Medicolegal

Another judgment on testing for HIV without consent

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Does a test for human immunodeficiency virus (HIV) need the patient's explicit consent or is consent to take blood for unspecified tests sufficient? Two QCs have given conflicting opinions. Mr Michael Sherrard QC advised the BMA's council that in testing for HIV without explicit consent doctors could be laying themselves open to negligence actions or even criminal liability. Mr Leo Charles QC told the Central Committee for Hospital Medical Services that in his opinion, unless the patient specifically asks, it will be up to the doctor's clinical judgment whether he tells the patient that the test is for HIV.

Mr Charles and Mr Sherrard agreed that the patient's consent is a necessary prerequisite before any medical procedure can be carried out, and that this applies to tests as well as to treatment. Mr Sherrard argued that there is no valid consent if a doctor carries out a test for HIV, having told the patient that a blood sample was being taken for "tests," because there is an implied representation on the part of the doctor that the tests to be carried out are merely routine. It is unlikely, he said, in the light of current medical opinion on the subject that the courts would decide that a test for HIV should be classified as routine.

On the question of liability in negligence for not giving sufficient information, Mr Sherrard accepted that most of the law lords in the Sidaway case—the leading case on a doctor's duty to explain risks¹—took the view that a doctor would not be negligent if he acted in accordance with a practice accepted as proper by a responsible body of medical opinion—the well known "Bolam" test for medical negligence.² He pointed out, however, that the law lords qualified this by stating that there could be some circumstances when the proposed treatment entailed a substantial risk of grave consequences in which a judge could conclude that, notwithstanding any practice to the contrary, a patient's right to decide whether to consent to the treatment was so obvious that no prudent doctor could fail to warn of the risk.

Mr Charles said that this qualification related to treatment. Furthermore, there is no risk inherent in the procedure—the blood test—itsself, and therefore the information to be given comes down to the question of what is acceptable medical practice. A positive result may produce grave social consequences, he conceded, but there is no risk of grave physical consequences in the blood test itself.

The importance of the motivation for testing

What if testing were done to protect hospital staff rather than in the patient's interests? Mr Charles said that the purpose of the test would therefore need to be disclosed because if information were withheld in bad faith consent would be vitiated by fraud. Mr Sherrard also advised that if a doctor reached the conclusion that testing was necessary in his own interests or in the interests of other staff or patients he should counsel the patient and seek the patient's

consent to testing. Any patient who refused consent could then be treated as if infected.

Interestingly, the motion passed last week by the committee's annual conference is noticeably silent on this aspect of Mr Charles's advice. Though the conclusions Mr Charles reaches are all based on the supposition that the doctor is exercising his clinical judgment in the patient's best interests, the motion makes no mention of the motivation behind the testing and simply states boldly that it is for the doctor to decide how much information to give the patient. Having received consent to carry out the procedure, the motion states, it is a matter of clinical judgment as to how much information the doctor should disclose to the patient about the nature and purpose of the procedure. Surely patients cannot consent until they know at least the nature of the procedure and, broadly, the purpose as well—unless they are simply content to put themselves in the doctor's hands.

How can the conflict of opinion on this vital issue be resolved? One answer is to wait for a disgruntled patient to bring a test case. Britain's first AIDS law centre, which opened earlier this year, has already heard from a number of angry patients tested without their knowledge, and its solicitor has said that he would consider bringing a case if asked.

A more satisfactory move might be for a consultant or a health authority to seek a declaration under Order 15 Rule 16 of the Rules of the Supreme Court that a doctor would not be committing an unlawful act in testing for HIV without the patient's consent. In the recent case of *Re T* the high court granted a declaration that it would not be unlawful to sterilise a mentally handicapped adult where there was no one who could legally consent to the operation.³

References

- 1 Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital. *Weekly Law Reports* 1985;2:480.
- 2 Bolam v Friern Hospital Management Committee. *Weekly Law Reports* 1957;1:582.
- 3 Dyer C. Consent and the mentally handicapped. *Br Med J* 1987;295:257-8.

Are the levels of blood gases altered in patients who have had a thoracoplasty?

As thoracoplasty was largely employed for collapse treatment of pulmonary tuberculosis in the prechemotherapy era this therapeutic approach is redundant and it is the long term sequelae of this operation that are likely to be of concern. Thoracoplasty was usually performed in association with pulmonary resection and the long term respiratory sequelae are related to the extent of the original disease, which causes both parenchymal lung damage and pleural fibrosis with mechanical restriction of ventilation, the amount of lung resected, and the extent of the thoracoplasty. In addition, a degree of scoliosis was an almost invariable complication of resection of the first rib and this additional chest deformity is associated with a reduction in pulmonary mechanics in proportion to the degree of scoliosis. All these factors, promoted with time by the natural decline in pulmonary function with age, may lead to arterial hypoxaemia. In later stages, if alveolar ventilation is impaired, this will also be accompanied by hypercapnoea.—PETER HOWARTH, senior lecturer in medicine, Southampton.

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