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"It's 100% for me": hospital practitioners' perspectives on mandatory HIV testing

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Abstract

This article explores the thinking of medical practitioners working in nine hospitals spread across five cities in India, on a contested subject – mandatory HIV testing of patients prior to surgery. We used in-depth interviews with practitioners and an interpretive analytical approach to understand their decisions to conduct mandatory tests. While many in the public health community see mandatory testing as an unacceptable violation of patient autonomy, the practitioners widely regarded it as a valuable cost-saving innovation for obviating transmission of infection during surgery. These conceptions are rooted in the day-to-day logic of practice which defines practitioners' actions - imperative of personal security, investment in core occupational roles and the importance of harmonious relations with co-workers. The experiences of hospitals with contrasting policies on mandatory HIV testing shows how an approach that balances patients' needs with an appreciation of practitioners' perspectives may result in more workable solutions for field-level ethical dilemmas.

Introduction

"Mandatory testing" is a term commonly used to describe HIV testing as a pre-condition for receiving a service or being granted a privilege. Widely regarded as an egregious and unconscionable practice in public health circles, mandatory testing is also categorically opposed by the National AIDS Control Organisation (NACO), the nodal body for HIV/AIDS control in India (1-3). The National AIDS Control Policy states: "There is no public health justification for mandatory testing... (on the contrary) such an approach could be counter-productive as it may scare away a large number of suspected cases from getting detected and treated (4)."

Numerous studies and informal reports, however, indicate that the practice of mandatory testing is widespread, both in government and in private institutions in India. Insisting on HIV tests before hospital admission or surgery, testing patients without their permission, and denial of care (either of specific services or complete denial) based on test results, are common and widely recognised infractions by doctors in India. While the term "mandatory testing" has wide connotations, ranging from pre-marital testing enforced by governments, to HIV testing by employers, this paper is focused on the specific issue of testing of patients for HIV prior to surgery or invasive medical procedures (5-8). Hence, the terms "mandatory HIV testing" and "pre-surgical HIV screening" are used synonymously and interchangeably in the text of this paper. "Mandatory testing" should also be distinguished here from "routine testing" or "routine offer of testing", terms describing the policy of offering the HIV test to all patients attending a health service. Routine testing has widely been advanced as a legitimate public health intervention, and is usually linked to assurance of continued care, even for patients who refuse to be tested (9,10). What distinguishes "mandatory testing" is that it is specifically requisitioned for the supposed benefit of the individual (or institution) who orders the test, and not for the benefit of the individual being tested, or for the greater public health good. It is a less widely legitimised practice, and often secretive or discretionary (1-3).

In a review of discrimination and stigma around HIV/AIDS in India conducted in urban private and public hospitals in 2001, Bharat et al reported multiple instances of testing without proper consent, and routine "mandatory" testing of pregnant women and patients before surgery (1). Furthermore, since the formal publication and promulgation of the national policy in 2003, a number of studies have shown a continuing trend of such transgressions in HIV testing. In a multi-centre study of practitioners in hospitals and health centres by Kurien et al, 67% of respondents reported that they screened patients for HIV before elective surgery, and 92% felt that universal pre-surgical HIV screening was a desirable policy (2). As many as 18% of doctors reported having refused care to HIV infected individuals. Mahendra and colleagues in a study of city hospitals reported that 79% of doctors supported the use of HIV tests on patients before surgery (to allow surgical staff to take greater precautions), and 66% supported mandatory testing of pregnant women (3). Sheikh et al from their study of private practitioners in Pune city reported that 40% of private practitioners interviewed routinely required an HIV test result before conducting invasive procedures (11). Widespread mandatory pre-admission testing and public labelling of hospital beds of HIV-positive patients were also reported by Grover et al. Rao, Nandakumar and Maya, in newspaper reports, have separately documented widespread pre-surgical HIV screening, denial of care and pre-natal HIV testing without consent in government and private hospitals (12-15).

In this paper we attempt to gain a deeper understanding of this extensive and commonplace practice from the perspectives of

Table I: Study participants by hospital type and speciality						
	Physicians	**Surgeons**	**Venere-ologists**	**Gynaecologists/ obstetricians**	**Microbio-logists**	**Counsellors**
Government hospitals (4)	8	3	4	4	2	1
Private hospitals/ nursing homes (3)	5	3	1	-	1	1
Charitable hospitals (2)	3	1	1	1	-	-
Total	16	7	6	5	3	

the medical practitioners who conduct mandatory HIV tests. We canvassed the perspectives of medical practitioners through in-depth interviews, and thematically analysed their accounts to explore underlying reasons and contexts for their actions. The study is restricted to practitioners working in government and private hospitals in urban areas.

Methodology

The data for this paper are drawn from a larger qualitative research study exploring the responses of medical practitioners to national HIV testing guidelines. The study methodology involved in-depth interviews with medical practitioners, and an interpretive analytical approach. In the study, nine urban hospitals located in five cities were selected purposively from the government, private, and charitable sectors, with representation from the North, West, South, East and Central zones of the country. Departments in the hospitals associated with HIV testing were identified and individual study participants were selected from the different departments using the principle of maximum variation (16) (Table 1).

Apart from two counsellors, all participants were medical professionals. The sample also included institutional authorities: participants with administrative responsibilities within the hospitals, either as superintendents or heads of departments, but who were also practising medical professionals in their own right. A total of 39 hospital-based respondents were interviewed, including 12 women and 27 men, ranging in experience from recent graduates to senior practitioners with 40 years of experience. All respondents were aware of the national policies prohibiting mandatory testing. With the exception of the counsellors and microbiologists, they were all involved in conducting invasive procedures on patients; however, there is a particular emphasis on the perspectives of surgeons.

Face-to-face in-depth interviews with the study participants were conducted by the first author using a topic guide (17). The list of topics included the following: the practitioner's experience of HIV testing and management; specific issues and concerns they faced in the context of testing; institutional norms of policies for HIV testing, if any; experiences of implementing policies for/against mandatory testing, if any; the appropriateness of the institutional policies (if any), and of national policies against mandatory testing.

All interviews were preceded by verbal consent and recorded electronically or in the form of detailed handwritten notes according to the respective respondent's preference. Names of individual respondents and institutions are masked for purposes of confidentiality. Recordings were transcribed verbatim and respondents' accounts were thematically organised guided by Ritchie and Spencer's "framework" approach of analysis for applied qualitative research (18). The framework approach permits the combination of a priori themes based on original research objectives, and themes emerging from respondents' accounts. Recommended steps of analysis in this approach are:

- Familiarisation with raw data
- Identifying a thematic framework based on pre-determined objectives and emerging field level issues
- Indexing - by applying the thematic framework to the data
- Charting the data into distilled summaries of views and experiences
- Mapping and interpretation of data.

The computer programme Atlas/Ti 4.2 was used to organise and collate chunks of textual data. Theme identification broadly followed an interpretative approach, focusing on respondents' underlying and implicit explanations for their actions, rather than those that were "officially offered" (19). Here, the emphasis is not so much on describing acts and events, as on elaborating the meanings that respondents attach to those phenomena (20). All findings presented below are derived from the accounts of the various respondents.

Findings

A majority of respondents interviewed said that they practised pre-surgical HIV testing, either universally on all their patients or on a discretionary basis on patients who they suspected were more likely to have the infection. Two private hospitals (one for-profit and one charitable) had policies permitting mandatory pre-surgical testing, and universal HIV screening was carried out by surgeons. In its most benign form, pre-surgical testing was accompanied by institutional policies requiring surgeons to undertake surgery on HIV-positive patients irrespective of the outcome of the test. In other instances, however, mandatory testing appeared to have been used as an instrument to discriminate against HIV-positive patients or deny them care.

Notions of risk

The predominant context for surgeons performing mandatory tests was their fear of acquiring HIV infection from a patient. The perils of conducting surgery on HIV-positive patients and the likelihood of being injured by infected surgical instruments were highlighted by a number of respondents, as also were the dangers for supporting staff. Needle-stick injuries were reported to be very frequent in government hospitals. The fear of acquiring HIV was considerable among surgeons, and emotionally charged, even as official figures of occupational transmission belied the notion of great risk.

> Although they say that the risk is minimal, the risk is there all the same. And someone who gets this is mortally struck down. He is going to die.
> - *Surgeon, private hospital*

> It is more of a psychosocial issue, it is not a scientific issue... that (the risk of acquiring HIV from a needle-stick injury is 0.1% really doesn't mean anything. The point is that I can be that '0.1% guy'. If it's me, then it's 100% for me.
> - *HIV specialist and administrator, government hospital*

Fear appeared to have a far-reaching impact on the psyche of surgeons, and led them to focus on risk avoidance and self-protection, for which they tended to favour mandatory testing rather than the nationally recommended practice of adopting universal precautions. When it came to adopting universal precautions for the prevention of infection, government surgeons were unanimously of the opinion that arrangements for protective equipment in their respective hospitals were inadequate, and several of them cited this as the reason for choosing to screen their patients for HIV.

Government guidelines for prevention of occupational exposure include instructions on hand-washing, disposal of sharps and body substances, reporting of injuries and the use of protective gear including gloves for low-risk exposures and, additionally, gowns, aprons, masks and eyewear for medium to high risk exposures. However, surgeons' expectations of adequate precautions extended to more sophisticated and expensive protective equipment than proposed by government policies. They focused on the equipment involved ("visors", "gumboots", "special gowns" were mentioned by respondents) rather than on safer procedures and practices.

A valued practice

Given their heightened expectations – focused around expensive equipment – of what constituted adequate precautions, surgeons paradoxically felt that the expense of procuring these was not justified in resource-strapped government hospitals with lower-income clientele. Instead, mandatory pre-surgical screening was seen by government surgeons as a low-cost alternative to procuring expensive protective equipment.

> We are not averse to treating these (HIV-positive) people, whether conservatively or surgically. But the thing is – are we in a position to justify that we get what we deserve... in terms of precautions and barriers etc.
> - *Senior surgeon, government hospital*

> Universal precaution will be a good thing, and we eventually have to follow it, but... where you don't even have proper medicines, are you going to take the investment of universal precautions?
> - *Senior surgeon, government hospital*

On the other hand, in the private sector, protective equipment was usually purchased at the expense of the patients. Respondents from the private nursing homes indicated that patients' inability or unwillingness to pay for expensive equipment prevented the use of universal precautions. "In the private sector, we have to think about cost to the patient," said one physician from a private nursing home. Again, here, mandatory testing (also at patients' expense) was seen to be a cost-saving alternative since greater precautions were taken only when patients were identified as HIV-positive, as emphasised by a senior surgeon with an administrative role.

Routine pre-surgical testing in the private sector was widely regarded as good practice and signified preparedness for the eventuality of dealing with HIV. Pre-surgical screening was characterised as a "policy", whereas government policies against screening were simply "recommendations", according to one gynaecologist. Pre-surgical testing was often conflated with the use of other precautions for hygiene and safety and its practice was seen as a sign of thoroughness and professionalism. In one private hospital, it was included as part of an in-service training curriculum for doctors:

> This was a part of high-risk virus training for Hepatitis B, C and HIV. Any patient who is going to the OT is screened for these things irrespective of suspicion.
> - *Physician, private hospital*

> Now we are not doing (HIV screening) routinely for all pre-operative patients...but I think that we should do it. I am interested and I tell my residents to do the HIV test. One thing (benefit) is that we will be more careful with these patients. Also, we can prevent hospital infections – like we know that this is a positive patient so (it helps in) the disposal of waste.
> - *Gynaecologist, government hospital*

Hence, it was the value that some practitioners attached to economising and thoroughness, that led them to regard mandatory testing as a positively meritorious and desirable practice.

Primacy of the surgical act

Another key context explaining the prevalence of mandatory screening was the surgeons' single-minded, almost exclusive, focus on the actual task of performing surgery. Surgeons perceived their work to be of a particularly critical and demanding nature, justifying unique requirements and close-to-ideal working conditions.

> Surgery is a different field... This is not a physician's group

> that are hands-off; they will be happy with universal precautions. For us, who are playing in pools of urine, pool of faeces, pool of blood, inside the body cavities of the patient, our situation is different... This microbiology doctor and the surgeon, is there no difference? Administrators, all these people – different pedestal. And surgeons who are actively handling – different pedestal. Their requirement is different.
> - *Senior surgeon, government hospital*

The energies of those involved, including surgeons and supporting staff, were ostensibly wholly directed towards successfully completing the act of surgery. Pre-surgical HIV testing was no more than one of many "supporting" investigations conducted in order for surgery to proceed. Regulations prohibiting mandatory testing were regarded by surgeons as obstacles to their work.

Relationships in the workplace

In the highly tuned and regimented environment of hospitals, all actions are geared to the successful completion of the actual act of surgery. Different actors take the stage, each with a designated role in a sphere of activity insulated from external disturbances. The role of support staff in the operation theatre (OT) was felt to be critical to the progress of the surgery, and the needs of other team members were often taken into account in decisions by surgeons. A number of surgeons from all sectors spoke of fear and resistance on the part of their support staff to participating in surgery on HIV-positive patients.

> The noise started coming from the OT (staff), you are bringing in HIV, you are bringing in HBsAg (Hepatitis B). You are bringing in all these people, what the hell...
> - *Senior surgeon, private hospital*

> The theatre staff they all feel as if it is an invitation to death or something and they really resist any such effort.
> - *Senior surgeon, government hospital*

Close-knit loyalties and affiliations characterise the formation of operation theatre teams. Co-worker protection was an imperative according to one government surgeon, who cited this as a reason for mandatory screening.

> My view is that suppose you (co-workers) are with me, should I protect you or not?...And when I can't do that, then everyone (patients) should be screened, and we must do it.
> - *Senior surgeon, government hospital*

In another instance, a private surgeon narrated how he refused to avail of protective vaccinations unless his staff received them too. In this context of close and interdependent surgical teams, surgeons were particularly resistant to changing their practices, a point noted by several respondents.

The role of institutional policy

Many of the themes around the response of surgeons to the issue of mandatory testing resonated across both public and private sectors. These included their perception of the risk of acquiring HIV, desire for more protective gear, close bonds with their respective operating teams, and preoccupation with the act of surgery over other facets of practice. However, clearer distinctions emerged between the responses of surgeons based on the stance taken by the respective hospital administrations around mandatory testing (Table II).

In government hospitals where mandatory testing was officially banned, surgeons continued to conduct screening tests, if to a lesser degree than in some private hospitals. However, since these tests were conducted "unofficially" (often by sending patients to nearby private diagnostic laboratories), the outcome of the test was similarly unofficial, and management decisions following an HIV-positive test result were usually made secretively and on a discretionary basis by the surgeons. These decisions varied, from use of greater protective equipment in surgery, to delays and refusal in conducting the surgery, as reported by a senior physician and administrator of a government hospital. In contrast, in a charitable hospital where mandatory screening was official policy and practiced openly and universally, processes following an HIV-positive diagnosis were also more transparent. According to

Table II: HIV screening and outcomes in hospitals with different policies

Institutions	Policy	Decision to screen	Process of screening	Surgery on HIV+ patients
All four government hospitals (4)	Policy against mandatory testing (all government hospitals)	Pre-surgical screening: Independent, sometimes secretive decision against hospital policy	In-house unofficially, no counselling OR Sent out to private labs, no counselling	Discretionary decision: Surgery with greater protection OR Delays, refusals
One charitable hospital (1)	Formal HIV policy permitting pre-surgical testing (one charitable hospital)	Universal pre-surgical screening, supported by institutional policy	In-house, signed consent, no counselling	Ostensibly, regular surgery with greater protection
One private hospital, two private nursing homes, one charitable hospital (4)	No specific policy on pre-surgical testing (one charitable hospital, private hospital and nursing homes)	Pre-surgical screening: usually independent decision	In-house, no consent or counselling OR In private diagnostic labs, no counselling	Delays, refusals, preference for conservative management

administrators, surgeries were regularly performed on such patients with greater protective equipment, and in the instance of the charitable hospital, channels for continued medical management of HIV were also well established.

In institutions with no specific policies (one charitable hospital, one private hospital and private nursing homes), there were no checks either on mandatory HIV testing or on subsequent management of patients. Decisions to screen were made independently by the surgeons, and HIV-positive outcomes reportedly led to delays and refusals of surgery, and in covert biases towards conservative (as opposed to invasive surgical) management, as reported by one senior physician involved in HIV management.

Discussion

In the literature on mandatory HIV testing, arguments in favour of the practice have tended to focus on the issue of obviating risk of transmission of HIV infection from patients to operating surgeons (21-23). According to some doctors, mandatory testing makes it unnecessary to use enhanced protection against HIV in all surgical procedures, which in turn significantly reduces expenses for themselves and for patients (7, 24). These arguments have generally not withstood close scrutiny on scientific grounds. While the frequency of needle-stick injuries to surgeons and healthcare workers may be high in hospital settings, the documented risk of transmission of HIV infection is reported to be very low, and it is likely that from a scientific perspective, surgeons' apprehensions in this regard are overstated (25, 26). Secondly, the possibility of a patient being in the "window period", when HIV infection cannot be detected through routine tests, diminishes the value of pre-surgical testing as an effective infection control technique (27). Also, according to a study by Lawrence et al, there was no apparent benefit in terms of costs in adopting routine pre-surgical HIV testing over using universal precautions (28).

Nevertheless, calls for compulsory pre-surgical HIV screening are still strident within sections of the medical community worldwide. As the findings of this study show, the doctors' insistence on pre-surgical tests is explained not so much by the strength of hard evidence as by their feelings and values, and the entrenched logic, habits and relationships that shape their occupational roles. Ensuring ethical HIV testing is clearly vital, especially in the private sector, where mandatory tests are conducted widely and indiscriminately and there is little by way of regulatory control. However, it is apparent that other healthcare processes and outcomes – successful surgery and continued care for HIV patients – are interconnected with mandatory HIV testing, and it becomes important to balance the quality needs of all these aspects. Sense of personal security, harmony and efficiency of procedures remain particularly important concerns given the critical and exacting nature of surgical practice.

As in other instances in which doctors diverge from normative practice, there is little to be gained from seeing mandatory testing simply in terms of ethical turpitude. Condemnation and refusal to recognise a widespread practice – and one that is actively valued by its proponents – may only drive it underground at the expense, eventually, of patients' well-being. The experience of the charitable hospital in this study reveals that solutions which are more likely to work are those which take into account the needs and concerns of both sets of actors who participate in the healthcare encounter – patients and healthcare providers.

Mandatory testing occupies the unique position of being seen simultaneously as a necessary, even progressive, practice on the one hand (by clinical practitioners), and as an outrageous and unacceptable transgression on the other hand (by the public health fraternity, and in particular by human rights advocates). A conceptual gulf exists between these two communities, both of whom are ostensibly focused on the common goal of improving health but who have different world-views rooted in their respective occupational realities and value systems. The way forward may lie not in reinforcing any uniform conception of correct ethical practice, but in opening channels of communication and discourse, exposing different stakeholders to the merits of alternative perspectives and arguments, in aiding them, and eventually in trusting them to make informed ethical decisions.

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