

Ethics briefings

RIGHT TO TREATMENT ABROAD

In October 2003, the High Court confirmed that where treatment cannot be provided without “undue delay” in the UK, patients have rights, under European Community law, to seek treatment in another member state and be reimbursed by the National Health Service (NHS).¹ Mrs Watts was 72 and had osteoarthritis in both hips. Having been originally told she would have to wait a year for treatment, this was later reduced to several months. She enquired about treatment abroad under the established procedures but was refused because her waiting time was within the government’s target of 15 months and did not involve “undue delay”. Nevertheless, Mrs Watts arranged private treatment in France and attempted to claim reimbursement from the NHS. Although she lost her case, she succeeded in demonstrating that the NHS would indeed have to reimburse the cost of treatment involving “undue delay”.

The court confirmed that “undue delay” is not synonymous with being outside the waiting list targets and, although relevant, waiting lists are not determinative. In assessing “undue delay” the Department of Health is required to consider all the circumstances of each case, including the patient’s medical condition, the nature and extent of the patient’s disabilities, and the degree of pain involved (R,¹ para 143). In Mrs Watts’s case, Mr Justice Munby held that an “undue delay” was “very much less than [a] year” but “a period significantly (though probably not substantially) greater” than two to three months (R,¹ para 174). The government was granted leave to appeal against the implications of the judgment.

ABORTION

Challenges to aspects of abortion legislation have occurred in the USA and Europe. In autumn 2003, President Bush signed into law the Partial Birth Bill. This prohibits abortions where a doctor “deliberately and intentionally vaginally delivers a living fetus until, in

the case of a headfirst presentation, the entire fetal head is outside the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother, for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus”. As soon as the bill was signed, however, federal judges in Nebraska, New York, and San Francisco blocked enforcement of the new law, ruling that it appeared unconstitutional in not allowing women to have partial birth abortions even if their health was at risk. Court action to resolve these disputes could begin in March 2004.²

In Europe, antiabortion groups were said to be planning a legal challenge to abortions of babies with genetic disorders.³ They argue that such abortions contravene article 3, the Right to the integrity of the person, of the European Union’s Charter of Fundamental Rights, to which the UK government is committed. The article prohibits “...eugenic practices, in particular those aiming at the selection of persons...”. The full text of the charter can be found at the European Union’s website.⁴ Some expert groups, such as the Pregnancy Advisory Service, have reservations about the legitimacy of the challenge.

In the UK, in December 2003, a Church of England curate won the right to a judicial review into a case where a fetus with a cleft palate was aborted late in pregnancy on the grounds of abnormality. British law does not define severe abnormality and until recently doctors lacked the ability to detect this problem before birth. The degree of disability involved with cleft palate varies but the curate argued that labelling it a severe condition was tantamount to eugenics.⁵

REVIEW OF REPRODUCTION LEGISLATION

After more than a decade in operation, the UK’s Human Fertilisation and Embryology Act is to be reviewed by the House of Commons science and technology committee.⁶ This follows legal cases concerning aspects of the legislation, such as: the export, for treatment, of sperm taken from an unconscious man⁷; the authority of the licensing body to permit the selection of embryos on the basis of tissue typing⁸; the legal definition of “embryo”; the so called “right” of people born following gamete donation to information about the donor,¹⁰ and the right of men to veto

the use of stored embryos by withdrawing their consent.¹¹

One issue likely to be considered by the committee is whether the scope of activities that need to be licensed should be expanded. In November 2003, the Human Fertilisation and Embryology Authority (HFEA) published a report, *Sex Selection: Options for Regulation*,¹² recommending that sperm sorting by flow cytometry, should be brought within the authority’s licensing powers, but that it should only be used for medical reasons. Sperm sorting by gradient methods, it recommended, should no longer be permitted. This is significant, not only for its effect on the future of sex selection but also because it recommends going beyond the original criteria for licensing: the creation and use of embryos, and the storage or donation of gametes and embryos. The HFEA’s reason for recommending the licensing of flow cytometry was “a theoretical risk to health with the use of the technique” (HFEA,¹² para 142). This clearly leaves open the possibility of further extending the licensing role of the HFEA, to incorporate treatments such as ovulation induction, gamete intrafallopian transfer (GIFT) and intra uterine insemination (IUI). At a time when the government is reportedly planning to reduce the number of health quangos,¹³ could we see a huge expansion of the role of the HFEA?

In addition to considering what treatments should be regulated, the HFEA’s report also considered the circumstances in which sex selection techniques should be used. Reaffirming the view it took in 1993, the HFEA rejected sex selection for all social reasons, including for “family balancing”—where a family already has one child of a particular sex and wishes to select a child of the opposite sex. In reaching this conclusion the HFEA took account of the results of a public consultation exercise and market research, although its reliance on the public’s opposition to sex selection to justify its position has been the subject of criticism.¹⁴

CRIMINALISATION OF HIV

In late 2003, a London court found a man guilty of two charges of causing grievous bodily harm for knowingly infecting two of his female lovers with HIV.¹⁵ Mohammed Dica was the first person in 137 years to be convicted of deliberately transmitting a disease in England and Wales. He was sentenced

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to eight years' imprisonment for what the prosecution termed "biological grievous bodily harm". Mohammed Dica claimed that both women knew he was HIV positive when they had unprotected sex with him but both denied this. Crucial to the conviction was the evidence of an expert virologist who through gene sequencing and genetic finger printing identified that the two women carried the same subSaharan strain of HIV as Mohammed Dica.¹⁶ An appeal has been lodged.

Although the case marks the first of its kind in England and Wales, the conviction is not the first in the UK. A man was convicted of culpable and reckless behaviour under common law in Scotland in 2001 when he had unprotected sex with his girlfriend without informing her that he was HIV positive.¹⁷ There have also been similar cases in Canada, New Zealand, and Cyprus.¹⁸

Leading HIV and AIDS charities and advocacy organisations in the UK expressed concern that such cases could have a negative impact on those living with HIV, fostering an environment where HIV positive individuals feel unable to discuss their HIV status for fear of stigmatisation or rejection.^{19, 20}

ASYLUM SEEKERS AND HEALTH

In the UK, the public health implications of immigration and asylum seekers have long attracted media attention. Throughout 2003, a cabinet office working party examined evidence concerning imported infections and immigration, provoking speculation towards the end of the year that it would recommend compulsory screening of asylum seekers for HIV and tuberculosis (TB).²¹ Almost simultaneously, the Institute for Public Policy Research (IPPR), published a report arguing that, on public health grounds, such compulsion would be counterproductive.²² Also in November 2003, a new Asylum Bill was announced in the Queen's speech and the Health Protection Agency (HPA) indicated that, in the previous year, the number of people living with HIV had reached 50 000—a twenty per cent increase (Health Protection Agency press release. HIV transmission in the UK is increasing, 24 November 2003). Key factors behind this rise were thought to be the continued immigration of HIV infected men and women from subSaharan

Africa as well as increased transmission among homosexual and bisexual men in the UK.²³

CHILDREN'S SERVICES GREEN PAPER

In September 2003, the government published a Green Paper outlining proposed reforms to children's services.²⁴ This was in response to a public inquiry into the death of eight year old Victoria Climbié.²⁵ Problems highlighted by the inquiry had included communication failures between health and social care professionals, preventing timely recognition of child abuse. In response, the Green Paper sketched out proposals for a local "information hub", creating a central record on all children in the area. A variety of professions with responsibility for children would contribute data, generating a complete record of every child's welfare. Although the emphasis on protecting children from intentional harm was paramount, the Green Paper also raised some concerns about achieving a balance between families' privacy and child protection.

NHS GUIDELINES ON CHAPLAINCY AND THE PROVISION OF SPIRITUAL CARE

Guidelines for the NHS on the provision of chaplaincy and multicultural spiritual care were published in late 2003.²⁶ In addition to practical advice, the guidelines emphasise that patients' consent to disclosure must be sought before information about their religion and spiritual needs is shared. For mentally incompetent patients, the guidelines advise that weight be given to the views of people close to the patient. Chaplains are apparently unable to claim exemption from the 1998 Data Protection Act provision permitting personal information to be used for medical purposes without explicit patient consent since the Information Commissioner does not consider "medical purposes" to include spiritual care. Patients' freedom to change their minds about receiving spiritual care is also discussed in the guidelines.

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