

Ethics briefings

“Mandatory” blood testing

In February 2005, the Scottish Justice Minister issued a consultation document¹ on proposed legislation allowing victims of an assault involving the transmission of body fluids to apply for information from the alleged assailant’s medical record. It argued that such information could allow rape and assault victims to make informed decisions about prophylaxis for HIV and notify them of other blood-borne infections. The legislation would also allow a sheriff to ask an alleged assailant to undergo diagnostic blood tests or face a fine. Similar laws exist in Canada and Australia. The main beneficiaries of the law would be the police, who have been pressing for such legislation. While accepting that the risks of infection inevitably cause anxiety for assault victims, health organisations generally opposed the proposals. The British Medical Association, for example, questioned their scientific basis and considered them to be an unjustified infringement of the rights of people accused (but not convicted) of assault. The consultation closed on 20 May and a report reflecting the responses was due for publication on 20 June 2005.

Confidentiality and young people

Mixed messages were sent to young people in England as schools offered access to condoms for those aged over 11 years in efforts to reduce teenage pregnancies.² Britain has the highest teenage pregnancy rate in Europe. At the same time, health organisations expressed concern about draft child protection guidelines,³ which mandate the reporting to the police of all sexually active people aged 13 or under. The guidance advocates routine disclosure to the police about the sexual partners of anyone under the age of 16. Similar guidelines have been drawn up in various parts of England, denying health professionals the ability to

exercise discretion about when to involve the police. Clearly, the younger the individual, the more serious the concerns when contraception or treatment for sexually transmitted infection is requested. Many cases involving patients aged under 13 are already known to social services or need to be discussed with them. Existing guidance from health organisations,^{4,5} however, stresses the importance of assessing the circumstances of each case and taking appropriate action. Premature sexual activity—even when voluntary—involves health risks, but young people should be encouraged supportively to postpone it rather than be deterred from consulting doctors. Abusive sex needs urgent action but, where possible, disclosure to the police should occur with the cooperation of the young person. Automatic referral removes room for manoeuvre and in some cases reduces opportunities for frank conversations in which suspicions can be tested.

Although sexual activity under the age of 16 is illegal, there is broad recognition that the law is not intended to prosecute teenage couples in voluntary relationships, unless there is abuse or coercion. Best practice requires that health professionals always encourage young people to involve their parents in treatment decisions but it has long been clear⁶ that competent under-16s can consent to treatment, including contraceptive advice, without parental involvement. The Sexual Offences Act (2003) protects young people by making it easier to prosecute those who pressurise them into sexual activity but also makes specific provision for health professionals to continue providing them with confidential advice and contraception. The Bichard Inquiry Report⁷ into the Soham murders, however, led to some uncertainty about the confidentiality of under-16s as it was interpreted by some as advocating police involvement in all cases. The report also said, however, that even where a criminal offence is suspected, there may be reasons for not automatically involving the police and a balance is needed between maintaining young people’s confidentiality and disclosing offences. Health organisations are continuing to advise doctors to use their discretion and make judgements on a case by case basis. The Government has undertaken to update its guidance⁸ to clarify this issue.

Expulsion of failed asylum seeker suffering from AIDS

On 5 May 2005 the House of Lords held that the expulsion of a failed asylum seeker suffering from AIDS to a country that could not provide medical treatment of the same standard did not constitute a breach of article 3 of the European Convention on Human Rights. Article 3 holds that no one shall be subject to “inhuman or degrading” treatment. The case⁹ relates to a 30-year-old Ugandan woman suffering from advanced HIV/AIDS whose claim for asylum was rejected. The House of Lords cited, and effectively set to one side, the case of D concerning the possible expulsion of an AIDS sufferer to St Kitts.¹⁰ D’s appeal against expulsion from the UK was allowed by the European Court on the basis of D’s “very exceptional circumstances”. The House of Lords argued, however, that the Strasbourg jurisprudence in this area lacked its “customary clarity”, and that, tragically, such suffering in relation to AIDS was in fact far from exceptional. Although D’s suffering—his proximity to death—might have made his particular case extreme, the real issue raised by these cases was whether or not article 3 imposed obligations on states to provide medical treatment to non-nationals. According to Lord Nicholls of Birkenhead there were no such obligations arising under article 3, and there was no requirement for contracting states to admit and treat AIDS sufferers, nor to provide an extended right to remain to would-be immigrants who had received medical treatment while their applications were considered.¹¹ The prospect of a serious or fatal relapse subsequent to deportation did not of itself reach the standard required for article 3 to be engaged.

Infectious diseases and the limits of compulsion

In May this year the Health Protection Agency released details to the media of a man in his forties who refused treatment for tuberculosis and went on to infect at least 12 others.¹² Although public health legislation permits the compulsory retention of people suffering

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from specified infectious diseases in hospital, it does not allow compulsory treatment. In this particular case, the individual concerned agreed to take treatment until his health recovered, but refused the 6-month course of treatment required to eradicate the disease. Without completing the full course of antibiotics the disease can become more resistant. This case has prompted renewed calls for compulsory treatment to be provided under public health legislation. The Government has stated its intention to review the Public Health (Control of Diseases) Act 1984, but no timetable for this review has been given.

The ethics of health professional migration

The effect of the migration of health care professionals from poor to rich countries on global health equity was the subject of media debate in spring 2005. It has been estimated that, in 2004, a third of nurses and two-thirds of doctors recruited in the UK were from overseas.¹³ In May the British Medical Association, in a joint statement with international partner organisations including the American Medical Association and the Commonwealth Medical Association, called on the world's wealthiest nations to end their reliance on health professionals from developing countries.¹⁴ The statement also called on countries to develop ethical recruitment policies and to move toward self-sufficiency in the education and training of health care staff. The call came just a few weeks after the Canadian Health Minister, Ujjal Dosanjh, announced a \$75 million federal initiative aimed at recruiting more than 2000 overseas health professionals.¹⁵ The UK has one of the first ethical recruitment policies prohibiting the active recruitment of health professionals from developing countries in the absence of an explicit government-to-government agreement.¹⁶ Non-governmental health organisations have called on developed countries to consider methods of compensation to redress equity imbalances further exaggerated

by such migration.¹⁷ The valuable skills possessed by health care workers can generate conflicts between health professionals' individual rights to free movement and the health rights of populations to access health services.

Family planning and coerced sterilisation

In May 2005, the Indian Medical Association President called for a one-child policy as operated in China to curb population growth.¹⁸ India already suffers, however, from an imbalanced gender ratio as a result of female feticide and infanticide, and many think that a one-child policy would exacerbate the problem. The British Medical Association has been very critical of enforced birth control and sterilisation in China and female infanticide in India.¹⁹ The *Indian Journal of Medical Ethics* has also highlighted the continuing high mortality rates and target driven nature of some sterilisation programmes in India.²⁰ It criticised public health policies in several Indian states that link assessment of health professionals' performance to the achievement of family planning targets. Although in the past, male mortality rates were particularly high when financial incentives were offered to patients willing to undergo sterilisation, Indian women appear now to be more at risk of coercion. The Journal quoted a 2004 unpublished report for the Indian Health Ministry indicating that some poor women are forced to undergo sex-selective abortions followed by sterilisation. The focus on achieving targets in family planning, it is alleged, has led to sterilisations being carried out in unhygienic conditions with poor equipment and without prescreening of prospective patients or any system of follow-up. Emphasis was placed on an Indian Supreme Court ruling in the spring of 2005 that doctors should have at least 5 years' experience before working in sterilisation programmes, and on a court instruction that compensation be paid if women should die as a result of enforced sterilisation.

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