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EDITORIAL REVIEW

An ethical dilemma: erectile dysfunction in the HIV-positive patient: to treat or not to treat

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Healthcare professionals are encountering an increasing number of HIV-positive male patients who seek medical help for erectile dysfunction (ED). The convergence of three factors contribute to this phenomenon: (1) high rates of new infection despite public health efforts, (2) the availability of non-invasive treatments for ED and (3) the emergence of highly effective anti-retroviral treatment which has transformed HIV disease from a terminal condition into a chronic disease. As patients are living longer and feeling better for longer periods, their interests understandably include development and maintenance of sexual relationships.

Physicians whose patients request treatment for ED will face a dilemma. How should one balance obligations to the patient with concerns about potential risks to his sexual partner or partners? Easy answers are suspect. A doctor with high regard for himself or herself as a judge of character will likely adopt a practice of case-by-case determination. Another doctor, more sceptical about the capacity of any of us to tell who will be sexually responsible, may adopt a rule of denying prescriptions to all but the rare person. This physician might cite striking and perhaps numerous examples, from personal experience or the testimony of others, of men widely thought to be paragons of responsibility who surreptitiously acted otherwise and lied about it to everyone, including their physicians. Still other practitioners will conclude that their responsibility for persons other than their patients is a concern only when the threat is immediate and clear. They will adopt the stance that their duty to protect others is discharged when they routinely discuss safer sexual practices with patients to whom they prescribe treatment for ED. This stance would be backed by many members of the public who maintain that everyone should protect themselves against the possibility of a sexually transmitted infection at all times.

Most physicians will want to review a variety of considerations before adopting a position. Ideally, HIV-seropositive patients, before receiving any such therapies, should be counselled regarding a variety of medical and social issues. A wide range of information should be provided. These include safer-sex precautions, HIV-related disclosure practices (particularly regarding the relation with casual sexual partners), and parenting issues. Specifically, the possibility of infecting the partner, and subsequently, in a heterosexual relationship an unborn child, should be discussed[1].

This article addresses ethical and legal considerations relevant to the treatment of ED in HIV-seropositive males.

ETHICS

One of the prominent features of modern medical practice is the extensive and rich body of ethics literature addressing the responsibilities of physicians. A small but significant segment of this literature addresses situations in which the physician's responsibility includes duties owned to third parties whose interests may be adversely affected by treatment decisions reached within the physician–patient relationship.

To be ethically defensible, professional decisions must be based on good information. One approach to ethical reflections by reference to basic principles thought to be applicable to virtually any clinical dilemma. Such an analytical framework has been that provided by Beauchamp and Childress[2]. They posed four principles: autonomy, beneficence, maleficence, and justice.

Beneficence (literally 'good-doing') refers to the most basic of a healthcare professional's obligations: to help, to benefit, to restore wellbeing where possible, and to ease distress. This principle expresses the core concept of the ancient Hippocratic ideal. In formulating his or her treatment recommendation, a physician weighs probable benefits against anticipated burdens. This familiar benefit vs. burden analysis, for which the old-fashioned apothecary scale is an apt model, includes most of what is signified by the ethical principle of Beneficence.

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Fortunately, these analyses are often rather straightforward; it is usually easy to decide what it means to behave beneficently, but, not always.

In the instance of a patient seeking oral therapy for ED, one could readily agree that, in the absence of medical contraindications, effective treatment would be life enhancing and therefore beneficial. Though it has been argued by some infectious disease specialists that immunocompromised patients are well advised to avoid sexual contact regardless of their CD-4 counts, balancing these risks against the benefits of restored erections is a value choice that should be made by patients, and not by physicians alone. There is another potential benefit. Many patients are now suggesting that an absent or failing erection makes them unable to use condoms and hence more liable to transmit infection or indeed gain new ones. Therefore counterintuitively by treating ED we may be decreasing the spread of infection in some circumstances.

The Principle of Autonomy obliges physicians to respect the personhood of their patients. To be a person means many things, but none higher or more essential than the capacity to make serious life choices in accord with one's own values. This ethical principle is reflected in the English common law doctrine of self-determination and the modern medical norm of informed consent. A robust commitment to the Principle of Autonomy would seem to suggest that, barring any clear medical contraindication, a physician should prescribe treatment for ED to any adult patient who, after due consideration of relevant concerns, requests it.

However, there are other principles which must be considered before the moral analysis can be properly concluded. Indeed, classical ethical dilemmas arise precisely when two substantive principles appear to suggest alternative behaviour. This is the 'damned if you do, damned if you don't' situation in which either of two options entails committing a significant violation.

The Principle of Justice refers to the physician's obligation to be fair, to 'give each his due'. A concern for justice often constrains liberty. The right of one person to do as he pleases may be bounded by the rights of others. It can vex a conscientious physician who recognizes in the request of one patient a potential threat to the wellbeing of other persons. The most common concern of conscientious physicians about treating ED in HIV-positive men is that restored function may put other persons at risk of infection. With the introduction of highly active antiretroviral therapy (HAART), plasma levels of viral RNA can become undetectable. However, replication-competent viruses can still be recovered from the seminal cells of HIV-1-infected men, suggesting that sexual transmission of HIV-1 is possible, despite the clinical success of seemingly effective therapy[3]. This realization should be of major concern, in that individuals with undetectable plasma viral loads may improperly perceive themselves as unlikely to transmit HIV.

Most of us would presumably think ill of a physician who prescribed treatment to an HIV-infected patient known to have a disregard for the interests of others, perhaps exacerbated by recreational drug use. The ethical rationale for our moral disapproval might go like this: To restore potency to an HIV-positive man likely to infect others is to put others at significant and avoidable risk. To knowingly put another person in harm's way (without special justification) is unjust. Avoidance of an injustice has priority over the wish to provide a benefit or to satisfy a patient's request. Therefore, the conscientious physician should decline to provide treatment to a patient who one believes is likely to infect others.

One could make a similar argument by reference to the **Principle of Nonmaleficence**. Nonmaleficence is the philosophic counterpart to the Hippocratic adage, 'First, do no harm', The 'First . . .' in this traditional medical norm invokes the familiar notion that negative obligations ordinarily trump positive ones. One should not do things that entail foreseeable, significant and avoidable harm.

Granting that medical expertise does not ordinarily encompass the ability to look into a man's soul or confidently predict his behaviour, what is a morally/ethically defensible rule-of-thumb for the conscientious physician? The foregoing ethical analysis would appear to suggest that the best answer depends to a considerable degree upon the physician's confidence in his of her own ability to judge whether particular patients are likely to be responsible with a newly erect penis.

LEGAL ISSUES

What are the legal ramifications for a physician who refuses to treat an HIV-seropositive patient, in particular, for ED. Currently, a number of grey areas pertaining to HIV and the law allow us some degree of flexibility, rather than forcing us to abide by a single, rigid set of rules under a boundless array of circumstances[4]. The legal liability of this issue relates more to when a physician declines to treat, rather than when the physician agrees to treat.

It would seem unreasonable to insist that a law be established to account for every set of circumstances. This is especially true when dealing with the law governing the physician–patient relationship in the context of HIV. There is currently no medical standard of care that would hold a practitioner responsible for predicting with certitude whether or not a given HIV-seropositive patient with ED may act recklessly in the future, after regaining potency. Accordingly, there are very rare instances when refusal to treat would be clearly justifiable, from a strictly legal viewpoint.

The Human Rights Act came into force in England on 2 October 2000. Since then, comparatively few cases have reached the English courts, and therefore their approach to cases brought under the Human Rights Act is as yet a matter for speculation. It is fair to say that, to date, the Human Rights Act has not had a dramatic impact in terms of medical decision-making.

Article 12, the right to marry and found a family, could be used to sustain a challenge if ED drugs were denied to patients who have HIV and AIDS. Similarly, it could be argued that denying such treatments amounted to inhuman or degrading treatment, a breach of Article 3, or perhaps a breach of Article 8, the right to respect for private and family life.

Article 14 may also be relevant as it prohibits discrimination—*'The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any grounds such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.'*

Whilst we would anticipate that the courts will continue to adopt a conservative approach to any Human Rights Act challenge to rationing decisions, the key question may be whether patients suffering from HIV and AIDS are being discriminated against. In these circumstances, clinicians must be prepared to justify a decision not to provide treatment if, in a similar patient who did not suffer with HIV or AIDS, such treatment would be provided.

CONCLUSION

As the treatment options for ED become more readily applied and more effective, and as the number of HIV-seropositive patients in our population continues to rise, it is only reasonable to predict that HIV-seropositive patients, in ever-increasing numbers, will be seeking treatment for ED. Their plea for restoration of their sexual function challenges healthcare professionals with a difficult ethical conundrum. A strong understanding of the medical, ethical and legal aspects of this issue is essential to achieving a principled, yet compassionate approach to this dilemma. We would strongly encourage continued, open, dispassionate dialogue among all healthcare professionals and their patients.

References

1 Sadeghi-Nejad H, Watson R, Irwin R, Nokes K, Gern A, Price D. ED in the HIV-positive male: a review of medical, legal and ethical considerations in the age of oral pharmacotherapy. *Intl J Imp Rsch* 2000, **12**: S49–S53

2 Beauchamp TL, Childress JF. *Principles of Biomedical Ethics, 4th edn*. Oxford University Press: New York, 1994

3 Zhang H. Human immunodeficiency virus type 1 in the semen of men receiving highly active antiretroviral therapy. *New Engl J Med* 1998; **339**: 1803–9

4 Hayter M. Confidentiality and the acquired immune deficiency syndrome (AIDS): an analysis of the legal and professional issues. *J Adv Nurs* 1997;**25**: 1162–6

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