

THE ETHICS OF ROUTINE HIV TESTING: A RESPECT-BASED ANALYSIS

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ABSTRACT

Routine testing is a practice whereby medical professionals ask all patients whether they would like an HIV test, regardless of whether there is anything unique to a given patient that suggests the presence of HIV. In three respects I aim to offer a fresh perspective on the debate about whether a developing country with a high rate of HIV infection morally ought to adopt routine testing. First, I present a neat framework that organises the moral issues at stake, bringing out the basic principles involved and exhibiting their logical relationships. Second, appealing to the Kantian principle of respect for the dignity of persons, I offer a thorough justification for routine testing when it serves as a gateway to anti-retroviral treatment (ART). Third, I present a respect-based defence of the controversial and novel thesis that routine testing is morally justified even if ART is unaffordable or otherwise unavailable.

I INTRODUCTION

Morally speaking, under what conditions should the state of a developing country with a high and widespread rate of HIV infection have its medical establishment routinely offer HIV tests to patients? Such a policy would consist of a medical practitioner asking patients whether they would like an HIV test, regardless of whether they were seeking help for an AIDS related symptom such as tuberculosis. The clinician would initiate discussion of whether to obtain an HIV test, differing from the much more common practice in which patients are expected to initiate such a discussion unless the clinician finds reason specific to a patient for suspecting she is HIV positive.

Routine testing has become a hot topic in the last two or three years, largely because anti-retroviral treatment (ART) has become more widely

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available. The ART regimen now can consist of taking a mere two pills a day which cost a little over one US dollar if using generics. As a result, activists and policy-makers have been seeking an efficient way to get ART to those infected with HIV, with routine testing being one strategy considered.

Members of the medical profession, non-governmental organisations, national governments and the United Nations have written a few dozen journal articles, book chapters, position papers and policy statements about whether states in southern Africa (and other states facing similar HIV pandemics) should adopt routine testing. The views they articulate generally fall into one of two camps. In one camp are those who claim that the debate about routine testing is a matter of a 'voluntary' or 'rights-based' approach opposing a 'serostatus' or 'public health' perspective. Here, the debate is cast in terms of a conflict between respect for human rights to informed consent, confidentiality, and fair treatment, on the one hand, and a concern to improve people's medical condition, on the other. Interestingly, both those who favour routine testing and those who oppose it often see rights in conflict with health, claiming that one must be sacrificed to some degree for the other, but differing over which to sacrifice.¹ In the other camp are those who claim that routine testing need not pose any tension between rights and health, typically asserting that the right to healthcare overcomes the potential conflict between them when ART is available.²

1 For some who suggest that we must de-emphasise human rights in favour of health and therefore adopt routine testing, see G Bauer 'AIDS Testing' (1987) 2 *AIDS & Public Policy J* 1; K de Cock, D Mbori-Ngacha, & E Marum 'Shadow on the Continent: Public Health and HIV/AIDS in Africa in the 21st Century' (2002) 359 *The Lancet* 67; M Dibel of the CSIS HIV/AIDS Task Force *Briefing: CSIS HIV/AIDS Meeting on Routine Testing* 42-43, <http://www.kaisernetwork.org/health_cast/uploaded_files/061704_csis_bjcc.pdf>; and some at a meeting of the African Comprehensive HIV/AIDS Partnerships as reported by A Minster 'Proceedings of the Consultative Meeting on HIV/AIDS Testing: June 12-13, 2003' 1 *ACHAP News*, <www.achap.org/downloads/achap_newsletter_issue_1.pdf>.

For examples of those who say that routine testing would be wrong since it would sacrifice rights in favour of health, see A Brandt, P Cleary, & L Gostin 'Routine Hospital Testing for HIV: Health Policy Considerations' in L Gostin (ed) *AIDS and the Health Care System* (1990) 134-35; and J Chettee of the CSIS HIV/AIDS Task Force (see above) 21, 24.

For overviews of the potential conflict between rights and health in the context of HIV testing, see UNAIDS Global Reference Group on HIV/AIDS and Human Rights *Issue Paper: Current Debates on HIV Testing and Counseling* (2003) 1; and M Kirby 'The Never-Ending Paradoxes of HIV/AIDS and Human Rights' (2004) 4 *African Human Rights LJ* 163.

2 J Berger quoted in K Bodibe 'Considering Routine Testing in SA' (2004) 199 *Living with AIDS*, <http://www.health-e.org.za/news/article_audio.php?uid=20031150>; World Health Organization *The Right to Know: New Approaches to HIV Testing and Counseling* (2003) 1; UNAIDS/WHO *UNAIDS/WHO Policy Statement on HIV Testing* (2004) 1. Some in this camp make the stronger claim that routine testing would promote health precisely in virtue of fulfilling rights. For instance, see W Landman 'Ethical Considerations in Routine Testing for HIV/AIDS' in Botswana Lawyer's Taskforce on HIV/AIDS Discussion Seminar *Routine or Compulsory Testing?*, <<http://www.bonela.botsnet.co.bw/Reports/SeminarReport.htm>>.

In this article, my aim is to offer a fresh perspective on the debate about the permissibility of routine testing, in three respects. First, I intend to provide a rigorous ethical analysis of the debate, something that has yet to be done.³ I present a neat framework that organises the moral issues at stake, bringing out the basic principles and exhibiting their logical relationships. I show that, at bottom, the moral debate about routine testing mirrors other debates found in English-speaking philosophical literature on ethics.

Second, I intend to offer a new justification for routine testing when it serves as a gateway to ART. I maintain that routine testing as a gateway need pose no conflict between rights and health, but that those who have held this position have not adequately defended it. Even if there is a right to healthcare, it has not been thoroughly established that routine testing is necessary to realise the right, something I aim to show here. Furthermore, even if the right to healthcare did require routine testing, it is not obvious that this fact would be sufficient to justify adoption of routine testing. One must consider the right to healthcare in light of other important moral values, showing that it either is consistent with them or outweighs them in cases of conflict. That has yet to be done, and is also something I aim to accomplish.

Third, and perhaps of most interest, I defend the novel and controversial thesis that routine testing is morally justified in the absence of the availability of ART. Even when routine testing does not serve as a gateway to treatment, I argue that the right to healthcare, properly understood, justifies adoption of routine testing. No one in the literature has defended the claim that a state must adopt routine testing even in the case where it cannot treat those who test positive for HIV, which claim I argue follows from an intuitively appealing moral theory and certain plausible empirical claims.

I begin by spelling out the question I seek to answer here in more detail (part II). I specify the nature of routine testing with care, distinguishing it from related practices with which it could be confused. I also briefly articulate the fundamental moral perspective that I believe underlies the debate about routine testing's permissibility, namely, the Kantian principle of respect for the dignity of persons. I maintain that all of the most important arguments for and against routine testing are well expressed in terms of this principle. Next, I present a framework for assessing the morality of routine testing and specify the conditions under which routine testing would be justified supposing ART were widely available (part III). In catch-phrases, I show that routine testing coupled

³ So far as I can tell, no other professional ethicist besides me has systematically addressed the issue (but see Landman, note 2 above). However, some have discussed the related issue of mandatory testing, for example, M O'Brien 'Mandatory HIV Antibody Testing Policies: An Ethical Analysis' (1989) 3 *Bioethics* 273; and J Childress 'Mandatory HIV Screening and Testing' in F Reamer (ed) *AIDS and Ethics* (1991) 50.

with ART could satisfy the respect-based criteria of: just cause, likely success, proportionate response, minimal necessity, impartial application, and correct state of mind. Then, I consider whether routine testing could feasibly satisfy these criteria when ART is not widely available, ultimately concluding that it could (part IV). I close the paper by noting some respects in which certain empirical data would be useful to obtain in order to decisively appraise the normative theses defended here (part V).

II ASSUMPTIONS OF THE ENQUIRY

In this section I spell out what routine testing essentially involves and articulate the respect-based moral framework I will use to appraise it. Although many readers already have some sense of what ‘routine testing’ and ‘respect for persons’ connote, it is worth specifying what these vague phrases mean in the present context.

(a) An Analysis of Routine Testing

‘Routine testing,’ as understood here, refers to a policy by which medical institutions offer patients an HIV test (with pre- and post-test counselling), regardless of whether patients have asked for one or exhibited symptoms suggesting the presence of HIV. My present aim is the narrow one of clarifying several elements of this definition.

Medical institutions here are hospitals and clinics, both public and private. Some other version of routine testing could limit these settings, but I am interested in whether all the major medical institutions in a country with a high rate of HIV infection that is not restricted to a readily identifiable locale should offer HIV tests (or whether as many as possible should, supposing resources are scarce).

Similarly, patients in this context are virtually all those who are seen by a medical professional, not merely those who are, say, pregnant or infected with tuberculosis. There have been versions of ‘routine testing’ that have offered tests merely to such groups. For instance, the United States currently offers HIV tests routinely to pregnant mothers who come for check-ups, but not to the general medical population. However, in this article, I am addressing countries unlike the United States in that they have a high rate of infection spread across their territories. So, I significantly broaden the scope of the patients, enquiring as to whether tests should be offered to patients regardless of why they have come to see a medical professional.

I have said that a policy of routine testing has medical practitioners offer tests to ‘virtually’ all patients, but not ‘literally’ all. Suppose the patient is a child or an adult lacking competence, but the patient’s legal guardian is not readily available. Or suppose the medical professional knows that the patient was tested only a matter of weeks before. In the rest of this article, I speak of ‘all’ patients, and it is only these sorts of exceptions that should be kept in mind when I do so.

Routine testing implies neither that medical institutions involuntarily test all patients, nor that medical institutions in fact test all patients. It instead consists of a practice in which medical settings *offer* a test to all patients, all of whom would be informed of their right to refuse the offer and some of whom would no doubt exercise this right. Some advocates use the phrase 'routine offer of testing' to clearly distinguish the practice from mandatory testing, which involves the withdrawal of some benefit, the imposition of some burden, or the threat of such for refusing to take an HIV test. For instance, the state might deny certain goods such as hospital services or marriage licenses to people who refuse to get tested.⁴ Routine testing, as construed here, is by definition voluntary as opposed to involuntary or mandatory. I neither aim to defend mandatory testing nor believe that the arguments I provide for routine testing can be used to defend it.⁵

However, routine testing differs from what is commonly called 'voluntary counselling and testing' (VCT), the HIV-testing policy that predominates throughout the world. VCT is largely a client-initiated testing scheme in which it is usually upon the request of patients that a physician discusses an HIV test. Under VCT, a medical practitioner does not offer HIV tests to patients, except in cases where they exhibit a symptom that would suggest the presence of HIV, perhaps a sexually transmitted disease (indicating unsafe sexual contact) or tuberculosis (being an opportunistic infection that often results from HIV). What I am calling 'routine testing' differs from the current practice of VCT in that a medical professional would typically not wait for patients to raise the issue of an HIV test, but would instead raise it herself if patients did not. It would be a largely provider-initiated testing scheme.

Although routine testing is not the same as 'voluntary counselling and testing,' it is on the face of it no less voluntary than what is referred to with this phrase (which phrase is somewhat misleading in the present context). Voluntary consent does not require 'volunteery' consent, ie, does not require volunteering to consent; it rather allows being asked for consent that one did not initially volunteer to provide. Both VCT and routine testing are voluntary in the sense that informed consent is fully consistent with them as they are defined.⁶ With VCT the patient requests a test, while with routine testing the physician would offer a test. Neither scheme is inherently coercive, deceptive, exploitive, manipulative, or anything else that would render the decision to obtain an HIV test involuntary.

4 For influential advocates of mandatory testing, see R Holbrooke & R Furman 'A Global Battle's Missing Weapon' *New York Times* 10 February 2004 (Holbrooke is the president of the Global Business Coalition on HIV/AIDS).

5 See part III (a) below for a short account of why mandatory testing is unjustified.

6 However, below I consider objections that, even if routine testing by definition is voluntary, implementing it would have the unintended result of weakening informed consent.

In differentiating routine testing from VCT and seeking to justify the former in this article, I do not mean to imply that the latter is unjustified. On the contrary, I argue for supplementing the current VCT policy with routine testing (which, after all, would cover only those who enter medical settings). Although VCT should be retained, there are forms of what might be called 'routine testing' that I think should be rejected. In particular, sometimes routine testing is associated with what I call an 'implied consent' or 'opt-out' approach, which Botswana has recently put into practice, if not clearly adopted as policy.⁷ Here, a medical professional conducts an HIV test without explicitly asking patients whether they would like one or informing them of their right to refuse one, though she refrains if patients proclaim that they do not want one. Patients are expected to know from public advertisements or posted signs that, on entering a medical setting, an HIV test will be conducted and that they may refuse the test; they are not informed of these facts by a healthcare worker. One version of this approach has an HIV test included in the battery of tests conducted when blood is drawn. Consent is obtained to draw blood and to conduct tests, as is often done throughout the world, but consent is not obtained to conduct an HIV test in particular. Such an approach does not constitute mandatory testing, since no coercion is employed and voluntary consent of a sort is obtained. However, it does not count as a form of 'routine testing' as construed in this article, for such an approach obtains consent that is neither genuinely *free* in light of an awareness of the right to refuse the test nor fully *informed* of the nature of the test.

Although my goal is to argue for routine testing and not to refute related practices, as an aside let me note that, in addition to mandatory testing, I find an implied consent approach to be unjustified. Under such a practice, some patients invariably will not have read the signs or heard the announcements. Others will have come into contact with these notices but not fully understood the implications of the procedure to which they are consenting. And still others will come with the belief that the physician is making an offer they cannot refuse. Medical practitioners ought not rely

7 For overviews of Botswana's adoption of a provider-initiated testing scheme, see C Stegling 'Botswana's HIV/AIDS Programme: A Model for SADC?' (2004) 5 *Development Update: From Disaster to Development: HIV and AIDS in Southern Africa* 225; and UN Office for the Coordination of Humanitarian Affairs 'Botswana: Model Treatment Programme Has Its Problems', <<http://www.plusnews.org/webspecials/ARV/botmod.asp>> .

For others who use the phrase 'routine testing' differently than I to denote an 'implied consent' or 'opt-out' approach, see P Nieberg of the CSIS HIV/AIDS Task Force (note 1 above) 5; B Mguni 'HIV Testing from a Government Lawyer's Perspective' Botswana Lawyer's Taskforce on HIV/AIDS Discussion Seminar (note 2 above); and Brandt et al (note 1 above).

For advocates of an implied consent approach, see President of Botswana Festus Mogae quoted in J Donnelly 'A Battle Line in Botswana AIDS Fight' *Boston Globe* 24 October 2003; and E Cameron 'AIDS Law Project Discussion on HIV Testing: Outline of Introduction and Provisional Thoughts' (unpublished manuscript).

on people's ignorance to treat them.⁸ And if one believes that the state should go to the trouble to obtain implied consent to conduct an HIV test (as opposed to not seeking consent at all), I see no convincing reason for it not to take the extra step of seeking explicit consent.

Routine offers of HIV tests should, furthermore, be distinguished from requests or pleas for them. Offering a test and noting the good reasons for accepting the offer differ from a 'request' approach of asking patients to take a test or perhaps pleading with them to do so. Offering and recommending also differ from a 'command' approach of telling patients to take an HIV test. A request or a command is the sort of thing that a 'please' can sensibly accompany. In contrast, neither an offer nor even a suggestion is something that warrants a 'please'; here, a physician would ask patients whether they would like to take an HIV test, perhaps noting why it would be desirable for them to do so. I distinguish routine testing from request and command approaches since the latter might, like mandatory testing, place undue pressure on patients.⁹

In sum, 'routine testing' as meant here differs by definition from VCT, (which is patently justified), and from mandatory, implied consent, request, and command approaches, (which are *prima facie* morally suspect). This analysis of routine testing should dispel some of the suspicions that it would violate people's rights or otherwise be immoral; for it would by its nature threaten neither to reduce patients' control (as mandatory, request, and command approaches), nor to act on them without full information (as the implied consent approach). However, many important ethical concerns about routine testing remain, and they are my focus in the rest of this article.

(b) An Analysis of Respect for Persons

To address the remaining concerns, I appeal to the Kantian principle that requires agents to express respect for the dignity of persons.¹⁰ This familiar moral theory implies that what has the highest value are persons, ie, beings with the capacity for autonomy, which capacity we are morally obligated to develop, actualise, and, above all, refrain from treating merely as a means to our ends. Autonomy consists of the ability of an agent to make decisions on the basis of her own reasoned

⁸ See part III (a) below for a brief explanation of why.

⁹ A trickier case is one in which a physician tries to persuade patients of the good reasons to take an HIV test. Seeking to convince with argument is neither to request that patients take a test nor to command them to do so, but it would involve more pressure than merely offering a test along with the good reasons for it. Would seeking to persuade constitute undue pressure?

¹⁰ Though the principle of respect largely stems from the writings of Immanuel Kant, I make no attempt to accurately recount his views. Instead, I appeal to ideas inspired by Kant's works that contemporary moral philosophers have found compelling. For my own philosophical articulation and defence of the principle of respect, see T Metz 'The Reasonable and the Moral' (2002) 28 *Social Theory & Practice* 277.

deliberation, with central ways of degrading this valuable capacity being sacrificing a person's autonomy for something worth less than it or treating one person as worth less than another. More concretely, coercion and deception are clear ways to treat a being with autonomy disrespectfully (except for cases such as punishment and self-defence), as they undermine an agent's ability to act on the basis of her own free and informed decisions.

The principle of respect is a non-consequentialist principle, which means, roughly, that the end does not always justify the means. A respect-based morality implies that one cannot accurately assess the rightness of an action or policy merely by considering the degree to which its consequences in the long run would improve people's quality of life. Instead, there are certain actions or policies that are wrong 'in themselves,' apart from their long-term, beneficial results. For example, if you are on a dune buggy and see two children drowning in the ocean, it would be disrespectful and hence immoral to run over one child in your way in order to get to the drowning two in time. That would treat the one as though she were worth less than the others, or as though she existed merely to be sacrificed for their sake.

Although the principle of respect implies that the results of an action do not alone determine its permissibility, that is not to say that an act's results are utterly irrelevant. When the consequences of an action are relevant to its moral appraisal, they will not be consequences having to do with people's happiness, well-being or pleasure, but rather their dignity, rights or autonomy. Furthermore, insofar as results are relevant to respect-based moral appraisal, they will be likely consequences as opposed to actual ones; for only likely results determine what a person has expressed with her action or how she has treated others. For instance, if you aim to rescue a child drowning in the ocean, it is morally necessary to use a means that will probably work; it would not give the child her due merely to wave what you think is a magic wand that will transport her ashore. Conversely, it is morally sufficient with respect to the results to use a means that will probably bring them about. If you jumped in to save the child but accidentally (non-negligently) failed to hang on tightly enough so that she were pulled into the undertow, you would have failed to produce the desired result, but would not have expressed any disrespect toward the child.

This reflection on the relationship between respectful treatment and the consequences of action means that an ethical appraisal of routine testing cannot merely in scientific fashion calculate the results of such a policy to ascertain how much people's medical condition would be improved relative to some alternative policy. Instead, one must normatively judge whether routine testing would constitute a kind of degrading treatment or would likely bring it about.

It is appropriate to evaluate routine testing in light of the principle of

respect for two major reasons. First, it is the most commonly accepted moral theory, at least in bioethics manuals, if not also bioethics journals. This theory is likely to be common ground between me and those who would initially disagree with my thesis that routine testing can be morally justified with or without ART. It is therefore a fair place to start the debate. Second, the principle of respect most promises to make sense of the debate about whether routine testing violates human rights. Consequentialist theories such as utilitarianism deny that there are basic rights, holding that the end always justifies the means. In contrast, the principle of respect is the most plausible and widely invoked normative ground of human rights. The idea that each being with autonomy has a dignity that must be honoured straightforwardly grounds the idea that people have rights to life, liberty and the resources needed to make free and informed decisions. Since my aim is to consider whether routine testing would violate anyone's rights or, alternatively, whether it may be required to fulfil them, the principle of respect is the natural moral foundation to use.

III ROUTINE TESTING AS A GATEWAY TO TREATMENT

In this section I suppose that ART is widely available to those who test positive for HIV in a given developing country with a high and widespread infection rate, and I consider whether a state in these conditions is permitted or even required to adopt routine testing. More specifically, I first provide a respect-based argument for the thesis that citizens of such a state have a right that it adopt routine testing (a), and then respond to objections ((b)-(g)). The objections progress in a logical order and form a framework by which to classify all the concerns about routine testing in the literature. At the end of this part, I note that the framework mirrors other ethical debates, which provides reason to think that the taxonomy of objections is exhaustive and hence that refuting all of them would firmly establish the respectfulness of routine testing.

(a) A Respect-Based Argument for Routine Testing

The moral principle of respect for persons entails a Samaritan principle or a duty of mutual aid. Since persons have a dignity but are not self-sufficient, every agent is morally obligated to rescue, protect and develop the autonomy of persons in need, at least when she can do so at relatively little cost to herself. It would not treat persons as the most valuable entities in the world if one never went out of one's way to help them. Expressing respect for persons entails a positive duty to aid them, so long as one can do so with comparative ease. And when persons face the prospect of death, ie, the eradication of the capacity for autonomy, there is a particularly urgent (though not necessarily overriding) requirement to provide the resources of time, work and money that are likely to save their lives.

Now, HIV/AIDS of course threatens to kill citizens, and the state is an agent that, by hypothesis, could without great burden provide the ART that would prevent them from dying.¹¹ It follows from the respect-based duty of mutual aid that the state would treat its citizens disrespectfully not to provide ART, supposing it had the resources to do so and would not thereby greatly sacrifice other programmes that have been democratically adopted. Of course, if a state utterly lacked ART, could do nothing to obtain it, or could obtain it only at great cost to other urgent policies, then it would not show its citizens disrespect not to provide it to them and citizens would not have a right to it. I am supposing in this section that a developing state with a high rate of HIV infection either has ART or could acquire it without enormous fiscal or other burden.

The moral obligation to provide ART grounds a further obligation to adopt routine testing. It is not enough merely to have the medical treatment necessary to prevent persons from dying; a state must also take steps to find out which of its citizens need the treatment so that it can be offered to them. Routine testing is essential for obtaining information about who needs ART, as statistics suggest that a very high percentage of those who are HIV positive do not know it.¹² A promising way for a state with a high and widespread infection rate to find out who among their citizens is HIV positive and needs ART would be to have all medical settings offer all patients an HIV test (along with pre-test and post-test counselling and an offer of ART when appropriate in light of CD4 count). A state that had ART or could easily acquire it but did not employ routine testing to find out who needs it would be like the person who waves what he thinks is a magic wand in the hope that doing so will save a drowning child. Such a state might mean well, ie, have good intentions, but it would be acting wrongly.

Since the moral duty of a state to provide healthcare to citizens grounds a correlative moral right on the part of citizens to obtain healthcare,¹³ it follows that citizens have a right that their state adopt routine testing, at least when the rate of infection is high throughout the state's territory, the state could afford both to provide ART and to employ routine testing, and the populace is not otherwise easily able to find out its HIV status. In sum, reflection on the principle of respect for

11 Or the state is at least the representative of people who could help other, poorer citizens at relatively little cost to themselves. For related discussion of a respect-based obligation of the state to help citizens by fighting crime, see T Metz 'The Justice of Crime Prevention: The Case of South Africa' (2004) 51 *Theoria* 104.

12 United Nations bodies often report that only five or ten percent of those infected know that they are. See, eg, UNAIDS Global Reference Group on HIV/AIDS and Human Rights (note 1 above); and World Health Organization *Increasing Access to HIV Testing and Counseling: Report of a WHO Consultation*, <www.who.int/hiv/pub/vct/pub36/en/> .

13 Here I gloss over the thorny issue of precisely when duties ground rights (which is not always).

persons has shown that citizens do have a right to healthcare, which right grounds a right to routine testing.

Now, just because the principle of respect entails a right to healthcare does not mean that the state may seek to fulfil it in any manner whatsoever. In particular, it does not follow that the state may adopt practices that might realise the end of improving people's health but would do so by means of undermining their autonomy. Just as respect forbids seriously infringing one person's autonomy for the sake of protecting the health of others (see the dune buggy case discussed above), so it forbids seriously infringing a person's autonomy for the sake of promoting her own health. Respect for the autonomy of persons requires trying to help them in ways that not only are likely to be effective, but also act on persons with their free and informed consent. If some patients would elect not to accept a physician's offer of an HIV test, then it would be degrading for him to use force or fraud to see that they would make what he deems to be a better choice. In short, respect prescribes Samaritanism but proscribes paternalism.¹⁴ It therefore forbids practices such as mandatory testing and an implied consent approach, but permits and even requires routine testing.

At this point I am far from able to conclude that the state must adopt routine testing. Indeed, this is where the debate truly begins. Although some theorists deny that people have a right to healthcare, I do not consider such an objection here. I instead focus, first, on objections that grant that there is a right to healthcare but deny that it entails a right to routine testing and, second, on objections that grant that a right to routine testing exists but deny that it would be sufficient reason for a state to employ routine testing. In the rest of this section, I organise and rebut these sorts of objections to the argument.

(b) Just Cause

The first way to object to the argument for routine testing would be to say that the goal sought by means of routine testing does not justify this particular means. The objection grants that citizens have a right to healthcare, the fulfilment of which is a worthy goal for the state to have, but denies that routine testing is an appropriate way to seek to realise this goal. Specifically, although there is nothing inherent to routine testing that would make it manipulative, it might damage people's autonomy nonetheless. It is to be expected that people will feel anxiety or depression upon accepting an HIV test, and contemporary friends of the principle of respect deem anxiety to be a psychological condition that inhibits

¹⁴ For a deeper explanation of why respect for persons typically forbids paternalism and an analysis of exceptional cases in which it does not, see T Metz 'Respect for Persons and Perfectionist Politics' (2002) 30 *Philosophy & Public Affairs* 417.

autonomous choice.¹⁵ Although making an offer is not coercive, deceptive or exploitive, what is being offered will produce anxiety or depression in the patient, thereby undermining her ability to make a wide array of reasoned decisions, and perhaps being disrespectful for that reason.

In reply, one might argue that it is not the physician's *offer* of a routine test that would substantially cause psychological harm, but rather the patient's *acceptance* of that offer and the disclosure of a positive result. While tempting, the friend of routine testing cannot make this reply; for she claims that routine testing is a means by which to save lives. If routine offers prevent AIDS from killing people in the long-term, then they surely are a partial cause of anxiety and depression in the short-term.

A better reply to make, therefore, must deny that doing something that is likely to cause anxiety or depression is necessarily disrespectful. Consider a case from a different context, one in which a woman intends to break up with her romantic partner. Her decision will cause her partner distress and she foresees this, but merely from these facts we cannot conclude that dissolving the relationship would treat her partner disrespectfully. The bare fact of producing anxiety or depression in another person cannot make an action degrading of autonomy. Whether this action is degrading depends on the end for which it is done. And the end of seeing that a person is given ART is surely one that would permit actions that foreseeably produce psychological harm. After all, if the medical practitioner did not conduct an HIV test, the patient would face much more of this harm later, once her immune system starts to decline. And death, of course, is a much greater impairment of autonomy than that associated with the offer of a test to ascertain one's serostatus when ART is available.

Some readers might have a lingering worry about paternalism, a classic form of disrespect. In causing the patient to feel anxiety or become depressed, would not the physician be impairing the patient's autonomy for her own good, and is that not paternalism? There are two reasons for a negative answer to this question. One reason is that objectionable forms of medical paternalism most clearly consist of direct interference, eg, coercion or deception, in which the physician intentionally and immediately restricts the patient's autonomy. However, in offering an HIV test, the physician merely foresees that the patient will likely suffer psychological harm down the road if a positive result obtains, harm the physician would seek to minimise. Another reason is that, assuming robust informed consent, the patient can by and large avoid the anxiety and depression caused by the medical practitioner, namely, by electing

15 For example, many follow John Rawls, who deems belief in the worthiness of one's goals and confidence in one's ability to achieve them to be conditions that partially constitute autonomy. See J Rawls *A Theory of Justice* (1971) §15, 67, 82.

not to accept the offer of an HIV test. Avoidable or chosen impairments of autonomy are much less morally suspect than are unavoidable or unchosen ones. Hence, routine testing need not constitute paternalism, or at least not a disrespectful form of it.

In this part I am of course supposing that ART is available to those who test positive for HIV. The objection regarding just cause will be harder to deal with farther below, where I imagine that ART is not available. There, it will not be a matter of offering an HIV test in order to provide medical treatment; I will need to consider some other ends. In the present context, however, I conclude that there is nothing inherent to or immediately associated with routine testing that would make it an inappropriate means to realise the end of preventing deaths from AIDS.

(c) Likely Success

Even if the goal of saving lives by providing ART would in principle justify the use of routine testing, routine testing would still be unjustified if it were unlikely to achieve this goal. The present objection maintains that the right to healthcare does not require routine testing since routine testing would have a poor chance of preventing AIDS from killing patients. Some suspect that routine testing would be unproductive or, still worse, backfire and cause even more deaths than there would be without it. There are four distinct reasons for thinking that routine testing might fail to be of use.

(i) *Avoiding Clinics*

First, if routine testing were adopted, it might be that people would avoid entering medical settings at all so as to avoid getting tested. And if fewer people entered medical settings, then of course fewer people's serostatus would be identified, not more.

The avoidance of medical settings would be a genuine concern for a policy of mandatory testing. There is evidence that when testing for a disease has been made a condition of receiving some good, people do tend to avoid seeking the good so as to avoid the test.¹⁶ However, routine testing of course would not require patients to get tested, and presumably the public could be made aware that it would be their free and informed choice of whether to accept the physician's offer. If people knew that they could refuse an HIV test without imposition of harm or withdrawal of benefit, then they would have little reason to avoid clinics and hospitals. Of course, some people might avoid these places because they would be misinformed or fear even having to make the decision of whether to obtain a test. However, this number would presumably be small and not

16 J Osborn 'Widespread Testing for AIDS' (1987) 2 *AIDS & Public Policy* J 4.

substantially threaten to undermine achievement of the goal of providing ART to more people.

(ii) *Refusing Tests*

Even if people came to medical clinics, there might be reason to think that they would largely refuse to get tested. Or if they accepted the offer to get tested, they might not stay to learn the results, at least if rapid (20 minute) tests were not available.¹⁷ Fear of discovering that one is HIV positive, that one has a life-threatening disease, would no doubt be great.

However, medical practitioners could make it clear to those considering an HIV test that ART would be available and that their best chances of staying alive and being healthy would be to get tested. Seeing the health of friends and community members improve upon ART would also help convince people to enter the gateway to treatment. So, a firm grasp of the medical facts would presumably make the fear of not getting tested greater than the fear of learning one's serostatus.

Yet there would be more to fear from an HIV test than merely discovering one's serostatus. One would also have to face the reactions of family and community, which could well include stigma, dissolution of a romantic relationship, discrimination and in some cases violence.¹⁸ Medical practitioners could offer counselling for those in sexual relationships with patients who test positive, indicating ways to prevent infection that might keep these relationships intact. Beyond that, it seems that individual physicians could do little to affect the way people react to those who test positive for HIV.

The solution would have to come at a more macro level and the results of such an approach would admittedly not be immediate. People's negative reactions are largely a product of ignorance and fear, which conditions could in time be overcome by state sponsored educational programmes and by the counselling that would accompany routine testing. Studies conducted in South Africa provide strong evidence that the more people know about HIV/AIDS, the less discriminatory their attitudes toward those suffering from it.¹⁹ Furthermore, insofar as a large part of the stigma results from the current association of HIV with a

17 Consider one site in India in which nearly all women agreed to get tested but few stayed for the results. See P Nieburg, T Cannell, & J Stephen Morrison *Expanded HIV Testing: Critical Gateway to HIV Treatment and Prevention Requires Major Resources, Effective Protections* (2005) 13.

18 For the concern that discrimination could lead people to avoid medical settings, see C Stegling 'Botswana Opts for Routine HIV Tests', <www.procaare.org/archive/procaare/200411/msg00030.php>.

19 A Kalichman & L Simbayi 'HIV Testing Attitudes, AIDS Stigma, and Voluntary HIV Counselling and Testing in a Black Township in Cape Town, South Africa' (2003) 79 *Sexually Transmitted Infections* 442; B Maughan Brown 'Measuring HIV/AIDS Stigma' *Centre for Social Science Research Working Paper No 74* (2004).

death sentence, routine testing as a gateway to ART should have the effect of reducing stigma in the long run.

Indeed, instead of suspecting that routine testing would break down because of stigma, one might reasonably have the opposite judgment, that stigma would break down because of routine testing. Interestingly, Botswana adopted a policy of something like routine testing—often using the implied consent approach in practice—for the explicit purpose of reducing stigma.²⁰ A few years ago, United States donors provided enough ART to treat all those needing it among Botswana's population. The government then created several VCT clinics, where people could find out their serostatus and then enrol for ART if appropriate. However, relatively few people sought out an HIV test and ART. Deeming stigma to be one major reason for people's reluctance to get tested, the government adopted a provider-initiated testing scheme, the thought being that making HIV testing and treatment common would reduce stigma and get more people enrolled in ART. The number of people in Botswana getting tested for HIV has definitely risen,²¹ but whether that is evidence that stigma is decreasing is hard to tell, especially since the implied consent approach makes it difficult to ascertain why people are getting tested. Better evidence that treatment can reduce stigma is the Médecins Sans Frontières (MSF) pilot project in Khayelitsha, South Africa, where, upon the widespread provision of ART, the number of people getting tested has also risen dramatically and without concerns about weak informed consent.²²

I am arguing neither that routine testing would be sufficient to reduce stigma, nor that routine testing is justified because it would. I am instead replying to the objection that stigma would prevent routine testing from realising the goal of making ART provision more widespread by suggesting that routine testing as a gateway to treatment might itself help to reduce stigma. Along with educating, counselling and treating, combating stigma and discrimination would no doubt have to use some measure of legitimate force. Enacting and enforcing laws that keep people's serostatus confidential and that ban unfair treatment in places such as housing and work would be essential.²³ In short, a state with the

20 President F Mogae and Dr E Darkoh in NewsHour 'Botswana Battles AIDS', <http://www.pbs.org/newshour/bb/health/july-dec04/botswana_7-12.html> .

21 E Darkoh, Operations Manager of Botswana's National Antiretroviral Programme, quoted in K Bodibe 'Botswana Opts for Routine HIV Tests' (2004) 198 *Living with AIDS*, <http://www.health-e.org.za/news/article_audio.php?uid=20031143> ; UNAIDS *Consultative Meeting on HIV Testing and Counselling in the Africa Region* (2005) 10.

22 Global HIV Prevention Working Group *HIV Prevention in the Era of Expanded Treatment Access* (2004) 6.

23 The Botswana Network on Ethics, Law and HIV/AIDS (BONELA) has documented what can happen if anti-discrimination laws are not in place before routine testing is adopted. See BONELA *Challenging HIV-related Discrimination: Protection for Employees in the Workplace* (2004).

relevant political will could, over time, influence people's reactions so that patients would have less reason from their neighbours to fear getting tested for HIV.

(iii) Failing to Adhere to Regimen

Now, even if people went to clinics, took the test and learned the result, there might be reason to think that routine testing would fail to achieve the goal of saving lives. Illiteracy and poverty might be considered obstacles to successful treatment. The current objection maintains that people in developing countries can have a difficult time understanding when and how to take the medication, and they can find it difficult to afford the transport needed to obtain it, let alone the medication itself. South Africa's Minister of Health, Manto Tshabalala-Msimang, has made this objection, saying that until illiteracy and other infrastructural obstacles are tackled, providing ART 'will only make more problems. . . . People don't have watches.'²⁴

The best reply to this objection is to point to counterexamples such as the ART programme that MSF runs in Khayelitsha, an extremely poor township.²⁵ By using generic drugs, the cost of treatment per person is affordable, and, as a result of a simpler regimen having been developed, adherence to it is extremely high, well known for being higher than in developed countries. MSF chose to run an ART programme in Khayelitsha precisely because of its stark lack of financial and educational resources. The United Nations cites it as an exemplary model of what can and should be done in developing countries to overcome such barriers.

(iv) Becoming Complacent

There is one remaining reason to doubt that routine testing would likely succeed in realising the end of saving lives. Were people to discover that there is treatment for HIV/AIDS, they might become less vigilant about avoiding the disease. There is some evidence that this has happened with the introduction of ART, in both developing and developed countries. For instance, in Kenya, as public awareness of anti-HIV/AIDS therapies has increased, use of condoms has decreased, and, still worse, there is

24 Quoted in L. Garrett 'Calling for a Global Solution: AIDS Fund Poses Worldwide Challenge' *Newsday* 17 June 2001, <<http://www.aegis.com/news/newsday/2001/ND010607.html>> .

25 See articles on the MSF website, e.g., E Goemaere 'Khayelitsha Mobilising to Fight HIV/AIDS'; S Charles 'HIV/AIDS Treatment in South Africa Proves Success in the Poorest Conditions'; and I Oransky 'African Patients Adhere Well to Anti-HIV Regimens', <<http://www.msf.org/countries/page.cfm?articleid=802183E8-3952-4736-A9439CB789B3BAE5>> . See also a study of ART adherence in Cape Town that is analysed and applied to Tshabalala-Msimang's remarks by the Treatment Action Campaign 'We Take Our Medicines and We Control Our Lives—Adherence to Antiretroviral Therapy in South Africa' *E-Newsletter* 3 August 2001, <http://www.tac.org.za/newsletter/2001/ns03_08_2001.txt> .

evidence that in the United States the widespread use of ART among those infected with HIV is now resulting in more infections than there would have been had there not been ART.²⁶ These unfortunate outcomes are the result of people having more unprotected sex either because they have acquired the false belief that ART is a cure or have become complacent even in the knowledge that it is not.

Some question the soundness of these studies.²⁷ However, let us grant their soundness for the sake of argument and see what follows. Presumably, educational programmes could be adopted to try to minimise false beliefs about the nature of ART. A mobilised educational effort could, one would think, inform people that treatment for HIV exists but not a cure. Somewhat more troubling, then, is the prospect of people being more willing to risk unsafe sexual practices even knowing that treatment but not a cure is available. Medical professionals and other social bodies could exhort people to practice sex safe even though ART would be available, but let us suppose that education and advice would not work. Imagine that transmission rates would remain the same or perhaps even increase because people, in light of accurate information about ART, would judge the potential benefits of unprotected sex to be worth its potential harms.

In fact, such an unfortunate outcome would not impugn the ability of routine testing to succeed in realising its goal, for two reasons. First, supposing the goal is to prevent deaths from AIDS, this could well be accomplished even if transmission rates increased, at least relative to a scenario in which ART is unavailable. If ART is available, more people who are HIV positive does not necessarily mean more people dying from AIDS.²⁸

Second, and more deeply, the precise goal of routine testing is not the consequentialist aim of *preventing people dying* from AIDS; it is rather to *provide ART* or to *give people the ability to avoid dying* from AIDS. To show respect for the autonomy of citizens, one need not forcibly keep them alive regardless of what they choose — indeed, that would be disrespectful. One need and should merely provide them the means to stay alive, which means they can make a free and informed choice to employ or not. Therefore, if the state has done all it reasonably can to provide ART, to inform citizens of the nature of HIV/AIDS and of ART, and to exhort them not to engage in risky behavior despite the availability of ART, then the state would be treating citizens respectfully even if citizens then chose to engage in risky behavior and thereby contracted

26 Studies suggesting complacency in both developed and developing countries are summarised in Global HIV Prevention Working Group (note 22 above) 6-7, 16.

27 N Nattrass 'Highly Active Antiretroviral Therapy and Risky Sex: Is There a Link?' *Centre for Social Science Research Working Paper No. 40* (2003).

28 Though it could if the transmission rates are very high, since ART does not work 100 per cent of the time.

HIV. Just as the state achieves its proper goal regarding smokers if they choose to smoke in light of widespread warnings from the state about the hazards of smoking, so the state would achieve its proper goal regarding those who acquire HIV as a result of complacency about safer sex in the face of similar warnings. Once it is clear what the precise, respect-based goal of routine testing is, namely, to provide people the ability to stay alive and remain healthy, we see that the bare fact of higher transmission rates or even more deaths would not in itself mean that routine testing would fail to achieve its goal.

(d) Proportionate Response

Even if the goal of enabling people to stay alive and remain healthy would in principle justify the use of routine testing, and even if this means were likely to achieve this goal, the indirect and long-term harms of routine testing could still outweigh its benefits, making it unjustified. There might be other disvalues that routine testing would have the side-effect of bringing about that overshadow the right to healthcare it would fulfil. There are two key harms to consider here, weakened informed consent, on the one hand, and stigma and discrimination, on the other.

(i) Weakened Informed Consent

First, even if the definition of 'routine testing' indicates that it is *in principle* fully consistent with robust standards of informed consent, *in practice* the adoption of routine testing might have the unintended result of undermining adherence to these standards. There are two versions of this objection, one of which is *prima facie* stronger than the other. The weaker version maintains that patients would perceive doctors to be authority figures and would thereby be induced to consent.²⁹ I find this objection to be weak because it would 'prove too much' if it were sound: it would prove that genuine informed consent is impossible for virtually any medical setting and purpose, which is absurd.

The stronger version of this objection says that medical practitioners would, over time, inform patients of their rights in a perfunctory way, making consent less than fully informed.³⁰ A useful analogy here is the way that police officers in the United States are known to read Miranda rights (to remain silent and to obtain an attorney) to those who are arrested. Police often do so quickly, without explanation, and in a tone that suggests that the rights are unimportant. Police do this because they not only want those arraigned not to take advantage of these rights, but

29 J Fleischmann of the CSIS HIV/AIDS Task Force (note 1 above) 52-53.

30 R Faden et al 'Prenatal HIV-Antibody Testing and the Meaning of Consent' (1994) 9 *AIDS & Public Policy J* 152; W Holmes '3 by 5, But at What Cost?' (2004) 363 *The Lancet* 1072.

also read the rights so often that they come to lack significance. One might reasonably suspect that medical professionals would be similarly motivated and affected, if they were to routinely offer HIV tests. They, too, would have some desire for patients not to take advantage of their right to refuse the test and would be affected by repetitive, standardised testing procedures.

In reply, medical institutions could monitor the way patients were informed of their rights, perhaps performing spot checks to keep medical professionals on their toes and obtaining written consent or recording oral consent prior to testing.³¹ Of course one might reasonably suspect that such measures would not fully eradicate the problem. There is, however, strong reason to think that routine testing would nonetheless be justified. Just because police officers often 'Mirandise' in a mechanical way to suspects does not mean the state should no longer have police protect society by arresting suspects. By analogy, even if medical professionals were to convey patients' rights to them in a mechanical way, it would not follow that the state should not have them save patients' lives by using routine testing as a gateway to treatment.

Beyond analogy and at a level of principle, the friend of respect for persons can maintain that the state permissibly adopts a policy that would have the effect of violating rights if the state meets the following three conditions: it merely foresees, ie, does not intend, the rights violations that others would do in the long-term; it seeks to minimise these violations (or at least to promote compensation for them); and it reasonably expects the violations to be outweighed by the fulfilment of another, more substantial right. This threefold principle basically explains why the US government rightly has police continue to arrest suspects even knowing that some police do not arrest them in quite the correct way, and it entails that a state in the developing world could respectfully adopt routine testing even knowing that some of its medical professionals would not inform patients of their rights in the correct way. *Medical professionals* who did not conform to robust standards of informed consent would treat patients disrespectfully. However, this would not mean that the *state* that adopts a policy of routine testing would also treat patients disrespectfully, so long as the state did not intend to weaken informed consent, took measures to prevent medical professionals from weakening it, and reasonably expected that the just cause of providing ART would be greatly furthered.

(ii) *Stigma and Discrimination*

I now turn to the second major harmful side-effect that routine testing

31 There is evidence that routine testing in pre-natal contexts has not had the effect of weakening informed consent. See Faden et al (note 30 above) 158-59.

might be thought to have, namely, to indirectly further negative reactions against those who test positive for HIV. Above I considered whether things such as stigma in the home and discrimination on the job would have the effect of discouraging people from getting tested. Here, I consider whether these conditions would in themselves be enough to render routine testing unjustified (setting aside the issue of whether people would be willing to get tested in the face of them). Although the state would not be violating the rights of patients by adopting routine testing, doing so would have the indirect effect of neighbours, employers and even family members violating their rights and ostracising them. Some judge such effects to constitute enough reason not to adopt routine testing.³²

I have three responses to this objection. First, above I noted several ways in which the state could seek to minimise negative reactions. The state, of course, ought to enact and enforce laws protecting confidentiality and forbidding discrimination, and it should ideally do so well before it adopts routine testing, not merely at the same time as it adopts it, and especially not after.³³ Such legal measures would go some way toward reducing at least the violations of rights and promoting compensation for their violation. In addition, I spoke of several respects in which routine testing might itself have the effect of reducing stigma over time. It would save lives, educate people, and publicise the issues, all of which could help to change people's attitudes and behaviour toward those who are HIV positive.

Second, with regard to those negative reactions that would remain, they would arguably not be sufficient to render routine testing unjustified, in light of the threefold principle I discussed above in the context of informed consent. Since the stigma and discrimination would be indirect effects of state action (ie, unintended and done by others in the long run), since the state would try to minimise these effects or at least compensate for them, and since the benefits of providing ART would on the whole outweigh the harms, the state would be justified in adopting routine testing. The threefold combination of indirect effects, precautionary measures, and proportionate benefits is sufficient to make routine testing respectful of citizens despite the harm that it could not avoid causing.

It is fair to question my judgment that the benefits of routine testing would be proportionate to the harms. That judgment relies not only on an empirical claim about the likely effects of routine testing, but also on a normative claim about how to weigh these effects, both of which claims are subject to dispute. My judgment of proportionality presumes at least

32 Perhaps Chetty (note 1 above) 27-28; and C Stegling cited in UN Office for the Coordination of Humanitarian Affairs (note 7 above).

33 As was done in Botswana (see note 23 above).

the following: that the state could reasonably expect to reduce stigma and discrimination over time; that the numbers of lives saved from ART would reasonably be expected to be substantial (reputable NGOs estimate, for instance, that 600 South Africans die each day from HIV/AIDS, a figure that is at least 10 times South Africa's murder rate³⁴); and that the duty to save lives outweighs the duty not to prevent ostracism, even if many more would suffer ostracism with routine testing than would die without it. I trust that most readers will find the presumptions to be reasonable.

A third response I make here is that the state would not degrade citizens by indirectly promoting stigma and discrimination, if patients voluntarily consented to get tested in the knowledge that they might face these reactions. Imagine the state required medical professionals to tell patients that, while the state has laws in place to protect them from discrimination, it cannot of course guarantee that they will not suffer from it.³⁵ Warning patients of the possible negative reactions they might face from others in their community would lessen the responsibility of the state for these effects. Although a warning would not relieve the state of an obligation to fight discrimination and stigma, it would arguably free the state of any charge of disrespect for adopting a policy that would indirectly further these negative reactions, even supposing (contrary to fact) that the harm of these reactions would be greater than the benefits of treatment.³⁶

I conclude that, while the problems of weakened informed consent and discriminatory reactions are serious, the state could take measures to minimise these effects, and that if it did so, it would not treat its citizens disrespectfully because of the threefold principle (indirect effects, precautionary measures and proportionate benefits) and because of the free and informed consent of patients. However, even if the benefits of routine testing would outweigh its harmful side-effects, it is not yet clear that it would be justified. There are three more objections to consider.

(e) Minimal Necessity

Even if the goal of providing ART would in principle justify the use of routine testing, even if this means were likely to achieve this goal, and even if the benefits of routine testing outweighed its indirect harms,

34 For South African death rates from HIV/AIDS based on government statistics, see the Treatment Action Campaign, < www.tac.org.za > . For South African murder rates, see the Institute for Security Studies, < www.iss.co.za > .

35 Brandt et al note that, traditionally, medical practitioners have warned patients merely of physical risks but that they plausibly ought to warn them of social harms as well (note 1 above) 129.

36 Of course, this third response to the second objection supposes that informed consent would not be weakened much, if at all. See part IV (d) below for more on this assumption of risk argument.

routine testing would be unjustified if there were another means that were likely to achieve roughly the same benefits but with fewer harms. The present objection maintains that routine testing would not *uniquely* fulfil the right to healthcare, that it might adequately fulfil it but not as efficiently as some other policy. In short, routine testing is not clearly the least costly means necessary to achieve the end of providing ART.

In particular, some object that a form of VCT on its own could obtain the same benefits as routine testing but with fewer harms.³⁷ In the developing world, only about 10 per cent of those who should get tested for HIV have access to voluntary counselling and testing.³⁸ Rather than adopt routine testing, a developing country could perhaps achieve the goal of providing ART by expanding access to client-initiated HIV tests and by strongly encouraging its citizens to take advantage of VCT. After all, this is what the MSF has done in Khayelitsha, the renowned success story of ART provision mentioned above.

In addition, it would appear that expanded VCT would risk fewer harms than routine testing, in three respects. First, patients might suffer less anxiety, having motivated themselves to go to the medical setting and ask for an HIV test on their own. Anxiety would presumably be greater with routine testing, since patients would be asked to take an HIV test without necessarily having taken time to mentally prepare for one. Second, VCT would not risk weakening informed consent as much as routine testing would. Since it is a client-initiated programme (unless there is something about the patient that suggests the presence of HIV), medical professionals would have much less scope to pressure patients into taking tests. Third, VCT would cost much less money than routine testing since not all patients would be offered tests. It would be quite expensive to test everyone who enters a medical setting for whatever reason, whereas it would be much less expensive to test only those who volunteer for a test (or who have TB or an STD).

Now, if VCT would be likely to obtain basically the same benefits as routine testing and to do so with fewer expected harms, then it would be unreasonable to adopt routine testing. More specifically, it would be disrespectful of a state to adopt routine testing since it would unnecessarily cause harm to citizens, even supposing the harm is proportionate to the benefits produced.

The first reply to make is that, if VCT would be much cheaper than routine testing, the only reason why is that much fewer people would be tested under VCT. Now, in countries with rates of HIV infection as high as 10 per cent – in Botswana's case, about 17 per cent³⁹ – of the population,

37 For example, Chetty (note 1 above) 25-26, 30-31.

38 UNAIDS/WHO (note 2 above) 1.

39 The figure of close to 40 per cent that the UN and other agencies had often cited was overblown, according to a recent study, <<http://www.afrol.com/articles/15067>>.

routine testing makes especially good sense, supposing the aim is to provide ART to all those who need it. In fact, in the case of Botswana as noted above, foreign donors had provided enough ART to cover all those infected, but too few citizens were seeking it out, even with the creation of a robust VCT network; people would often come in for treatment too late, at a point when ART would not do any good. Botswana therefore decided to adopt a provider-initiated scheme to help citizens acquire information about their HIV status and ART. The most recent evidence indicates that 95 per cent of those offered an HIV test in Botswana accept it, a rate utterly unmatched by the VCT programme.⁴⁰

Of course, since Botswana often uses an implied consent approach, one might reasonably suspect that fewer would get tested if fully free and informed consent were sought. Still, routine testing as I understand it could be expected to substantially increase the number of people who obtain HIV tests relative to VCT, and without using undue pressure. There could be any number of reasons people would not go out of their way to obtain an HIV test, but would make a fully free and informed decision to take the test upon being asked by a medical practitioner whether they would like one, eg, not having worked up the courage to do what one believes one ought to do, not knowing where a VCT clinic is, not being able to afford transport to a VCT clinic, not wanting to be seen going to a VCT clinic, and not knowing the basics about HIV/AIDS. Since VCT is unlikely to reach as many HIV positive individuals as routine testing, it is simply not as likely to produce the same benefits in terms of ART provision as routine testing would.

Furthermore, if it is true that VCT would not inform as many people about their HIV status as would routine testing, then the claim that VCT would have fewer costs is suspect. It is likely true that VCT would have fewer costs in the short run. Administering such a programme would require less money than routine testing. And it might be true that patients would feel somewhat less anxiety if they were to volunteer for an HIV test as opposed to be offered one out of the blue. However, deaths from AIDS are well known for taking heavy tolls on developing economies, since the disease particularly strikes down the most productive segment of the population.⁴¹ And the anxiety from discovering that one is HIV positive too late for ART to be of any use would presumably be much greater than that associated with an unexpected offer of an HIV test in a medical setting. In the long run, then, it is not clear that VCT would even have fewer costs than routine testing. I conclude that VCT would not

40 E Darkoh (note 22 above); and UNAIDS (note 21 above).

41 For recent evidence of the cost effectiveness of routine testing in developed countries with low rates of HIV: see A David Paltiel et al 'Expanding HIV Screening in the United States—An Analysis of Cost Effectiveness' (2005) 352 *New England J of Medicine* 586; and G Sanders et al 'Cost-effectiveness of Screening for HIV in the Era of Highly Active Antiretroviral Therapy' (2005) 352 *New England J of Medicine* 570.

promise as many benefits as routine testing and for this reason would not even promise fewer costs.

(f) Impartial Application

Even if the goal of providing ART would in principle justify the use of routine testing, even if this means were likely to achieve this goal, even if the benefits of routine testing outweighed its indirect harms, and even if there were no other way to achieve the same benefits with fewer harms, routine testing might be unjustified if implemented in an arbitrary or unfair way. To see the issue, consider a racist police system. The end of preventing crime would justify punishing the guilty, where punishing the guilty would be likely to prevent crime, would produce benefits that outweigh indirect harms such as the accidental punishment of innocents, and would be the least costly means to preventing crime. These considerations justify a punishment scheme of some sort, but what if the particular punishment scheme in place were applied in a discriminatory way? Suppose, for example, that police arrested *prima facie* guilty minorities disproportionately more often than *prima facie* guilty majorities. Such a system would be disrespectful.

By analogy, one might worry that, in light of certain facts about developing societies, routine testing could not for the foreseeable future avoid a discriminatory application. Specifically, some voice concern that women would face a disproportionate share of the harms associated with routine testing such as stigma and abuse.⁴² One might also worry that those in urban centres would receive a disproportionate share of the benefits of ART provision. To some, such inequalities constitute inequities.

Now, whether an unequal distribution of benefits and burdens is an injustice depends on the reason for the inequality. Women are well known for having a higher rate of HIV infection than men, for both biological and social reasons. In light of this fact, the state would not degrade women if more of them were tested for HIV and hence faced greater indirect harms. Since the benefits of ART provision outweigh the indirect harms caused (as I assume here, having already argued for it above), the state would not be treating women as inferior to men if women faced more of these harms only because they were getting more of the benefits they urgently need.

The case of men versus women differs somewhat from that of urban versus rural. So far as I am aware, there is no evidence that urban centres have higher rates of HIV infection than rural areas, meaning the state cannot justify providing more ART treatment to the former for such a reason. If the state were to put more resources into urban centres when

42 Chetty (note 1 above) 26-27.

infection rates are at least equal in rural areas, then this form of routine testing might well seem disrespectful. However, there might be a reason why the state would favour urban centres, other than a higher infection rate, that would rebut the judgment that the state would be treating urbanites as worth more than country folk. In particular, suppose the state were initially better equipped to adopt routine testing in cities. So long as the state worked hard to bring rural areas up to speed, there need be no disrespect. Doing what one can, but failing in the face of temporarily unavoidable fiscal and personnel shortages, is not degrading of those left out.

To take the issues a step farther, suppose that the state were to neglect rural areas when it could do more to provide routine testing in them, perhaps because those in the ministry of health identified more with cities. I grant that this would be a disrespectful programme. However, it does not follow that the programme would be all things considered morally unjustified. It would be even more disrespectful not to enact routine testing at all, supposing the right to healthcare indeed requires it, as I have argued above. Return to the punishment analogy. Racism in the criminal justice system means that such a system is degrading, but it does not follow that one should not have a criminal justice system at all. It would be even more degrading of citizens for a state to refrain from punishing any of the guilty, supposing this would mean many more innocent victims. By the same token, even if the state were to adopt routine testing in an arbitrary way, it would not follow that it should then stop altogether. The task would instead be to work to promote fairness in the way routine testing is employed.

(g) Correct State of Mind

Even if the goal of providing ART would in principle justify the use of routine testing, even if this means were likely to achieve this goal, even if the benefits of routine testing outweighed its indirect harms, even if there were no other way to achieve the same benefits with fewer harms, and even if routine testing would be implemented in a fair way, it might be unjustified if adopted for the wrong reasons. For instance, some African National Congress members and traditional healers in South Africa accuse those advocating ART of wanting to enrich pharmaceutical companies and to glorify Western approaches to medicine.⁴³ If such motives were behind the adoption of routine testing, adopting it would appear to be disrespectful of people in developing countries.

43 Such criticisms of South Africa's Treatment Action Campaign have been levelled in the ANC's online newsletter, <<http://www.anc.org.za/ancdocs/anctoday/2004/text/at50.txt>> and by the Traditional Healers Organization, <http://www.tac.org.za/newsletter/2004/ns23_11_2004.htm>.

This is the least important criticism of the argument that respect for persons requires routine testing. It is, however, worth addressing because of the routine conflation between judgments of *good character* and judgments of *right action*. People often assume that an agent's action is wrong merely because the agent's motivations are bad, but this assumption is deeply flawed. A good person can perform a wrong action, and, more relevant here, a bad person can perform a right action. For an example from the recent philosophical literature, consider the hypothetical case of United States President Eisenhower who sends Americans to fight in World War II because he, for some reason, would like to see them die.⁴⁴ Even though Eisenhower's motivation and hence his character would be awful, his decision to send troops would be justified, at least if he were aware of a sufficiently good reason to send them such as stopping the Nazis. By analogy, even if the state's ulterior motives were to maximise the profits of drug companies or to promote Western ideas, it would be justified in adopting routine testing, so long as it also were aware of the good reason for adopting it, namely, that its citizens have a right to life-saving treatment.

I have been supposing for wild sake of argument that the state would have suspect motives if it were to adopt routine testing, but, of course, this empirical claim is false. There could be some members of a developing country's government that would have such motives, but it is highly unlikely that most would or that the state as such would, if the state eventually did adopt routine testing. More likely are good intentions such as wanting to help citizens or more neutral intentions such as wanting to get re-elected or to bolster the economy.

(h) Summary and Transition

This completes my defence of routine testing as a gateway to ART. I have argued that the principle of respect for persons entails a duty on the part of the state to aid its citizens (in certain ways), which duty in turn entails a right of citizens to the provision of ART and routine testing as the way to identify those who need it. I then examined six different objections to this argument, objections that progress in a logical order and that are more systematic than the oft-cited Siracusa Principles.⁴⁵ Some of the objections have questioned the claim that the right to healthcare entails a right that the state adopt routine testing because: this means would be inappropriate for the end of providing ART (b); routine testing would be unlikely to achieve this end (c); or some other means would achieve the

44 J Jarvis Thomson 'Physician-Assisted Suicide: Two Moral Arguments' (1999) 109 *Ethics* 497.

45 For brief applications of the Siracusa principles to routine testing, see UNAIDS Global Reference Group on HIV/AIDS and Human Rights (note 1 above) 2, and Chetty (note 1 above) 24-26.

end with fewer drawbacks (e). Other objections have granted that the right to healthcare requires routine testing, but have denied that the latter is justified because: the indirect harms of routine testing would outweigh the benefits (d); it would be applied in a discriminatory way (f); or the motivations of those backing it would be pernicious (g).

All of the weightiest objections to routine testing from the literature take one of these six forms. In addition, there is independent reason to believe that all important criticisms have been considered here, namely, that the sorts of objections made to routine testing mirror those made to other policies. In particular, those who criticise wars as being unjust typically make one of the six arguments made here, claiming that there is no just cause, the war is unlikely to promote it, the just cause is outweighed by the war's side-effects, the war is unnecessary to achieve the just cause, the war unfairly singles out one party, or the war is conducted with the wrong state of mind. Conversely, although traditional just war theory comes in a variety of forms, most just war theorists would take a war to be justified if none of the six criticisms were sound.⁴⁶ Now, if I have succeeded in showing that routine testing survives all these challenges, then there is strong reason to believe that it is conclusively justified, ie, that there is no other, unexamined objection weighty enough to defeat the respect-based argument for routine testing advanced above.

I conclude that respect for persons entails a right to healthcare that in turn requires a developing country with a high and widespread rate of HIV infection to adopt routine testing when it serves as a gateway to treatment and when it is affordable. In the next section, I aim to extend this basic argument, contending that the right to healthcare also requires such a state to adopt routine testing even when treatment is unaffordable or otherwise unavailable.

IV ROUTINE TESTING IN THE ABSENCE OF ART

Here, I suppose that a developing country simply cannot afford the medicine and the services needed to deliver it (or could do so only at grave cost to other urgent domestic programmes) and that foreign donations are also not enough. No one in the literature has defended the adoption of routine testing for HIV under such conditions, with most typically rejecting it out of hand. I would like to reconsider this position, providing as much defence for it as I can. I maintain that, in fact, the right to healthcare requires routine HIV testing even when no ART can be given to patients.

⁴⁶ Invoking only half of the principles mentioned here, Childress (note 3 above) notes the analogy with just war theory potentially applicable to mandatory testing.

(a) More Respect-Based Arguments for Routine Testing

It is straightforward why the right to healthcare plausibly entails a duty for the state to adopt routine testing, supposing that treatment for HIV/AIDS is available. It is much less clear why the right to healthcare might entail such a duty in the case where no treatment can be provided. Upon reflection, though, one finds two major reasons for thinking so.⁴⁷

First, routine testing in the absence of ART might reduce transmission of the virus. When people discover they are HIV positive, they typically warn their sexual partners or engage in safer sex.⁴⁸ In the previous part, I discussed the possibility that transmission could actually increase upon the adoption of routine testing, but that concern does not apply here; for the issues of complacency and false beliefs about an available cure are out of place in the current context, where ART is presumed not to be available. When people find out they have a communicable, terminal and untreatable disease, statistics show that they often take steps not to pass it on to others. Hence, routine testing that is not a gateway to treatment (RTNG) could still have the effect of protecting health, even if not that of the person getting tested.

Second, the right to healthcare is not merely a right to help with preventing, treating and curing disease; it is also a right to information about disease. The nature of the right to healthcare is informed by the underlying principle of respect for persons, which requires the state to aid citizens with regard to healthcare insofar as doing so protects and develops and thereby honours their autonomy. Autonomy, the capacity to make decisions about the central aspects of one's life, is enhanced by virtue of acquiring information about the status of one's health. Such information is essential for planning for the future.

Note that if the right to healthcare sprang from a consequentialist moral foundation, then it would not entail a duty to provide information about health, unless this information would have the effect of improving people's adherence to a treatment regimen or otherwise improve their quality of life. In contrast, respect for persons suggests that the state can have a duty to provide information to citizens upon their request, even supposing they will be worse off upon receiving it. And this respect-based construal of the right to healthcare squares with intuitions about best clinical practice. For instance, a medical professional incontestably has

47 A third reason is that a physician can better treat opportunistic or secondary infections if she knows the HIV status of her patients. I set this compelling rationale aside since I think it would be revealing to demonstrate that the right to healthcare requires routine testing even in the case where the health of the person getting tested cannot be improved at all.

48 D L Higgins et al 'Evidence for the Effects of HIV Antibody Counseling and Testing on Risk Behaviors' (1991) 266 *J of the American Medical Association* 2419; The Voluntary HIV-1 Counseling and Testing Efficacy Study Group 'Efficacy of Voluntary HIV-1 Counseling and Testing in Individuals and Couples in Kenya, Tanzania, and Trinidad' (2000) 356 *The Lancet* 103.

the duty to provide information to a patient of an incurable brain tumour that is soon to kill him, if he asks for it and even if the news would make him miserable for the rest of his life. Since the right to healthcare includes a right to information about the state of one's health, we have strong reason to think that the right to healthcare entails a right to RTNG.

In the rest of this part, I address the same kinds of objections to these arguments that I considered in the previous section: just cause, likely success, proportionate response, minimal necessity, impartial application, and correct state of mind. I argue that RTNG can overcome all six of these criticisms.

(b) Just Cause

The first way to object to the respect-based arguments for RTNG would be to say that the ends sought by routine testing do not justify this particular means. The objection grants that citizens have a right to healthcare, the fulfilment of which is a worthy goal for the state to have, and might even grant that the right to healthcare includes a right to information about one's serostatus. However, it denies that RTNG is an appropriate way to seek to realise this goal, because of the psychological harm of anxiety or depression it would cause.

I rebutted this objection in the context of routine testing as a gateway to treatment (RTG), but it resurfaces here in a *prima facie* more serious way. With RTG, I argued (roughly) that the anxiety and other sorts of anguish that would result from testing positive would plausibly be outweighed by the distress, not to mention death, that an HIV positive patient would later face if he were not offered an HIV test and ART. That argument does not apply here since treatment is presumed to be unavailable. It might therefore seem that with RTNG the patient would not receive sufficient net gain to justify the mental harm it would do. Perhaps RTNG would treat a patient merely as a tool if the medical establishment reduced *his* ability to make free choices (by virtue of inducing anxiety or depression) for the sake of protecting *others* from HIV transmission.

In reply, recall that offering a test is only a partial cause of anxiety or depression in the patient; accepting the offer and choosing to learn the (positive) results of the test are also large causes and (assuming robust informed consent) are a function of the patient's choice. In addition, note that being offered and receiving information about one's health is a matter of one's autonomy being enhanced. It could be that one's autonomy would be compromised by the anxiety or depression that would arise upon knowing that one is HIV positive and that there is no treatment available. However, consider the following analogy, which suggests that it can be respectful for an agent to cause a person anxiety in order to protect others, if the agent foresees that the anxiety will result from information that would itself enhance the person's autonomy and if the person has freely consented to receive the information.

Imagine you are a bodyguard for a local businessman or government official. Suppose that you are with your client in his home, that you learn of an impending attack on him, and that you know that it is extremely unlikely that you can save your client. Your client's spouse and children on their way home, and you know that you could save them by informing the client and suggesting that he warn them to stay away. You then make the following offer to your client: 'Should I ever tell you when assassins are targeting you, if it would mean that I could save your family but not you, or should I just keep my mouth shut?'

My intuitive judgment indicates such an offer would not be disrespectful, even though your client would of course be very upset if he accepted the offer and thereby discovered that he is doomed. Indeed, imagine that you did not make the offer and that your client somehow discovered during the shoot-out that you had information that could have saved his family. Would he not resent your silence? And would not that resentment be a reaction to the disrespectful treatment of failing to help him make informed decisions about central aspects of his life?

Such a case, I submit, is strongly analogous to the case of a medical practitioner who could easily acquire information about a patient's HIV status. Doctors are, after all, 'bodyguards' of a literal sort; they protect people's lives not from assassins, but from diseases. A patient could rightly complain that a physician did not help him find out that he has a terminal and incurable illness that he could prevent his spouse or romantic partner from acquiring. I conclude that, although RTNG might well impair a patient's autonomy by causing some psychological harm, all things considered this does not mean that offering an HIV test is a degrading way either to provide information to a patient about his health or to reduce transmission of HIV.

(c) Likely Success

Even if the goals of informing patients about their serostatus and of preventing transmission of HIV would in principle justify RTNG, it would still be unjustified if it were unlikely to achieve these goals. The present objection maintains that the right to healthcare does not clearly require routine testing in the absence of ART, since it would have a poor chance of realising its ends and hence would be a waste of state resources.

This objection might not seem to apply to the goal of providing information to patients about their health, for routine testing is an extremely reliable way to achieve that goal. However, the objection cuts deeper than this, for imagine that people would not often accept the offer of an HIV test if ART were unavailable. Then they would not obtain information about their serostatus.

Now, there is in fact an easy way to take care of this objection, namely, by recalling the precise, non-consequentialist nature of the state's goal. Remember from the previous part that, in terms of respect for persons, it

should not be the state's goal actually to ensure that those with HIV stay alive, but rather to give them the ability to stay alive if they choose. Likewise, here it is not the state's goal actually to inform people of their status, but rather to give them the substantial opportunity to acquire the information. If people were routinely offered HIV tests but refused to take them, the state would have fulfilled its respect-based goal regarding the provision of information about patient health. The objection therefore clearly fails.

Now, I cannot make this response regarding the other goal of reducing transmission. This aim is best understood to be a matter of preventing people from acquiring a deadly disease, and part of realising that aim by means of RTNG will, of course, require people becoming actually informed about their status and then engaging in safer sexual behaviour in light of that information. So, the claim that patients would routinely refuse routine offers is worrisome in light of the other goal of RTNG. It is reasonable to suspect that people would often not accept offers of HIV tests, if treatment were known to be unavailable. Fear of knowing that one has an incurable and terminal disease, along with fear of negative reactions from others, would likely lead people to remain ignorant of their serostatus and hence to continue to infect others.

Unfortunately, the responses to this concern made in the context of RTG do not readily apply to RTNG. With RTG, the availability of treatment means that one should fear ignorance of having the disease more than knowledge of having it. It also means that, over time, stigma and discrimination might be reduced. If treatment were unavailable, in contrast, the 'death sentence' aspect of HIV would remain, plausibly meaning that negative reactions from others would remain as well. In addition, with regard to one's own well-being, one would rather receive a 'death sentence' later rather than sooner.

Perhaps active enforcement of confidentiality and discrimination laws, as well as the vigorous promotion of educational programmes, would help reduce people's negative reactions to those they perceive to be HIV positive. And many a patient would identify with his family closely enough for him to brave learning of his serostatus so as to protect them. Still, I admit that not as many people would accept offers of an HIV test under RTNG than RTG, risking failure to substantially reduce transmission. The question is whether this means that RTNG would be morally unjustified to adopt.

I think not, for three joint considerations. First, note that, unlike RTG, with RTNG there is no risk of actually increasing transmission of HIV and hence causing more deaths from AIDS. These outcomes could arise from false beliefs about the existence of a cure or complacency in the face of an effective treatment, neither of which is at all likely under RTNG. Second, RTNG would quite likely reduce transmission to *some* degree. Third, RTNG would certainly achieve the important goal of providing

patients the opportunity to learn of their serostatus. Although there is some question whether these just causes would be outweighed by the drawbacks of RTNG (which I take up next), this concern is not germane to the present issue, which is whether RTNG would adequately promote its just causes. An affirmative answer to this question is fair.

(d) Proportionate Response

Even if the goals of providing information about people's health and reducing HIV transmission would in principle justify RTNG, and even if this means were likely to achieve these goals to a requisite degree, the indirect and long-term harms of RTNG could still outweigh its benefits, making it unjustified. Supposing that the right to healthcare requires routine testing even in the absence of ART, one might deny that RTNG should be adopted on the ground that it would undermine other important moral values. It is far from clear that the just causes of providing information and reducing HIV transmission, or the extent to which they would be promoted, would be worth the potential costs of ostracism from friends and relatives and discrimination by landlords and employers.

Of course, the state could take some practical measures to curb these effects, as I discussed above. Laws that effectively protect confidentiality and forbid discrimination would be crucial. However, the state would of course foresee that confidentiality would still get broken and that discrimination would still occur. Perhaps it should therefore have medical professionals warn patients of these possible effects when offering an HIV test. If it did so, then the patient would assume the risk of bearing these burdens when she consented to the test.

Note that this assumption of risk by the patient is what occurs in the context of VCT when no treatment is available. A patient volunteers to take an HIV test, which a physician then administers. If the patient turns out to be positive, the physician has risked promoting ostracism and unfairness in the allocation of competitive goods such as housing and work. Now, consider: no one reasonably suggests that these risks are sufficient reason for a physician not to conduct VCT in the absence of ART. Routine testing is analogous to VCT in the relevant respect of obtaining voluntary consent from the patient. So long as the patient has made a free and informed decision to take an HIV test, the state would do no wrong by informing her of a positive result even if as a result the person risked negative reactions from the community. Another way to put my point is this: if the risk of stigma and discrimination were enough moral reason to forbid routine testing in the absence of treatment, it would 'prove too much,' for it would also forbid VCT in the absence of treatment, which is patently absurd.

Naturally, this reply presumes that informed consent is robust. If informed consent were not fully obtained, then patients would not be voluntarily assuming the risks of exclusion and unfairness in the

distribution of scarce resources. This point is particularly urgent, given that RTNG could have the indirect effect of weakening informed consent. Recall that, in the previous section, I discussed the concern that routine testing would lead to perfunctory procedures for obtaining consent from patients. The state should of course make great efforts to ensure that medical professionals would not compromise informed consent. If the state could not prevent this result, however, then the strength of the assumption of risk reply would be inversely proportional to the degree to which informed consent would be lacking.

Suppose, now, for the sake of argument that fully voluntary consent would be difficult to obtain or that voluntary consent to take an HIV test would not fully absolve the state of responsibility for the promotion of stigma and discrimination. In particular, although one can assume the risk of harm that might befall oneself, one cannot do so for harm that would befall third-parties. I therefore need to show that RTNG can satisfy the threefold principle analysed above. Recall that this principle says that an agent may respectfully adopt a policy that would result in harm, if: the harm would not be intended but would instead be foreseeably done by others in the long run; the agent would try to minimise the harm; and the policy would have benefits such as the fulfilment of rights that outweigh the harm done. RTNG could obviously fulfil the first two of these conditions, but what about the crucial, third one?

The key issue is whether RTNG would promote the right to healthcare to such a degree as to be worth the likely drawbacks of discrimination and stigma. Answering this question partially requires empirical evidence about the probable effects of routine testing with regard to the reduction of HIV transmission. The more that RTNG would reduce HIV rates, the more reason there would be to think that RTNG would be worth the costs of stigma and discrimination.

Unfortunately, I lack the relevant evidence indicating how much RTNG would promise to reduce transmission of HIV. It would therefore be nice if I could show that the other just cause of RTNG, namely, the provision of information about a patient's health, would *itself* be worth these costs. Information about one's health, and particularly about one's HIV status, is a crucial component of autonomy, the ability to make decisions about the central aspects of one's life. And the virtually 100 per cent likelihood of knowing one's HIV status might outweigh the less than 100 per cent chance of negative reactions from others. What follows is an analogy to support this claim.

Suppose that you are a psychologist considering whether to treat a prospective client who is confused about his sexuality, wondering whether he is gay. You are aware that the client's family and other members of his community are bigoted, prone to ostracise and discriminate against people they perceive to be gay. You also know that if your client discovered that he is gay, there would be some chance that others would find out; although you

of course would keep the information confidential, the client might tell them himself, files could get stolen from your office, etc. In light of these risks, would it be disrespectful for you to help the client acquire insight into his sexual identity?

I am inclined to answer 'no,' at least if there were not a high likelihood of your client facing violence. I grant that part of the intuition here might be a function of the client's consent to face the risks; so, let us try to set that aside. Focus instead on the values of self-reflection and of knowledge of one's sexual identity. Your duty as a psychologist to promote autonomy in these respects is, I submit, comparable to your duty not to do something that could foreseeably prompt others to ostracise or discriminate against your client. By analogy, the state's duty to offer information to people about their physical health is at least comparable to, if not more important than, its duty not to do something that could foreseeably prompt others to ostracise or discriminate against those who are ill (at least if the state seeks to block such reactions).

In sum, I have made two principled replies to the objection that the indirect and long-term harms from RTNG would outweigh the benefits it promises, making it unjustified. The first and most powerful reply is that, so long as the state tries to minimise these harms, the state may foreseeably cause them if the patient makes a free and informed decision to accept RTNG in the face of them. If the bare fact of stigma and discrimination were enough to make RTNG unjustified, it would also make VCT in the absence of treatment unjustified, which is an absurd implication. The second reply is that such harms might in fact be worth it, given the expected benefits of RTNG. In particular, I suggested that, from the perspective of respect, the duty to provide another person information central to his autonomy is perhaps as weighty as the duty not to do something that would have the unintended result of people treating each other unreasonably in the long-term.

(e) Minimal Necessity

Even if the goals of providing information about people's health and reducing HIV transmission would in principle justify RTNG, even if this means were likely to achieve these goals to a requisite degree, and even if its benefits would be worth its indirect and long-term harms, RTNG would be unjustified if it were not the least harmful means necessary to realise the just causes of increased information and reduced transmission. In particular, the combination of VCT and educational programmes might achieve the same benefits as RTNG but with fewer strains on patient mental stability, informed consent, and the state's budget.⁴⁹ There

⁴⁹ Osborn (note 16 above) 3; C Collins 'The Case against AIDS Testing' (1987) 2 *AIDS & Public Policy J* 9, 11; and G James Wood 'The Politics of AIDS Testing' (1987) 2 *AIDS & Public Policy J* 41, 47-48.

is some evidence that such a combination worked well in Uganda, for instance.⁵⁰

Some question this evidence, suggesting that Uganda's HIV transmission rate declined largely because a high death-rate from AIDS reduced the number of HIV carriers.⁵¹ Furthermore, as with RTG, the only reason that alternatives to RTNG would have fewer costs is that they would have fewer benefits as well. The reason they would be financially cheaper is that fewer people would get tested, which means that fewer people would find out their serostatus and hence more people would contract HIV. One might think that education would lead people to change their sexual behaviour in the absence of knowing whether they or their partner is HIV positive, but educational programmes directed at the general public, while effective to some degree, are unlikely to be as effective as knowledge of one's status or that of one's sexual companion. People are astonishingly good at ignoring evidence that is not in their face, preferring to believe they are not at risk of having HIV.⁵² In fact, denial that one has the disease would be likely even if one knew that 50 per cent of the population were infected.

Furthermore, the reason that RTNG might cause more anxiety and threaten informed consent more than VCT and educational alternatives is that the latter would not offer as great an opportunity for people to learn their serostatus. A person's ability to obtain information about her health is as robust as possible when a medical practitioner offers it to her on the spot in a confidential setting; that ability is weaker if a person merely reads a billboard exhorting her to get tested and then needs to discretely look up and travel to the nearest VCT clinic.

There is no doubt that RTNG would pose some risks. However, relative to the most promising alternatives, RTNG would likely do more to reduce the transmission of HIV and would certainly provide more of an opportunity for people to acquire information of their serostatus. It is therefore reasonably deemed to be the least harmful means necessary to realise its goals.

V CONCLUSION

The four objections to RTNG addressed so far are both the most serious and require responses that differ somewhat from ones that I made in the

50 UNAIDS *HIV Prevention Needs and Success: A Tale of Three Countries* (2001) 1-3.

51 MJ Wawer et al 'Declines in HIV Prevalence in Uganda: Not as Simple as ABC' unpublished manuscript presented at 12th Conference on Retroviruses and Opportunistic Infections (Boston, February 2005).

52 A large majority of those who are HIV positive believed they faced little risk of contracting the virus both in developed countries (L Altman 'AIDS Study Finds Many Unaware They Have Virus' *New York Times* 8 July 2002) and in developing ones (UNAIDS *AIDS Epidemic Update: Sub-Saharan Africa*, <http://www.unaids.org/wad2004/EPIupdate2004_html_en/Epi04_05_en.htm >).

context of RTG. The two objections that remain are less serious and permit responses similar to ones that I made above with regard to RTG in part III (f) and (g). These objections are concerned that RTNG could not avoid being applied in an unfair way and that those advocating RTNG would have pernicious motives. I leave it to the reader to apply my previous discussion to the present context.

My goals in this article have been to provide a taxonomic framework that organises the major issues at stake in the morality of routine testing; to present a new, thorough and respect-based justification for routine testing as a gateway to ART; and to defend the novel thesis that routine testing is justified even when it does not serve as a gateway to treatment for the person tested. In doing so, I have worked to demonstrate that there is a form of routine testing that can promote health without violating rights. Specifically, I have argued in detail that routine testing is morally justified because it is necessary to fulfil citizens' right to healthcare. RTG would likely improve people's access to ART, while RTNG would inform people of their serostatus and promise to reduce HIV transmission. I have argued, contrary to critics, that these ends in principle justify routine testing as a means, that it is a means that is likely to achieve these ends, and that no other means could achieve the same ends. I have also argued that fulfilling these ends of the right to healthcare is justified in the face of certain disvalues that might accompany routine testing, namely, weakened informed consent, stigma and discrimination, unfair application, and pernicious motives. Even if the reader does not find some of my discussion convincing, I hope that it serves to sharply identify the moral claims on which there is disagreement.

In addition, I hope that this analysis clarifies the empirical controversies. The results of routine testing have been less relevant to a respect-based moral evaluation of it than they would have been if I had used a consequentialist ethics. Still, routine testing's likely consequences have been relevant, and the defence of my theses has at times relied on empirical claims about them, claims for which I have not provided very substantial evidence. I conclude by posing empirical questions that I, as a professional ethicist, cannot answer but that would be useful for social scientists to take up in a different context: would RTG substantially reduce stigma and discrimination? Could RTG avoid promoting much complacency about safer sex? Could the state ensure that medical professionals would not weaken informed consent much, if at all? Could the state's laws protecting confidentiality and forbidding discrimination work well? Would RTG and even RTNG save more lives than VCT? Are affirmative answers to these questions, which I have suggested are reasonable, in fact correct?