The Truth About AIDS

AIDS is a development issue

The reason why AIDS is such a sensitive issue is because it touches on so many different aspects of conscience and morality. Different moral dilemmas present themselves in different cultures and nations.

AIDS is a disease which thrives on poverty, and spreads fastest in the poorest nations with the least health or education infrastructure. That means scarce medical resources to treat huge numbers of people, or to prevent further spread. And it also means we *must* take a holistic view of AIDS - seeing AIDS as a development issue, not just a health issue. For example, what's the point of educating a young girl about HIV if she is an orphan of civil war and can only stay alive by selling her body to soldiers for sexual favours? If you want to save the lives of girls like her you need to think about setting up income generation projects as well as education

programmes.

It could be as simple as providing micro-loans to help people set up their own businesses. Five women club together to borrow enough for a sewing machine that will keep them all busy, and so on.

The fact is that the better educated people are in general, and the more economic choices they have, the more likely they are to be able to follow health advice. It's also a fact that AIDS spread is one of the faster ways to wreck an economy, and to put back economic development by 20 years.

So HIV and AIDS should be an integral part of every development programme, whether a clean water project or a new school. Just build it in to all you do, and it costs nothing extra to do that. The best programmes often cost the least, using local people, who bring HIV awareness into whatever they are involved in, as a part of everyday life.

Nations with most HIV infections have very few resources - treatment dilemmas

In these situations there are huge pressures on doctors and nurses to use every dose of every medicine wisely, to treat larger numbers with less expensive methods, rather than a very few and then have to turn everyone else away.

Every day very difficult decisions need to be made about what is appropriate and what is not. For example, if a hospital has a supply of anti-viral drugs, who gets them and for how long? For the same money as treating three people with anti-viral drugs for a year, you could save the lives of hundreds of children with malaria or dysentery. You could also provide painkillers, anti-diarrhoea medicines and chest infection antibiotics for many with AIDS, prolonging many more lives much more effectively. Is it morally right in such a place to use anti-virals at all?

Even with recent price reductions, anti-virals remain some of the most expensive (and poisonous) medicines in the world and are still far beyond the reach of ordinary men and women in most nations of the world if they were to buy the medicines themselves. Should the

hospital or clinic use government health budget or donations from wealthy nations to buy these drugs? And it's highly dangerous for people to just go into a pharmacy to buy the medicines and treat themselves without proper hospital or clinic supervision.

In poor countries t is impossible to spend a huge proportion of the total hospital or clinic budget for drugs on a very expensive treatment for a few people who will remain uncured and at best will gain only a few months of life. This may seem cruel if it is your own life that could benefit from the anti-virals, or the life of someone you dearly love, but it is also cruel for one person to have their lives extended by a few months at the expense of a hundred others who could be permanently cured of other conditions.

Rationing has always been with us, and happens in every government or private hospital in every country of the world. Doctors do the rationing in government hospitals, and insurance companies in private hospitals, by placing a limit on what they will pay for.

So does that mean that ant-virals should not be used at all in poorer nations. Not at all! For a start some may wish to spend their own money to prolong life by a few months, and that is their choice. Secondly, there is overwhelming evidence that a short course of anti-viral medication can save the life of an unborn baby of given to the mother in late pregnancy and during the birth period. A short course can also save the life of a doctor or a nurse who has been accidentally exposed to HIV.

It seems to me that anti-viral drugs are most appropriately used when the aim is to *prevent transmission*
, given for a short period, rather than to prolong life of someone already infected. So then, use of anti-virals for pregnant women should be part of every prevention programme. Expensive.

This is an agonising area.

Prevention MUST take priority over care if we are to stop AIDS deaths

You only have today to save someone from becoming infected with HIV. You have the next

decade to plan their care if you fail.

One infection saved today is a life saved, is a family protected.

One infection prevented today, may be a hundred lives saved over the next decade, because of the way that HIV tends to spread.

Part of the problem is that people always tend to be pulled towards the immediate needs of the person they are caring for. And often the result is a catastrophe.

I see this especially in churches and Christian programmes, driven by compassion for the sick and the vulnerable. They feel the urgent need to show the unconditional love of God to all affected by HIV, and are right to feel this way. But we MUST not neglect preventing more tragedies.

What's the point of having a wonderful hospital if every person who comes in is already fatally ill from a disease that could easily have been prevented. Do you go on blindly caring for people one by one with infinite compassion until the whole city is dead or do you go to the root cause and stamp out the problem?

The trouble is that care is popular, and prevention is not. People will give millions to build a hospital but only a few thousand to fund community educators. This is total madness. Churches will devote buildings and people to create a clinic, but spend almost nothing educating youth in their area.

Imagine a flyover being built over a busy road in Mumbai. It is not complete. One stormy night the diversion signs are blown down and a stream of cars and lorries drives up over the flyover and in the dark monsoon rains they shoot off the middle of the unfinnished bridge and crash down ten metres below. As a doctor I rush to help, and no sooner am I pulling one seriously injured man out of his vehicle than another car lands near me with a desperately injured family inside. I rush from car to car, shouting for help and for ambulances.

But this is stupid, insane, emotional and well meaning, but misguided, foolish nonsense.

Every ten seconds another vehicle shoots across the bridge, into the air, and crashes into the ground.

I must tear myself away from the sick and the dying, ignore their cries and pain, and run as fast as my legs can carry me to the place where the signs have fallen down and raise them again, seizing other men and women to wave down the traffic, block the road, start a fire, do whatever we possibly can to stop another thousand tragedies.

But when it comes to AIDS I see churches, organisations and individuals rush to care, without putting even a tenth of the same effort into preventing further deaths. Every singly one of the people who come to you for care with HIV is someone you cannot cure. And every single one of those infections was preventable. That is why we MUST focus on prevention.

Prevention, prevention, prevention.

A friend of mine called Phil Wall has launched one of the biggest AIDS orphan programmes ever created. It's called Hope HIV and is a wonderful scheme. I am proud to be associated with it. But he realises that we have to look at prevention too: for the sake of the next generation of children who want to grow up with their mother and father still alive.

Here is the challenge for any church, or relief and development organisation:

Look at your budget for HIV-related work

For every dollar. shilling, pound, bhat that you spend on helping those with HIV or their families, spend an equal amount saving lives through prevention. It will be a challenge because it is easy to raise the biggest money for care. How short-sighted. No wonder that we are losing the global battle against AIDS. No wonder then that the number of new people infected every day is now

twice what it was a few years ago.

Prevention works!

euthanasia and depression--a word to those who care for others

I remember going to see a man dying at home. He asked me to kill him as an act of mercy. euth anasia
literally means `mercy death'. In some countries it is legal. Why did he ask? He was in no pain because of the proper use of painkillers, nor was he feeling sick. He had a very slight cough but was eating quite well. His mind was superbly clear but he was confined to bed and unable to walk. He knew he was dying and talked about it freely without fear. He had a faith and felt he knew where he was going.

He felt his life had lost its meaning. He felt he would rather be dead than continue like this. Some doctors in some countries would have killed him. He would have been in a coffin by the following morning. But look at the situation more closely: many different emotions are tied up together and need separating. He felt a terrible burden on his wife. They had a happy marriage and this was destroying it. He had always led the way and now felt helpless.

It is rare for someone to ask for euthanasia without `burden on other people' being a major factor. If we give way and agree, we are then killing people because they feel they are too much trouble to family or friends. This is a hazardous course. We are then killing people because, say, a friend, partner, or child is getting fed up and resentful. When do you agree that the patient is too much of a burden on others, or disagree and say that others are coping fine?

Sometimes I have been asked to `put someone away'---admit them into a hospital or hospice. Tensions are rising at home or there is no love lost in a relationship---it has been non-existent for years. The carer takes me to one side: `I want him put away somewhere.' My first priority is that if someone wants to die at home, that person should be able to do so.

Therefore it is vital to provide care and support for relatives and friends to enable that to

happen. There are times when we have to admit someone to a hospital for `social reasons' which usually means the collapse of support at home. You cannot force people to care, nor are they always physically able to. And their home may not be a suitable place, or they may have no home at all. However, whatever the situation, one tries to create a situation where the sick person's wishes are observed. An atmosphere of resentment, hostility or tension produces unimaginable, unbearable pressures for someone who is dying. They often feel compelled to agree to going back to a hospital or even to ask for euthanasia.

The second major reason why people make this request is because of depression. I am not talking about natural sadness. To feel overwhelmed by sadness because of leaving loved ones, losing strength, and because of dashed hopes for the future is normal. It is abnormal to be spectacularly cheerful in such circumstances. Natural sadness is not depression. Depression is where feelings of sadness are out of all proportion to the situation.

This exaggeration of natural emotion can be caused by all kinds of things including hormonal changes or chemicals in the body, and needs treatment. Occasionally it is because lots of minor or major sad events have been brushed under the carpet for years without tears or low spirits. Behind the mask of ecstatic happiness there has been a growing mountain of grief for losses of various kinds. Eventually something happens and the mask cracks. The person cannot hold back the flood any longer. An exam is failed or someone breaks into the house and the person has a major breakdown. People think they are `off balance', crying all the time for no obvious reason because they fail to look deeper to the root of major hurts and losses over a longer period of time. Many have breakdowns in adult life because of childhood sexual abuse by a parent, for example---a deadly secret that has never been shared.

When someone is depressed, he or she always loses a sense of self-worth. Everything is useless and hopeless. Everything is an effort and may result in self-centredness or a feeling of being a burden. Suicide is becoming increasingly common in many countries. Indeed, the wealthiest nations have the highest suicide rates - money cannot buy inner contentment and peace, nor purpose, nor a sense of meaning, nor love. These things you will find in great abundance in the very poorest communities of the world. I have seen a brightness of spirit in the slums of Calcutta, and among the very poorest in Uganda, that you will rarely find in Europe or America.

If a person is very ill, that person will be unable to commit suicide without help. Would you sit and watch a friend who was depressed, but not physically ill, swallow a hundred tablets without trying to stop him or her? No. Nor would you give the person a bottle of pills if he were unable to walk. You see, depression is quite common when you are unwell. When the body is physically

low it can affect the brain so that you feel an exaggerated sadness. Sometimes this is due to chemical imbalances in the blood caused by the illness.

Someone who approves of euthanasia must be absolutely sure that the person is only naturally sad, and not depressed. Even psychiatrists find it hard to distinguish the two. Depression always lifts given time, with or without treatment, although treatment may shorten its course. Are you really going to kill someone who is emotionally ill, who may feel differently in a few weeks? Are you going to kill someone who is feeling a burden, when he may be under pressures you do not understand from others? Yes, you may say, because you feel his quality of life is awful. But who are you to judge?

Many people find being with someone who is ill or disabled, emotionally traumatic and disturbing. Many panic phone calls come from people---even professional carers---who cannot cope with their own anxieties. You may be in danger of killing someone because you have a problem coping and this colours your reaction to the person's request. With your own reaction, the patient's mood, and subtle pressures from others, you are on dangerous ground to do an irreversible, eternal act.

If you are still unconvinced, consider this if you are a doctor or a nurse---especially if you are regularly caring for people who are dying. A nurse visiting dying patients may get a reputation as an `angel of death'. You know death is never far away when she visits someone in the next bed to you or a neighbour on your street.

Doctors and nurses are in a vulnerable position. If ever there was the faintest suspicion, grounded in fact, that foul play had been committed, we would lose all trust from patients and other colleagues. I cannot warn you more strongly. If you practise euthanasia as part of care of the dying you will cut your own throat, bring into disrepute yourself and the whole of terminal care, an area which scares many people anyway.

From my own perspective, to harm a patient is to break part of the ancient Hippocratic oath. As a doctor I understand how we are made. There is more to life than life. There is a mystery here. No one can create life, and life is to be respected. Abortion and other things have cheapened human life. I believe human life needs to be treated with the highest regard. I will never commit euthanasia
and I believe the man I mentioned at the beginning of the chapter was actually relieved when I told him so. I took away an unbearable pressure. It was not an option. If I had said that I was

willing to do it, he would then have been faced with a ghastly sense of obligation. This man was unusual in any case. Most people who ask for
euthanasia
do so because of inadequate relief of pain and other symptoms. With proper control of symptoms and accurate information, the terrible fears about what will happen as they get worse melt away.

Fortunately those attempting euthanasia often fail---even doctors. I remember coming onto a ward one day to see a patient, looking at the drug chart and being amazed to see that three vast overdoses of a particular drug had been given only hours apart to this person without her consent or knowledge. Not even a cry for euthanasia. She survived and died peacefully in her own time a week or two later. The staff had been unable to cope with their own distress. Let's stop playing God in secret, behind closed doors, and start giving <back to people control over their own lives, with dignity, self-respect and respect for human life.

Withholding treatment

We need to make a careful distinction between withholding treatment and euthanasia. Making a carefully planned decision not to start a particular treatment, or to stop one that may be artificially prolonging life or directly causing distress in someone who is near death and for whom the possibility of recovery is extremely remote, is not
euthanasia
. Relatives, friends, the patient himself and staff can be involved in the decision, although responsibility for it must always rest firmly with the treating doctor.

Someone who is very ill with an incurable disease may decide that he or she cannot bear the thought of another long struggle with many tests and special treatments, and decide to stay at home to die. Radical, mutilating surgery may be declined by a cancer patient. Most people with cancer or AIDS die of chest infections. Pneumonia used to be called the `old man's friend' because it allowed a stricken body finally to die peacefully. It may not always be appropriate to leap in with aggressive treatments - even assuming they are available.

People who have problems with this are usually scared of death. Death is seen as failure. They may be too emotionally attached to allow the person to go. Failure to use common sense in this area, failure to see death as a natural conclusion to the process of living, drives many

doctors---especially surgeons---to absurd lengths, ridiculous operations, and ever more exotic procedures designed to fight to the end whatever the costs. Doctors are treating their own problems. Doctors often feel guilty because they raise hopes too high in the first place, the person gets worse and is justifiably puzzled, upset and angry. The doctor feels under pressure to do something .

The result is often catastrophic. We must learn to allow the body to die. Every year new medical methods make death more elusive. In some countries doctors can now keep someone's body warm and healthy for many years without any brain. This is not medicine. This is inhuman science gone mad.

Living Wills

As a reaction to what some people in wealthy nations see as bad medical care, they are now writing down in advance what they want to happen towards the end of their lives, and they want it to be legally binding. Communication is always a good thing and anything that helps a doctor to understand his or her patient's wishes is to be encouraged. Many treatment decisions are difficult and a strongly expressed view can be very helpful---even if written in advance.

It can be hard to be allowed to die---and I am not talking about euthanasia which is a deliberate act designed to kill. If I was dying of very advanced illness with many complications, I would make it absolutely clear to my doctor that my next pneumonia should be my last. There is no need to `strive officiously to keep alive' when the end is in sight, so why pump me full of antibiotics?

However, once a written directive is backed by law, then doctors risk prosecution if the exact wording is not followed regardless of circumstances---medicine by lawyers. But how could you agree if you thought the person might have been depressed, under pressure or feeling a burden? How could you be sure that every medical option had been fully explained and understood? There is also doubt over our ability to get the diagnosis or prognosis right. These issues also affect the euthanasia debate. Many legal experts say an Act of Parliament for `Living Wills' or `Advance Directives' could be a back-door route for legalised euthanasia
.

Involving police, magistrates, judges, jury and prisons is no way to care for the dying---much better to encourage good communication, compassionate common sense and expert appropriate treatment, taking into account the expressed wishes of the individual.

Suicide

Suicide is a common terminal event in people with AIDS---usually early in the illness---but also tragically in people who have had a positive test result, especially if counselling afterwards was poor. A small but growing number are also committing suicide because they fear they have AIDS.

When someone has lost his job, been thrown out of his home, been rejected by family and deserted by friends, it is not surprising he feels suicidal. Glances in the street and people muttering in the shops are easily imagined but may be quite real. News of AIDS spreads only too fast. We need to show that we really care and go out of our way to make infected people feel accepted, loved and welcome. If someone is depressed it may be wise to ask them if they have ever thought of harming themselves. You may be afraid of putting a wrong idea into the person's head. You won't, but the answer is vitally important.

If the person says no, then suicide is much less likely. If the person says yes, then ask if they have thought out how they would do it. Most people have not. Someone who can describe to you with clinical detachment and in great detail exactly how he would kill himself is probably at great risk.

The doctor should be told, and the individual should be persuaded to seek medical help. Tablets and other parts of the plan should be destroyed. Often someone who is suicidal has secret supplies.

Threats of suicide can be a most powerful means of blackmail, however: `If you leave me I shall throw myself under a train,' or, `If you go on holiday for two weeks I shall probably drown myself. I won't be here when you get back.' But like euthanasia, suicide is harder than people think, and the after-effects of an attempt can be horrible.

Suicide is often attempted as a cry for help. Particularly tragic is the person who takes twenty paracetamol tablets expecting to go off to sleep. After most of a day has passed, the person walks into casualty looking sheepish. The psychiatrist is asked to help. It was a cry, not a serious attempt, but the liver is now permanently damaged. Within a few days the person begins to die an awful death and is dead in a week. Many over-the-counter preparations contain paracetemol.

HIV testing without consent, or mandatory testing

In some countries a doctor who tests someone's blood without prior agreement could be struck off the medical register or prosecuted. However, most doctors want to do so under special circumstances---usually where they believe the patient's life may be at risk through not knowing that he or she has HIV or AIDS.

The reason for these rules is to protect people who are infected. People with the infection need protection because although they may be free of any signs of illness for years, it is a hard secret to keep and the knowledge that you are positive can be totally devastating. People lose jobs, houses, friends and partners as a result. They cannot get a mortgage, a car loan, or life insurance.

The other reason for the regulations is, strangely, the ultimate protection of society. Control of sexually-transmitted diseases has always been hard because people are reluctant to seek help so the disease is untreated and more people are infected. The whole ethos of a clinic is to go overboard in providing a non-judgemental, tolerant, relaxed, attractive atmosphere with easy access and long opening hours. Clinics pride themselves in being busy with people coming from large distances because of their pleasant atmosphere. Judgemental, condescending behaviour puts people off and they continue to infect other people. It drives the problem underground, endangering the health of a whole community.

If people were afraid that while attending a hospital clinic for an unrelated reason or while in a hospital being prepared for an operation, a sample of blood would routinely be tested for HIV, there would be one result: manywould be too scared to seek medical help at all. People would die at home of appendicitis or even from treatable chest infections as a result of developing AIDS. The entire problem would go underground.

Take the plight of a surgeon: should he not know when to take special care not to cut or scratch himself? It would be wrong to refuse to operate on someone who was ill and needed surgery, but what about someone wanting cosmetic surgery? Is it right for someone who may know he is positive to ask a surgeon to take that risk when the patient's own life is not at stake.

Most emergency rooms now use paper strips to close minor wounds instead of stitches. In most cases with small wounds the results are just as good, if not better, than with stitches because stitches can get infected and cause a body reaction. Metal surgical clips can be used to close wounds after surgery. It has been suggested that they should be used with all patients.

The fact is that a large number of doctors and nurses world-wide are going to die of AIDS over the next decade or two unless there is a cure or a vaccine. Accidents with needles and during operations happen in every hospital every day---most too minor to report but still capable of transmitting infection. It is worth considering the total lifetime risk to a medical student beginning to train as a doctor in a country like Malawi where up to half the patients on hospital wards are infected.

The argument in favour of selective testing without consent is that the alternative is to assume that everyone is positive and take incredibly elaborate precautions. Time may be wasted and lives lost. Some countries are now preparing to force certain groups of people to be tested. Military recruits in the United States army have all been tested routinely for some time. Iraq is testing all long-term visitors to the country. I think some people are going to disappear rather than be tested.

However, unless a cure is found quickly, HIV testing will become part of the routine work-up before any operation in a number of countries. It will be justified by surgeons as in the patient's interests on the grounds that fevers and chest infections after the operation may be mistaken for normal consequences of anaesthetic and surgery, correct treatment will not be given and the patient could suffer.

The public climate is shifting rapidly in many countries. For example, in the US a jury decided that a woman had committed fraud by not disclosing her AIDS illness to a surgical team before having a breast reduction operation. One of the team accidentally cut herself with a scalpel and became infected. She was awarded compensation of over $100,000.

HIV testing will be done on many patients in hospital wards with unusual symptoms of almost any kind. AIDS is such a complex disease because it opens the body up to so many other kinds of illnesses. It must therefore be on a physician's list of possibilities in an enormous number of people who are ill these days. In wealthy nations with wide access to anti-viral treatment, testing without consent will become widespread and justified on the grounds that prompt treatment with anti-virals could prolong life---although the real motive may be different.

It may seem shocking to test people for a disease without their knowledge, but we have been doing it for years: blood testing for syphilis is common for similar reasons. It mimics such an enormous number of diseases. People are not always confronted with their result. In fact the vast majority of blood tests are done with what is called `implied consent'. By agreeing to come into a hospital the person is accepting treatment. By agreeing to allow a blood sample to be taken "for various things---like to see if you are anaemic'.

However, the great problem is keeping the result strictly confidential. Medical teams must improve at this, especially family doctors and occupational physicians in work places.

Counselling following a positive test is vitally important. As we have seen, it is not uncommon for someone to commit suicide following the discovery of a positive result.

Revenge sex and other situations

What do you do if someone you know is positive and has decided to get revenge on society by having sex with as many other people as possible? A man visiting New York woke up after a date to find `Welcome to the AIDS club' written on his mirror. He is now infected. A man was recently murdered after announcing to the man he had just had sex with that he was positive. He made the mistake of laughing.

This opens up the broader issues of confidentiality: a man is positive and has no intention of telling his wife, who is wanting to have a baby. If she is positive, pregnancy could mean death for her and her child. Do you just sit back and wait for the inevitable? Human rights are always complex. You cannot have rights without responsibilities. If someone is raped, should that person have the right to insist that the rapist is tested?

Many doctors recognise that a small minority may be using their rights to confidentiality as a passport to injure and destroy others. Practice varies among `contact tracers' in sex disease clinics. Some will contact partners without the person's consent as a last resort if the person will not co-operate despite many hours of counselling.

It is incredibly worrying that a number of people who know they are positive return to clinics only a few weeks later with a new infection of gonorrhoea. Some will have contracted this from promiscuous behaviour without a condom, wilfully putting others at risk.

For the sake of the community, some think that prostitutes / commercial sex workers should not be allowed to practise if they are positive. But that is far easier to say than achieve - unless prostitution is legalised and brothels licenses by the government. How many men do you think each sex worker services each year? In some countries the answer can be up to 10,000!

Another problem is that control measures can backfire and make the situation worse. For example, a crack-down on the Thai sex industry by police resulted in people being reluctant to come forward if they thought they might have HIV. As a result, doctors had great difficulty monitoring spread.

Infected doctors, nurses and dentists

While health care workers may be anxious at times about the risk of being infected by their patients, there is also enormous public concern in low incidence countries about the far smaller risks of being infected by an HIV-carrying doctor, nurse or dentist. We know the risk is small because despite the growing number of infected care workers, very few cases of care-worker transmission to patient have been seen.

In high incidence nations it is hardly practical to insist that only HIV-negative health care professionals carry out operations, even if it were ethical to insist on testing health care workers. You would land up decimating hospital teams and the results could be far worse for general standards of patient care. The surgeon may have HIV but he or she may be the only surgeon within a fifty miles along rough jungle roads. What would you prefer? An infected surgeon or no surgeon at all. It's yet another example of the way in which well-meaning officials in a distant land can write policy guidelines which are worse than useless in a poor nation. But in the

wealthiest nations where there is near hysteria at times over these issues, contact tracing is the standard response of a hospital when they find out a surgeon has HIV.

There have been several cases recently where infection of a surgeon only came to light after the person had treated a very large number of people. Hospital authorities have often been unsure what to do. How do you trace such a large number of people, many of whom may have moved more than once over the last ten years? Even if you have a complete list of addresses and phone numbers, how long would it take to contact them all?

It is not surprising that information has sometimes leaked out in an uncontrolled manner before helplines were ready, or before a proper public announcement. Often the individual has been quickly identified in media coverage, making the person's life a misery, affecting family, violating privacy and confidentiality, and making it less likely others will come forward promptly if they think they too could be infected.

The risk of someone being infected by a health worker is very low. For this to happen, the surgeon would need to be cut badly without realising; so badly in fact that he or she cuts right through the glove into the pulp of a finger, carrying on so blood contaminates a patient's wound. This is hardly likely. Nevertheless, we have to face the fact that in a tragic series of events a number of different people became infected by the same dentist, and we have seen the more infectious hepatitis B virus transmitted from a surgeon to patients.

Care workers in wealthy nations who think they may be infected and are or have been involved in invasive procedures have a well-recognised duty to arrange to have an HIV test, and to inform their employers promptly if the result is positive. In the case of the surgeon, the issue is not just transmission of infection, but also possibly manual dexterity, given that late HIV infection can sometimes affect someone's ability to perform complex tasks.

The British Medical Association, The Royal College of Surgeons and the UK government agreed together that those involved in invasive procedures (operations, injections and other procedures where wound contamination could occur) should cease if they are carrying HIV. They should receive practical help and support in switching to non-invasive medical jobs. In practice, this can often be quite difficult and a terrible blow to an experienced surgeon for example. The General Medical Council has gone further and said that doctors failing to disclose they have HIV to a senior colleague could be struck off the medical register.

Hospitals in turn clearly have a duty to do all they can to protect the confidentiality of the individual, and to provide appropriate help. This is also in the public interest. It is surely against the public interest to broadcast the name of an infected surgeon on TV news if it means another ten infected surgeons vow to take their secret to the grave.

Hospitals in wealthy nations also clearly have a duty to recall patients where there has been a risk of infection, for example operated on. It is essential to retain public trust, and if people feel there has been a cover-up, the result can be a backlash against the very people we are trying to protect. People do not need to be told the identity of the member of the health care team who is infected. It is true that many will guess, but it is better for a few hundred to guess than for it to become national knowledge.Ideally patients need to be contacted by letter or telephone before they hear in the press, offered access to telephone advice, or a personal interview, and a test if they wish.

There should be an agreement with national media to abide by a code of practice so that if, say, an infected individual is named in the local press, that name is not then regarded as national information in the public domain. The hounding of individuals in some countries has been truly disgraceful. Where do you go? Where do you live? What about your children? Once photographs are printed the end of normal private life has arrived. This is a bitter reward for someone who has had the courage to be honest and open.

Unless doctors and other care workers can be assured they will be well treated, they will delay coming forward, if necessary until days before death. If this continues to happen, pressure may become irresistible to test all surgeons on an annual basis - cheaper and less traumatic than recalling of up to 30,000 patients a year.

Compulsory testing would be a great step backwards, since once you start with surgeons, where do you stop? Airline pilots are already routinely tested by some airlines, because of worries about mental performance. Before we know where we are, a great number of different groups could end up being tested on a regular basis, with resultant loss of freedoms, breaches of confidentiality, oppression and fear. Nevertheless, its introduction for some health care workers is inevitable, unless surgeons agree to testing on a voluntary basis.

Sex education in schools

While HIV infection raises many issues, so does prevention, most of all among young people in schools. What is an appropriate message? What is the right age? Should people be allowed to opt out? Many have feared that certain groups will use AIDS as a platform, either aggressively promoting gay lifestyles as normal to young teenagers, or aggressively promoting a right-wing moral crusade. Young people clearly need to know the facts about HIV, and also need room to think through for themselves how they are going to respond.

Christian-based AIDS organisations have been very successful in developing schools programmes, presenting the facts in a context encouraging people to see sex in terms of health, relationships, choices and their long-term future. Most schools reject a simplistic message based on using condoms, and also reject a moralistic approach. However, they do want values to be communicated in a way which gives a positive view of waiting for the right person and of being faithful.

See Chapter 12 for fuller discussion.

Age of consent

One traditional way to discourage sexual activity in the young is through a legal minimum `age of consent' below which sexual activity becomes a crime.

Age of consent varies widely from one country to another, even in Europe, and from one kind of sexual activity to another. In many countries there are campaigns to lower the age of consent, particularly where it is much higher for homosexual acts. The law is a blunt instrument with which to regulate private behaviour between consenting individuals. Prosecutions are rarely brought except where there is evidence of exploitation. Pressures are likely to grow for a unified age for both heterosexual and homosexual sex.

Some argue on the basis of their own views on morality that all homosexual acts should be illegal, and therefore an age of consent of twenty-one is already too low. However, there is inconsistency in the argument since the same people may regard adultery or heterosexual sex before marriage as morally wrong, but would not make these things illegal.

The basic question is this: Do you want to see people put in prison with criminal records for violating an age of consent as it stands? If the answer is no, then the age of consent needs review, or it could make a mockery of the law.

Telling the truth?

I will never forget the day I went to visit a particular person who was dying at home. I was accosted by an anxious relative who was convinced that the only reason I was there was to tell the patient his diagnosis and that he was dying. Nothing I could say would convince this relative otherwise. She was terrified. In fact we found as a team that working with this family became impossible. The sticking point was that I said that although I would never mention his probable death unless he himself asked, I was not prepared to lie to him. I might give an indirect answer such as, `Why do you ask?' or, `You don't seem to be getting any better, do you?' but I was not prepared to say, `Of course not, don't be stupid!'

The reason is very simple: trust. One day he would have realised I was lying. Actually, as far as I could see from what he said, he knew he was dying anyway---most people do. Most people with cancer or AIDS have guessed what is happening long before they are told, although there can sometimes be denial, associated with fear or guilt. Having established myself as a liar whenever it suits me to save embarrassment or calm fear, what happens when the person asks if they will die in terrible pain? This time I answer truthfully---but will I be believed? Often when people are first referred to us, they are convinced they are going to `suffocate to death'. They may have terrible nightmares and be consumed with fears. Every time they get a cough we get a telephone call---the reason is overwhelming fear of what may be around the corner.

The truth is that no one suffocates to death these days. Hospices have advanced our care of those with lung disease enormously over the last twenty years. That is the truth---but will the public believe it? Fear of death can be worse than the dying itself.

Trust is the most powerful tool a doctor has. It is the reason why support teams and hospices are so successful. They inspire trust because they do not engage in the same frauds, cover-ups and webs of petty deceit that are practised daily on the wards of every hospital. If only doctors realised that people see through it all!

The reason for dishonesty by doctors and dishonesty by families and friends is simply this: we many people like to pretend that death does not exist. AIDS then hits us like a thunderbolt straight between the eyes, because it brings us face to face with death and all our deepest fears. But before we take a look at the whole life/death issue, I want to turn to just one more moral dilemma which I get faced with every day as a church leader. The question people ask is this: Do you agree with those who say that AIDS is the wrath or judgement of God?

The Truth About AIDS