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### Clinical Ethics Committee Case 17:

## **A paramedic sustains a bite while attending a callout. The assailant refuses testing for HIV or Hepatitis C: what should we do?**

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### **Biographical Information**

Dr Ainsley Newson is Senior Lecturer in Biomedical Ethics at the Centre for Ethics in Medicine, School of Social and Community Medicine, University of Bristol. She has a PhD in Medical Ethics and Bachelors degrees in Science and Law. Her research interests include clinical and reproductive decision-making in genetics and synthetic biology. Ainsley is a member of the European Clinical Ethics Network, the Board of Trustees of the UK Clinical Ethics Network, The BMA Medical Ethics Committee and the Editorial Committee of this journal. She has been a member of Clinical Ethics Committees for 9 years; and is currently a member of the CEC at Royal United Hospital Bath.

### **Introduction**

This is the seventeenth in a series of cases provided and discussed by clinical ethics committees. Any clinical ethics committee may submit a case, which is then discussed by another committee. To publish case discussions for this section of the journal, a member of the *Clinical Ethics* editorial committee attends the discussion of the case and writes a summary of the discussion. This is then published once the discussing committee and the journal editor has approved it.

**Sheffield Children's NHS Foundation Trust Clinical Ethics Forum** agreed to discuss the following case. The CEF was officially launched in March 2003 as the second purely paediatric ethics committee in the UK. There are currently 25 members, including medical, nursing and other professionals from within the Trust, augmented by a professional philosopher, a university lecturer in law, a solicitor lay member, a qualified GP, a chaplain, and patient representatives. The CEF meets bi-monthly and discusses individual cases as well as reviewing various policies and procedures. The CEF has close links with a nearby adult trust CEC with which it has organised conferences and tries to raise the profile of clinical ethics within the trust by contributing to The Grand Round. A report is presented to the Clinical Governance Committee annually.

## **A paramedic sustains a bite while attending a callout. The assailant refuses testing for HIV or Hepatitis C: what should we do?<sup>1</sup>**

Helen works as a paramedic for an NHS Ambulance Trust that serves a medium-sized city. She attends a huge variety of incidents in the course of her work; including those arise from excessive consumption of alcohol.

On Saturday night, Helen was on duty when a call came in to attend a brawl involving approximately 10 young men near the city centre. Members of the public had reported the men drinking heavily in a local bar before being ejected from the premises. Police were already in attendance and there were reports of injuries requiring onsite assessment with a view to hospital admission. On arrival at the site of the brawl, Helen and her colleague began to assist those that had sustained injuries.

While assisting a man with a deep cut to his face, Helen was approached by another man, Joe, who had previously been fighting with the man Helen was treating. Joe shouted at Helen to “stop helping that thug – he doesn’t deserve it.” Helen replied calmly that her role was to treat those who needed her help. Joe then lunged at Helen, grabbing her and pulling her to her feet. In the process, a gap between her glove and her uniform sleeve became exposed, and Joe bit Helen on her wrist, drawing blood. Joe had previously been punched in the mouth and so was bleeding around this area. At this point the police (who had meanwhile been trying to contain the brawl) intervened and arrested Joe. Helen’s colleague called for another ambulance as Helen now also required treatment herself.

At the time of this assault, Helen was 10 weeks pregnant. Although the bite itself did require stitches, Helen did not have to be admitted to hospital for treatment. Her wound was also sore and bruised. An accident and emergency duty doctor mentioned to Helen that she might want to think about any occupational exposure to disease that might have occurred and whether she might like to think about Post-Exposure Prophylaxis (PEP: taking drugs that are around 80% effective at preventing infection<sup>2</sup>). He also mentioned that expert on-call advice was available if she wanted it. Tired and sore, Helen said she just needed to get home to sleep and would think about it the next morning.

Early the next morning, Helen returned to the accident and emergency department. Visibly distressed, she talked with a different doctor about the fact that she was pregnant and was concerned about infections resulting from the bite she had sustained, in particular HIV and hepatitis C. Helen explained that she “wouldn’t be able to live with herself” if she had contracted either of these conditions and then passed them on to her baby, especially as there were things that could be done during pregnancy and birth to prevent transmission. However she also knew that the options for PEP were reduced due to her being pregnant and that PEP would likely have unpleasant side effects and toxicity.

The doctor discussed with Helen that if she did decide to go ahead with PEP she would need to do so soon: PEP should ideally be initiated as soon as possible after exposure and no later than 48-72 hours afterwards. She also explained that PEP should not usually be delayed while waiting for information on the source individual. Helen would then need to take these drugs for 28 days. The doctor also explained to Helen that the chances of HIV infection being transmitted in this way were around 3 in 1,000 or 0.3%. Helen was initially reassured by this information. However she then stated: “Actually, I just want this to

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<sup>1</sup> The author thanks Laura Strumilo for helpful discussions during the drafting of this case study.

<sup>2</sup> Statistical information about PEP obtained from: Knott, L. (2011) “HIV Post-exposure Prophylaxis” Available at: <http://www.patient.co.uk/doctor/Post-HIV-Exposure-Prophylaxis.htm> (accessed 15 November 2011).

be over with; I don't want it hanging over me for the rest of my pregnancy. I also don't want to take PEP when I don't have to. Can't we just test the guy that bit me?" The registrar explained that consent would be necessary for this test to go ahead; Helen asked her to look into it.

An hour or so later, the registrar returned. She had talked with a police officer at the site where Joe was being held pending being charged. Joe had been approached regarding testing for HIV and hepatitis C but he had refused consent, saying that apart from his drunken loss of judgement on Saturday night, he was a "solid bloke who didn't need to be tested for anything."

"Great," said Helen. "So where does that leave me? Are my rights worth less than those of the guy who bit me?" The doctor frankly admitted that she wasn't sure and offered to contact the Clinical Ethics Committee.

*We are approaching the Clinical Ethics Committee with the following questions in mind:*

1. Assuming that we can't have Joe tested against his will, is this fair on Helen, particularly given that she is pregnant? What about her psychological distress?
2. Would it ever be appropriate to test a competent patient for HIV or Hepatitis C without consent? If not, does this mean that healthcare workers' rights are subordinate to those who refuse testing?
3. What if this dilemma were the opposite, for example, if a health professional refused consent to test after possibly infectious contact with a patient?
4. Are there any other ways we could find out this information about Joe?
5. Are there any other ways we can resolve this problem that we haven't thought about?
6. Should Helen be able to continue to work in the meantime? If so, should any extra provisions be made or precautions be taken?

#### **Response from the Sheffield Children's NHS Foundation Trust Clinical Ethics Forum:**

Thank you for your referral, which we considered at our meeting on 24 November 2011. Our discussion of this case involved reflecting on consent, confidentiality and the risks inherent in working as a health professional. We also discussed whether and how this particular case departs from similar scenarios such as an exposure during routine clinical care. As our committee is part of a Children's NHS Trust, this case differed from those we usually tend to receive. However the opportunity to discuss a topic slightly different to our regular case load was a welcome one.

#### Background

Helen's case gives rise to a mixture of questions, necessitating a balancing of ethical issues, professional guidance and civil and criminal law. In some parts of our discussion we felt that we would need to have the opinion of a solicitor practising in criminal law and we have indicated below where we feel more information would be of help.

As the clinical members of our committee do not tend to practice in the area of PEP, some more detailed information about this treatment, particularly its application and toxicity in pregnancy, would have assisted in our deliberations. For example, do the side effects of PEP in pregnancy tend to affect the pregnant woman, or her fetus? We are aware that HIV positive pregnant women who take quadruple therapies during pregnancy obtain very good results such as reduced viral load, and that this combined with other interventions can dramatically reduce the chances of HIV transmission to a fetus. For this reason most pregnant women would choose to take this therapy if it reduced the risk of transmission of

HIV to their fetus. If PEP is similar then it could be well tolerated. How serious are the side effects of PEP when weighed up with the risk of contracting HIV?

We also thought it would be helpful at the outset to determine the options that may be possible in this scenario. We consider the options available are to: (a) take no action; (b) offer Helen PEP (which she would be advised to take at this point regardless of whether Joe agreed to testing or not); or (c) test Joe to assist Helen in deciding what to do. Regarding the third option, we noted that one possibility might be for Joe to agree to be tested but to not be told the result. We discuss Joe's refusal to be tested for HIV further below.

Considering Joe's refusal, another possible factor in his decision may be his considerations of what plea he may enter to any charges against him. That is, if Joe were considering pleading 'not guilty', then his consent to have an HIV test may, in his view, affect his presumption of innocence at trial. On the other hand, it could be that Joe's agreement to an HIV test could be used as leverage in determining sentencing in the event of a 'guilty' verdict.

If this exposure were to have taken place in a clinical context, Department of Health Guidance<sup>3</sup> recommends that information about the source patient be obtained, with consent. The guidance stipulates that if this approach is sensitive, consent is rarely withheld. This may be because some blood borne viruses, such as HIV, are now very treatable and that the stigma and impact of living with this condition has decreased. We discuss this point further below but it is worth noting that Joe may not be aware of the medical advances in treating conditions like HIV.

Finally, it is also worth noting that Helen has been advised to start taking PEP now regardless of Joe's consent or refusal of testing. Rapid HIV testing is now possible and so if Joe was tested she would have a result within 24 hours. Yet even if Joe's result were negative, there is a slim chance he may have been recently infected but has not sero-converted, giving rise to a false negative result. Yet a negative test result may still give Helen the reassurance she seeks to cease PEP.

#### Addressing the questions posed by the committee

*1. Assuming that we can't have Joe tested against his will, is this fair on Helen, particularly given that she is pregnant? What about her psychological distress?*

In general it is ethically and legally unacceptable to subject a competent individual to an intervention when that intervention is against their expressed wish. Thus if Joe adamantly refuses this testing then it would be difficult to justify testing him against his will.

We noted that there is now routine testing for some blood borne viruses in pregnant women, with high uptake due to the opt-out mode of consent. Helen may or may not have had these tests already (it would depend when she is first seen by a health professional). If her result was positive this may change the dilemma as (for example) Helen could not sero-convert for HIV twice. However if her test results had been negative, this would not alter her current dilemma. We have therefore assumed for the purposes of this discussion that Helen is currently HIV negative.

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<sup>3</sup> UK Health Departments (1998) *Guidance for Clinical Health Care Workers: Protection Against Infection with Blood-Borne Viruses*. Recommendations of the Expert Advisory Group on AIDS and the Advisory Group on Hepatitis. Available at: <http://tinyurl.com/HIV-guidance> (accessed 24 November 2011). See especially Section 5. Note that the GMC *Serious Communicable Diseases* guidance referred to in paragraph 5.17 of this document has been withdrawn.

We also noted that Helen would also have to have an HIV test as soon as possible after this exposure. Even though a negative test result for HIV is still liable to subsequent sero-conversion, her status at that point in time would be important to know with regards to any possible subsequent compensation claims.

The interests, risks and benefits at stake in this case were also discussed and weighed against each other. For Joe, the risks of testing are relatively minimal, assuming that his job does not depend on a particular viral status. Testing may also benefit Joe: it is now generally considered that it is better to know than not know about one's status for blood borne viruses such as HIV and Hepatitis C, as the treatments are much more effective than they were previously. For Helen, the main benefit to her will be to relieve her stress and also to know about her status for these diseases so she can take the relevant action for her pregnancy and beyond.

Joe's refusal is, in our view, 'unfair' on Helen. Or, to put it in another way, Joe is acting unfairly, unjustly and unreasonably towards Helen. The bulk of the disadvantages of the test not doing ahead do seem to lie with Helen and not Joe. However the question is then whether any action against Joe is justified on the basis of this unfairness. We think this unfairness, Helen's psychological distress, or her best interests will still not change what we can do: it will be difficult to justify overriding Joe's autonomy and testing him against his will. However to maximise fairness to Helen we would want to ensure that the test had been presented to Joe in the best possible way – a point we return to further below.

Additionally, we don't think Helen's pregnancy makes a significant difference to our answer to this question. That is, although Helen's pregnancy possibly brings with it a greater emotional impact and psychological dimension to the discussion, our premise and position – that it is difficult to override a refusal of consent from a competent individual – remains the same.

A possible nuance to our position in response to this question is whether our answer to this question would or should be different if Joe was a high-risk individual, such as a known intravenous drug user or whether he already knew that he was infected with a blood borne virus (which in itself could give rise to a charge of grievous bodily harm if he was shown to have knowingly attempted to infect Helen). However we determined that in scenarios such as this it would be more appropriate to assume that anyone involved in a possible exposure to a blood borne virus would risk transmission.

We also considered the role of Joe's possible culpability in assaulting Helen with respect to its impact on the 'fairness' of his conduct towards her. We explored some parallel situations, such as what the impact on fairness would be if Joe had accidentally injured Helen. Ultimately we decided that testing should still be encouraged no matter the situation under which the need for the test arose. But if Joe refuses it will be difficult to override this refusal no matter how unfair it is on Helen.

*2. Would it ever be appropriate to test a competent patient for HIV or Hepatitis C without consent? If not, does this mean that healthcare workers' rights are subordinate to those who refuse testing?*

Prior to the passage of the Human Tissue Act 2006 and the Mental Capacity Act 2005 in England and Wales, guidance on *Serious Communicable Diseases* from the General Medical Council did sanction testing a patient who has refused a test like Joe has, albeit in exceptional circumstances.<sup>4</sup> Where it was felt that exceptional circumstances were met (such as there being a good reason to think a patient has

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<sup>4</sup> General Medical Council (1997, withdrawn November 2006) *Serious Communicable Diseases*. Available at: [http://www.gmc-uk.org/serious\\_communicable\\_diseases\\_1997.pdf](http://www.gmc-uk.org/serious_communicable_diseases_1997.pdf) 25416216.pdf (last accessed 7 December 2011), see paragraph 9.

HIV) the guidance also sanctioned testing a blood test obtained for another purpose. However this guidance has now been withdrawn and we do not know of any other guidance that covers such a scenario. We would also not have considered this scenario to be 'exceptional circumstances'. Further, under common law competent individuals are able to refuse a health intervention without giving a reason.

It is in general difficult to override a competent refusal of a test like this. However it is worth exploring the fact that Joe is currently under arrest and will already have been (or will be) subjected to some sampling without consent. That is, a sample of his cheek cells will be taken for the purposes of DNA profiling (which every arrested person in England and Wales is required to provide). We wonder whether Joe's current right to refuse testing could or should change given his current status as under arrest, or whether it should change were he to be charged with an offence against Helen. However were this to be successfully argued we would also have to be mindful of any repercussions this may have for other kinds of testing in persons under arrest or charged with assault.

It may therefore be useful to obtain a legal opinion to assist in determining the legality of testing a competent patient for HIV or Hepatitis C without consent given these specific circumstances. This could also clarify whether it could be legally sanctioned to test a sample that Joe may have left at the scene of the fight, although this in itself would give rise to concerns over accuracy of results and attribution of the sample to Joe. It should also be noted that the supposed legality of any such testing it does not follow that it would also be ethically acceptable.

There is also debate in the literature regarding testing incompetent patients without consent, with conflicting reports as to how often this occurs.<sup>5</sup> It seems that testing in incompetent patients does occur in English hospitals despite current English legal requirements that any such testing to be in the best interests of the incapacitated patient.

We did also discuss a scenario involving a competent high-risk individual who was serially biting or otherwise transferring tissue to health professionals, but then refusing consent to testing. In this kind of situation it does seem more justifiable that testing should take place and that legal mechanisms should be found (such as a court order) to sanction it. However it is less clear where a 'line' should be drawn between a scenario such as this and the situation with Helen and Joe.

Therefore, in answer to the first part this question, on balance it does seem inappropriate to test a competent person like Joe, in a situation like this, for a blood borne virus without consent.

Turning to the second part of this question and Helen's status as a health care worker, we agreed that respecting Joe's refusal to be tested does not mean that (*all* of) Helen's rights are subordinate to Joe's. What it does mean is that in this instance, a particular right of Joe's (to refuse testing) trumps a particular right of Helen's (to know Joe's status to make a decision about continuing PEP).

Of course we also understand that Helen may not feel the same way, particularly given the way that she has come to be in this situation. This matters to her, teleologically.?? (*see e-mail*) It is therefore

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<sup>5</sup> See, for example: Halpern, SD. (2005) HIV testing without consent in critically ill patients. *JAMA*. 294(6): 734-737; c.f. Burrows LA, Padkin A. (2010) A survey of the management of needlestick injuries from incapacitated patients in intensive care units. *Anaesthesia* 65(9): 880-884.

important to ensure that health care workers do not feel that their rights are subordinate to those of the people they treat as if this were to occur then it could foster a culture of defensive medical practice? (see e-mail, something like reluctance to offer medical help in potentially dangerous circumstances) . It also raises the broader question of whether health care professionals are deserving of different protections and whether they should have a greater right to this kind of information given the risks that they are subject to in the course of their work. If it is not already covered in the curriculum, we think that it would be useful to discuss this issue with students studying to become health professionals, in particular discussions about the risks that they may face that are higher than that in the general population.

3. *What if this dilemma were the opposite, for example, if a health professional refused consent to test after possibly infectious contact with a patient?*

We returned to this question throughout our discussion of this case. We noted that if Helen were to hide her HIV status or knowingly put a patient at risk, she would be disciplined. This is because Helen owes a particular legal duty of care to her patients that Joe as a member of the public – assuming he is not a health professional - may not owe Helen (although they may both have ethical obligations towards each other and Joe may be criminally culpable if he knowingly exposed Helen to risk).

We also noted that Department of Health guidance on health clearance for infectious diseases (including HIV) is silent on the issue of refusal of testing.<sup>6</sup> We are however aware that testing for blood borne virus testing is routine among health professionals and it is therefore highly likely that Helen has already been tested for blood borne viruses such as HIV and Hepatitis C? (see e-mail as health professional Helen will have had to prove Hep B status but not HIV or Hep C. She may, however have had them tested routinely because of her pregnancy).. If Helen refused testing, at the very least this would impact on her daily work (in that she may be limited in the actions she can perform by her employer)

4. *Are there any other ways we could find out this information about Joe?*

We discussed a few other ways in which we could find out this information about Joe. The first way is to ask Joe if he has already been tested and to then obtain his test result from a third party with Joe's consent; for example by talking to his general practitioner, or from a relevant hospital clinic (such as genito-urinary medicine). A second way, which would not give an exact answer but may assist Helen with her reasoning, would be by inspecting his police record (if he has one) to gauge further information about his risk status.

If Joe has been tested but does not give consent to this information being found out, then the options are more limited given the legal and ethical obligation to respect confidentiality. We did discuss a scenario in which we knew that Joe had already been tested in the same hospital and that the results were accessible via the hospital IT system, by Helen or someone else. In a practical sense it may not be difficult to access this result but this would also have data protection implications (as this would be sensitive data) which could give rise to further legal sanctions. That said, GMC guidance does appear to sanction disclosure of pre-existing information about infection status without consent if that information is needed in the 'public interest', which they interpret to include decisions about PEP.<sup>7</sup> However if this option were to be explored in greater detail, it would perhaps be prudent to obtaining a legal opinion or court order to sanction breaching confidentiality before the breach took place.

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<sup>6</sup> Department of Health, UK (2007) *Health clearance for tuberculosis, hepatitis B, hepatitis C and HIV: New healthcare workers*. Available at: <http://tinyurl.com/DH-clearance> (last accessed 7 December 2011)

<sup>7</sup> General Medical Council (2009). *Supplemental Guidance: Confidentiality: disclosing information about serious communicable diseases*. Available at: <http://tinyurl.com/GMC-conf-communicable> (last accessed 7 December 2011), paragraph 18.

Also difficult to justify would be using a pre-existing sample from Joe for the purpose of testing for blood borne viruses without consent. He may for example, have had to give a 'relevant sample' to be admitted into evidence as a part of the investigation into the criminal charge of assault. This may be to prove his blood alcohol level. However even then, if the sample or result is from some time ago, it will be less reliable given that infection may have occurred in the meantime. This will further dilute the argument in favour of obtaining this information to help Helen, as in a practical sense it may not help her very much at all.

*5. Are there any other ways we can resolve this problem that we haven't thought about?*

There are two things that we would explore here. First, we would want to make sure that every effort has been made to gain consent from Joe. Second, we would seek legal advice to make sure there are no options for securing a test or result that have been missed.

We would be interested to explore further the question of who has spoken to Joe about being tested, and how. Was it someone with appropriate knowledge and training, who could explain the testing and its implications clearly? If not, then testing can be talked through with Joe again, using a different approach.

If the test has been offered by someone with appropriate knowledge and training and the environment in which the test was offered was appropriate yet did not elicit agreement, then it may also be worth talking through with the police or a criminal lawyer as to whether any degree of incentive to Joe may be appropriate in these circumstances. It may also be worth discussing whether any other form of pressure can be exerted to induce Joe to agree to testing.

We could also explore with Joe his reasons for refusal, for example whether he is simply 'fed up' or needle phobic. Or we could explore the possibility, mentioned above, of taking Joe to court to compel testing, also exploring the impact that his status as an individual under arrest may have on this. At the very least, legal advice may be helpful here.

*6. Should Helen be able to continue to work in the meantime? If so, should any extra provisions be made or precautions be taken?*

Assuming she is well enough, Helen should be able to continue to work following Joe's assault on her. All health professionals should practice universal precautions against blood borne viruses in any case and there is no reason to think that Helen will not do this. Until her stitches have healed or have been removed Helen should not be undertaking 'front line' work but this would have been the case whether or not a potentially infectious exposure had occurred.

**Conclusion**

This case has allowed us to discuss a wide range of issues that affect modern health care practice. In this particular case, considering that Joe has capacity, on balance it does seem to be inappropriate to test him without his consent. If he has previously been tested it may be possible to disclose this result on 'public interest' grounds but even then the result would have less value if it was not obtained recently.

We are sympathetic to Helen's plight and the fact that she perceives that she is being treated unfairly even though the options open to her are limited. So we would also want to make sure that Joe has had the entire situation explained to him (with Helen's consent) and has had a discussion about testing in a

confidential space with an appropriately trained individual. If handled sensitively, it may be possible that Joe will change his mind.

**Members of Sheffield Children's NHS Foundation Trust Clinical Ethics Forum who discussed this case:**

Rachel Brown, Lay Member and Solicitor

Janet Chessell, Lay Member

Alison Hunter, Consultant Community Paediatrician

Vincent Kirkbride, Neonatologist (Chair of nearby CEC)

James Lenman, Professor of Philosophy

Julian Roberts, Paediatric Surgeon (CEF Chair)

Jeff Perring, Paediatric Intensivist