Case Study

Ethical Dilemma and Management of Infertility in HIV Seropositive Discordant Couples: A Case Study in Nigeria

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Abstract

The traditional African society places an invaluable premium on procreation and, in some communities, a woman's place in her matrimony is only confirmed on positive reproductive outcome. Infertility is rife in Nigeria, and HIV/acquired immunodeficiency syndrome (AIDS) infection is a global pandemic, which has led to a drop in life expectancy across the world. In Nigeria, a number of cultural norms relating to gender roles and power dynamics constitute a serious barrier to issues of sexuality and infertility. Couples are concerned about their infertility diagnostic test being disclosed to each other, especially before marriage. This concern is understandable, especially in an environment that lacks the modern concepts and attitude toward sexual matters. This is complicated by the advent of HIV/AIDS infection and the societal mind-set that look at seropostive individuals as transgressors. At present, sexual and reproductive health rights are currently not in place because ethical issues are not given prominence by many physicians in Nigeria. A case of an infertile and seropostive discordant couple, which raised a lot of medical and ethical concerns, is presented here to awaken the consciousness of Nigerian physicians and stimulate discussions on the ethical matters such as this in clinical practice.

Keywords: Confidentiality, Disclosure, Ethics, Family, HIV/AIDS, Infertility

Introduction

Nigeria has the largest population in Africa, with over 250 ethnic groups and more than 510 languages.[1] Extended families are still the norm, and, in fact, remain the backbone of the social system in Nigeria. Grandparents, cousins, aunts, uncles, sisters, brothers and in-laws all work as a unit through life. Family relationships are guided by hierarchy and seniority. Individuals turn to members of the extended family for solving health issues such as fertility and other ailments, and the family is expected to provide for the welfare of every member. Therefore, individuals that benefited from the family structure are expected to owe allegiance to the system in return and, in certain situations, do not have autonomy to decide on his or her health matters without the family input. Infertility is rife in Nigeria, with secondary infertility predominating and commonly associated with tubal pathologies.[2,3] HIV/acquired immunodeficiency syndrome (AIDS) is a global pandemic that earlier has led to a drop in life expectancy across nations.[4] It is generally believed that HIV/AIDS is the most formidable pathogenic disease to confront modern medicine. In Nigeria, as it is often the case in most of the developing countries, the societal attitude toward HIV infection, lack of advanced technique for prevention and the limited options of treatment when infected places most physicians in a dilemma of disclosing the HIV-positive status of an individual to the family members. In an environment where ignorance and poverty are commonplace, women especially may be concerned about their diagnostic test being disclosed, because this may lead to increased discrimination and harassment. For the married women, they may be subjected to violence or abandonment by their male partners. However, the introduction of potent anti-retroviral drugs has converted this highly fatal illness to a chronic condition, and people with HIV/AIDS now have

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prolonged life and desire fertility. Heterosexual transmission is the most common mode of transmission in Africa,[3] but vertical transmission accounts for the greatest proportion of the infected children in Africa.[4] Sexual and reproductive health rights are currently topical. Ethical issues are not given prominence by many physicians in Nigeria. A case of an infertile and serodiscordant couple that raised a lot of medical and ethical concerns is presented here to awaken the consciousness of Nigerian physicians and to stimulate discussions among other colleagues internationally on the ethical matters such as this in clinical practice.

Case Study

Mrs. KC was a 26-year-old graduate of management studies from one of the Nigerian Universities, and a Christian. She has recently married Mr. EC, a 38-year-old Mechanical Engineer who was self-employed and also a Christian. They presented to Dr. TO at the gynecological clinic with a 6-month history of inability to achieve conception despite regular unprotected sexual exposure. Eighteen months earlier, Mrs. KC then unmarried (Miss. KA) and in her National Youth Service scheme, had been managed by Dr. TO for pelvic abscess following complicated unsafe abortion. Abortion is illegal in Nigeria. Findings at surgery then were that of a frozen pelvis and mutiloculated intraperitoneal abscess. The abscess was drained and the surgeons believed her future reproductive career has been severely compromised.

Seven months after the surgery, Mr. EC who was Dr. TO's friend introduced the then Miss. KA to him as his fiancée. Dr. TO, stunned, struggled with himself not to disclose Miss. KA's gynaecological status to his friend. Eventually, he did not and now the couple presents to him with infertility. In the course of the infertility investigation, Dr. TO discovered that Mr. EC is retroviral positive and Mrs. KC returned a negative retroviral test. Hysterosalpingogram reveals bilateral tubal blockage in Mrs. KC. After due counselling, Mr. EC's HIV positive status was confirmed by Western blot testing. He asked the doctor not to disclose his status to his wife. Meanwhile, Mrs. KC had also earlier pleaded with the doctor not to reveal her past medical history to her husband. Now, the doctor is caught in this couple's web.

Ethical Concern

a. Disclosure of Mrs. KC's past medical history to her husband as the primary cause of infertility (confidentiality, truth-telling)
b. Disclosure of Mr. EC's HIV status to his wife (confidentiality, truth-telling, duty to inform)
c. Management of a sero discordant infertile couple (right treatment, ethics of responsibility, physician's duty to care)

Discussion

Mrs. KC had related to her husband that the surgical scar on her abdomen was for complications resulting from an appendicectomy that she had earlier on. She admitted to pre-marital sex but never disclosed the induced abortion she had. She did not want this past revealed, to maintain her husband's trust and confidence. In the Catholic context, this is very important for matrimonial harmony. They were of the Catholic faith. Dr. TO had no problem with this part as he recognized her autonomy as one of the core principles of confidentiality. Confidentiality is also based on respect for relationship, shared information and benefit of confidentiality to those who require advice and help, and, in turn, to the society.[5] The problem arose when the husband wanted to know the exact aetiology of her tubal blockage that has been implicated as the cause of the current infertility. Truth telling, an important ingredient in Medical Ethics, required the elaboration of Mrs. KC's past medical and surgical history, but this at the same time could lead to a break up in the marriage. After much internal conflict between truth telling, confidentiality, autonomy and the reality of the truth jeopardizing a marriage,[6] Dr. TO considered that Mr. EC knowing the proximate cause of the tubal blockage would have no bearing in the couple's decision for further management of their infertility, and did not disclose this history to him. The doctor rather emphasized the uncertainty of medical sciences in many aspects of disease aetiology and posited that the appendicectomy could probably have been responsible.

Doctor TO encouraged Mr. EC to disclose his HIV status to the wife as this will pave way for safer practices and necessary follow-up of the wife. They have been having unprotected sexual intercourse for about 6 months, and the wife might have been infected but still within the window period. He refused stating that his young wife will be shattered and the family put in peril. The doctor explained that otherwise might put both his wife and the family in greater peril. He refused and reminded the doctor of the principle of confidentiality, which he believed was absolute. This raised the ethical issue of confidentiality as well as the physician's duty to warn. Many workers have evaluated the issue of medical confidentiality,[5-9] and the consensus weighs in favor of duty to inform in certain conditions including infectious diseases like HIV, where the possibility of transmission to another unsuspecting partner might be very high.[4] The Royal College of Physicians Edinburgh asserts that HIV is such an infectious disease with serious physical and psychological morbidity consequent upon it; therefore, all efforts must be made to prevent its transmission to a vulnerable individual and this may involve breaking of the medical confidentiality.[7] With these considerations, Dr. TO informed Mr. EC that he, the doctor, would disclose his status to his wife at their next appointment if he had not done so himself. Mr. EC did eventually. He was referred to the Medical Out Patient Department for further management of the HIV infection. The wife was scheduled for further screening tests at intervals.

Advances in management, increased life expectancy and major reduction in vertical transmission rates using highly active anti-retroviral therapy have led to increasing desire for procreativity among HIV-positive individuals.[10] Mr. and Mrs. EC presented with infertility (for which a definite cause was evident even though they were yet to co-habit for 12 months) and desired fertility. Mr. EC was HIV positive, and this raised ethical concerns as follows: the right of the couple to seek and obtain treatment; the right of his partner to remain negative if not already infected; the right of the resulting off spring to be free from disease and have a quality extrauterine life in a stable and long-lasting family; and the right of the care providers to minimize exposure to the virus to themselves.[11] There is no doubt that the couple had right to seek and obtain treatment of their infertility, but the sero status of the husband introduces another dimension to their state. Should Mrs. KC sero convert and should they get pregnant, there is a possibility that their off spring would be affected. This was painstakingly detailed to them and they were asked to consider the ethics of responsibility to the unborn baby that accompanies their desire. Modalities to reduce vertical transmission were also explained to them to include compliance with highly active anti-retroviral therapy (HAART) should the need arise, consistent use of condoms, elective caesarean section and infant formula feeding, among others.[3] At the next appointment, they reiterated their fertility desires.

The next consideration was the physician's responsibility to the off spring.[11] In spite of the numerous strategies to reduce vertical transmission, there still exists the real risk of the infant being infected. Is it not possible that this infant may one day bring litigation to the doctor for "wrongful birth"?[12] Nevertheless, the physician has to weigh the balance of the baby being infected, becoming an AIDS orphan, be raised in a family with HIV/AIDS morbidity and possibly a shortened life span.[11] These issues are real and, in some centers in Europe, fertility treatment may be denied such couples.[11] It is believed that the duty of care, which the physician owes to the baby, should not be overshadowed by autonomy or perceived patient's right to treatment and reproduction. Such rights are to be respected only within the physician's duty to care and not just for the sake of autonomy.[11]

The next consideration was the mode of treatment. This was made easy because of the underlying pathology: bilateral blockage of the fallopian tubes, there was also mild oligospermia on the side of the husband. They were referred to an *in vitro* fertilization center. Artificial reproductive techniques are quite expensive in Nigeria. The couple could not access the treatment and were weighing other homeopathic and traditional alternatives. However, for sero discordant couples where the male is HIV positive with no underlying infertility, natural conception is said to pose a 0.1-4% risk of infection to the female partner with timed unprotected sexual exposure.[13] This risk is reduced with sperm washing and artificial insemination, but poses a risk to the care providers who could get infected.[11]

Conclusion

Fertility desires among seropositive discordant couples pose medical and ethical dilemma to the gynecologist. These border on confidentiality, autonomy, right to obtain treatment, right of the unborn baby to be free of disease and have a good life in a stable family as well as the right of the care provider not to be exposed to the virus. The couple should be treated with empathy and all ethical and medical issues discussed with them. Responsibility ethics toward the desired off spring must also be emphasized.

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