CORRESPONDENCE

- *All letters must be typed with double spacing and signed by all authors.*
- *No letter should be more than 400 words.*
- *For letters on scientific subjects we normally reserve our correspondence columns for those relating to issues discussed recently (within six weeks) in the BMJ.*
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- *Because we receive many more letters than we can publish we may shorten those we do print, particularly when we receive several on the same subject.*

HIV antibody testing

We have received many letters about the BMA council's decision that, despite the annual representative meeting's resolution to the contrary, doctors do need to obtain consent before testing for antibody to HIV and about the legal opinion on which that decision was based. We print a selection of them below together with a comment from Clare Dyer, our legal correspondent. Dr John Marks, the chairman of council, also replies to criticisms of the BMA's handling of the issue.—ED, *BMJ*.

SIR,—The legal opinion obtained by the British Medical Association on the requirement for informed consent before subjecting a blood sample to testing for antibody to human immunodeficiency virus (HIV) (10 October, p 911) is unlikely to find universal acceptance.

Thus it is confidently asserted that taking blood and subjecting it to a test to which the patient has not consented constitutes "an invasion of the patient's bodily integrity," which can give rise, inter alia, to an action for assault. Provided consent is obtained for the venepuncture, the physical act of taking blood—for whatever test—can never constitute an assault in law.

For the purposes of the law of assault the courts recognise a distinction between the type of fraud or deceit which induces consent that would not otherwise have been obtained, but which is none the less valid consent, and the type of fraud which prevents any real consent existing.[1] In other words, consent to the *act* of taking blood frees the doctor of criminal responsibility.[2,3]

The opinion is silent on the legal liability of medical practitioners who refer patients known to be—or reasonably suspected of being—seropositive for HIV (or any other contagious disease) to colleagues without informing them of their knowledge or reasonable suspicion. If, in those circumstances, anyone in the health team contracted a condition which could have been prevented if precautions appropriate to the condition had been taken I have no doubt that the referring practitioner would be liable for all the foreseeable consequences which flow from the omission to warn. Such liability arises under the ordinary principles of tort liability.[4] Confidentiality between doctor and patient is no defence against third parties. Dr Raanan Gillon's ethical considerations may have to be read in that context.[5]

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1 *R* v *Harms* 1944 2 DLR 61.
2 *R* v *Martin* 1840 9 C & P 213.
3 *R* v *Wollaston* 1872 12 Cox CC 180.
4 *Donoghue* v *Stevenson* [1932] AC 562.
5 Gillon R. AIDS and medical confidentiality. *Br Med J* 1987;**294**: 1975-7.

SIR,—If the opinion of Messrs Michael Sherrard and Ian Gatt (10 October, p 911) concerning testing for human immunodeficiency virus (HIV) antibody becomes accepted in law the practice of medicine will become effectively impossible. Almost everything contained within the argument of these two gentlemen could apply to any investigation performed on a patient. At only two points does their opinion suggest that an HIV antibody test is to be considered differently from other investigations, and then because the result has "far reaching implications" and "will not . . . lead to . . . life saving treatment." The same comments could be made of the diagnosis of rheumatoid disease, tertiary syphilis, malignancy, pregnancy, and a host of other conditions, depending on circumstances.

Their argument implies that the wise clinician should not only obtain the patient's permission for every investigation made but should also ensure that the patient is aware of the implications of all such investigations. In the case of a biochemical profile this might take hours to explain, as even a simple haemoglobin measurement might eventually lead to a diagnosis of carcinoma of the colon, something the patient might have preferred not to know. Perhaps the solution would be to give all patients a course of lectures in pathophysiology before beginning investigations, so that they could then prohibit those which might lead to unwanted diagnosis.

Sadly, the guidance we have been given takes us one more step down the road to defensive medicine.

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SIR,—Mr Michael Sherrard QC and Mr Ian Gatt have used a false analogy as the basis for their opinion that testing for HIV antibodies without obtaining a patient's consent could be construed as assault.

The cases they cite have all to do with surgical treatment, which inevitably imposes some kind of permanent alteration, and consent to such alteration naturally requires safeguards. Of course, even the skin puncture that is necessary to withdraw blood could in some circumstances constitute an assault, but these barristers have failed to take account of the clinical circumstances in which doctors would mostly wish to test for HIV.

Patients who have developed, or are developing, pathological changes induced by the virus may display a variety of signs and symptoms. None of these manifestations is specific for the virus, and a differential diagnosis is therefore necessary. A battery of suitably chosen blood tests is normal in

diagnosing such cases, and a doctor who did not include in that battery any specific test that might plausibly be crucial to the diagnosis could be accused of negligence. One who included tests that were unlikely to yield useful information might be accused of extravagance but never of failing to act in the patient's interest, since the making of the correct diagnosis is a prerequisite for the correct treatment. Moreover, any addition to the doctor's knowledge may enhance his ability to help his patient but can never reduce it. Therefore whenever it is clinically reasonable to take a blood sample for any purpose it is equally reasonable to test that sample by whatever methods may usefully add to that knowledge.

The question of a technical assault (and the aseptic withdrawal of a blood sample could never be construed by a court as other than the most trivial of technical assaults) could arise, therefore, only if the taking of the sample were not a reasonable part of the management of a patient. If this were not so, and the bizarre misapplication of surgical case law by the barristers were to prevail, any doctor would be in jeopardy who, in drawing a blood sample for any standard battery of tests, did not obtain the consent of the patient to each of the tests. The lawyers would no doubt argue that informed consent would require an explanation of the nature and purpose of each test.

A separate issue arises when a doctor discovers that his patient is infected with HIV, but it is not unique. While examining or treating a patient for unrelated purposes—for example, an insurance examination or inoculation—a doctor may find evidence of transmissible or lethal disease. He may also acquire confidential information, either from the patient himself or through privileged professional communications. If he should then decide to make use of such information without the patient's consent he does so at his own risk and may find himself subject to disciplinary action or to civil litigation, but this is unlikely to stop him if he discovers that his patient is an undetected murderer, a dealer in heroin, or another Typhoid Mary. In such circumstances almost all doctors would conclude that their duty to their fellow citizens overrode their duty of confidentiality to such patients and that both the courts and the General Medical Council would probably uphold that view.

It is a tragedy that many people who are positive for HIV must be unwittingly disseminating the virus and criminal that anyone who is knowingly infected should deliberately endanger others. It is therefore the duty of doctors to detect those who are infected whenever the opportunity occurs and at the very least to make sure that infected patients are made aware of the danger that they constitute to others. I do not believe that any court in Britain could be so misguided as to conclude that a doctor who had behaved in this responsible fashion in the face of the most dangerous epidemic that the world has suffered in modern times was guilty of assault.

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SIR,—In the matter of testing non-consenting patients for HIV antibody the council's original acceptance of the decision of the annual representative meeting (by 183-140 votes) seemed to be sensible, responsible, professional, and right. To abrogate that acceptance (by 25 votes to 6) seems to some of us in acute hospital practice to show a disturbing lack of common sense and an ethic whose overdefensiveness borders on cowardice.

We read with interest the lengthy academic opinion of Messrs Sherrard and Gatt, which superficially justifies council's inept volte face, but will confine our case to one specific but neglected area of far reaching practical importance.

Counsel state, "It appears . . . open to doubt whether tests for HIV antibody taken in an emergency involving an unconscious or desperately ill patient would be justified in *any event* [our emphasis] because of the length of time taken to obtain a result." The obvious "event" where HIV testing is now an imperative routine on an unconsenting patient is where that patient is brain dead by United Kingdom criteria and is about to become an organ donor.

Should the test be positive transplantation obviously must not proceed. In our department we have not yet, among 20 renal and multiorgan donations from September 1985 to October 1987, encountered a positive result. When, sadly, we do we will have no compunction about passing on the information (*a*) to the deceased's next of kin, if deemed appropriate, and (*b*) to the general practitioner. That would be proper practice in any other serious communicable disease. We would, moreover, be prepared to defend our action in court or before the General Medical Council if called on to do so. So ought any self respecting practitioner.

The further views of learned counsel on the dilemma, if it is one, of clinicians responsible for possible organ donors and of the implications for the United Kingdom transplantation programme will be read with equal interest.

Incidentally, the minimum laboratory time needed for an emergency HIV antibody assay is 1 hour and 40 minutes, much less than the time constraint between organ removal and transplantation of four to six hours for heart and liver and 72 hours for kidney. Cytomegalovirus assay and hepatitis B assay, also both routine, take 10 minutes and 2 hours 25 minutes respectively.

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SIR,—The advice that testing patients' blood for HIV antibody without their explicit consent may result in legal proceedings is based mainly on the premise that, for the patient, the social consequences of the knowledge of a positive test result would be dire. This seems to beg an important question. What about the knowledge of equally serious import that is gained without laboratory tests?

The clinical definition of the acquired immune deficiency syndrome (AIDS) remains robust and characteristic, having been established before HIV was confirmed as the causative agent. HIV tests are not a prerequisite for the definition or diagnosis of AIDS. Consider then my problem if a patient gives me general consent to perform a clinical examination. If without explicit consent I find wasting, lymphadenopathy, oral candida, and perhaps Kaposi's sarcoma, am I risking a legal action?

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SIR,—The BMA's guidelines for consent when testing a patient for HIV are now reasonably clear, but I find it difficult to see the legal differences between this test and many others that may be performed. What therefore is the legal position over other tests that doctors might consider routine? There are many tests available for unpleasant, fatal, and socially undesirable diseases.

The guidelines do not seem to cover the testing of tissue donors. When material is taken from a living donor, such as bone for banking, HIV and hepatitis testing is mandatory. Should consent be obtained for these tests in such cases? The problem becomes greater when taking material from dead donors. In these cases who gives permission for the test and who is told if the results are positive?

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SIR,—The decision of the BMA council to condemn testing for HIV without consent is unambiguous and logical given that proved seropositivity may not only confer no advantage but be detrimental to the patient.

The guidance provided by Mr Michael Sherrard QC and Mr Ian Gatt (10 October, p 911) makes no reference to the problem of testing the mentally impaired who cannot give consent and for whom no one may give consent on their behalf. This mental handicap unit receives patients from the North West Thames region, from which 47% of the cases of the acquired immune deficiency syndrome in Britain have been reported. It is only a matter of time before a seropositive patient is admitted to an environment which inevitably fosters homosexuality. The general public can protect themselves by, if necessary, modifying their behaviour, but most mentally handicapped people cannot comprehend and adapt. If seropositive patients were identified through routinely testing people admitted from high risk groups it might be possible to prevent dissemination.

A pronouncement from the Department of Health and Social Security gives guarded support to testing those mentally handicapped patients who pose a risk to others, and an article by Brahams on HIV and the law could be interpreted as allowing testing in these circumstances.[1] What is required is an unambiguous answer to the following question: Is it legal to test a mentally handicapped person from a high risk group in whom there are grounds for believing that he or she will be participating in activities with other mentally handicapped people which are reported to have up to a 70% chance of transmitting an infection with a 30% mortality?

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1 Brahams D. Human immunodeficiency virus and the law. *Lancet* 1987;ii:227.

OUR LEGAL CORRESPONDENT'S COMMENT,—Anything a doctor does to a patient's body is an assault if done without consent. To be lawfully done, therefore, treatment needs consent, but so does the taking of a blood sample for tests. A general consent to "tests" would normally cover whatever tests are necessary, but in the case of AIDS the consequences of a positive result are so serious that it probably requires a separate explanation and specific consent. This would, in my opinion, also apply to live tissue donors. Obviously a doctor who performed a clinical examination, with his patient's consent, and who found physical signs of HIV infection would not thereby lay himself open to a legal action. But at that point he would need to seek his patient's consent to carry out the test which would confirm the diagnosis.