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MEDICAL EDUCATION

HIV/AIDS Ethics Education

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The University of South Carolina School of Medicine (USCSOM) opened in 1977 and graduated its charter class in May 1981, just weeks before what we now call HIV/AIDS came to public attention [1]. Issues related to the ethics of HIV/AIDS—for example, physicians' obligations to assume risk of exposure to the virus and patients' rights to know whether their providers were seropositive—engendered heated controversy at the USCSOM as they did elsewhere.

An article in 1989 documented the paucity of courses focusing on HIV/AIDS in medical schools at that time [2]. While other universities were trying to figure out the role of HIV/AIDS in their curricula, the University of California-San Francisco (UCSF), this article reported, offered an informal lecture on safe sex to first-year medical students on their first day of orientation, and subsequently discussed various aspects of AIDS in several courses over the next 2 years [2]. Even at the UCSF, however, it was believed that a separate course on the ethics of HIV was unnecessary due to the omnipresent nature of ethics throughout medical education. Our formal medical ethics curriculum at the USCSOM has integrated HIV/AIDS into other topics (for example, professionalism, confidentiality, truth telling, and informed consent) as opposed to treating the viral disease as a unique entity.

The Early Years (1981 to 1995) and a Profile in Courage

A series of editorials by Charles S. Bryan in the *Journal of the South Carolina Medical Association* chronicles many of the topics that came to the forefront and were widely discussed at the USCSOM and elsewhere during years before the introduction of highly active antiretroviral therapy (HAART) [3-9]. USCSOM students were sensitized to the ethical issues in a positive way by the heroic example of one of their own: Sue Piggott Kuhlen (1956 to 1993) [10].

In the spring of 1988, Kuhlen, a registered nurse, was working in the emergency room of one of the major teaching hospitals affiliated with USCSOM. She had been accepted into the school of medicine and was the recipient of a scholarship from the county medical society. While drawing blood from a patient with HIV, she suffered an accidental needlestick injury. Despite postexposure prophylaxis with zidovudine (ZVD; known then as AZT) she quickly seroconverted to HIV status. She started therapeutic doses of zidovudine and, upon beginning medical school that fall, informed the chair of the Department of Anatomy of her HIV status. Several faculty members called for her withdrawal from medical school. The entire student body was highly supportive of Kuhlen, as were other faculty members. A meeting was

called with university President James B. Holderman during which it was determined that Kuhlen be allowed to continue medical school. She completed medical school and 6 months of residency training, becoming a model of the caring physician despite the relentless progression of her disease. Planning her own funeral, she told the minister: "Don't make it sad." Today, the medical student lounge in the hospital where she acquired HIV disease is named for her.

The Middle Years (1996 to 2003): Reflection and Analysis

The introduction of HAART to treat HIV in 1996 was a watershed occasion at many levels of HIV care. Even though the causative agent and transmission avenues had been identified, the lack of successful treatment contributed to fear and stigmatization of the disease through the 1980s to the mid-1990s [11]. At a keynote address at a symposium on HIV/AIDS and bioethics, Bryan made the following observations [12, 13]:

- HIV/AIDS struck society during the coming-of-age of molecular biology and bioethics, and the epidemic stimulated the growth of both disciplines.
- The number of articles published about AIDS and ethics (as identified by a MEDLINE search) peaked in 1990, just before the incidence of HIV/AIDS peaked in the United States. Thereafter, the number of articles rapidly declined, so that, beginning in 1995, fewer than 10 articles were published each year on ethics and AIDS.
- Articles written about HIV/AIDS and ethics prior to the early 1990s focused on familiar moral quandaries such as civil liberty (including individual privacy and autonomy) versus public welfare. Those published after 1995 focused on a different set of issues, such as the ethics of vaccine trials and public policy toward the developing world.
- The introduction of HAART made the care of patients with HIV/AIDS a highly technical process in which the disease could be diagnosed, staged, and treated using the latest tools of molecular biology. Patients needed technical expertise more than they needed caring and compassion. Put differently, no amount of caring could compensate for want of technical competence when adequate technology became available.
- Reflecting on the impact of HAART on medical practice, Bryan proposed that "medical professionalism" should not be construed as a monolithic entity but rather as a tiered construct. A distinction was made, and subsequently amplified, between basic professionalism and higher professionalism [14-17]. Basic professionalism can be defined as "doing the right thing well" using discipline-specific competence. When the patient's medical condition is well-defined and when there is available technology to deal with it, basic professionalism suffices. Higher professionalism can be defined as a service that clearly transcends self-interest. It involves compassion in the strict sense of suffering with—compromising one's own social, emotional, financial, or even physical well-being to care for the less fortunate. Higher professionalism is called for when the patient's medical condition is poorly defined or when treatment is unavailable.

When a formal curriculum in clinical ethics was introduced at the USCSOM, HIV/AIDS was integrated into other topics such as truth-telling, confidentiality, end-of-life issues, and informed consent, as had been done in the preclinical curriculum.

Recent Years (2003 to 2009): A Vertical Curriculum

Disclosure of a patient's HIV status is a familiar ethical dilemma. It can arise when a physician is aware that a patient with HIV is knowingly exposing others or when discussing critically ill HIV-positive patients with family members who are unaware of the patient's HIV status. One study compared medical residents' views on disclosing the status of a newly diagnosed HIV-positive patient to the patient's partner without the patient's consent with their views on disclosing a cancer diagnosis under the same circumstances [18]. Medical residents were found to place significantly higher importance on the rights of the partner in the case of an HIV diagnosis than on those of the partner in the case of a cancer diagnosis. Commonly stated reasons for supporting disclosure without patient's consent included the infectious nature and "public health threat" of HIV [18].

In 2001, instruction in ethics and professionalism at the USCSOM was made a vertical curriculum, meaning that the two areas of study were integrated into the subject material in all years of medical school. Existing instruction during the preclinical years was determined to be adequate, based on prevailing standards. The challenge was to integrate material pertaining to ethics and professionalism into the clinical years, during which the class is exposed to a process of enculturation known as "the hidden curriculum" in diverse clinical settings under different mentors. After much discussion and deliberation, the committee decided that each third-year student would be required to write a one-page essay pertaining to some aspect of ethics and professionalism, chosen from topics covered in a synoptic manual of clinical ethics given to the students during the second year. Students were instructed to base these essays on experiences (either specific or general) encountered in the wards and clinics during the third year. These essays were then brought to small-group discussions attended by no more than five students and one or two faculty members. Ground rules for these discussions included: (1) anonymity of specific persons and places involved, and (2) confidentiality. Summary data were presented to fourth-year students just prior to graduation. These data and also a tabulation of the scenarios were also presented to clinical department chairs. The overall purpose of the exercise was to encourage ethical reflection as a lifelong habit [19].

During the years 2003 to 2007, 350 third-year students wrote essays [20]. Strikingly, only 22 of those pertained specifically to patients with HIV/AIDS. None of the 77 essays on physician behavior and professionalism—the most common topics chosen—involved HIV/AIDS. The most common HIV/AIDS-related topics had as their focus: confidentiality and privacy exclusive of minors (8 students); patient-physician relationships, including difficult patients (4 students); confidentiality and surrogate decision making involving minors (4 students); and end-of-life issues, advance directives, and surrogate decision making (3 students). None of the 350

essays commented on unethical or unprofessional behavior of physicians toward HIV-positive patients.

One student, who reported that a patient notified his or her partner after confrontation by the ward team, wrote: "I found the hardest part of ethical behavior is not determining the correct course of action but following through with it in a professional manner that does not hinder patient care." Inexorably, HIV/AIDS has entered the mainstream of clinical ethics. The burning ethical issues of the late 1980s—the subjects of so many task forces, conferences, and papers—have been, by and large, figured out, as evinced by the paucity of recent literature pertaining to these issues. HIV/AIDS has, at least in developed countries, become "medicalized." Its ethical dimensions, like its clinical dimensions, are now part and parcel of the daily practice of medicine. Still, the issues presented by HIV/AIDS exemplify the truism that character-building should be regarded as a lifelong process, built upon the habit of ethical reflection on daily events [17]. Although the frameworks for addressing issues related to ethics and professionalism in the care of patients with HIV/AIDS are now well-delineated, specific issues and cases will continue to challenge medical students and physicians for the foreseeable future.

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19. This essay requirement and the small group discussions were determined to be exempt from institutional review board oversight under the conditions stipulated by the Code of Federal Regulations.
20. For the purpose of this tabulation, essays that touched on more than one topic were assigned to the predominant topic.

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