

CASE #10

STATE HOSPITAL HIV SEROPOSITIVE PATIENT REFUSES TO WEAR A CHASTITY GARMENT

Abstract

The strain between individual autonomous choices and obligations to the community is a familiar tension. The AIDS epidemic raises a host of ethical questions which seem to require a balancing of rights of the infected and the uninfected. There is a major conflict between private goals of assuring treatment and respecting the civil rights of those infected with HIV, and the public health or social goals of limiting the spread of the infection.(1) In the following case these questions of respect for individual civil rights versus responsibilities to public health are examined within the microcosm of an inpatient ward in a state mental hospital.

Query

How may the treatment team provide the least restrictive environment for a sexually promiscuous decision-impaired HIV seropositive man with schizophrenia, and at the same time fulfill their duty to protect all other patients in an understaffed ward of a state mental hospital?

CASE PRESENTATION

K. is a 29 year old male with schizophrenia, a history of drug abuse, and is HIV seropositive. He was committed to a state mental hospital in 1989. K. is on Ward X. This a long term ward for committed chronic mentally ill patients suffering from schizophrenia, bipolar affective disorder, and organic impairment. These are patients who cannot be discharged back into the community: either appropriate housing facilities cannot be found, or--as in K.'s case--the patient is refractory to medication, or refractory to other kinds of treatment.

When K. first entered the state hospital he was decompensating and had a complex paranoid delusional system. He still suffers from bizarre delusions. He frequently comes to the ward nursing station and says, "You're not going to let them do that to me are you? You know, they're cutting up people down in the basement." No medication for his schizophrenia has been effective. He is currently taking Loxitane, a Monoamine Oxidase inhibitor for depression, and AZT.

In July of 1991, an AIDS patient, Mr. R., was admitted to Ward X. Mr. R. knew he had AIDS and publicized it. He made no attempt to conceal the fact. Even though it is now believed that K. became HIV seropositive due to sexual contact with Mr. R., he and R. were never actually seen indulging in sexual activity together. However, a ward aide found Mr. R. sodomizing another patient, a Mr. J., in Mr. J's cubicle. Six months later, Mr. R. became acutely ill (with a fulminating pneumocystosis and a marked dementia) and was transferred to a local hospital where he died the following day.

Education on AIDS is compulsory and routine at this hospital (in addition, condoms are made available to all patients). These educational talks occur twice per month throughout all the wards. After one of these lectures K. approached the ward physician and said that he wished to be tested. K. tested HIV seropositive.

At that point, the ward staff monitored K. more closely. He widely advertised his HIV status. K. never admitted to having any sexual contacts, but other patients on the ward complained about K's sexual advances. They reported that he was very persistent in asking for sexual favors. This sexual activity occurred nocturnally when he would approach other patients in their cubicles. Consequently the treatment team resorted to program seclusion for K., from 10:00 p.m. to 6:00 a.m., in order to protect the other patients.

K. continued, however, to be a threat to patients on the ward during the day. He was found giving a massage to another patient, Mr. M., in M's cubicle. It appeared that no sexual act had actually taken place. A patient, Mr. L., newly admitted to the ward, was approached by K. for sexual purposes. Mr. L., described as quiet and timid, telephoned his mother. She contacted the ward physician for reassurance that her son would be safe.

K. can give a lucid account of how not to get AIDS, but his actions negate his own advice. The other patients on the ward also are indiscriminate in their behavior. K.'s psychosis and disorganization has prevented him from being a candidate for off-ward privileges. The ward staff, however, are concerned for the safety of the other

patients on Ward X. At any given time, there are--at the most--three staff for 36 patients. They cannot adequately keep K. under observation while concurrently fulfilling their duties to care for the remaining 35 patients.

In order to protect their other patients from exposure to a potentially life-threatening disease and at the same time ensure K.'s right to freedom of movement, the treatment team proposed that night time programmed seclusion be continued *and* that the use of a chastity garment be initiated. They proposed that K. wear this garment when he was not in programmed seclusion in order to provide protection to the other patients. This garment would require that K. be provided with staff assistance whenever he needed to use toilet facilities.

K. was approached by the ward physician who explained this treatment plan to him, for the purpose of getting his informed consent. K. vehemently refused to give consent. Subsequent to this meeting with K., the ward physician formally requested an outside consultant's (an independent examining physician) assessment of K.'s capacity to consent or refuse treatment.

The hospital ethics committee met to discuss the treatment team's proposal regarding the provision of a chastity garment for K. and their concomitant concern with their duty to protect the patients on Ward X.