that ‘most doctors are now prepared to regard these conditions as similar in principle to other infections and life-threatening conditions, and are willing to apply established principles in approaching their diagnosis and management, rather than treating them as medical conditions quite distinct from all others.’ There may be here an echo of Hippocrates on epilepsy [4]—‘I do not believe that the ‘sacred disease’ is any more divine or sacred than any other disease but, on the contrary, has specific characteristics and a definite cause. Nevertheless, because it is completely different from other diseases, it has been regarded as a divine manifestation by those who, being only human, view it with ignorance and astonishment.’ I believe the attitude expressed in the GMC statement to be correct; if so, two important consequences flow from it in relation to HIV testing. The first is that testing for antibody or virus is only one element, and not necessarily the most important one, in arriving at a clinical (or epidemiological) assessment. The second is that, in addition to the particular limitation imposed by the substantial delay between infection and the appearance of detectable antibody (the ‘window’), the test is also liable to those general errors from which no isolated test can be considered free. Even if these can be avoided in the actual performance of the test, errors in the collection and transmission of specimens, and in the reporting of results, reprehensible though they are, may still occur. A false positive or a false negative result could have most serious consequences; and positive results in particular must be confirmed at least once before leading to any clinical decision. There are indeed few tests with 100 per cent selectivity and 100 per cent specificity.

Another very important recognition in the GMC statement is the need for doctors ‘to make judgments which they may later have to justify. This is true both of clinical matters and of the complex ethical problems which arise regularly in the course of providing patient care, because it is not possible to set out a code of practice which provides solutions to every such problem which may arise.’ A comparable recognition is implicit in the resolution passed at the 1988 Annual Representative Meeting of the British Medical Association [5], which reads:

‘That HIV testing should be performed only on clinical grounds and with the specific consent of the patient. There may be individual clinical circumstances where a doctor believes that in the best interests of a particular patient it is necessary to depart from this general rule, but if the doctor does so he or she must be prepared to justify this action before the courts or the General Medical Council.’

[The first sentence of the BMA resolution can be translated as saying that ‘When HIV testing is done on clinical grounds, the specific consent of the patient is required.’ The phrasing of the sentence as passed was endorsed legally, which does not prevent it from being obscure, so much so that a reader had later to be adopted, indicating that the BMA was not precluded from supporting ‘anonymous prevalence testing for HIV without specific consent.’ In the second sentence I would have welcomed some reference to the need to justify one’s actions to one’s conscience and to the judgment of professional colleagues, as well as to ‘the courts and the General Medical Council.’ But it is in the nature of proclaiming policy by Procrustean resolutions that not everyone will be pleased; and the important message is clear, that specific consent by the patient is the normative rule for the transaction dealt with in the resolution.]

The ethical considerations relating to HIV testing are in general terms governed by the requirements for informed consent; for confidentiality; for access to counsel-
ling; and for the maximising of good and for the minimising of harm to the individual and to the community. It may be at once apparent that these requirements may come into conflict with each other. To give specific examples, confidentiality for the AIDS sufferer may involve a risk of harm to others; inexpert counselling may make a bad situation worse; and rigid insistence on prior consent may give rise to a completely unfounded suspicion that a patient has been infected with the AIDS virus. The relative importance of these potentially conflicting requirements is materially affected by the context in which the question of HIV testing arises. There is the ‘straightforward’ clinical situation where the patient approaches the doctor, or is referred to him, with a problem; there is the ‘need to know’ interest of third parties, such as insurance agents or directors of blood banks; and there is the need for epidemiological surveillance.

The clinical context

This general term covers a number of situations which may have quite different ethical connotations. At one extreme, the patient himself may ask to be ‘tested for AIDS’, either on good evidence or as a result of morbid fear; in such a case, in which even the most hardened ‘autonomist’ might allow the concept of ‘implied consent’, the need for expert counselling remains, and may indeed be greater than normal. At the other extreme, given that AIDS may have replaced syphilis as the great mimic of other diseases (a relationship which is of course reciprocal), the need to rule out AIDS may well occur to a physician, whereas the possibility may not have entered the patient’s thoughts. This seems to me a situation in which professional judgment can properly be exercised in the best interests of the patient. The historical accident, whereby the care of patients with AIDS has so far in this country been concentrated in special clinics of various kinds, has perhaps led to emphasis on consent and confidentiality, with insufficient appreciation of the dilemma of the general physician who sees AIDS as one possibility among many, and it may be an unlikely one, in the differential diagnosis of a difficult clinical problem—yet a possibility which it is important to exclude. This dilemma will of course be further sharpened when an effective treatment for AIDS becomes available. It is also a situation for which a general guideline is singularly inappropriate, since the ethical decision hinges on the interplay of three factors, none of which can be standardised so as to allow of a generalised solution. These are the likelihood of AIDS relative to the other possibilities; the make-up and attitudes of the patient; and the degree of rapport between patient and doctor. The argument is often advanced that a lack of openness by the doctor will destroy trust, and indeed that argument is in general true; but there must surely be exceptions to it when the test for HIV is done simply to rule out a remote possibility. To be concrete, a doctor faced with a nervous patient with a generalised lymphadenopathy would in my view be unwise to omit a test for HIV, and also unwise to burden the patient by revealing a miniscule suspicion of AIDS.

I recognise of course that extreme cases have no bearing on the great majority of clinical situations to which sensible guidelines apply; prior informed consent and specific counselling must be the norm of practice. It is also of course strongly in the patient’s interests that strict confidentiality should be maintained; but is it always in the interest of other individuals and of society?

Third parties

The closest and most important ‘third parties’ are of course, in old-fashioned terminology, the wife or husband; or in gradations of modernity, ‘boy- and girl-friend’; ‘stable sexual partner’; and ‘casual sexual contact’. Another group of ‘third parties’ is drawn from the sad underworld of drug abuse. Vulnerable contacts of these various kinds can best be protected by sympathetic counselling, in which any ‘judgmental’ bias in the counsellor must be sacrificed for the greater good of potential victims; even in the utterly promiscuous there may be some soul of goodness in things evil. Perhaps the tension between confidentiality for the patient and protection for others is most acute where there is a true stable relationship such as marriage, which may then itself be at risk. In spite of the sadness of it, the great majority of people, with the help of counselling, would be able to tell a stable partner about their misfortune; the real dilemma for the doctor or counsellor comes if the patient refuses to do so. My own bias, given that AIDS is currently an incurable disease, would be to make a wife or husband aware of the risk they might be running; but in saying so I am probably confessing to the sin of being judgmental. But I may derive some indirect support from the view of the GMC that it is proper to report a doctor with AIDS who is putting patients at risk, and who refuses to limit his practice appropriately.

Some types of ‘third party risk’ can be adequately dealt with on the basis of fully informed consent before testing. This is now the rule for blood-donors in this country, and this is satisfactory in ensuring a supply of HIV-free blood, though there may be the occasional dilemma arising from a positive test result. A more difficult area is that of insurance practice, where the insurers have a clear ‘right to know’, but in their own interest and that of other clients, not in that of the patient himself. Again, fully informed consent is necessary.

There are two further problems of disclosure, which arise in the course of practice. When a patient is investigated in hospital or a special clinic and found to be infected with HIV, he should clearly be advised to allow his general practitioner to be informed. Otherwise the family doctor is in the difficult position of being responsible for general medical care while unaware of an important clinical finding. But if the patient refuses, and cannot give an adequate reason, the protection of confidence has to be weighed against the risks to the patient himself, and to the doctor and other health care staff. A somewhat similar problem relates to patients listed for surgical treatment. Not only the surgeon himself, but also the theatre staff and other patients on the list, could be exposed to contact with HIV-infected blood. Such risks
are not imaginary, and I have sympathy with surgeons who would ask patients to submit a sample of blood for HIV testing. This might be stigmatised as 'self-preservation', but it is also in the interest of other staff and of patients, and in any case the preservation of a surgeon is not a crime.

The community

As doctors, we cannot afford the unworthy luxury of allowing our attitude to patients to be influenced 'on the basis of a moral judgment that the patient's activities or lifestyle might have contributed to the condition for which treatment was being sought'—to use the delicate GMC formula. On the contrary we must extend in our professional life the same charity and understanding to all our patients as doctors do to friend and foe alike in time of war. Aside from it being our duty, it is also the attitude which will encourage patients to come forward for such help as we can give them, and by so doing they open the opportunity for counselling which may help to limit the spread of the disease.

It is also important for the public health that we should know what is happening to the population, as well as to individuals. Valid epidemiological information can only be obtained from samples of adequate size and free from bias. This rules out, for example, samples drawn from special clinics, or from communities with particular styles of life. Even if a sample is not pre-selected in such a way, bias could still arise from the requirement, normal in clinical practice, for soliciting specific consent—the bias then arising from selective self-exclusion of those considering themselves to be at increased risk. In agreement with BMA policy, I take the view that anonymous prevalence screening can legitimately be done without specific consent. There is, however, a cost inherent in anonymity—samples yielding a positive test cannot be traced back to the individual donor who might benefit from counselling and from the possibility of treatment in the future. A possible approach would be that suggested [6] in a letter to the Lancet in November, 1987, of which I was a willing co-signatory. Women attending ante-natal clinics would be asked whether they would wish to know the result of an 'AIDS test'. Those who assented would be registered, and other test samples would be treated anonymously. This particular proposal was related to pregnant women, a group on whom it would be important to have information, but a similar protocol would be applicable to other defined groups.

Let me end as I began, by emphasising that this is a personal discussion of an important problem, or set of problems. In no way am I attempting to be 'prescriptive', which is perhaps a crime even greater than to be 'judgmental'. I sincerely hope that the more extravagant projections of 'the AIDS epidemic' may not prove correct but, should they do so, AIDS will become a major problem for general physicians, as well as for AIDS specialists, and so we will all have to become involved in AIDS-related ethical decisions.

References
1. Black, D. (1984) Iconoclastic ethics. Journal of Medical Ethics, 10, 179.
2. Black, D. (1987) Medical ethics. In Oxford textbook of medicine (eds D. J. Weatherall, J. G. G. Ledingham and D. A. Warrell). Oxford: Oxford University Press.
3. General Medical Council (1988) HIV Infection and AIDS: the ethical considerations. Statement, May, 1988.
4. Chadwick, J. and Mann, W. N. (1950) The medical works of Hippocrates, p179. Oxford: Blackwell Scientific Publications.
5. 'Scrutator' (1988) The week in Norwich. British Medical Journal, 297, 206.
6. Black, D., Bodmer, W., Cox, D. et al (1987) HIV testing on all pregnant women (Letter). Lancet, November 28, p1277.