Identity cards for patients infected with HIV?

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Dr A C Srivastava has written to us to describe a case that raises the suggestion that people infected with the human immunodeficiency virus (HIV) should carry identity cards. We asked two physicians, a general practitioner working with patients with the acquired immune deficiency syndrome (AIDS), and a general practitioner with a special interest in medical ethics to respond to the broad issues raised by Dr Srivastava's letter.

The time has come when we must ask people who are positive for HIV antibody to carry an identity card in case they are injured and unable to warn anyone of their antibody state.

Recently a young man received a head injury and bled profusely. His parents tried to stop the bleeding and their hands were covered with his blood. The ambulanceman dressed his wound and took him with his parents to the casualty department. As the patient was constantly moving his head the nurse who was removing the bandage pricked her finger while unlocking the safety pin. The wound started to bleed again, and when his parents left the room the patient asked the medical and nursing staff to take extra precautions as he was positive for HIV antibody. All those who had had contact with the patient's blood were counselled, had their blood tested, and were requested to have another test after six weeks.

Even at this stage the patient insisted that his parents should not be told—a wish that has to be honoured under the present rules of confidentiality. Accordingly, the parents were counselled and told that their son had an infection. They were cooperative and agreed to have blood tests without asking any questions.

This episode raises various questions: (1) Why did the patient not warn his parents, the ambulancemen, or the hospital medical and nursing staff of his infection immediately? (2) What would have been the effects had he been unconscious, undergone an operation, and been placed in a hospital ward? (3) How much mental torture has been caused to the nursing staff, ambulance crew, and their families? (4) Should the families of people who are positive for HIV antibody be told?

I discussed the possibility of an identity card system with this patient. He agreed that it was a good idea and said that he would have no objection to carrying such a card.

There remains the question of whether the carrying of an identity card should be compulsory or whether people who are positive for HIV should be educated to carry one. While it is vital that the card should be carried by as many people as possible the fact that it is compulsory would make some people resentful of the law and less likely to cooperate. In any case such a law would be difficult to enforce.—A C SRIVASTAVA

Little risk of infection

Dr Srivastava's suggestion that people who are positive for HIV antibody should carry an identity card assumes that they present a risk to others in an emergency. Yet there is substantial evidence that there is no risk of infection to non-sexual family contacts, nor to carers, so long as certain basic measures are adopted, notably to avoid self inoculation, though even this seems to pose minimal hazard. The general philosophy underlying infection control approaches in HIV infection and the reasons for rejecting an identity card approach are outlined by Gerberding.[1]

AIDS and HIV infection have reminded us of the basic precepts of infection control, which should be understood not only by health care workers and rescue service personnel but also by members of the public. Body fluids, especially blood, must be treated with care; self inoculation must always be avoided. It is also prudent to avoid major blood exposure on broken skin or mucous membranes. Common sense, basic hygiene, and good technique are the best protection.

Identification of people infected with HIV might reinforce the need for such care but should be superfluous as no additional measures are required by families, members of rescue services, or health care workers. Undue concern about HIV infection in an individual case can even lead to non-routine practices that are inadvertently less safe, because of inexperience or nervousness. On the other hand an identity card system cannot identify all people infected with the virus but could lead to complacency about those not so identified. Although this patient was prepared to carry a card, many would see it as a threat, not least to confidentiality. Given the widespread public misunderstanding about HIV, card carriers may unjustifiably be denied care in an emergency.

The perceived need for this proposal reflects the ignorance of the public and some professional groups about HIV and about the procedures to follow in caring for patients. We should not give way to such attitudes but eradicate them by education. There is certainly no cause for mental torture among a well informed staff or public. An identity card system would reinforce unjustifiable fears and would do nothing to protect staff or public that could not be achieved better by other means; it could potentially harm those who are positive for HIV. I oppose.—ANTHONY J PINCHING

Impracticability of compulsory screening

At first glance the idea of identity cards to avoid the position outlined by Dr Srivastava seems attractive. To offer the sort of protection to health care staff that he wishes, however, and for them to feel secure the system would need to be applied universally. Whether this is both possible and desirable requires logical rather than emotional analysis.

Who should undergo this screening? The current high risk groups for acquisition of infection with HIV are certain homosexual men, intravenous drug abusers, and haemophiliacs. I will concentrate on homosexual men who, with heterosexuals, are a heterogeneous group with different lifestyles and sexual practices. In view of the different "at riskness" of these men it is not appropriate or cost effective to screen all gay men. Compulsory screening of a whole group, regardless of risk, would work only if we were prepared to give special powers to, for example, the police to hunt down those who refuse to be screened, force them to have blood taken, and then carry an identity card. Not only is this abhorrent but it suffers from the practical fallacy that homosexual men are not obvious with characteristics, such as orange hair, which allows for immediate identification. Furthermore, there is no central register of homosexual men that could be drawn on to enforce compulsory screening.

The impracticability of compulsory screening and the resulting serious clash with our civil liberties make it an unworkable proposition. This brings us back to a voluntary system that relies on those who perceive themselves to be at high risk, because of their lifestyle, coming forward to be screened. The reasons for some such homosexual men not wishing to be screened are complex and many. One is the fear of how the positive result would be used. Homosexuals see it as being used against them all too often by denying them employment, life insurance, dental and certain types of medical investigations, and care. None of us can expect a certain

section of society—who, by the way, have acted responsibly and voluntarily desisted from donating blood—to take part in a system that brings with it such disadvantages. Compulsory screening would not work and voluntary screening would work only if we did not use the result against the individual.—MICHAEL W ADLER

Education, the major preventive measure

The questions being raised and the anxieties expressed in this letter are familiar responses in the presence of a new and threatening problem. Would the issue of identity cards protect bystanders and professionals from unwitting harm, and would it prevent spread of the virus by any means?

With the possible exception of penetrating wounds from needles, scalpels, etc—something that we all try hard to avoid—transmission of infections of this sort does not seem to occur professionally. Those concerned in the cameo presented seem to have come to no harm other than anxiety. What has happened has been educational, not the way one would plan it, but nevertheless is unlikely to happen to those individuals again. If appropriate awareness had been present by education in a more controlled way the problems would have been diverted or predicted. The missing ingredient was awareness by all concerned of possible dangers.

The second question, that of containing spread by drug use or sexual contact, is unlikely to be answered by this provision. Education again must be the major preventive measure. Many drug users and much of the heterosexual population may still be unaware of the real risks.

The issues of confidentiality, compulsion, and control of the AIDS epidemic are closely related to the stigma associated with the disease. Homosexuality, drug abuse and sexually transmitted disease, and the fear of an incurable disorder have caused a fear and inevitable prejudice against those at risk of infection. If this were removed then the confidentiality problems and the communications problems would largely resolve themselves. They will not be resolved if control by litigation or force is attempted; understanding, sympathy, and support must be offered.

Identification cards therefore create an illusion of safety that is dangerous, unaccompanied by appropriate septic technique. If, on the other hand, techniques are adequate for all cases then cards become irrelevant.—ROY ROBERTSON

Gloves for the doctor rather than a card for the patient

Medical gossip is more transmissible than any infection yet known in nature. Because we like it so much prohibitions need to be strong and rationalisations must be examined carefully. Nevertheless, confidentiality was made for man not man for confidentiality, and when others are put at great risk, as in this case, it is legitimate to ask whether medical secrecy as a principle is inviolate.

Freedom of choice about personal issues for the citizen is at the basis of Western culture, and this has made the autonomy of the individual patient one of the most important legal and moral principles in medicine. The restrictions on physical freedom of action inherent in most illness make this even more precious. Confidentiality can be seen as the freedom to prevent the passing of the patient's personal information without consent and includes control not only over what is said but also by whom and to whom and when and how. Those facing a life threatening disease may think that it is the only real freedom left.

In this case, however, the attendants have been exposed to real danger and this must be weighed against these traditional liberties. Providing explanation and education is a duty, but forcing a card on a sufferer against his will seems more dubious, especially if this means that the doctor may divulge the information to others at the doctor's own discretion. At the present level of prejudice in society the publicised AIDS sufferer is likely to have the insult of threat to job, insurance, and relationships added to the injury of his illness.

Relatives may be deeply distressed if presented with unpalatable and inexplicable details by a stranger, while society can do without a further erosion of trust between client and professional. Openness is increasingly practised between doctor and patient and is an important medicine in a disease where there may be no cure. Abandoning confidentiality may make the sufferer or potential patient hide away until illness blows his cover.

There are also practical issues. AIDS is not the only serious infection spread by blood, and patients and public should be sensibly educated on responses to bleeding. Better precautions by staff, considering all blood to be potentially contaminated, would seem more logical than relying on a card, which might not be read in time, or a bracelet, which might be revealed in the checkout queue. If either were compulsory what sanctions exist against those who refuse? At a time when civil liberties seem easily brushed aside public safety measures must be carefully examined. The analogy with seat belts requires that the doctor should wear gloves, not that the patient should carry a card.—ROGER HIGGS

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Reference

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Is there any effective treatment of the (harmless but troublesome) condition that used to be known as "intestinal carbohydrate dyspepsia"?

This question is hard to answer in 1987 because intestinal carbohydrate dyspepsia vanished from the textbooks around 1960. Some older physicians believed that there was a specific entity of gaseous distension of the colon caused by rapid transit of starch through the small intestine and consequent fermentation to acids and gases.[1] Patients complained of bloating, pain, increased flatus, and borborygmi with episodic diarrhoea. Nowadays such patients are diagnosed as suffering from irritable bowel syndrome and their claims of having excess gas inside them have been disproved.[2] They may well pass gas through their intestines more quickly than normal but probably they are excessively conscious of and worried by abdominal gas. There is no evidence that patients with irritable bowel syndrome lack the ability to digest starch. On the contrary, patients with the closely similar condition of symptomatic diverticular disease[3] may be more than usually efficient at digesting starch.[4] All the same, some patients with irritable bowel syndrome are reported as responding to withdrawal of wheat products from the diet.[5] Undoubtedly, intolerance to starchy foods does occur but so it does to many other foods.—K W HEATON, reader in medicine, Bristol.

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