Correspondence

Guidelines for Physicians Testing for HIV Antibody

To the Editor:

The circumstances surrounding the testing of an individual for the antibodies against HIV abound with personal, public, and professional ethical concerns. The federal AIDS Policy Act proposed in the House and Senate very properly addresses most of these concerns. It encourages appropriate counseling and testing and authorizes funds for such activities.

Individuals and organizations involved in providing testing should assure that an individual not request or allow testing without full understanding of the significance of the test and the consequences of the results to themselves and to others. The testing of blood for the presence of HIV antibody can be likened to a biopsy to determine if a malignancy exists. A positive result for either can be a life-threatening outcome. Both can threaten others in terms of potential loss of life of the person tested; a positive HIV antibody test can literally threaten the physical health of others. A physician's responsibility in both cases is a heavy one.

The companion bills in Congress address the physician's responsibilities and place a burden upon physicians to notify individuals when they believe that the individuals have been exposed and that the circumstances of exposure are of serious magnitude. While it should not be the purpose of legislation to prescribe specific methods of accomplishing the intent of the legislation, the following is offered as one approach.

A physician under no circumstances should test an individual for the presence of HIV antibody without the fullest explanation of the significance of both positive and negative test results, and the potential consequence to others of a positive test result. The physician should, after this explanation, obtain a written request from the individual to have the test performed, just as one would for a biopsy.

In addition, the physician should assume the obligation to obtain agreement from the person being tested that the person's sexual partner(s) will be informed of the result by the patient, or that the patient allow the physician or a qualified counselor to inform the sexual partner using the name of the patient. The patient should be urged to have the sexual partner tested simultaneously.

No physician or public health worker should, under any circumstance, inform a person that he or she has been named as a sexual partner of an individual infected with HIV without written permission to use the infected individual's name. To do otherwise could make the physician or counselor party to a malicious act of abuse. Persons having found themselves to be infected could name other individuals as contacts from anger or from a sense of retribution. Because of this possibility, physicians should exercise extreme caution in agreeing to inform or doing so on their own volition.

If the patient does not consent to this approach, he or she should be referred to a site where anonymous testing and counseling are provided. The official health agency should not be requested to inform people of their possible exposure since this would be a breach of confidentiality.

David J. Sencer, M.D., M.P.H.
Chief Operating Officer
Management Sciences for Health
Director, Centers for Disease Control (1966–77)
Commissioner of Health, New York City (1982–86)

California's "AIDS Confidentiality Laws"

To the Editor:

In April 1985 the California State Legislature enacted measures that became known as the "AIDS confidentiality laws," which were codified as sections 199.20 and 199.21 of the California Health and Safety Code.

Section 199.20 prevents, with limited exception, the compulsory identification of anyone as the subject of a blood test to detect antibodies to the human immunodeficiency virus (HIV), the probable causative agent of AIDS.

Section 199.21 prevents disclosure of results of a blood test for HIV antibodies to a third party, without written authorization for such disclosure from the person tested. If such disclosure is made without written authorization, there are civil and in some cases criminal penalties, including imprisonment.

Only two other states, Florida and Wisconsin, and the District of Columbia have confidentiality laws similar to those of California.[1]

Jack E. McCleary, M.D., president of the Los Angeles County Med-

https://doi.org/10.1111/j.1748-720X.1987.tb01021.x Published online by Cambridge University Press

ical Association, has recommended that the California AIDS confidentiality laws be reformed to allow physicians to disclose, with immunity, to an endangered third party that his or her sexual partner has tested positive for HIV antibody and is therefore infected and contagious.[2]

Physicians practicing in California frequently discuss among themselves the dilemmas imposed upon their performance of medical care by the California confidentiality laws. At least one peer-reviewed report has discussed and documented the conflict existing between the law's imposition of confidentiality and the existing community standards of medical practice and medical ethics, which demand disclosure.[3]

No other contagious public health menace has similar legally imposed confidentiality restrictions that are in conflict with medical care standards and medical ethics that demand disclosure. This is especially problematic in California,[4] which currently has about 8,000 persons with AIDS, and ARC, and at least 400,000 who are infected with HIV but seem well. These nearly half-million persons infected with HIV at the present time, and more later, may not be aware of their status and so may, wittingly, or not, infect innocent others including fetuses.

Does the confidentiality of 400,000 or more Californians infected with HIV take precedence over medical standards and ethics? These demand disclosure of the infective status of these individuals to innocent sexual partners, health care workers, and others exposed to their genital secretions and/or blood.

Sylvain Fribourg, M.D., F.A.C.O.G.
Panorama City, California

References

1. Matthews, Neslund, The initial impact of AIDS on public health law in the United States—1986, Journal of the American Medical Association, 1987, 257(3): 344–52.
2. McCleary, The doctor's and the legislature's dilemma, LACMA Physician, 1986, 116(20): 9–11.
3. Binder, AIDS antibody tests on inpatient psychiatric units, American Journal of Psychiatry, 1987, 144(2): 176–81.
4. Steinbrook, Officials drop AIDS isolation proposal, Los Angeles Times, May 23, 1987.

[Editor's Note: Since this letter was written, California passed legislation allowing physicians to disclose the results of positive HIV-antibody tests to "spouses."]

A Reply to Dr. Fribourg

To the Editor:

The recent proposals to amend California's Health and Safety Code to permit physicians to disclose HIV-antibody status ignore the social reality antibody-positive individuals face and dangerously offer a false sense of security to all Californians.

People with AIDS have experienced the overwhelming burdens of discrimination in employment, housing, and insurance, and are regularly denied access to businesses and health care services. Individuals merely suspected of HIV-antibody positivity, and their friends and families, are frequently the victims of harassment, abuse, and physical violence. Support organizations such as the Lambda Legal Defense and Education Fund, Inc., are deluged with accounts of unfair (and frequently, unlawful) treatment —the doctor who is locked out of his home, his possessions thrown out onto the street; the patient denied treatment for a major injury; the child prevented from attending school; the young man murdered for confessing mere seropositivity. To suggest that health care workers may, with impunity, disclose a patient's HIV status against the wishes and without the consent of the patient in this hostile social climate is to open the door for even further discrimination and abuse towards HIV-positive individuals. Like all patients—perhaps even more so—seropositive persons have the right to their privacy.

Perhaps more importantly, policymakers must avoid creating the dangerous impression that the medical profession will protect the public from exposure to HIV. The consensus of health experts and all those who have studied AIDS is that the only effective way to slow the spread of HIV is to educate the public that each individual must take the responsibility to engage in safer sexual practices and avoid the sharing of intravenous needles. Yet if doctors are encouraged to disclose HIV status to the sex partners of seropositive persons, many will be lulled into the false sense of security that health care workers will protect them in advance from those who are seropositive. In this time of crisis, no one should be led to believe that his or her sexual partners are free from exposure to HIV unless they are informed otherwise; it is essential that efforts to persuade each person to take responsibility for his or her own high-risk conduct not be undermined.

Lisa Bloom, J.D.
Cooperating Attorney
Lambda Legal Defense and
Education Fund, Inc.
New York City

The Case Against Active Voluntary Euthanasia

To the Editor:

In her article "The Case for Active Voluntary Euthanasia" [*Law, Medicine & Health Care* 1986, 14(3–4): 145–48], Helga Kuhse claimed to have made persuasive arguments for legalizing physician-administered lethal injections to patients on request. I would like to suggest that her arguments are not persuasive, and that legalizing voluntary active euthanasia is a bad idea.

Kuhse suggests that there is no morally relevant difference between passive or allowing-to-die and active mercy killing, but this view is not supported by our common perceptions. She has obscured the moral difference between allowing to die when death results from the underlying patholog-