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Date 6th June 2005
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Blood Testing Following Criminal Incidents Where There Is A Risk Of Infection

Thank you for the opportunity to comment on this proposal. This response has been informed by a number of colleagues here in Lothian.

The issue is very important and there will be a lot of sympathy with the underlying thrust of the proposal - the protection of frontline public workers from unnecessary anxiety and risk. As the consultation paper rightly points out, this is an issue that we are very experienced with in the NHS, with A&E staff in particular. However, if the reduction of anxiety and risk is the objective we should ask whether the proposal is the best way of achieving it. It would be very undesirable for attention to be focused on this proposal at the expense of an effective occupational health service that is most likely to deliver protection and reassurance in the vast majority of incidents.

The document makes a passing reference to occupational health. A well-resourced and effective occupational health service is the only way of delivering high quality risk management of such incidents. It would be useful to see this proposal in the context of an assessment of the current occupational health service for the Police. For instance, how many officers are currently unvaccinated against hepatitis B? It could be argued that no officer undertaking front line police duties should be unvaccinated.

I understand from colleagues in the NHS that they perceive that the current arrangements for the management of police officers who have been subject to a potential exposure to BBVs is haphazard. I also understand that there is a great willingness to assist in the improvement of this situation, which I greatly welcome.

The results from the type of order that is being proposed may inform a risk assessment in the event of an incident but it will likely be additional information rather than conclusive evidence. In the case of HIV, post exposure prophylaxis for occupational HIV exposure is a developing field with a number of uncertainties and a reliance on animal studies. There is a protocol with the Cochrane Collaboration for a systematic review of the issue. Specialist input is therefore highly desirable in these instances.

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Lothian NHS Board is the common name of Lothian Health Board

The proposal raises a number of ethical and practical questions. These must be balanced against the likely value of the information that may be gained from such a power.

From a Communicable Disease Control perspective the potential public health gains here are minimal. The consultation document states that only one case of BBV transmission to a police officer has been documented. This was a case of hepatitis B, which is by far the most easily transmissible of the three, and also the most preventable through a vaccine. The strength of the case from a public health point-of-view depends on the health gains to be achieved from:

- i. the reassurance/lessening of anxiety that may follow from knowing the results of mandatory tests;
- ii. the avoidance of unnecessary administration of post-exposure prophylaxis.

There is a latent period after infection with a BBV before the markers of infection that are routinely tested for appear in the blood giving rise to the possibility of false reassurance. In the light of this, will the benefits of i. be diminished? Are we lulling the police officer in to a false sense of security if the test is negative? It may be that the suspect is antibody negative for HIV but still infected or that their viral load is undetectable but they may be capable of transmitting infection.

The consultation document mentions examples of similar legislation in Canada and Australia but does not offer any evaluation of the success of this legislation in achieving the desired aims. The existence of legislation elsewhere does not of itself mean that it is a good idea.

The practicality of the proposal is a key concern and there are many issues that would need a lot of time and effort to sort out. Colleagues within NHS Lothian have highlighted the following:

- Who would do the pre test counselling of the suspect and the applicant?
- Who would take the blood samples?
- Who would do the testing?
- Who would give post test counselling of the suspect and the applicant?
- Who would give them the results? Would the suspect be told his or her results before the police?
- What will happen if the police officer is found to be positive but the suspect is negative and therefore, the officer's infection has nothing to do with the suspect? Would the suspect have a claim against the applicant e.g. the police officer?
- Are officers' samples being stored in case they become ill in the future or are they going to be tested at intervals and will they have follow up testing?
- How quickly can a sheriff be contacted to give permission? Are both parties "hanging around" until permission is granted?
- How skilled would the counsellors be? It is suggested that this needs to be undertaken by very skilled people e.g. the people with skills as good as those in GUM clinics.

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Ethical issues

The consultation acknowledges that there is an ethical dimension, although it avoids any discussion of the issues. A situation that offers some insight into the issues occurs where a health worker or other person is put at risk of a blood-borne virus (BBV), and it is not possible to obtain consent. The General Medical Council (GMC) in its guidance document "Serious Communicable Diseases" outlines the situations where they believe testing for serious communicable diseases is justified in the absence of patient consent.

These are (in the order they occur in the booklet):

1. Where the legal guardian of a minor refuses consent for the child to be tested and there is reason to believe that the guardian's judgement is distorted (the example given is where perhaps the guardian may be the cause of the infection – implicitly alluding here to suspicion of sexual abuse).
2. In unconscious patients where clinical judgement deems that testing is in the patient's best clinical interests.
3. Where a person refuses or is unable to give consent "in exceptional circumstances ... for which prophylactic treatment is available". In this case an existing blood sample may be used for such a test. The decision to test may be challenged (by the court, or as a result of a complaint to the GMC) and the decision to test must therefore be justifiable.
4. Where a patient has died, a health care worker has been exposed to risk of infection and there is "good reason to think that the patient may have been infected".
5. In the course of an authorised post-mortem where such a test is necessary as part of determining the cause of death.

Regarding confidentiality about information regarding a person's status with respect to serious communicable disease (such information may have been obtained from either existing medical records or a recent blood test), the GMC makes the following statement: "If patients still refuse to allow other health care workers to be informed, you must respect the patients' wishes *except where you judge that failure to disclose the information would put a health care worker or other patient at serious risk of death or serious harm*" (emphasis added).

In all relevant cases, the GMC recommends that the patient be told (preferably beforehand) that testing and/or disclosure is to take place.

Thus, the statutory body responsible for licensing doctors in the United Kingdom has outlined some professional ethical standards in this area. Although such guidelines could not be considered binding on other professions besides the medical profession, they could be seen as providing a baseline for discussion. Where it is decided that variations from these guidelines should apply, such variations would require appropriate justification.

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Additionally, the GMC Guidelines apparently leave certain questions unanswered. For example, although existing knowledge about someone's BBV status may be disclosed where a patient refuses, there is no provision for carrying out such tests if they have not already been done, even if there is an existing specimen. Furthermore, there is no provision for the taking of a blood specimen for that specific purpose where such a specimen does not exist. Additionally, there is no mention of testing in the situation where prophylaxis is unavailable but where the at-risk person is seeking the reassurance that a negative test might bring (e.g. for hepatitis C infection).

The BMA book "Medical Ethics Today" (2004) essentially takes the same position as the GMC. The emphasis is on balancing the duty of confidentiality with the risks of serious harm to another person, disclosure being justified to prevent serious harm to another person; "Health professionals have clear moral duties to individual patients and to colleagues that may come into conflict with wider obligations to avert serious and preventable harm to others".

The question thus comes down to whether the anxiety provoked to those at risk of BBV constitutes averting serious and preventable harm.

The Scottish executive document itself refers to the case of needlestick injury on page 12 and sees some analogy with exposure to BBV in the context of assisting at an accident. While the GMC/BMA guidance therefore gives some indication of the ethics of weighting the duty for confidentiality with the risk of serious and avoidable harm to another, they do not directly address the issue of the mandatory performing of such tests.

This guidance is issued to health professionals. By virtue of their professions' code of ethics, they have accepted a role that requires consideration of the patients' best interests. While such considerations are not absolute, the GMC guidelines, and generally acceptable professional ethical standards would dictate that this duty cannot be overridden without serious justification. However, where sufficiently serious justification exists, there are circumstances where the normal duties of confidentiality and the requirement for fully informed consent are overridden. One question, therefore, is whether health care workers, by virtue of the ethical duties imposed by their profession, must adhere to a different standard in relation to this question than others who are put at risk of BBV in the course of their work, in the course of being a victim of crime, or as a result of stopping to assist an injured person.

There is probably not a uniform answer to this. In general, health professionals would have a higher duty regarding confidentiality of information than applies to the public in general. Whether it is higher than other "professional" duties of confidentiality (e.g., between solicitor and client) is a matter of more debate.

Another way of analysing this issue is through what are known in health circles as the 'four principles' of ethical debate and behaviour. Beauchamp & Childress are noted for their development of the notion of the four *prima facie* principles of medical ethics.

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These are:

- respect for autonomy – the right to individual self determination;
- beneficence – the doing of good;
- non-maleficence – the avoidance of doing harm;
- justice – equity, fairness.

They recognise that these principles can give rise to competing ethical claims and state the following to take into account when balancing competing claims made by each of these 4 principles - which is what is happening in the case of testing for BBV:

"The following conditions must be met to justify infringing one prima facie norm in order to adhere to another...

1. Better reasons can be offered to act on the overriding norm than on the infringed norm (e.g., if persons have a **right** (italicised in the text), their interests generally deserve a special place when balancing those interests against the interests of persons who have no comparable right.
2. The moral objective justifying the infringement must have a realistic prospect of achievement.
3. The infringement is necessary in that no morally preferable alternative actions can be substituted.
4. The infringement selected must be the least possible infringement, commensurate with achieving the primary goal of the action.
5. The agent must seek to minimise any negative effects of the infringement.
6. The agent must act impartially in regard to all affected parties; that is, the agent's decision must not be influenced by morally irrelevant information about any party."

(Source: Beauchamp TL & Childress JF. Principles of Biomedical Ethics (5th ed.). Oxford: Oxford University Press, 2001. pp.19-20.)

It seems that all of these bear upon BBV testing in one way or another. For condition 1, does whatever "beneficent" or "non-maleficent" motive for conducting compulsory BBV testing constitute the "overriding norm" that justifies infringing "respect for autonomy"? Can better reasons be offered for giving primacy to beneficence/ non-maleficence than to respect for autonomy?

For condition 2, would the infringement of autonomy that mandatory testing introduces achieve the moral objective of beneficence or non-maleficence (in this case the reduction of anxiety). As I outline above, I suspect that it would not.

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Condition 3 asks whether there is no more preferable action. In this case it seems that a review of arrangements for risk assessment and the more structured involvement of expert advice would be more preferable.

Conditions 4 and 5 are addressed to some extent in the consultation document but only on the premise that the infringement is one that needs to occur, which answers to previous conditions throw into question.

In condition 6, things that would need to be considered include whether the allegation of committing a criminal offence constitutes a "morally relevant" piece of information. Acting impartially in health is usually expressed in terms of responding to clinical need, treating those whose need is greatest first, regardless of who they are or what they have done. The consultation document tacitly acknowledges that to restrict the right to apply for a mandatory test to the police or public sector workers may lead to situations that are demonstrably unfair. But any extension then removes any "moral relevance" that the allegation of criminal behaviour might have brought. The right should therefore exist for everybody or nobody.

The consultation paper fails to engage with these issues in any meaningful way and thus makes it difficult to accept the basic proposal at face value. With this in mind, answers are provided where possible to the consultation questions below.

Question 1

It is difficult to see a justification for allowing application for information to apply to groups of people. Belonging to a specific group (e.g., police officer or other emergency services) may make the probability of occurrence of an event that may transmit a BBV more likely. However, any individual (e.g., a passer-by who goes to the assistance of an accident victim) experiencing such an event could be argued to have an equal right (see condition 6 above).

One interesting case arises where it may be the criminally culpable assailant, who, during an altercation is exposed to the body fluids of a police officer, security guard or any other person. Is this person entitled to apply for this information in order to assess their need for post-exposure prophylaxis?

Question 2

Mandatory testing, if introduced, needs some protection from trivial or vexatious application. Whatever is judged the best safeguard of this should be in place – and most likely application through a sheriff is the best way to achieve this, though ready access to expert medical advice on degree of risk in an individual case is also essential. It must not be forgotten that application to the law will not of itself reduce the risk for an individual.

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Question 3

The answer to this question depends on the justification used for introducing mandatory testing. If the justification is based on the fact that by virtue of allegedly committing a criminal offence, a person surrenders some of their rights to refuse testing for BBV then it is perhaps justified not to apply mandatory blood testing to those who may have *accidentally* exposed another person. However, if the justification for mandatory testing is the prevention of serious harm to another individual, then such a distinction may not be justified. On these grounds anyone who is exposed to another person's body fluids in such a way as to constitute a risk of transmission should be able to apply for a testing order.

Question 4

The answer to this depends on the relative merits of the answers to all of the other questions. In terms of enforcement of mandatory testing, presumably there would be a situation similar to a person refusing to provide a specimen if suspected of drunk driving. However, it should be remembered that unlike the situation regarding the drunk driver, a refusal in this circumstance means the applicant for results is deprived of any benefit.

Question 5

The answer to question 3 applies here

Question 6

The response to question 3 applies here as well.

Further issues

A number of further questions and issues arise:

1. To what extent does the assailant (or whoever is the source of the potential infecting body fluid) retain a right "not-to-know" his or her own status with respect to Hep B, Hep C or HIV? The life-changing nature of finding out this information is mentioned in the consultation. Should some mechanism exist where mandatory testing occurs to ensure that only the applicant gets the results if the person being tested indicates they do not want to know? There are practical as well as ethical issues involved here. For example, it would probably mean the assailant's doctor could not be given the results because once aware of such results that doctor may be under a degree of ethical obligation to inform his or her patient.
2. Are there special considerations where a crime involves the assailant making a threat that they have a BBV part of the crime; e.g. someone with HIV or Hepatitis B making a threat that involves a risk of infection ("I'll stab you with this syringe" etc.). Would the mandatory test requirement apply even more stringently in this situation? Would someone using a claim to an infected status as a weapon in this manner effectively lose some of the rights they would otherwise have?

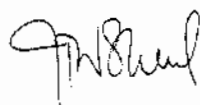
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3. What is the current laws regarding mandatory testing in the context where someone has been the victim of a sexual assault (where relevant tests may be for conditions other than the BBV)? Ethically, it would seem there are relevant parallels that should be considered.

In summary, there is not the justification as set out in the consultation document for the introduction of such a power. It would be a troubling step to take without further discussion, guidance and information. It is highly questionable whether it would be likely to achieve the aim of protecting frontline staff. It is imperative that staff in all organisations have access to high quality occupational health services. The possibility of false reassurance from the existence of such a power as is proposed is a real and unhelpful one.

I would like to thank colleagues throughout NHS Lothian for their comments and, in particular to Dr Rob Carlson, Senior Lecturer in Medical Ethics at the University of Edinburgh.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Alison McCallum'.

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