The Morality of Refusing to Treat HIV-positive Patients

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Abstract Do physicians and nurses have an obligation to treat patients who are HIV positive? Although an initial review of the possible sources of such an obligation yields equivocal results, a closer examination reveals a clear obligation to treat. The current risk of job-caused HIV-infection is not sufficient to warrant a refusal to treat. This is so because there exist rationally justified, general social, as well as specific peer expectations, that health care professionals treat HIV-positive patients. These expectations impose moral obligations on doctors and nurses. Moreover there is no sound libertarian argument entitling doctors and nurses to refuse to treat HIV-positive patients. A morally appropriate identification with his or her role would disincline a health care professional to refuse treatment to an HIV-positive patient. The likely source of such refusal is occupational alienation and an irrational reaction to AIDS symbolism.

On 13 March 1987 the New York Times reported that Dr W. Dudley Johnson, a distinguished heart surgeon, had refused to operate on two patients because they were positive for HIV, the virus associated with AIDS [1], The 31 January 1988 Boston Globe cites a recent poll of 4000 doctors showing that "15% would refuse to treat a patient with AIDS and half thought they had a right to do so". A New York University study indicates that as many as 25% of interns would refuse to care for AIDS patients if given the choice [2], Other doctors have also stated that they would refuse to treat HIV-positive patients. How are we to assess these refusals? Are they morally proper, reasonable refusals to be exposed to grave risks? Are they a failure to live up to a fundamental obligation to treat the ill? Or are they something in between; perhaps moral failings less extreme than derelictions of duty? I attempt to answer these questions first by examining whether doctors and nurses have a general obligation to treat the ill. Since there is more to morality than the fulfilment of obligations, I next assess the refusal to treat the ill from a perspective that moves beyond a duty-defined morality. Finally, I look at how these abstract and general arguments apply to the specific case of HIV-positive patients. Philosophers have given various accounts of the source of our obligations. Each account provides at least a prima facie case that doctors and nurses have an obligation to treat the ill. However, in each case there is a prima facie refutation available as well. Promising Obligations can be viewed as arising out of promises, either explicit or implicit. One ought to do something simply because one has promised to do it. Ethical codes
require a physician to "be dedicated to providing competent medical service with compassion and respect for human dignity" [3] may imply a sort of promise to treat the ill (in so far as an oath resembles a promise). In some codes, like the declaration of Geneva in which physicians are supposed to "consecrate [his/her] life to humanity" or the International Council of Nurses which states that the "primary responsibility [of nurses] is to those requiring nursing care", the implication of a promise to treat is fairly strong. Still, no modern codes explicitly require physicians or nurses to serve all needy comers. Indeed a provision of an earlier American Medical Association code calling for physicians to face the danger of pestilences and to "continue the alleviation of suffering even at the jeopardy of their own lives" was dropped in 1957. A phrase in the current code asserting that physicians ought to "except in emergencies be

free to choose whom to serve" seems explicitly to deny any promise of universal treatment. The venerable Hippocratic Oath comes closest to a promise to treat the ill when it has physicians swear "to help the sick according to ability and judgement". But here again it is open to debate whether this requires doctors to treat all patients who need their assistance. While codes and oaths lend some support to the notion that doctors and nurses have promised to help anyone who needs it, they fall very short of demonstrating that claim. It could even be argued that the failure to make this obligation explicit implies that there is no such obligation. Actual and Hypothetical Reciprocity A closely related but distinct possible source of obligation is found in reciprocity. You have received something from someone so you owe, or are obliged to that person. A variant of this view (albeit with significantly different theoretical grounds) claims you are obliged to others when and because you would rationally expect or want them to be obliged to you in similar circumstances. Both promises and each version of reciprocity have been employed in contract theories of obligation. Doctors are given an elaborate education, status, and wealth by our society. Nurses also receive a substantial education if considerably less overall benefits. These goods are social goods. Neither tuition nor anything else provided by the health care student comes close to covering the social cost of creating these goods. Only the health professional's readiness to serve the ill will fairly compensate for the goods they have received. Hence reciprocity can be viewed as the source of an obligation to treat the ill. However, the claims of reciprocity can be acknowledged without admitting an obligation to treat any individual patient or even any specific class of patients. Since the goods health professionals receive are given by society in general, they are repaid by a willingness to serve society in general. Such a willingness does not entail service to any particular segment of society, if that segment has made no special contribution to health care workers. Moreover, even if the need to treat AIDS and other HIV infected patients is seen as a social need, it is unclear how an obligation to treat them devolves on particular practitioners. Perhaps the field as a whole owes society treatment of these people, but so long as an individual practitioner serves society in some way, isn't that practitioner adequately paying his or her debt? While it is true that doctors and nurses would want and perhaps expect treatment if they were HIV-positive patients, it is not obvious that they could rationally expect such treatment. The assumption that such an expectation is rational begs the question. Surgeons like Dudley Johnson argue that it is not reasonable to require that they expose themselves to the risk of catching AIDS. This claim is a central issue in our enquiry and we will explore it in some detail later. Rights and Obligations Obligations have also been viewed as originating from the existence of rights. In so far as someone has the right to something, others are obliged to provide it. Even the bare right to be left alone obliges people to leave you alone. It is difficult to evaluate the proposition that doctors' or nurses' obligation to treat HIV-positive patients is based on the patients' right to health care. The existence of a right to any health care is controversial. Granting such a right, its extent and limits are disputed. Moreover, even if HIV-positive patients have a right to be treated, and someone has an obligation to treat them, we need a further argument to show that a particular physician or nurse has that obligation. Of course one might argue that since no physician or nurse has a special obligation to treat HIV-positive patients, once we posit the existence of a general obligation, it would seem to fall on all health professionals equally. Even if this line of argument is accepted, it leaves unanswered the scope and force of this equal obligation, i.e. what sort of treatment the practitioner is obliged to provide and how this obligation would be weighed against other considerations. Utilitarians have made the promotion of the general welfare the sole fundamental obligation. As a practical matter, utilitarians have endorsed the imposition of a host

of particular obligations as serving the general welfare. Special emphasis has been laid on avoiding harmful acts. A utilitarian case for the obligation to treat HIV-positive patients would ultimately rest on the empirical claim that such an obligation would promote the general welfare. But it can be plausibly maintained that the selective refusal of patients who would probably be voluntarily treated by others, poses no great harm, and indeed a great harm might come from the moral compulsion involved or the endangering of skilled doctors or nurses. Tradition Finally obligations may come from a tradition; we may have an obligation because a group we belong to has long taken it to be an obligation. The tradition may or may not give a rationale for particular obligations. They may stem from divine commands or promises our ancestors made. But for the individual the source of the obligation is simply membership in a group that holds these things to be obligations. Does the tradition of Western medical practice impose an obligation on doctors to treat HIV-positive patients? We have seen that the Hippocratic Oath's vague injunc tion to help the ill gives no definite answer. It does not say explicitly to help all the ill or to help them even at the risk of one's own life. The historical record of physician behaviour from ancient Rome to eighteenth-century Philadelphia is mixed. It seems that in each great plague many physicians fled while at least some remained to tend the ill. Public reaction was usually scornful of the fleeing physicians, indicating that the public at least thought of the doctors as duty-bound to confront the plagues. In some instances (e.g. fourteenth-century Venice) doctors were not allowed to leave the plagued cities; in others some physicians were hired by the city as plague doctors, thereby releasing other doctors from any plague duty. Physicians as eminent as Galen and Thomas Sydenham have fled plagues; others, like Benjamin Rush have felt duty bound not to 'desert' their patients. There is simply no consistent tradition on the issue [4], The nursing tradition, with its religious roots, inclines more to self-sacrifice. The emergence of modern nursing is closely associated with service to disease-ridden theatres of war. Still there is no explicit tradition demanding the nurse to attend all patients, heedless of the possible dangers. The Defence of the Refusal to Treat: libertarianism Such then are the prima facie arguments for the existence of an obligation to treat along with the prima facie rebuttals. But 1 believe most health care workers who refuse to treat HIV-positive patients would justify their refusal with a different, positive argument. It is a radical libertarian argument claiming we have no obligation to others beyond leaving them alone. Robert Nozick, a contemporary philosopher, holds that your single natural duty to others is to not make them worse off than they would have been if you had never existed [5]. The only additional duties you accrue are those you freely accept. Since HIV-positive patients do not appear any worse off from a physician's or nurse's refusal to treat them than they would be if the physician or nurse had never existed, doctors and nurses are free to reject these patients. Here the professional's relation to the patient is conceived of as contractual. (Although recently this contractual model has been recommended for nursing, its application there is problematic. I focus on doctors, for whom the contractual model is more plausible.) Both parties are morally free to contract or decline to contract. In the later case no doctor-patient relationship is created, no obligations assumed. Moreover there is no requirement to explain a refusal to enter a contract. There are some problems with the contractual model of the doctor-patient relation ship, which I discuss below. But first I want to examine the way we normally assess refusals to enter into a contract. Typically we do consider the reasons for refusing to enter a contract as relevant to our moral evaluation of the refusal. If the reasons are arbitrary, irrational, irrelevant or invidious, we might not posit a right to remain uncontracted. Dislike of a person's race is not a morally permissible reason to refuse to contract with him or her, and we are morally repelled by doctors who refuse to treat for racist reasons. Frivolous reasons, while less repellent, are still

unacceptable. The stereotype of the doctor off to golf in lieu of treating patients is not a picture of doctors exercising free choice, it is a picture of doctors neglecting duty. However, a doctor who refuses to treat HIV-positive patients would argue that she has a reason which is neither pernicious, like racism, nor frivolous, like a desire to play golf. Rather it is relevant and serious; the avoidance of risk to her career, health and life. If we are to judge the adequacy of this reason we must begin by assessing the risk. There are two dimensions of risk assessment to consider, the probability of harm's occurring and the extent of the harm should it occur. There seems to be no dispute that if she cares for HIV-positive patients there is at least some risk of a health care worker, especially one who may encounter patients' bloods, becoming infected with the AIDS virus. A small number of health care workers seem to have caught the virus through contact with infected blood. Once one is infected, the harm one sustains is unquestionably grave. There is a strong chance (some would argue an inevitability) that the disease, invariably fatal, will develop. At the least, one's career and sexual life will be devastated. 'Surely', the doctor may argue, 'it is unreasonable to require, or even expect, me to take a chance with my life'. It is quite true that people are normally excused from performing a task if they can point to a threat to their lives as an excuse. Naturally, if the threat is highly improbable the excuse might not hold. But putting the probability issue aside for now, there is another element to consider; the role of the person whose life is at risk vis a vis the life-threatening task. A passing stranger may have no obligation to chance rough seas to save someone from drowning. A friend of the drowning person, however, may be under a greater obligation, and a parent of the drowning person may be absolutely obligated. Occupational roles are especially good at creating obligations where they would not otherwise exist. The lifeguard on duty is morally required to attempt the rescue while others (perhaps equally good swimmers) may be permitted to stay safely ashore. Some jobs come with life-threatening risks. Why are lifeguards, and others such as firefighters and police officers, expected to confront life-threatening situations? Quite simply because it is part of the job. In accepting the job, these workers have implicitly agreed to a job description that includes a relatively high degree of danger. This agreement to risk their lives is never made explicit, but it is clearly understood. While the agreement is partially with the employers who have hired them, it is also with society at large, for society has indirectly provided their training and directly licensed them. In addition there is an implicit agreement with their colleagues who are deeply involved with both the training and licensing procedures. The acceptance of the relevant training, the license and the wages obliges firefighters to enter burning buildings occasionally and lifeguards must swim in rough waters. Note that they have not made agreements with the individual trapped in flames or buffeted by waves; they have become obliged to those individuals through a more general agreement. Are doctors and nurses in a reasonably analogous situation? They are certainly trained and licensed as rigorously as members of any other occupation, and it is fairly obvious that the job entails exposure to diseases, including contagious, potentially fatal diseases. Moreover, the state grants them a monopoly on nursing and medical practice. Perhaps some specialist could plead that they entered an occupation (psychiatry, radiology) in which no contact with contagion was foreseen. But those specialties are a minority, and in so far as every registered nurse and medical doctor gets general practitioner's training, they all enlist in the struggle with disease in general. A doctor who would not expose herself to disease is as absurd as a lifeguard who would not brave rough seas or a firefighter who would not enter burning buildings. Still, although an occupational role may require one to confront some life-threaten ing risk, it does not require that all such risks be taken. Even a lifeguard can forego attempting a rescue if it entails the lifeguard's certain death. Firefighters are expected to go into burning

buildings risking their lives, but can legitimately demur if the risk is too great. Police must show up when called to dangerous hostage situations; they are not required to charge the armed hostage-taker without regard to their own safety. There are limits. At some point some risks are too great to demand of any occupation. Soldiers may be an exception to this rule, but even soldiers are not required to face certain death. Suicide missions are voluntary. How high a risk excuses workers in high-risk jobs from taking a risk? Something considerably less than certain death. If a firefighter has a 90 per cent chance of being killed in a rescue attempt we do not think he is obliged to make the attempt. Standard lifeguard training actually instructs a rescuer on how to avoid situations that pose too great a risk to the rescuer's life. Lifeguards are taught when they ought to let someone drown.

It is, of course, unacceptable for these workers to refuse all life-threatening tasks. The lifeguard who declines rescues in any tricky waters, the firefighter who refuses ever to enter burning buildings and the policeman who avoids all potentially dangerous crime scenes—all of these people are failing to do their job-created duties. Yet to some risks they can just say 'no'. The question is 'Which risks are too great to be morally compulsory?' At what point are the workers in implicitly high risk jobs entitled to say 'no'? I maintain that point is reached when one's professional peers determine it is. Only firefighters can judge whether a firefighter ought to be expected to attempt a given rescue. Only firefighters can judge whether another firefighter's performance was inadequate. The people who do a job best understand the dangers involved, and the resources they have to meet those dangers. It is professional peers who determine job performance standards and who are called upon to testify as experts at malpractice trials. In addition to having the requisite technical knowledge they have an existential sense of the situation. They have 'been there'. Professional consensus, rather than individual practitioners' judgement, does, and for the most part should, set technical and ethical standards in a profession. This is not, however, done free of social and rational constraints. Social Constraints on Standards What if a profession, out of group self-interest, sets unreasonably low standards? Suppose firefighters as a group decided that they ought not approach any building that had the smell of smoke about it? In such cases, social forces would effectively deny the group's right and ability to practice or to monopolise the practice. It is the profession's role to set precise standards, but the standards must allow for a minimal fulfilment of function. Fire departments that had a policy of avoiding smoke would not be funded. Lifeguards who would not go into deep water would not be hired. Whether through public funding, licensing or simply the market, society has the power to enforce the minimal standards. Hence, assuming socially acceptable minimal standards are met, it is for physicians and nurses to determine whether an individual doctor or nurse is meeting his or her professional duties. The American Medical Association, while adhering to the position that a doctor is "free to choose whom to serve" has stated that "a physician may not ethically refuse to treat a patient whose condition is within the physician's current realm of competence, solely because the patient is seropositive" (i.e. infected with the AIDS virus). The American Hospital Association imposed similar obligations on their employees [6]. Practitioners are obliged to treat HIV-positive patients because their peers judge there to be such an obligation. I shall argue below that this judgement is sound. But first I want to expand the discussion beyond the question of duty; for to describe duties is not yet to prescribe action. It is merely to state minimally decent action. There remains the category of the heroic. Refusal to Treat and Professional Identity Some firefighters go where others would not go, and would not expect anyone to go. They act, in the worn phrase 'above and beyond the call of duty'. We approve of

such actions and award medals for them. And although we might like everyone to act 'heroically' we do not mandate such actions. It would be unrealistic and therefore counter-productive to expect any group routinely to run serious life-threatening risks.

In rare situations, when a group is extraordinarily motivated, it is possible to make martyrdom a duty. But this is not the case in normal occupations. Our moral codes must take our psychology into account. It is interesting that heroes sometime explain their actions as 'just doing my job'. If a firefighter is asked why he ran into a terribly dangerous fire to rescue a child, he might well reply, 'Because I'm a firefighter and that's what firefighters do'. Sometimes this is false modesty. But I believe it is often sincere and indicates a very strong identification with the occupational role. Attitudes of professionals towards risk will be affected by their identification with the job. From the internal perspective the morality of rejecting certain risks also depends on this identification. In certain jobs, we have come not only to expect a strong identification, but think it is morally inappropriate if this identification is absent. We speak of such occupations as 'callings'. (Clergymen are the paradigmatic case, but medicine and nursing are also often viewed as callings.) Plumbing is not a calling. Conceivably a plumber might use his plumbing skills, at great risk to himself, to prevent a disaster. Plumbing can be heroic. Yet it would sound odd to hear the plumber explain his heroism by saying 'I did it because I'm a plumber and plumbers plumb'. Doctors and nurses however, can explain their heroism by pointing to the nature of their jobs. Their role engages their entire person more than other jobs. We may debate whether this identification is a socially useful and good thing, or a destructive mystification of the health professional's role. In any event, it is a decreasing phenomenon. Medicine and nursing are increasingly becoming just another 'job' and less a calling. This is especially true of medicine. The disappearing house call is symptomatic of the disappearing 'calling'. Indeed, more and more doctors are employees of institutions to whom their relationship is no different than that which most workers have to their bosses. In the context of medicine as a regular job, and not a calling, doctors' refusals to take serious risks are more acceptable. Why should someone risk his or her life to do a job? However, there is a price physicians pay for the loss of this deep role-identification; a growing alienation from their work. There is a substantial literature analysing the nature and injuries of work alienation. In essence, alienation is a separation of one's life from one's work, resulting in a profound loss of job satisfaction. Of course the reluctant practitioner may argue that even if a refusal to treat HIV positive patient is a sign of alienation, that provides only a prudential, not a moral, reason to treat a patient. But it does suggest that doctors and nurses may be better off if they adhered to a moral code that disallowed such refusals. Refutations Refuted: the rationales for requiring treatment 1. Promising and Reciprocity I want now to apply points made above to the specific situation of AIDS. Currently the risk of a health care professional becoming infected while working with HIV positive patients is very small. Some infections have occurred, but they are rare. Given the small apparent risk I think that most associations of doctors and nurses would follow the American Medical Association in imposing an obligation on practitioners to treat AIDS and HIV-positive patients. Moreover they would be right to do so. For our health care professionals are trained at a great cost to society and given a valuable monopoly. In return, we can expect them to take a small risk. Moreover, by accepting the role and continuing to benefit from it, they have implicitly promised to practise medicine even where it involves some risk. 2. Utility and Hypothetical Reciprocity From a utilitarian point of view, the smallness of the risk argues for a duty to treat. The public's trust in doctors depends on the belief that doctors will help in times of need. More directly, by treating HIV-positive

patients and especially AIDS patients, doctors can alleviate or mitigate great suffering. The prospect of AIDS patients suffering unattended, medically abandoned deaths is horrifying. The denial of nursing care to these patients is even more harrowing. We would be hard pressed, given the small risk involved, to find utilitarian considerations in favour of not treating that would outweigh these horrors. This is not to make light of the harm a physician or nurse would endure if she or he became infected. Nor is it to dismiss the harm that would befall their families. But the current utilitarian calculation must weigh a large actual number of victims against a small potential number of victims. Moralists from a Kantian tradition would also find a duty to treat HIV-positive patients. To paraphrase the first formulation of the categorical imperative, we ought only to act according to those principles whose universal application we could endorse. There are many ways to describe the principle a health care practitioner, who refuses to treat HIV-positive patients out of fear of infection, is following: 'avoid any possibility of death', 'only help others when such help poses no possible serious threat to oneself, 'health care providers should treat illness only when it can be done without any possible danger to the provider', etc. I think no practitioner reasonably could accept any of these principles, or any plausible substitute. The acceptance of such a principle ultimately would make medical and nursing practice impossible. On a more personal level, doctors and nurses would expect others to care for them were they ill, and given the risk involved, this would be a rational expectation. They would have to abandon this expectation if they accepted a principle justifying their refusal to treat HIV-positive patients. The irrationality of the refusal to treat HIV-positive patients is morally significant and worth dwelling on. Doctors and nurses in their daily lives, and probably in their practices too, do things which are far more likely to lead to their deaths than would treating HIV-positive patients. A surgeon is more likely to die from contracting Hepatitis B from a patient than from contracting AIDS [7]. Medicine and nursing style themselves as scientifically based professions. Rationality ought to inform all their standards and practices. Refusal to treat HIV-positive patients is a deviation that needs explanation. Is the symbolic freight of AIDS a factor here? Would Dr Johnson shun treating a disease whose victims were cub scouts and brownies rather than gay men and intravenous drug users, even if treating the little boys and girls ran the same sort of risk? Would the fear be the same if the disease were commonly spread through My Little Ponies and Care Bears rather than anal intercourse and drugs? Irrationality alone does not indicate immorality, but it does when it involves pernicious discrimination. Like racism, refusal to care for AIDS patients is both unreasonable and hurtful. Moreover, the hurt is compounded since heath professionals are looked to for guidance on health practices. If doctors will not operate on HIV-positive patients and nurses will not care for them, it becomes difficult to convince the public to work, eat or play with them.

I conclude that doctors and nurses are obligated to treat HIV-positive patients [8], The conclusion is based on the judgement that the current chances of health professionals' developing AIDS from caring for HIV-positive patients is very small. Developments may require a revision of that judgement. It may turn out that caring for HIV-positive patients, or at least certain kinds of care, does run a serious risk of infection. In that case the treatment of HIV-positive patients would no longer be a duty, it would be an heroic act. But that time is not now and given present knowledge it seems not on the horizon. The duty to treat is not one it would be wise to enforce with any formal sanctions. Health professionals compelled to treat certain patients by state agencies or profes sional associations might be suspected of giving perfunctory care. Who would choose to have an appendectomy performed by a surgeon who is just protecting his license; one

trying to get in and out as quickly as possible with minimal exposure to blood? Some duties can only be properly performed voluntarily. But doctors and nurses should feel an inner compulsion to treat HIV-positive patients. In part this compulsion should derive from their perception of the task as a duty, and in part from their perception of the task as integral to a role that partially defines them.

NOTES Lawrence Blum, Joel Greifinger and the editors of the Journal of Applied Philosophy made helpful suggestions on an earlier draft of this paper. [1] New York Times, 13 March 1987, p. 1. [2] The Boston Globe, 31 January 1988, p. 1. [3] American Medical Association (1984) Code of Ethics, revised. [4] Abigail Zuger & Stephen Miles (1987) Physicians, AIDS and occupational risks, Journal of the American Medical Association, Vol. 258, No. 14, pp. 1924-1928. This article provides a useful sketch of the relevant history. [5] Robert Nozick (1974) Anarchy, State and Utopia (New York, Basic Books). [6] The Boston Globe, 31 January 1988. [7] Of course, once contracted, AIDS is by far the deadlier of the two diseases. But Hepatitis B is occasionally fatal (Eugene Braundwald et al. (1987) Principles of Internal Medicine (New York, McGraw-Hill), p. 473) and is much easier than AIDS to contract accidentally in a surgical setting. Between 12 per cent and 27 per cent of health care workers who suffered needlesticks with HBV infected blood seroconverted, whereas only 0.13 per cent to 0.39 per cent similarly exposed to HIV seroconverted (G. H. Friedland et al. (1987) Transmission of the human immunodeficiency virus, New England Journal of Medicine, 317, pp. 1125-1135; E. McCray et al. (1986) Occupational risk of acquired immune deficiency syndrome among health care workers, New England Journal of Medicine, 314, pp. 1127-1132). Approximately 20 per cent of American surgeons are HBV-positive (William Schneider (1984) Hepatitis B infection control among physicians, dentists and laboratory personnel, in: Irving Millman et al. (Eds) Hepatitis B: the Virus, the Disease and the Vaccine (New York, Plenum Press). Nor does the vaccine afford complete protection. It is 8 per cent to 25 per cent ineffective (Arlene McLean, Clinical experience with the hepatitis B vaccine, in Millman, op. cit.). [8] I have not dealt with the issue of whether HIV-positive patients should be denied certain treatments on the grounds that others could 'make better use', of the treatment. It may be the case that no one who is terminal has a claim on certain scarce resources. (Of course whether all HIV-positive patients are terminal is an open question.) The issue is not unique to AIDS. It applies to anyone who is, or is likely soon to be, terminally ill. Indeed it concerns all old people. In any event W. Dudley Johnson and the 15 per cent of doctors in the Boston Globe cited survey, presumably were not basing their refusal to treat HIV-positive patients on a concern for the best use of limited resources.