# THE MEDICAL DEFENCE UNION

# CONSENT TO TESTING FOR AIDS

## OPINION

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## OPINION

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## 1. INTRODUCTION

We are asked to advise the Medical Defence Union as to whether and if so in what circumstances it may be permissible for medical practitioners to test for AIDS (or, more accurately, HIV antibodies) without the consent of the patient. This is a question of considerable public importance and interest but it has not yet been considered directly by the courts. There is also, as we shall explain, very little relevant statute law on the subject at present. It is therefore necessary to rely mainly on an examination of the problem in the light of general legal principles as they have been applied in other and so far as possible analogous cases. There are however no simple answers, because the common law principles applicable are not always easily reconcilable with each other. They include the right of a patient to protection from assault and battery on his person without his consent, the doctor's duty of care to his patient in negligence, and the same duty owed to other patients and persons, such as wives, unborn children, health care workers and other contacts of the patient. There is also the duty of patient confidentiality, and the duty in some circumstances to inform.

## 2. RELEVANT FACTS ABOUT HIV INFECTION AND TESTING

We have been helpfully supplied with a considerable amount of factual information on the current state of knowledge about HIV infection, AIDS Related Complex, AIDS and associated conditions. For convenience we shall use the term AIDS in its popular sense to cover all of these. We are conscious that continuing research and experience of the disease will alter this knowledge in the future, and this may in turn affect the legal position. The following is a summary of the salient facts currently relevant to the legal questions.

### (1) Those at risk

HIV infection is a virus which is primarily transmitted via blood and genital secretions, although the virus is present in other body fluids. As a result, almost all of those who contract the disease in the United Kingdom fall into the following high-risk categories:-

(a) Homosexual and bi-sexual men and their sexual contacts;

(b) Haemophiliacs and others who received HIV contaminated blood products between about 1976 and 1985, after which such products began to be effectively screened for HIV. Current blood products are also heat-inactivated and will, therefore, not transmit infection.

(c) Intravenous drug abusers who share needles;

(d) Visitors to Haiti and extensive areas of tropical Africa in the last five years, where the disease is endemic in the heterosexual population;

(e) Prostitutes.

(2) Health care workers

Some cases have been reported in the literature of health care workers being infected, primarily by accidental self-innoculation with infected blood through injury with needles (needle stick) or other sharps. However, the numbers are extremely small, and the latest statistic that we have been supplied with puts the risk of sero-conversion even after percutaneous exposure at only 0.4%. Despite the very grave consequences of such infection, this is in legal terms a negligible risk (cf Sidaway v Bethlem [1985] AC 871 at 890B-C).

(3) Cases in which there is no risk

There are no reported cases of infection being contracted through normal social contact and the overwhelming evidence is that such contact carries no risk. Mr Justice Rose, when considering this point recently after hearing expert evidence from the Government's Chief Medical Officer and leading specialists in the field both English and American in the case of X v Y (1987) 137 NLJ 1062 reached the following conclusions:-

> "The way in which the virus is communicated is not fully understood although much is known. It is not contagious; indeed it does not transmit easily and is readily killed by detergents and common disinfectants. The three clearly established and predominant means of transmission are sexual intercourse between homosexuals and between heterosexuals, the transfer of contaminated blood (particularly through the use of hypodermic needles but also through fissures in the skin) and

from pregnant mother to foetus. Transmission in any other way is extremely rare."

(4) Diagnosis

The early stage of infection by HIV is generally asymptomatic; although some patients may develop an acute but self-limiting glandular fever-like illness just prior to the development of HIV antibodies. As yet it is not known what proportion of infected patients will eventually develop AIDS. However, after a variable and often extensive period, ranging from months to years, the patient may develop progressive generalised lymphadenopathy (enlargement of different groups of lymph nodes throughout the body) and in due course the AIDS related complex (ARC). At this stage features such as fever, diarrhoea and weight loss may be present. Such symptoms are, of course, not specific since they may be present in other medical conditions. Eventually patients develop severe opportunistic infections; for example, pneumonia caused by such organisms as P. carinii or malignant tumours the commonest of which is Kaposi's sarcoma. But in the early stages of disease the only information that may alert a doctor to consider the possibility of HIV infection is that the patient falls into one of the high risk categories.

(5) Treatment

Critically important to the legal position is the fact that there is currently no known cure or vaccine for HIV or AIDS. However, some success in retarding the progress of the disease and possibly even prolonging life for a short period has been experienced with the drug AZT. (Experimental studies in animals suggest

that prompt treatment with AZT within the first few hours of parenteral exposure of viruses in the same group as HIV may actually inhibit infection; but evidence as to the efficacy of AZT in man under such circumstances is not yet available.) AZT does cause unpleasant and in some cases dangerous side effects. Apart from AZT treatment, it is possible to give relief to AIDS sufferers by treating the secondary infections which they habitually develop as a result of the failure of their immune systems, and also to help them to come to terms with the effects of the disease with proper counselling. Indeed, counselling is presently the primary remedy for the benefit of the patient and the protection of those around him. For those who are still asymptomatic, counselling remains of importance, and diagnosis is also thought to be valuable in assisting diagnosis of characteristic illnesses to which they may subsequently succumb as the disease progresses.

(6) HIV testing

Current serological tests for HIV infection are highly sensitive and specific. The specificity of tests is of the order of 99.5%. It can be estimated that a single test will lead to a false positive in about 1 in 200 samples. If, as is current practice, a positive specimen is then tested by an alternative, methodologically different, test which also has a false positive reaction of 1 in 200 samples, this particular specimen will be found to be falsely positive in 1 in 40,000 cases. If yet a third test is employed then a false positive result would be obtained in fewer than 1 in 1,000,000 cases.

One of the commonest sources of error is not failure of the test systems but such other factors as incorrect labelling of blood containers in Out Patient Departments and technical errors, perhaps due to the interruption of a busy Medical Laboratory Scientific Officer performing the tests. An incorrect report may also be issued as a result of clerical error. In view of the serious medico-legal consequences and distress which may result from a false positive test some pathologists recommend that risks are further minimised by requesting a third sample, when a serum sample is found to be positive by two tests, and laboratories may consider sending this third sample to a different reference centre. A final report can then be issued when the results have been confirmed by testing the additional blood sample from the same patient.

False negative results appear in the very early stages of infection, currently estimated at three months, during which the antibodies to which the test applies have not had time to develop. Again, this problem is met by secondary testing after a suitable lapse of time in suspected cases of infection where a negative result has initially been obtained. However, in cases of urgency, clearly this precaution is not possible. Apart from the possibility of human error, false positive results are not thought to occur, although many persons actually infected with HIV and correctly diagnosed as such have not gone on to develop full-blown AIDS. However, even in those without the main condition there is a danger of infecting others.

(7) Test procedure

Much of the discussion of the questions we are asked to address has centred around the concept of routine

testing. However, in the context of HIV we are instructed that there is no routine testing in the sense that the there is no automatic testing without request or decision by the medical practitioner. It is not possible for an HIV diagnosis to emerge unexpectedly in the course of other tests. HIV testing can only be performed after a definite decision to do so, perhaps during a continuing course of diagnostic tests, and the decision is usually left to the referring practitioner. In this context, therefore, routine testing only means habitual testing on request without the specific consent of the patient; it is therefore a reformulation of the question we are asked rather than an answer to it.

(8) Counselling

The present view of the DHSS is that counselling is essential not only after but also before testing, because of the very serious consequences of diagnosis. We have seen in our Instructions many references to cases of patients committing suicide on learning of HIV infection because of insufficient preparation for the result. It is also relevant, while testing is unusual, that even the fact of having a test may result in refusal of life insurance, because this is thought to constitute an indication that the patient is in one of the high risk categories; and so even (perhaps especially) in cases of low risk, testing may be discouraged. This received opinion of the importance of pre-test counselling (and therefore, necessarily, consultation) is of relevance when examining standards of conduct in the context of negligence. On the other hand, it has been pointed out to us that knowledge that a test is to be performed may cause acute anxiety to a patient before the result is known. Where the result

is most unlikely to be positive, therefore, causing such anxiety by pre-test consultation may be unnecessary and unjustified. There is a difficult balance to be struck taking into account the likelihood of positive result, the level of likely pre-result anxiety, and the danger of reaction to a positive result without previous counselling and preparation.

(9) Protection of others

In many of the cases in which it is desired to test for AIDS without the knowledge or consent of the patient this is for the protection not of the patient but of others who may be at risk from infection. These include sexual partners, unborn children of the patient or such partners, communal intravenous drug users, organ donees and, important in the context of the present Opinion, those who may treat the patient and are therefore at some risk of self-innoculation or other blood contact. In this context there are three relevant considerations:-

(a) There is some evidence that some of those at risk may prefer not to know that they are HIV positive. Diagnosis without consultation or counselling therefore exposes the doctor to very grave criticism.

(b) If HIV is diagnosed without the knowledge or consent of the patient, acute conflicts of ethics and confidentiality arise, since it then becomes necessary to consider whether to inform third parties who are potentially at risk: to do so without consent may be a serious breach of confidence, while not to do so may be a breach of duty to the third party at risk.

(c) In the case of health care workers at least, precautions against HIV infection can be taken in every case without the necessity of knowing whether the infection is actually present. Increased expense and inconvenience will not justify a departure from the general principle that consent must be obtained from the patient in advance and no test performed if it is withheld. In any event, a negative test result would not rule out the possibility of infection, in the early stages.

(10) Confidentiality and Consent

HIV infection carries a unique stigma. This is because unlike other fatal and incurable diseases familiar to the public, such as cancer, it is infectious, and popularly thought to be more infectious than it in fact is. It is also perceived to affect principally homosexuals and drug addicts, so that a man diagnosed as infected will inevitably be suspected of falling into one or other of those categories. In order to encourage people to come forward for testing, therefore, very great importance is attached by health authorities to ensuring absolute confidentiality. Without this, the patient may prefer to remain in ignorance of whether or not he is infected (particularly since he will know there is no cure) rather than risk disclosure. The current assurance to patients of absolute confidentiality, by the DHSS and others, might expose doctors to complaints of misrepresentation if they later decided to inform third parties of the patient's HIV status for the protection of persons other than the patient himself. The same charges are possible in respect of the testing without consent of patients who have presented themselves for

treatment in the knowledge that the DHSS has publicly declared that there will be no HIV testing without fully informed consent by the patient. Of course, such a declaration may be withdrawn in the future. Until such withdrawal occurs in our view it will be extremely difficult to justify any departure from the rule that express consent must precede any testing for AIDS. The advice that follows on certain otherwise exceptional cases must be read in that light.

(11) Professional Obligations

We have been shown a variety of examples of the professional and contractual obligations of surgeons, GPs, pathologists, consultants and nurses. There is no standard form, but there are examples of professional and contractual duties (a) to treat the patient when this is required, without provision for refusal in cases where the patient may pose a risk of infection, and (b) to respect the confidentiality of information obtained about the patient.

(a) Duty to treat

The Terms of Service for Doctors (i.e. general practitioners) in Schedule 1 to Regulation 3 provide at Paragraph 13 as follows:-

> "...a doctor shall render to his patients all necessary and appropriate personal medical services of the type usually provided by medical practitioners"

The Consultants' Contracts, which we have seen, do not specifically address this question.

The General Medical Council's 'Blue Book'* includes the following:-

> (Paragraph 35) "In pursuance of its primary duty to protect the public the Council may institute disciplinary proceedings when a doctor appears seriously to have disregarded or neglected his professional duties, for example by failing... to provide or arrange treatment for a patient when necessary."

The Code of Professional Conduct for the Nurse, Midwife and Health Visitor (2nd edn 1984) provides:-

> "Each registered nurse, midwife and health visitor is accountable for his or her practice and, in the exercise of professional accountability shall:
>
> "1. Act always in such a way as to promote and safeguard the well being and interests of patients/clients.
>
> "2. Ensure that no action or omission on his part is detrimental to the condition or safety of patients/clients."

(b) Duty of confidence

There are lengthy provisions in the General Medical Council's 'Blue Book'* at paragraphs 79 - 88 governing professional confidence. The general rule is laid down at paragraph 80:-

> "It is a doctor's duty, except in the cases mentioned below, strictly to observe the rule of professional secrecy by refraining from disclosing voluntarily to any third party information about a patient which he has learnt directly or indirectly in his professional capacity as a registered

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* "Professional Conduct and Discipline: Fitness to Practise" (April 1987 edition)

medical practitioner. The death of the patient does not absolve the doctor from this obligation."

The exceptions relate mainly to disclosure with the consent or in the interests of the patient himself: paragraphs 81(a), (b), (c), (d), 84, and 85. Some relate to court orders and other legal compulsion: paragraph 81(e) and (f). There is provision for disclosure in the public interest but only in very limited circumstances such as the police investigation of serious crime: paragraph 81(g) — or otherwise (e.g. epilepsy) may put others at risk. 85

The Code of Professional Conduct for the Nurse, Midwife and Health Visitor (2nd edn 1984) provides:-

"Each registered nurse, midwife and health visitor is accountable for his or her practice and, in the exercise of professional accountability shall: ...

"9. Respect confidential information obtained in the course of professional practice and refrain from disclosing such information without the consent of the patient/client, or a person entitled to act on his/her behalf, except where disclosure is required by law or by the order of court or is necessary in the public interest."

(c) Effect of professional obligations

The above professional and contractual obligations may be changed at will. They do not themselves have the status of Acts of Parliament or common law principles, although breach would obviously carry a risk of professional misconduct proceedings or proceedings for breach of contract. However, the obligations may also have a wider significance in setting the standards to be applied by the courts in respect of the general duties of care in tort which are considered below.

## 3. THE STATUTORY BACKGROUND

We are aware of only two statutory enactments primarily relevant to the testing of those suffering or suspected of suffering from AIDS. These are the Public Health (Control of Disease) Act 1984 and the National Health Service (Venereal Diseases) Regulations 1974. The Mental Health Act 1983 is relevant to the questions we have been asked about the consent of mental patients, and will be considered later. The Health and Safety at Work Act 1974 imposes a duty on employers "to ensure so far as is reasonably practicable" the health of employees at work; but we consider that this adds nothing to the general common law duty of care which we shall be considering. The AIDS Control Act 1987 is concerned only with reporting requirements for statistical purposes and is not relevant.

### (1) Public Health (Control of Disease) Act 1984 ("the Act")

Although AIDS is not a "notifiable disease" within the meaning of the Act itself, sections 35, 37, 38, 43 and 44 of this Act are applied to AIDS cases by the Public Health (Infectious Diseases) Regulations 1985, made under section 13 of the Act. However, sections 37 and 38 deal only with persons already diagnosed as suffering from the disease, while sections 43 and 44 apply to corpses, so only section 35 is relevant for the purposes of testing for AIDS without consent. Section 35(1) provides as follows:-

**"If a justice of the peace (acting, if he deems it necessary, ex parte) is satisfied, on a written certificate issued by a registered medical practitioner nominated by the local authority for the district -**

practitioner or private doctor or other person not employed by a Regional or District Health Authority would be subject only to the common law duty of confidentiality, which is subject to a general public interest exception as considered at sub-paragraph (4) below, and to the professional obligations considered previously at paragraph 2(11).

(3) Examples of duties to third parties

The most important situation in which there may be high degree of risk known to the diagnosing practitioner and in which precautions will not be taken without actual knowledge of HIV status is the case of the wife or sexual partner of the patient. Another example is the case of an organ donor who is diagnosed positive and who will clearly risk infecting the donee if information about his HIV status is not communicated. A more difficult case is that of the unborn child. Since the disease cannot be cured, the child born with AIDS as a result of (for example) his mother not being made aware of the risks of conception when HIV infected could only complain on the basis that if the test result had been communicated the birth of the child might have been prevented altogether by prophylaxis or abortion. This amounts to the infant plaintiff claiming that it would have been better if he had never been born. This concept of "wrongful birth" has been rejected in English jurisprudence and discloses no cause of action: McKay v Essex Area Health Authority [1982] QB 1166 in which the argument that the Congenital Disabilities (Civil Liability) Act 1976 might ground such a claim was rejected. However, if the mother is shown to have been free of infection at the time of conception and to have contracted the

(a) that there is reason to believe that some person in the district -

(i) is or has been suffering from [AIDS], or
(ii) though not suffering from such a disease, is carrying an organism that is capable of causing it, and

(b) that in his own interest, or in the interest of his family, or in the public interest, it is expedient that he should be medically examined, and

(c) that he is not under the treatment of a registered medical practitioner or that the registered medical practitioner who is treating him consents to the making of an order under this section,

the justice may order him to be medically examined by a registered medical practitioner so nominated."

We make the following observations on the section:-

(a) By section 35(3), medical examination may include "bacteriological and radiological tests and similar investigations." Although the HIV test is a microbiological examination, we are instructed that this is within the phrase "similar investigations" and therefore permissible under the section.

(b) No order can be made under the section unless there is "reason to believe" that the patient is suffering from the disease or its forerunner. While this might extend to allow testing of apparently healthy individuals who are in high-

risk categories, or known to have been exposed to the virus, it would not allow testing for general screening purposes or other more or less indiscriminate purposes.

(c) Section 35(1)(a)(ii) is broadly worded to include, in our view, asymptomatic HIV infection as well as fully developed AIDS.

(d) Section 35(1)(b) is worded to allow examinations only if they are in the interest of the patient or his family or in the public interest. We do not believe that the public interest would extend to protect the private interests of particular individuals who believed themselves exposed to potential risk but were not part of the patient's family. Thus, in the cases of policemen and doctors and others who sought medical examination for the purposes of personal reassurance or protection, we do not consider that testing for HIV would be permitted under the section on the basis that it was in the public interest. It would be otherwise if the patient posed a general threat to the public at large, which is possible, although we are conscious of the relatively low infectivity of the disease, particularly in its asymptomatic stages. It might also be otherwise if it could be shown that certain environments such as special hospitals or prisons were a particular source of the spread of infection and that testing would be in the public interest in order to control that spread. It might however also be considered whether testing could be shown to be in the interests of the patient himself.

(e) The patient's own general practitioner must approve the examination in every case. This he may not always be willing to do.

(f) Even when all the necessary conditions are fulfilled, the magistrates are empowered but not obliged to make an order. They retain a discretion to refuse it in each case. However, in practice refusal by the magistrates in a proper case is exceedingly unlikely.

This is a draconian and somewhat dramatic remedy, requiring application to the court in every case, and so it is unlikely to be of practical use save in very exceptional cases. The only order under the section actually made against an AIDS sufferer of which we are aware was reversed on appeal on the grounds that it was no longer necessary - see (1985) 291 BMJ 1102. Despite this, we consider the section of great relevance in considering the common law principles likely to be applied by any court in cases of testing without consent. It may well be said that where Parliament has been so cautious in the powers it has conferred to test without consent, it would not be right to suppose more general powers of testing without consent derived from the common law, without the statutory safeguards. It is always open to Parliament to pass further permissive legislation if it should appear to be required.

(2) <u>The National Health Service (Venereal Diseases) Regulations 1974</u> (as amended)

These Regulations apply in respect of "any sexually transmitted disease" which is thought to be a broader term than "venereal disease" as used in the previous Regulations of 1968 (see the Government's "Explanatory

Note"). AIDS is obviously a sexually transmitted disease when transmitted sexually, which it is in the large majority of cases. In our view it is also properly described in broad terms as a sexually transmitted disease even in those cases where it has not in fact been transmitted sexually, as for example in the case of drug abusers who contract the disease by sharing needles. The Regulations oblige all Regional and District Health Authorities to ensure that any information obtained by them capable of identifying a person examined or treated for any sexually transmitted disease is not disclosed except

(a) for communication to a medical practitioner or a person employed under him, and

(b) in connection with the treatment of persons suffering from the disease, or the prevention of its spread, and

(c) for the purpose of such treatment or prevention.

The Regulations therefore recognise the general duty of confidentiality in strict terms but with certain exceptions. It is notable that the exceptions do not permit disclosure of information about AIDS tests on identifiable persons to anyone who is not a medical practitioner or a person employed under a medical practitioner, or to anyone merely seeking reassurance following past exposure to risk. There is a common law duty of confidence in addition to and independent of that imposed by these Regulations, and the effect of this is considered at paragraph 9(4) below. For professional duties of confidence, see paragraph 2(11) above.

## 4. THE LEGAL PRINCIPLES

At the moment that the blood is taken for HIV testing without consent there are two separate heads of potential liability which are very different in concept and which it is therefore essential to consider separately. Firstly, there is potential civil and indeed criminal liability for assault and battery, the patient having an absolute right to protection from any physical invasion without his consent. Secondly, there is tortious liability for any breach of the doctor's general duty of care to his patient, adjudged by a more flexible standard based on a responsible body of skilled and experienced medical experts. Once the blood has been obtained, there is continuing duty in negligence, but questions of assault cease to be relevant. There is also a duty of confidentiality and a possible duty to third parties arising out of any information obtained.

## 5. ASSAULT AND BATTERY

### (1) Principles of assault and battery

The law against trespass to the person is traditionally strict.

> "The fundamental principle, plain and incontestable, is that every person's body is inviolate. It has long been established that any touching of another person, however slight, may amount to a battery."
>
> Collins v Wilcock [1984] 1 WLR 1172 at 1176, CA.

However, there is no liability if the patient has consented to the battery. The important question is how far this consent must be a fully informed consent

in order to constitute a defence; in other words, how much the patient must be told about the reasons for taking a blood sample and the possible consequences if it should be used to test for HIV and the test proved positive. The leading authority on the question of "informed consent" in English law is Sidaway v Bethlem [1984] QB 493 (Court of Appeal), [1985] 1 AC 871 (House of Lords). However, in that case the Court of Appeal emphatically rejected any suggestion that consent as a defence to a claim for trespass to the person (and we stress that there remains the question of negligence, which we discuss separately) must be a fully informed consent.

> "I am wholly satisfied that as a matter of English law a consent is not vitiated by a failure on the part of the doctor to give the patient sufficient information before the consent is given. It is only if the consent is obtained by fraud or by misrepresentation of the nature of what is to be done that it can be said that an apparent consent is not a true consent." (Per Sir John Donaldson MR at 511D)

> "The first argument was that unless the patient's consent to the operation was a fully informed consent the performance of the operation would constitute a battery on the patient by the surgeon. This is not the law of England. If there is consent to the nature of the act, then there is no trespass to the person." (Per Dunn LJ at 515A-B)

> See also per Browne-Wilkinson LJ at 519F-G.

In the House of Lords the claim in assault and battery was not argued or considered, but the reasoning of the Court of Appeal seems to have been approved by Lord Scarman at [1985] AC 871 at 885D.

(2) Consent vitiated by fraud or misrepresentation

A number of the authorities, including the dictum of Sir John Donaldson MR in Sidaway already cited, suggest however that if the consent relied upon was obtained by fraud or misrepresentation it may be vitiated and fail to constitute a defence to charges of assault and battery. One view is that fraud or misrepresentation is only relevant in this context if it goes to the nature of the act of battery itself, as opposed to matters collateral or consequential to the battery. In the numerous cases of men accused of rape after obtaining consent to sexual intercourse by deception, for example,

> "...the distinction was accepted between a consent given under a deception or mistake as to the thing itself, that is to say as to the act of intercourse, and a consent to that act itself induced by a deception or mistake as to a matter antecedent or collateral thereto... Consent obtained by frauds of the latter character is nevertheless consent." (Per Dixon CJ in Papadimitropoulos (1957) 98 CLR 249 at 254).

Thus, where a woman consented to intercourse because she was deceived into believing that what was taking place was only a breathing exercise or a medical examination, the fraud was as to the act itself and vitiated her consent: R v Flattery (1877) 2 QBD 410, R v Williams [1923] 1 KB 340. Where however she consented because of some misrepresentation about the context or consequences of the assault, the consent to the assault itself was not vitiated and so no offence was disclosed. So in Papadimitropoulos (1957) 98 CLR 249 there was no vitiation of consent to intercourse itself despite the man's fraudulent representation that he and his partner were man and wife, and in R. v

Clarence (1888) 22 QBD 23 there was no vitiation of consent to intercourse even where the man had failed to tell his partner that he had VD and that the consequence of intercourse would be that she too would contract it. On this view it might be possible to argue that as long as the patient consented to the taking of blood, misrepresentation or fraud as to the reason for the sample and the possible consequences of allowing it would not vitiate consent.

However, the cases are not all as rigorous in distinguishing misrepresentation of the act and misrepresentation of surrounding circumstances and implications as these are. See for example Rosinski (1824) 168 ER 941, aff'd 168 ER 1168, and Burrell v Harmer [1967] Crim LR 169 in both of which misrepresentation about matters purely collateral and consequential to the assault were allowed to vitiate actual consent to the act complained of. See also Chatterton v Gerson [1981] QB 432 per Bristow J at 443:-

> "In my judgment once the patient is informed in broad terms of the nature of the procedure which is intended, and gives her consent, that consent is real, and the cause of action on which to base a claim for failure to go into risks and implications is negligence, not trespass. Of course if information is withheld in bad faith, the consent will be vitiated by fraud..."
> (Our emphasis)

Although none of these cases appears to have been decided with the benefit of full argument on the implications of the Clarence and Papadimitropoulos line of authorities considered above, they make the point sufficiently doubtful in our view for it not to be safe to rely on any consent obtained by fraud or

misrepresentation. In our view, therefore, although in most cases any liability of doctors for failure to obtain consent to testing for HIV is likely to be in negligence and not assault and battery, where there has been actual deceit about what is to be done with the blood sample, there is a serious risk of liability for assault also.

(3) Examples

We understand that the usual procedure when diagnosing HIV or indeed any serious medical condition is not to warn the patient about the doctor's worst fears until there is already substantial support for them from test results. Thus, a young man suffering from unusual weakness and lassitude may be suffering from anaemia, or glandular fever, or leukaemia, or the early stages of AIDS. The doctor in such case might say to him

> "I am just going to take some blood to do some tests"

without further explanation. In our view, this would not be a misrepresentation vitiating consent to the tests despite the lack of information provided. If however, the doctor says

> "You may be anaemic: I will just take some blood for a test"

while in fact intending to test also for more serious illnesses, including AIDS, that would be nearer to a misrepresentation. If the doctor lies in answer to a direct question, such as

> "You're not thinking of AIDS are you?"

then he would most certainly be at risk of liability. We are particularly conscious of the fact that the current policy of never testing for HIV without specific informed consent is now well-publicised, and might itself be held to constitute a positive representation on which patients consenting to blood samples for unspecified tests might currently be said to rely.

(4) Implied consent

Implied consent is often cited as a defence to battery during emergency treatment where the patient is unconscious or otherwise unable to give express consent: Wilson v Pringle [1987] QB 237. Although we are instructed that testing in the urgent interests of the patient (which is the only proper consideration for the purposes of implied consent) has on occasion been found to be necessary to avoid psychiatric crisis, we assume that in such cases consent can and will be given. On the other hand, in certain circumstances it may be so obvious or well known that AIDS testing will be carried out that a patient by a general consent to treatment may also be said to have impliedly consented to that test. We have seen material shown to all potential blood donors, for example, which makes it quite clear that HIV testing will be carried out. Such cases will however be rare, and generally speaking we do not consider that implied consent is a reliable defence in these cases: T v T [1988] 2 WLR 189, at 202C. It is in any event always liable to be overridden by express disapproval, and would clearly not apply, for example, where the reason for not obtaining express consent was the fear of a refusal.

(5) Conclusion

Our conclusion is that save in cases of actual misrepresentation or fraud as to the nature of what is to be done when blood is taken for testing, mere silence or failure to give full information about the tests to be subsequently performed does not vitiate consent to the taking of the blood (which must, however, be obtained, expressly if not impliedly) and therefore does not expose the doctor to liability for assault and battery. Instead, the proper legal standards likely to be applied are those of the general duty of care in negligence. Furthermore, once the blood has been taken, any subsequent use of it cannot be a battery (whatever other breaches of duty it may entail) because once a person has given samples of body fluids he ceases to retain any proprietary rights over them as his own: Welsh [1974] RTR 478, Rothery [1976] RTR 550.

6. THE LAW OF NEGLIGENCE

DUTY OF CARE WHEN TAKING BLOOD

(1) The duty of care

The more important duty, therefore, even at the actual moment of taking blood from the patient, is the general duty of care that a doctor owes to his patient. This is measured by the standard laid down for the jury in Bolam v Friern Hospital [1957] 1 WLR 582 at 587-88:-

> "...he is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art... Putting it the other way round, a man is not negligent if he is acting in accordance with such a practice, merely because

> there is a body of opinion who would take a contrary view... it is not essential for you to decide which of two practices is the better practice, as long as you accept that what the defendants did was in accordance with a practice accepted by responsible persons."

This is a flexible test, but it depends on two essentials: conformity with an opinion shared by a skilled body of medical men and responsibility on the part of those men. It is therefore necessary to ensure that the practice followed is approved by a body of medical opinion and that it is a responsible opinion. On the first point, we have already stressed that we consider it of very great significance that all the guidance presently offered by the DHSS lays stress on the general necessity of obtaining fully informed and counselled consent before an AIDS test is performed. That shows that the most important body of medical opinion is presently in favour of obtaining such consent in every case. On the other hand, the Motion passed by the annual representative meeting of the British Medical Association in July 1987 was as follows:-

> "Testing for HIV antibodies should be at the discretion of the patient's doctor, and should not necessarily require the consent of the patient."

Even this resolution does not rule out consent as a general rule but only provides that it should not <u>necessarily</u> be required, in the exercise of the doctor's discretion. Nevertheless, it is phrased in terms which suggest a far broader power for doctors to test without the consent of the patient than can be justified in law. It must be strictly understood that the doctor's discretion to depart from the usual practice of obtaining full consent to HIV testing will

apply only in exceptional cases and must be very carefully exercised. It is also necessary that it is exercised responsibly, which means in our opinion that the interests of the patient himself will be paramount.

(2) Interests of the patient paramount

We have said that the interests of the patient must be paramount when exercising any discretion to take blood to test for HIV without consent.

> ""The doctor, obedient to the high standards set by the medical profession, impliedly contracts to act at all times in the best interests of the patient." (Sidaway v Bethlem [1985] AC 871 at 904B)

Although there may be some exceptions to this rule, such as those considered below, at this point there is no overriding need to prefer the interests of third parties. If there is reason to suppose in the particular case that the result of a test might be positive, then the interests of third parties can be protected by acting on the assumption for their purposes that the patient is in fact HIV positive. Indeed, given the incubation period during which the disease is infectious but undetectable even by tests, it would be right to proceed on this assumption in such a case even where the test result was negative. Where on the other hand there is no reason to believe the patient is in one of the high-risk groups or otherwise exposed to infection, the danger to third parties is not so immediate as to justify qualification of the doctor's primary duty towards his patient. When this primary duty prevents HIV testing without full consent, such full consent must be sought, and (we are informed) when sought it is usually forthcoming. Refusal is

sufficiently unusual to be an indication of higher risk of infection in itself, and this is again sufficient warning of possible danger to third parties.

(3) Special factors in the discretion

The following factors are we consider of importance in distinguishing the exercise of such a discretion in AIDS cases from the practice with respect to testing for other diseases:-

(a) A patient who has been tested for HIV may be obliged to disclose this fact to insurance companies by allowing them access to his medical records when applying for life insurance. Such disclosure may prejudice the application, because many insurance companies currently assume that all those tested for AIDS are likely to be in categories of high risk for AIDS, even when the test result is negative.

(b) Whereas most disease can be treated if not cured, relief available to diagnosed AIDS patients is limited, before symptoms appear, entirely to counselling. There is no vaccine, no primary treatment and no cure.

(c) A positive result carries the trauma associated with diagnosis of all serious conditions, but increased by the particular public horror and stigma attached to this disease. There is evidence that many patients prefer not to know whether they are infected until it becomes obvious from the progress of the illness.

(4) Exercising the discretion

At the moment of taking the blood for testing, deciding whether to warn the patient that an HIV test will be performed requires a difficult exercise of judgment. There is no simple answer: it is not in our opinion possible to say that fully informed consent is invariably necessary and it is certainly not right that it is never necessary. It normally will be required, but each case must be considered in the light of its particular circumstances, in accordance with the principles we have outlined. Although this lacks simplicity, it is a test which at least has the merit of allowing flexibility in accordance with the varied situations which arise in the clinical context. The following considerations must be balanced:-

(a) The disadvantages to the patient should the test be performed without consent and prove positive. These would include the effect of learning this without warning, which some patients might bear better than others, and the social consequences already discussed, which some patients might prefer to avoid through ignorance even if in fact positive;

(b) The advantages to the patient should the test be performed without consent and prove positive. On present instructions the only advantages appear to be improved long-term medical care as a result of correct diagnosis, and counselling as to lifestyle;

(c) The advantages to the patient should the test be performed without consent and prove negative. These would include the avoidance of unnecessary

anxiety by the patient, which again might be felt more acutely by some patients than by others;

(d) The disadvantages to the patient should the test be performed without consent and prove negative. There would not seem to be any disadvantages in such a case.

Since it is apparent from this analysis that testing without informed consent is mainly disadvantageous to the patient when the result is positive, and mainly advantageous to the patient when the result is negative, there is a fifth factor to weigh in the balance:

(e) The likelihood or otherwise that the test will prove positive in the particular case.

Thus, it is when HIV infection is most suspected that the doctor must be most careful about exercising his discretion to go against the normally advised practice of proceeding only with fully informed consent and counselling.

## 7. CONSEQUENCES OF ASSAULT OR BREACH OF DUTY

Even if an assault or breach of duty were proved against the doctor who took blood for HIV testing without the informed consent of the patient, the damage flowing as a result is likely to be limited. Most of the suffering of the patient will flow from the infection itself rather than from the result of the test performed without his consent, and such damage will not be recoverable: Barnett v Kensington & Chelsea Hospital Management [1969] 1 QB 42. However, there may be some recoverable damage if the shock of

the diagnosis causes distress amounting to illness in itself. Perhaps the most likely source of loss would be the refusal of insurance cover, which might have been allowed if the patient had no reason to suspect that he was HIV positive. However, in many cases he will know that he is at risk and might therefore be ineligible for insurance even without a test, as a result of the specific enquiries about lifestyle now made by insurance companies. Another possible source of loss is loss of employment and there is a sufficient risk of at least some recoverable loss by the patient for it not to be possible to rely on this point to defeat any otherwise well-founded actions in tort. Actions for breach of contract (as to which see paragraph 10) are maintainable without proof of damage.

8. CONTINUING DUTY AFTER OBTAINING TEST RESULT

Unlike the potential liability for assault and battery which, as we have said, ceases once the blood has been taken from the patient's body, the doctor's general duty of care to the patient is a continuing duty and must therefore be considered even after the test result has been lawfully obtained without the consent of the patient. If the result of the test is negative, there is unlikely to be any difficulty - and this is a further reason for expecting that it is where a negative result is overwhelmingly probable that consent is most likely to be dispensed with. When however the test has been taken without the knowledge of the patient and turns out to be positive, the doctor is placed in a number of dilemmas which he must resolve without breach of his continuing duty of care. He must decide:-

(a) Whether to inform the patient. This will depend on a balancing of the advantages and disadvantages to the patient as before, but in most cases the doctor may well feel that actual knowledge of a positive result is something that ought to be communicated to the patient, subject to proper preparation and counselling.

(b) Whether to inform third parties even after consent to do so is sought and refused. There would seem to be no justification for not seeking such consent at all, once the patient himself has been informed of the test result.

(c) Whether informing third parties, even when not otherwise a breach of the general duty of care to the patient, would be a breach of confidence.

9. DUTY TO THIRD PARTIES

(1) When the duty may arise

Where a positive test result is obtained, this may have serious implications for persons other than the patient himself. There may be a risk of infection to sexual partners or future children, which could be avoided by counselling and changes in sexual behaviour. The risks to the public at large and even to the medical profession are likely to be limited, as we have seen, but in exceptional cases these may also be relevant, as for example where bones or blood or organs from the infected person are intended for donation, or where invasive procedures increase the danger of self-innoculation with infected blood. Once a positive test result has been obtained, the doctor's duty of care in negligence to these third parties who may be

foreseeably and seriously injured by his failure to protect them by information or otherwise from the disease of his own patient becomes potentially in conflict with his duty towards the patient himself. If the patient can be persuaded to consent to the result being passed on to third parties or otherwise acted on for their benefit then these difficulties are resolved. This is always the best and safest course and must be the usual rule. However, in wholly exceptional cases it may not be possible to obtain the patient's consent but there may nevertheless be an overriding obligation to consider passing on the information for the protection of third parties. There is no English authority directly on this point but see Marshall v Lindsey C C [1935] 1 KB 516 and Heafield v Crane The Times 31 July 1937 which support the view that there may be a duty to warn third parties of a risk of infection, although these were not cases in which there was a conflicting duty to the infected person, nor in which the person to be warned was not himself a patient of the defendants. More directly in point is an American case, which would be of persuasive authority in English courts: Gammill v United States 727 F 2d 950 (1984). In that case a surgeon's employers were sued inter alia for his allegedly negligent failure to notify the authorities that he had diagnosed hepatitis in his patient. It was claimed that a member of the public who might otherwise have been innoculated had subsequently contracted the disease as a result, and that the employers were vicariously liable for his negligence. The claim was dismissed, but only on the grounds that the the Plaintiffs were not sufficiently proximate to the negligent surgeon, the Court of Appeals ruling as follows:-

"Colorado courts have never directly addressed the issue of a physician's duty to prevent harm to a third person who is not a patient. Generally, however, a person does not have a duty to protect another from harm except where a special relationship exists between the parties, or when the first person placed the other in peril. See Restatement (Second) of Torts paras 314-314(A) (1965). Clearly, there is no "special relationship" between Dr Hamilton and the Gammills; they were not even acquainted. Neither could it be said that Dr Hamilton placed the Gammills in peril.

The Gammills contend, however, that Dr Hamilton's duty to them arises from his professional position and relation to people who contract disease. They argue that, as a physician, Dr Hamilton owed the public the duty of ordinary care to protect them from the diseases of his patients. In support thereof they cite Davis v Rodman 147 Ark 385, 227 SW 612 (1921); Wojcik v Aluminum Co of America 18 Misc 2d 740, 183 NYS 2d 351 (1959); 61 Am Jur 2d Physicians and Surgeons para 245; 41 Am Jur Physicians and Surgeons para 101; and 70 CJS Physicians and Surgeons para 48.

We understand these authorities, however, as expressing a much more limited duty than that urged by the Gammills. A physician may be found liable for failing to warn a patient's family, treating attendants, or other persons likely to be exposed to the patient, of the nature of the disease and the nature of exposure. 61 Am Jur 2d Physicians and Surgeons supra; Davis v Rodman, supra. We note the limited persons to whom such a duty is owed, again suggesting the necessity of some special relationship between the physician

**and those to be warned. It would appear that as a bare minimum the physician must be aware of the specific risks to specific persons before a duty to warn exists. Here, Dr Hamilton did not know the Gammills; clearly he was unaware of their risk of exposure. Under these circumstances, we agree with the district court that to impose a duty upon Dr Hamilton to warn the Gammills would constitute an "unreasonable burden" upon physicians."**

(Underlining is that of the Court of Appeals throughout).

(See also to the same effect Tarasoff v University of California 551 P 2d 334 (1976) which is more often cited by English writers than Gammill but less relevant on its facts, and Hofmann v Blackmon Fla 241 So 2d 752 (1970))

We consider this American authority to be significant for two reasons. First, it clearly recognises that a doctor may owe a duty to report that he has diagnosed a patient as suffering from an infectious disease in order that third parties at risk of infection from the patient may thereby be informed and protected. But, second, it limits those covered by the doctor's duty to "a patient's family, treating attendants, or other persons likely to be exposed [and specifically known to the doctor in question]". Since American courts are as a rule more rigorous in holding doctors liable in negligence than English courts, it is unlikely that an English court would hold that doctors owed any wider duty to inform third parties of the risk of infection than was allowed in Gammill v United States.

(2) Factors relevant to the duty to third parties

Where the question of a possible duty to warn third parties of a risk of infection does arise, a decision can in our opinion only be made in the light of three factors:-

(a) The degree of risk. In most cases, we stress, the actual risk to third parties is on the evidence negligible, despite the widespread anxieties that are felt even by medically qualified persons on this score. It is only in the case of the most intimate contact that the risk is appreciable.

(b) The need to know. Again, in most cases sufficient precautions can be taken on an assumption of risk, as a matter of prudent practice, without the need to be informed of the actual result of HIV testing in each case.

(c) The duty of confidence. As we have explained above at paragraph 3(2), the National Health (Venereal Diseases) Regulations 1974 impose an absolute prohibition on all Regional and District Health Authorities (and therefore on their employees also) conveying any information capable of identifying a person examined or treated for any sexually transmitted disease except to a medical practitioner or a person employed under him. As result, there could be no question of, for example, a National Health Service hospital doctor or laboratory worker informing any person who was not a medical practitioner or employed under a medical practitioner of an HIV diagnosis, even where the other requirements of the Regulations were satisfied. However, a general

disease subsequently and passed it on to the foetus after conception then it would be possible for the child to bring an action after birth under the 1976 Act in respect of a failure to warn, provided that the possibility of conception was sufficiently known to the prospective Defendant at the relevant time.

(4) Duty of confidence

We stress that the question of informing third parties of HIV status will only arise if every effort has been made to obtain the consent of the patient and yet consent has been refused. We stress also that it is only in the most exceptional circumstances that the doctor's duty of care to the third party might entitle him to communicate the information in the teeth of that refusal. However, even in such an exceptional case, there remains the question of the doctor's separate duty of confidence. Information about the HIV status of a patient is subject to a duty of confidence, whether or not the National Health Service (Venereal Diseases) Regulations apply; the doctor patient relationship in which the information is obtained coupled with the extremely sensitive nature of the information itself make this in our opinion clear beyond argument. Where the Regulations do apply, the restrictions on the transfer of the information are subject only to the express exceptions which we have set out above. Where the Regulations do not apply, for example in the case of General Practioners, there is a common law exception to the duty of confidence where breach of confidence is necessary in the public interest: Lion Laboratories v Evans [1985] QB 526, X v Y (1987) 137 NLJ 1062. We consider that such a defence would extend only to cases where communication of information was necessary to prevent the spread of

serious infection: Tarasoff v Regents of the University of California 529 P (2d) 553. We do not consider it would extend to cases where the test result was to be communicated for the purposes of reassurance only.

10. CONTRACT

Most patients are not in contractual relations with their doctor. All the duties which we have considered so far as potential sources of liability are duties in tort. But where the parties are in contractual relations, there is no reason why the tortious duties should not be overridden or waived by express agreement between the parties in contract. Freedom of contract in English law is almost absolute, and any doctor (for example, a company doctor or a doctor in private practice) who is in a position to see his patient only on an express contractual condition that the patient submits to AIDS testing and that the result may be communicated to others in certain circumstances is fully at liberty to impose such a condition. This is a simple point, but it is of considerable importance in many of the situations on which we are asked to advise. However, existing contracts cannot be varied to add such a condition unless the parties agree to this.

11. APPLYING THE LEGAL PRINCIPLES

We now turn to the specific cases upon which we are asked to advise in our Instructions.

(1) "Mr Michael Sherrard QC's view was that it was unlikely a Court would decide that an HIV test could be classified as routine"

We have seen the Joint Opinion of Michael Sherrard QC and we consider that too much importance has been attached to his use of the term "Routine testing". We note that in his further Opinion he said (at paragraph 1.3):-

> "The principles to be applied depend not simply on whether a test is "routine" or not, but the extent to which, by virtue of the nature of the treatment or test, the practitioner must fulfil his duty to the patient to obtain consent on an explicit basis."

and at paragraph 1.3:-

> "The doctrine of implied consent will apply in very few cases. In all other cases the question is not whether the treatment is routine in the sense of being commonly used, but whether the practitioner has fulfilled his duty to the patient."

The concept of "routine testing" is not really an answer to the question of when fully informed consent to HIV testing may not be required, but at best a reformulation of it. Because of the very special sense in which Michael Sherrard QC used the phrase (see the explanation he provides at paragraph 1.2.1 of his further Opinion) we do not find this reformulation helpful, and indeed it appears from the correspondence and debate we have been shown that it has caused some confusion. We therefore do not adopt it ourselves, and this makes answers to questions specifically on what is "routine" unnecessary.

(2) "How does testing for HIV antibody differ from a great many other tests which are carried out on patients without those patients being told the nature of these tests e.g. syphilis and Hepatitis B?"

The principles applicable to HIV testing are not in any way different from the principles applicable to other testing. The main principle is the doctor's duty of care to the patient, with assault and battery of lesser importance as long as there is consent to the "needle in the arm" without fraud or misrepresentation. The difference in practice is that the assessment of the duty in tort is influenced by special factors in AIDS cases, such as that the disease itself is incurable and untreatable, that the social and psychological consequences of diagnosis are uniquely grave, and that the DHSS has publicly declared that HIV testing will be done only with full consent in all cases.

(3) "If a medical staff committee as a collective body, or any other collective body of responsible medical opinion forms a view that HIV is sufficiently widespread to include this in routine testing would the members of the body collectively and individually be placing themselves in jeopardy if they establish routine testing as a policy, without consent?"

Granted consent without fraud or misrepresentation to the "needle in the arm", granted also publication of the view that such routine testing should be carried out, this question depends upon the doctor's duty of care to his patient together with those duties referred to in paragraph 9. If the doctor acts in accordance with a responsible body of medical opinion then he will not be in breach of his duty of care. But not every collective body of medical opinion will be judged responsible, and in exceptional cases even a unanimous body of medical opinion may be so obviously wrong that the court will decline to follow it: Sidaway v Bethlem [1985] AC 871. 900D-F. The doctor must make his own assessment of what is required by his duty of care to

his patient, and if he makes it conscientiously and responsibly and in accordance with the principles we have outlined, the court will not hold him liable. But "It is for the court to decide, after hearing the doctor's explanation" and there are no short cuts to avoiding liability: Sidaway v Bethlem [1985] AC 871, 903G.

(4) "Alpha Feto protein testing in pregnant women is a test which is done routinely without specific consent and yet not for the benefit of the patient. The effect of the test is to show whether the foetus is abnormal and it is done without enquiring whether the mother would wish to act on the result in any event."

On further enquiry we have learned that it is not correct that Alpha Feto protein testing is done routinely without specific consent. In any event, we consider that the principles applicable to HIV testing would apply equally to such cases.

(5) "If a patient who is admitted for urgent treatment is in a high risk group it is assumed that the patient is HIV positive. However, to treat patients as HIV positive makes treatment more expensive and lengthy. In what way does an HIV test without consent differ from a Hepatitis B test without consent and given the monetary considerations would it be possible for a surgeon to test without gaining consent?"

Since there is a danger of false negative results where the infection is in its very early stages, even a negative HIV test will not rule out precautions when a patient is known to be in a high risk category. This makes it unlikely that exposing the patient to the hazards of such a test without specific consent would

be justified as a departure from the usual rule on grounds of urgency. In any event, as we have said, we do not consider that the mere saving of expense and inconvenience would justify so serious a step without the patient's consent. In cases where the test is absolutely necessary (and we do not consider this question disloses such a case) the patient's condition may be relevant to deciding whether it is in his interests to be fully informed of what is to be done, in accordance with the principles we have outlined.

(6) "Before an elective operation would it be possible for a surgeon to insist on an HIV test before operating? If the patient is HIV positive could he refuse to carry out the operation? Would the advice be different if the surgeon was operating in private practice?"

It is not possible for a surgeon to insist on an HIV test before operating, in the sense that the patient has a right to refuse such consent, and he cannot be obliged to give it. Indeed, efforts to force him to consent, even if successful, might be self-defeating as consent in such circumstances could be void for duress. However, if the operation is truly elective and not, for example, necessary to save life, then duress is unlikely. The true question is whether if the patient refuses to be tested, as he is entitled to, the surgeon is then justified in refusing to operate. We think the answer to this question will depend on balancing a number of factors:-

(i) the doctor's contractual and professional obligation to treat his patients: see paragraph 2(11) above;

(ii) the nature of and need for the operation;

(iii) the degree of risk to the surgeon;

(iv) the precautions against infection which could in any event be taken.

The position is different in private practice, because the rights and obligations of the parties can be regulated by contract. There is no reason why consent to HIV testing should not be made a contractual term in such a case. However, there might still be difficulty in refusing to treat a patient who proved to be HIV positive, in that this could be a breach of the contractual and professional obligation to treat patients, as to which see paragraph 2(11) above.

(7) "If a skin or other organ donor is positive, should he be told?"

As we have advised, in most cases the donor's express consent to the original test will have been required. In such a case and in the exceptional case where the patient is not aware that the test has been performed, we repeat our advice at paragraph 8(a) above: what the patient should be told about the result will depend on a balancing of the advantages and disadvantages to the patient as before. However, in most cases the doctor may well feel that actual knowledge of a positive result is something that ought to be communicated to the patient, subject to proper preparation and counselling. Indeed it might be negligent not to warn the patient in order to prevent him from acting so as to infect others.

(8) "If the donor is unconscious and dying and the transplant needs to be carried out urgently would it be

sufficient to obtain just the next of kin's consent to the test?"

In law the answer to this question is no. The test should not be performed without specific consent because it is not necessary in the best interests of the patient. If (as in many cases) there could be no damage suffered by the dying patient as a result of this technical breach, no liability in tort will accrue: see for example Rich v Pierpoint (1862) 3 F & F 35, in which the administration of tartaric acid to the patient "turned out to be of no consequence", and Barnett v Kensington & Chelsea [1969] 1 QB 42. However, we do not think it safe to rely upon mere absence of loss as a defence in every case, and when the patient has a claim in contract (as for example in a private hospital) he is entitled to sue even without proof of damage. After his death, the patient's estate is entitled to sue on his behalf: section 1(4) Law Reform (Miscellaneous Provisions) Act 1934. The safest course would be to test without consent only after death has occurred: as to which, see the next question.

(9) "If the donor has died should the next of kin's consent be obtained?"

There is no need for such consent after death. Although a man's executors (who may very likely be the next of kin) are entitled to possession of his corpse, they have no other rights in his body, and there is no property in a corpse: Williams v Williams (1882) 20 Ch D 659. No question of consent therefore arises, there clearly being no duty of care to a person who is dead. Of course, when the executors exercise their right to claim possession of the corpse it must be given to

them, and thereafter testing without their consent will not be possible.

(10) "Whether or not consent has been obtained should the next of kin be told if the result is positive?"

Again, once the donor is dead there is no duty owed to him, nor are actions for breach (as opposed to damage) alleged to have taken place after death maintainable by the estate. However, there may be a continuing duty to living persons, including next of kin, if the information is relevant to them, as, for example, when a wife is at risk of past infection and ought to be warned or counselled. Again, this is a question to be answered in accordance with the standard test of the doctor's general duty of care, but as applied to surviving persons only in this case.

(11) "Some donors such as old spinster ladies may be upset at being at being asked to undertake an HIV test and yet if they undergo a hip replacement their bone would be suitable for use by others. Given that such people are in such a low risk group would it be acceptable to test without consent?"

The normal principles must be applied. However, given the very low risk of a positive result and the potential distress to the patient should consent be sought, this may well be one of the exceptional cases in which specific consent might not be required.

(12) "Can pathologists test for AIDS without consent in order to protect themselves and their staff in a case where the clinician has not asked for this test to be undertaken?"

The answer to this question is no. Only in the exceptional circumstances that we have considered can HIV testing without specific consent be justified, and only the clinician is in a position to judge whether such exceptional circumstances apply in any particular case, bearing in mind that the primary consideration is the interests of the patient. Where there is no reason to suspect infection it would be wholly unwarranted for pathologists to break the general rule of testing only with specific consent. Where there is reason to suspect infection, precautions can and should be taken whether or not a test is obtained, since even a negative test does not guarantee that there is no infection in the early stages. Besides, as we have said, the risk to pathologists and staff who follow proper procedures is negligible.

(13) "Is it the pathologist's responsibility to ensure that the medical practitioner has the patient's consent to test or may the pathologist rely on the medical practitioner who has requested the test following the necessary procedures to obtain consent?"

We are instructed that (contrary to the procedure for operations) when blood is sent to the laboratory for testing for AIDS or any other disease there is no consent form or other written evidence of consent that is generally supplied with the blood sample. In these circumstances, unless the pathologist has definite reason to believe that the practitioner is in breach of his duty when requesting the test in any particular case (as for example where a doctor says "I have not asked for consent because it is not my practice to do so"), we are of the view that the pathologist is fully entitled to assume that the appropriate consent has been obtained. We do not consider that the pathologist

would be held to be liable for any breach of duty by the practitioner of which the pathologist was not actually aware, nor do we think that carrying out the practitioner's instructions without such knowledge would be a breach of the pathologist's own duty of care. This question is the reverse side of the previous question: in both cases the important factor is that the pathologist is not generally in a position to say whether or not consent can properly be dispensed with, and he is therefore neither entitled nor called upon to do so.

(14) "In special hospitals and other secure psychiatric facilities, history of drug abuse, sexual promiscuity and in some cases injury requiring transfusion are not uncommon. In view of the high risk that these patients pose it could be argued that a widespread screening policy would be desirable."

The position of patients detained under the Mental Health Act 1983 is governed primarily by Part IV of the Act (sections 56 - 64). These sections apply to treatment for mental disorder, and HIV infection is not a mental disorder, although in the later stages of full-blown AIDS pre-senile dementia and related mental disorders may appear as symptoms. However, the Act recognises as a principle that even patients detained under the Act must generally speaking give their fully informed consent to treatment (s 57, s 58(3)(a)), and are entitled to withhold and even withdraw such consent once given (s 60). There are a number of exceptions, for cases of urgency in the interests of the patient himself (s 62), for specified treatments (currently including ECT only) certified to be necessary having regard to the likelihood of it alleviating or preventing a deterioration of the patient's own

condition (s 58(3)(b)), and for other treatment for the mental disorder from which the patient is suffering given by or under the direction of the responsible medical officer (s 63). The significance of these provisions, although they do not apply directly to AIDS, is that they indicate that generally speaking even a patient detained under the Mental Health Act is not only able but entitled to consent or refuse consent to any proposed treatment, and that the only exceptions concern treatment of the patient's own mental disorder and are for his benefit and not the benefit or protection of others.

(15) "What is the position of the mental patient who is considered to be a high risk but who is unable to give consent? Would it be possible to obtain the consent of the next of kin for the test on the patient's behalf?"

Guidance in the very exceptional case in which a mental patient is so ill as to be actually incapable of giving consent was recently given by the Family Division of the High Court in the case of T v T [1988] 2 WLR 189. In that case a nineteen year old girl with a mental age of 2.9 and an IQ of less than thirty, was found to be pregnant, but incapable of consenting to an abortion and thereafter to sterilisation, although both were for a number of medical reasons clearly necessary in her own interests. It was held by the judge that there was no power for any person, or even the Court, to give consent on behalf of an adult who could not herself consent, and that there was no provision for such consent under the Mental Health Act. It was also held that in the absence of such consent, to proceed with the proposed treatment would prima facie be tortious and unlawful. However, the judge (Wood J) nevertheless granted a declaration that the treatment would not in

fact be unlawful, on the following grounds (at 199C-D, 203H-204A):-

> **"This defendant is never going to be able to consent... and there is no one in a position to consent. A medical adviser must therefore consider what decisions should be reached in the best interests of his patient's health. What does medical practice demand?**
>
> **I use the word "demand" because I envisage a situation where based upon good medical practice there are really no two views of what course is for the best...**
>
> **I am convinced, as are all the lay and professional persons involved in this case, that it is in the best interests of the first Defendant that these procedures should be carried through and I have made the declarations which were sought. I am content to rely upon the principle that in these exceptional circumstances where there is no provision in law for consent to be given and therefore there is no one who can give the consent, and where the patient is suffering from such mental abnormality as never to be able to give such consent, a medical adviser is justified in taking such steps as good medical practice "demands" in the sense that I have set it out above and on that basis it is that I have made the declaration sought."**

We would make three observations on this decision. First, it unequivocally states that where consent is required, it cannot be obtained from next of kin or any person other than the patient himself. Second, it confirms our advice that the primary consideration is the best interests of the patient himself, and

indicates that it is only in the clearest and most exceptional case that consent may be dispensed with. The number of cases in which "there are really no two views of what course is for the best", as required, will be very few, and AIDS testing will be sought in mental homes for the protection of other inmates and not in the interests of the patient. Finally, the judge stated that the wisest course, even in such a case, would be to seek the protection of the court by application: p 204B-C. This means that the answer to this question is to make an application under the Public Health (Control of Disease) Act 1984.

(16) "What is the position where a high risk mental patient who is able to consent is unwilling to consent?"

In such a case, we do not think that on the principles we have outlined it would be lawful to proceed with the test. However, this is a very good example of an instance in which it may be appropriate to make an application to the magistrates for an order permitting a test without consent under section 35 of the Public Health (Control of Disease) Act 1984 - see paragraph 3(1) of this Opinion.

(17) "Would it be possible that the doctors may be considered negligent if they failed to ensure a safe environment for such patients and as a result of such failure a patient not infected becomes infected?"

Yes. It is possible for a doctor to be liable for negligence in allowing patients to contract infection by admitting them to an unsafe hospital or other environment: see Evans v Liverpool Corporation [1906] 1 KB 160, Marshall v Lindsey C C [1935] 1 KB 516, Heafield v Crane The Times 31 July 1937, Gammill v

United States 727 F 2d 950 (1984) and paragraph 9 of this Opinion. The doctor must therefore do all he can, consistent with his other duties as explained in this Opinion, to protect those under his care, if necessary by making assumptions about positive HIV infection in appropriate cases. However, should infection nevertheless spread, the doctor will only be liable if he has been negligent in permitting this; in other words, if he has fallen below the standards of the reasonable man in his position. As long as the doctor has done what he is able and obliged to do in accordance with the law as expounded in this Opinion, he will not be liable for any consequences which could not have been prevented without breach of duty to other persons.

(18) "Like doctors dealing with the mentally handicapped prison medical officers have good grounds for wishing to know the HIV antibody status of any prisoner to prevent further spread of the virus and to protect other prisoners. In a prison population large numbers of patients may refuse to co-operate. Practical problems would be posed by attempting to treat all prisoners who refuse to consent to treatment as if they were positive. In those circumstances, what is the position of a medical officer who wishes to test without consent?"

The same principles apply. Without consent, the test cannot be performed save in exceptional circumstances of the kind already considered for the benefit of the patient, and the circumstances of this question do not fall within that category. A prisoner is entitled to withhold his consent to treatment in the same way as a free man. Indeed:-

"...where, in a prison setting, a doctor has power to influence a prisoner's situation and prospects a court must be alive to the risk that what may appear, on the face of it, to be a real consent is not in fact so." (Freeman v Home Office (No 2) [1984] QB 524, 557C-D)

If it is desired to screen all inmates, then this should be done with consent, and if consent is refused, then a judgment must be made as to whether the known circumstances (including the refusal) are such as to justify treatment of the prisoner as if he were HIV positive. The factors mentioned in question (17) above would be equally relevant to that judgment. It may well be that most prisoners will consent to the test rather than live under the stigma and disadvantage of being deemed HIV positive, which we know to be very great in prisons. If it could be established that it would be in the public interest there is the possibility of an application under the 1984 Act: see paragraph 3(1)(d) of our Opinion. If this situation proves unworkable, then no doubt legislation will have to be considered to provide special powers in prisons, which are widely thought to be a nursery for the spread of the disease in future. However, we are able to advise only on the law as it presently stands.

(19) "There is a possibility that a prisoner may bite a prison officer and, in order to lessen the officer's concern as to whether the prisoner is HIV positive, may the prison officer test the prisoner without consent?"

The risk that AIDS might have been transmitted in this fashion is negligible. See X v Y (1987) 137 NLJ 1062, citing Professor Michael Adler:-

"He said the virus is not passed by casual or social contact and there is no evidence that it is spread by saliva."

A prison officer bitten by a prisoner may not have the prisoner tested without his consent: see previous question. Nor would the Public Health (Control of Disease) Act 1984 apply, because the prison officer's interest is not the public interest - see paragraph 3(1)(d) of this Opinion.

(20) "School doctors are under an obligation to ensure the safety and welfare of children. In respect of haemophiliac children may a doctor test without the patient's consent?"

The doctor must make his decision in the light of his duty of care as before. In accordance with the principles we have set out, the doctor may not test without consent simply on the grounds that this may be in the interests of other pupils. See previous question, and see also paragraph 9 of this Opinion. Consent should be obtained from the child's parents, until the child achieves sufficient maturity and intelligence to understand the nature and implications of the test, at which point the child himself is entitled to give or withhold the necessary consent: Gillick v West Norfolk AHA [1986] AC 112. The proper course is to seek consent (unless this would not be in the interests of the child himself) and if it is refused, and the circumstances (such as a history of blood transfusion between 1976 and 1985) justify it, to act as if the child is infected. In other words, the duty of care to other children must be performed in the light of the doctor's knowledge including his knowledge that a test has been sought but refused.

(21) "Does the doctor have a duty of care to the other pupils?"

Yes. But see the answer to question (17) and (20) above for the limits of this duty.

(22) "Would it be possible for doctors to test military personnel for HIV without their consent?"

No. But such consent may be required as a contractual term, since soldiers and other military personnel are employed persons. See paragraph 10 of this Opinion.

(23) "Would the doctor be under an obligation to inform the spouse of the soldier of the result of such a test?"

A doctor employed by a Regional or District Health Authority and subject to the National Health Service (Venereal Diseases) Regulations 1974 is prohibited from supplying this information to the spouse directly: see paragraph 3(2) of this Opinion. Apart from this consideration, the doctor should make every effort to obtain the consent of the patient to informing his spouse. If this is not forthcoming, the circumstances in which the doctor might be subject to an overriding obligation to consider warning the spouse in any event are those set out in paragraph 9 of this Opinion.

(24) "If a doctor treats a health care worker and suspects the health care worker is HIV positive could he test without consent bearing in mind that it may well be in the public interest to test?"

The usual principles apply, and if it is desired to test health care workers, consent must be obtained unless this would not be in the interests of the health

care worker himself. If consent is refused, then if necessary precautions can be taken on the assumption that he is positive. Since health care workers are in contractual relations with their employers, it is possible to require consent to HIV screening as a condition of employment: see paragraph 10 of this Opinion. It is also possible to make an application to the magistrates under section 35 of the Public Health (Control of Disease) Act 1984 for an order for testing without consent; but clearly only a very extreme case would justify such a procedure. The risks posed to patients by health care workers, save in exceptional cases such as during invasive procedures where proper precautions have wrongly not been taken, are negligible: X v Y (1987) 137 NLJ 1062. This must be borne in mind when an allegation of public interest is relied upon.

(25) "Should there be compulsory provision for testing health care workers bearing in mind that if positive a health care worker may have to change his working practice or desist from working altogether?"

This is more a question of policy than of law. Such a compulsory provision is possible in law because of the contractual relationship referred to in the previous answer. It would only be necessary in law if failure to incorporate such a provision could be said to be negligent. Given the low level of risk to patients, the likelihood of obtaining test results by consent and the possibility of implementing precautionary measures and procedures without a test result in appropriate cases, including cases where consent is refused, we do not think that failure to impose universal compulsory HIV screening of health care workers by contract would be negligent.

(26) "Urologists are frequently sprayed in the face by patients' bladder contents which contain blood. It is not possible to carry on endurology wearing a mask and visor. In those circumstances what would be the position on testing without consent?"

The usual principles apply. On further enquiry we have been instructed that it is not correct that adequate precautions against infection during endurology, cannot be taken, and testing may not be performed without consent merely in order to save trouble or expense.

(27) "What would be the position of a practitioner if blood taken for another purpose was later tested for HIV antibodies without the patient's specific consent? This was in fact the case when a consultant kidney specialist was discovered to be HIV positive. The stored blood of patients on whom the doctor had performed renal biopsies was tested without consent to ascertain whether the HIV virus may have been passed from doctor to patient."

Since the blood has already been taken from the patient, it is clear that there is no risk of battery or assault: see paragraph 5(5) above. The decision on whether to test without first seeking consent must be made in accordance with the usual principles governing the doctor's duty of care: see paragraph 6(4) above. If it is thought unlikely that infection would in fact have been transferred, then it may be permissible to spare the patient anxiety by testing without consent in this case. Otherwise, the patient is entitled to be consulted. The best interests of the patient himself remain paramount.

(28) "Many clinicians feel that to tell patients that they consider it possible although unlikely that HIV infection may be related to their illness would cause immense emotional disturbance. Clinicians feel it would be fruitless to distress patients unnecessarily by seeking specific consent to HIV antibody testing in these circumstances."

This is a relevant consideration in weighing the doctor's decision on whether to seek consent in accordance with his duty of care to the patient. See paragraph 6(4) and question (11) above.

(29) "Some clinicians treating patients who have recently learned that they have a very serious condition such as leukaemia which requires cytotoxic drug therapy feel it is inhuman and unnecessary to raise the possibility of HIV infection with these patients. However, it is essential to know the patient's HIV antibody status before treating with immunosuppressant drugs."

The answer is as for the previous question.

(30) "Certain countries such as Saudi Arabia require a test to be undertaken for the purposes of visiting the country or emigration. If the test proves to be positive is there any duty on the doctor to inform the patient's GP and/or to apply a treatment function as a result of this test?"

Since the test cannot be performed in these circumstances without the patient's consent, appropriate action following a positive result should first be discussed and agreed with the patient. Under the National Health Service (Venereal Diseases) Regulations a hospital doctor is permitted to inform a

patient's general practitioner of an AIDS test if that is for the purpose of treatment or prevention of spread of the disease: see paragraph 3(2) above. Save in the extreme cases governed by the Public Health (Control of Disease) Act 1984, it is not permissible to "apply a treatment function" against the patient's will.

(31) "A number of insurance companies now require doctors to carry out the test for life assurance purposes, Is a doctor who carries out such a test under an obligation to ensure that consent has been obtained from the particular person undergoing the test?"

Yes. This can be done by requiring the insurance company to obtain a consent form from the patient which can be shown to the doctor.

(32) "What would be the position of the doctor if he treated a patient whom he had tested without consent and found to be HIV positive and who, on being informed of this refuses to tell his spouse? Would the position be different if the doctor was a doctor of both the patient and the spouse?"

We have considered this situation in paragraph 9. The rule is that every reasonable effort must be made to obtain consent to informing the wife of the diagnosis in all cases where this is thought desirable, even if the process of persuasion proves delicate and lengthy. We are informed that most patients will eventually consent to disclosure when properly approached. However, where such consent proves impossible to obtain (and, we stress, only in such a case) we think that there is a clear risk that a duty to warn without consent may arise and the fact that the wife is also a patient of the doctor is a significant but not decisive

factor in that conclusion. The doctor will have to make his judgment in the light of the interests of the husband (for example, his reasons for refusal) and the risks to the wife (including, for example, whether or not she is likely to have been infected already). If it is his judgment, reasonably arrived at, that in all the circumstances the health and welfare of the wife require disclosure to her then we think there is a reasonable prospect that such disclosure would be held to be a justifiable breach of confidence and indeed that non-disclosure might be a breach of the duty of care owed by the doctor to the wife.

(33) "What would be the position of a doctor who treats a patient in a high risk group who he suspects may be found to be HIV positive and whose partner is pregnant? Does the doctor have any obligation to the mother and/or the unborn child to test with or without consent?"

No test can be carried out without consent in these circumstances. The duty of care which may be owed to others cannot require a doctor to commit a tort or a crime. However, where a doctor has such a suspicion, and if it is well founded, then we think that his duty may well require him to seek consent and see that the concomitant counselling is provided. If consent is refused, the same considerations as to warning the partner arise as in (32) above. For duties to the unborn child, see paragraph 9(3) above.

(34) "If a doctor carries out an HIV test without consent which turns out to be positive this may well affect the patient's eligibility for life insurance and retention of his/her employment. In these circumstances would the patient have any recourse against the doctor?"

If, on the basis of the principles we have set out, the doctor is liable in battery or negligence then he will be liable for such loss as it was reasonably foreseeable would be suffered by the patient as a result of the battery or negligence. Potentially that could include loss of life insurance and employment but it would depend on the particular circumstances of the patient and the doctor's knowledge of them. See also paragraph 7 above.

(35) "One possible consequence of AIDS is that the patient may suffer from HIV encephalopathy i.e. slowness of mentation, short term memory defects, alterations in cognitive functions. What would be the position if a doctor and, in particular, a company doctor suspected an HIV infection or full blown AIDS but the patient refused a test in a situation where the doctor knows the patient holds a job where, if his faculties are impaired, he may be dangerous to others? Is the doctor in these circumstances entitled to test and, if positive, is he required to inform the employee's employer?"

Paragraph 86 of the General Medical Council's guidelines on "Professional Conduct and Discipline" provides as follows:-

> "Special problems in relation to confidentiality can arise in circumstances where doctors have responsibilities both to patients and to third parties, for example in the practice of occupational medicine. An occupational physician should ensure that any employee whom he sees in that capacity understands the duty of the occupational physician in relation to the employer and the purpose of the consultation. In particular, where an occupational physician is asked by the employer to assess the fitness to work of an employee he should not undertake such

assessment except with the informed consent of the employee."

For the legal significance of these guidelines in setting general standards of duty in tort, see paragraph 2(11)(c) above. A company doctor is not entitled to test the employee without his consent. Consent may be obtained expressly in a given instance or alternatively it may be given in a blanket form as a contractual term. If consent is refused, the employee may be treated as if he were positive where this is truly necessary, but we note that in the view of the Department of Employment:-

> "...there are generally no grounds for treating those who are or may be infected differently from other employees or potential employees, or for seeking to know who they are." HC 182-xii p 134 para 4.

However, in extreme cases in certain sensitive employments, reasonable grounds for suspecting infection and refusal to take a test might justify dismissal. In Buck v The Letchworth Palace Ltd (1987) Case No 36488/86 an Industrial Tribunal upheld as fair the dismissal of an employee who was suspected of having AIDS by fellow employees (who would not work with him as a result), although there was no evidence that he was in fact infected. If a positive result is obtained, since the usual considerations of confidentiality and duty to the patient apply, generally this should not be communicated to the employer without express consent save where permitted by contract, or in the exceptional case where to the knowledge of the doctor the patient is or is likely to be a danger to other identifiable people.

(36) "Should a proven rapist be tested with or without consent? His rape victim may be in a state of extreme distress increased by not knowing whether the rapist is HIV positive."

We understand that even those infected with the disease do not always pass it on to their sexual partners. There is no reason why a rapist should not be asked to consent to a test. But if consent is refused, the test cannot be applied against the will even of a proven rapist: see the answer to question (18) above. Nor would the Public Health (Control of Disease) Act 1984 apply, because the victim's interest is not the public interest - see paragraph 3(1)(d) of this Opinion. The only course is to test the victim herself, although we appreciate that there will be a delay before this can provide a useful result, because of the time required for HIV antibodies to develop after infection.

(37) What is the position of doctors who are refused the results of HIV tests taken in venereology clinics? By reason of the National Health Service (Venereal Diseases) Regulations 1974, Health Authorities are obliged to take all necessary steps to secure that any information capable of identifying an individual who has been examined or treated for any sexually transmitted disease is not disclosed save, inter alia, for the purpose of communicating that information to a medical practitioner."

The only answer we can give to this question is that doctors must discharge the duty of care they owe to patients and third parties in the light of the knowledge they do have, including knowledge that they have been refused the results of the test. The test itself is the major but not the only diagnostic weapon.

It may well be possible for a doctor to conclude that a patient has AIDS without a test result, in which case he will still be faced with many of the difficult questions on which we have expressed our views above.

27th May 1988

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