Medico-legal aspects of sexually transmitted infections

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Abstract

The past decade has seen significant changes in the treatment of patients with sexually transmitted infections (STIs). The introduction and developments in anti-retroviral therapy have revolutionized the treatment of HIV. While it is essential that those involved in the care and treatment of such patients keep abreast of clinical developments, it is also important to be aware of changes in legislation and professional guidance. Many of the principles that underpin good practice, such as consent and confidentiality, remain fundamentally unchanged but new legislation and updated professional guidance impose new obligations. In England and Wales, the Mental Capacity Act 2005, which came into effect in October 2007, gives statutory recognition to common law principles. The Human Tissue Act 2004, which came into effect in September 2006, regulates the storage and use of human organs and tissue from living individuals, and the removal, storage and use of human organs and tissues from the deceased. Because of these changes, the General Medical Council issued further ethical guidance on serious communicable diseases in 2009. These changes have coincided with an increase in the number of people convicted in the UK for the reckless transmission of HIV. This paper will review the medico-legal issues as they relate to the treatment of STIs and the impact of recent changes.

Keywords confidentiality; HIV; Human Tissue Act; medico-legal; Mental Capacity Act; sexually transmitted infections

Confidentiality

From its origins in the Hippocratic Oath,[1] confidentiality is the cornerstone of the doctor/patient relationship. The patient's right to confidentiality is protected by law,[2] ethical obligations,[3] code of practice[4] and contracts of employment.

While confidentiality is crucial to all areas of healthcare, it is particularly so in patients being treated for sexually transmitted infections (STIs); without reassurance that their treatment is confidential, patients may avoid seeking appropriate advice and treatment to their own detriment and that of others.

This is emphasized by existing regulations, which require every National Health Service (NHS) Trust and NHS England to take all necessary steps to ensure that information capable of identifying an individual who is examined or treated for any STI is not disclosed except in limited circumstances.[5]

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A breach of confidentiality may result in a number of legal remedies including the award of damages. In the healthcare setting, the most likely consequence is investigation or sanction by the relevant regulatory body or employer.

The duty of confidentiality is not absolute and information can be disclosed with the patient's consent, or rarely without his/her consent. It may be helpful to consider a number of circumstances further.

Disclosure to other healthcare professionals

Most people appreciate that adequate information sharing is crucial to the provision of care. However, given the sensitivity associated with STIs, it is essential that the patient's express consent is obtained before sharing any patient-identifiable information with his/her general practitioner or with colleagues in secondary care. The General Medical Council (GMC) in its guidance 'Confidentiality: disclosing information about serious communicable diseases' explains that doctors should make sure that information is readily available to patients explaining that personal information about them will be shared in the healthcare team, including with administrative and other support staff who support the provision of care unless they object.

If a patient does not consent someone outside the healthcare team being informed of their infection status, their wishes must be respected unless the doctor considers that failure to disclose the information will put healthcare workers or other patients at risk of infection. Such situations are likely to be very rare, not least because of the use of universal precautions to protect healthcare workers and patients, particularly during exposure-prone procedures.[6]

Each case requires careful consideration and it is advisable to explore the patient's reasons for requesting non-disclosure. These may be based on fear of stigma or concerns about potential breaches of confidentiality. It may be possible to allay a patient's concerns but it is important to refrain from unduly influencing his/her decision.

If there is concern that non-disclosure may compromise the patient's safety it is essential that he/she is informed of the possible consequences of his/her decision and the discussion is carefully documented.[7]

Disclosure after death

The ethical duty of confidentiality endures after death. An application for access to the medical records of the deceased may be made under the Access to Health Records Act (AHRA) 1990 by the personal representative of the deceased's estate and by any person who may have a claim arising from the patient's death. In accordance with the Act, disclosure should be limited to what is relevant to the claim.

The Act stipulates that information should not be disclosed if:

- it is likely to cause serious harm to the physical or mental health of any individual.
- it relates to or is provided by an individual, other than the patient, who could be identified from that information unless they consent to its disclosure. This provision does not apply to health professionals who have been involved in the patient's care.
- it was provided by the patient in the expectation that it would not be disclosed to the applicant.

Aside from the provisions of the AHRA 1990, there is no other legal entitlement to access information of a deceased patient. Where relatives have queries that fall outside the remit of the AHRA, disclosure of medical details of the deceased is at the discretion of the holder of the record. Disclosure in these circumstances needs to balance the interests of the family or relatives with the known wishes of the deceased and the doctor needs to be able to justify any decision to disclose.[8]

Where STIs (e.g. HIV) may have contributed to or caused a patient's death, the doctor needs to exercise caution. It is advisable that patients in the terminal stages of disease that involve such sensitivity are advised of the possibility of disclosure after death, that their views are sought, and that the discussion is clearly documented.[9]

However, there is a statutory obligation to provide accurate information on a death certificate and on cremation forms and this is emphasized in GMC guidance.

Disclosure in public interest

While recognizing the importance of confidentiality, both case law[10] and GMC guidance[11] acknowledge that on occasions it may be overridden, for example, if it is in the public interest. Devoid of a specific definition the threshold for disclosure in the public interest is set quite high and is ultimately for the courts to decide (if the disclosure is challenged). Public interest includes a number of situations where disclosure may be considered, such as to prevent harm to others or to prevent or detect serious crime.

GMC guidance emphasizes that such disclosures involve a balance of risk and benefit, that where practicable the patient's consent should be sought and, even if he/she declines, generally he/she should be informed before the disclosure takes place.

Any disclosure in the public interest should be the minimum that is necessary and should be made to the most appropriate person.

When a patient with an STI declines to inform his/her partner, the doctor is faced with the dilemma of whether or not to breach the patient's confidentiality by disclosing information to the partner.

Unlike other jurisdictions, UK courts are unlikely to find that a doctor has a legal duty to disclose to those at risk.[12]

However where the person/persons at risk are identifiable, there may be an ethical obligation to do so.[13]

If those at risk are not identifiable there is no obligation to disclose since it is unlikely that measures can be taken to protect an unknown individual or individuals.

When considering a disclosure in the public interest, it may be helpful to take the following into account.

The patient

- Is it possible to obtain his/her consent?
- What are the possible consequences of disclosing without consent (e.g. disengagement from the service)?

The risk of harm

- What is its nature?
- How immediate is it?
- What is the likelihood of it occurring?
- How significant is it (e.g. what is its magnitude)?

Person or persons at risk

- Are they easily identifiable?
- What measures can be taken to avoid or reduce the risk?

Any disclosure in the public interest requires careful consideration and it is advisable to discuss individual cases with more senior colleagues, the Trust's legal department and Medical Defence Organizations (MDOs). The justification for making a disclosure should be carefully documented in the patient's records.

Disclosure to employers

The majority of persons being treated for STIs should be able to continue their employment with little or no risk to others.

However, where the nature of a person's work would place others at risk he/she should be encouraged to disclose his/her status to his/her employer or the relevant occupational health department.

If the person declines, consideration should be given as to whether a disclosure in the public interest is justifiable.

Where a person works in a healthcare setting, his/her own regulatory body is likely to impose a professional obligation on him/her to disclose any health issues that may place patients at risk.[14] More recently the Department of Health has asked Public Health England to produce guidance for the NHS to implement changes in policy, and to establish a centralized database to monitor healthcare workers with HIV. This updated guidance has not yet been published.

Consent to treatment

Consent is crucial to all areas of healthcare delivery. Without valid consent a healthcare professional may be exposed to allegations of assault or negligence. Valid consent requires that[15]:

- the patient is competent
- there has been adequate information disclosure
- consent is given voluntarily

In legislation, those aged 16 years and over are presumed to be competent and the onus is on those who challenge it to prove otherwise. Before the introduction of the Mental Capacity Act 2005 (MCA), assessment of capacity was based on a three-stage common law test that included a person's ability to comprehend, retain and weigh up the information provided to arrive at a decision.[16] These same principles form the basis of the current statutory test.[17]

In line with the MCA, the GMC emphasizes that '*You must not assume that a patient lacks capacity to make a decision solely because of their age, disability, appearance, behaviour, medical condition (including mental illness), their beliefs, apparent inability to communicate, or the fact that they make a decision that you disagree with.*'[18]

If a patient is assessed as lacking capacity, any decision regarding his/her care and treatment needs to be based on his/her best-interests. The MCA does not define best-interests; rather it sets out what needs to be considered as part of a best-interests decision.[19] The Act also introduces Lasting Power of Attorney (LPA) (personal) as a means by which a suitable individual can act as a decision-maker for those who lack capacity. Only adults aged 18 years and over who have capacity can make a personal LPA. There are a number of provisions that need to be fulfilled before an LPA is valid and there is a limit on the decisions that an LPA can make.[20]

When seeking a patient's consent it is essential that they have the requisite and adequate information with which to make an informed decision. The GMC outlines this in its guidance on