The unanimous views of Doncaster Local Medical Committee upon the BMA document concerning HIV Antibody testing in the light of Mr Shawcross opinion

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The conclusions of this document are largely based upon the spurious argument that the legal jeopardy confronting a surgeon who decides, in the interst of his patient, to perform some measure of treatment other than that for which he had prepared the patient can be equated to a General Practitioner investigating the condition of a patient who has elected to join his list for the purpose of obtaining primary health care and has presented himself with some complaint for which he either expects reassurance or treatment in accordance with the G.P.'s ability to diagnose the nature of his complaint, knowing full well that this may require a variety of invasive measures of investigation.

To assert that only in certain very rare circumstances (undefined) would such a G.P. be able to claim that he was acting with implied consent is, I submit, nonsense and to strengthen this view by invoking "current medical opinion" is equally ridiculous because no such authoritative opinion representing the views of the whole profession has yet been concluded. The only circumstances which could conceivably deprive the General Practitioner of the protection of implied consent would be:-

i) If he carried out a pure screening process which included HIV Antibody Testing upon an apparently fit patient without disclosing this fact.

ii) If he gave a false or evasive answer to a specific question as to the precise nature of the tests being performed.

Virtually any condition which causes the patient to seek advice for which blood chemistry or seralogical investigations are potentially appropriate could legitimately include HIV Testing.

The opponents to HIV Testing without specific consent raise two chestnuts:-

i) How do you handle a positive result without harm to the patient?

ii) How do you justify testing for HIV when there is no known effective treatment?

In answer to the first question such a situation, albeit perhaps less dramatic, is not new to a G.P. Each case will need individual evaluation according to personality, family, nature of business and so on. There could be circumstances to justify the withholding of such a disclosure. Sometimes the social circumstances will make disclosure essential in the interests of other people. Counselling with a background of known positivity could admittedly lead to a disasterous reaction in a patient who anticipates the worst even though the disease has not yet developed. It is argued that, given a choice before hand, some patients elect to remain in ignorance rather than risk being made aware of a positive finding. I believe that such patients are likely to

have grounds to anticipate a possible positive result and, whereas a negative result would release them from an oppressive anxiety and perhaps assist them to change their social habits, a positive result would merely confirm their gnawing suspicions. Of course there is the so called window, the latent period of serum negative findings, and the need for follow-up testing will have to be explained. With regard to the second question "how can you justify exposing someone to such emotional trauma for a condition for which no effective treatment is so far available?" Well, at least positive cases will know that they will be early in the queue for treatment when it does arrive and some measure for at least alleviating the condition is likely to be available before much longer. Is it reasonable to argue that the ethics of testing without pre-counselling can hinge solely upon whether or not effective treatment is available? Why should this disease be picked out from all the other potentially fatal conditions which may be unexpectedly identified by differential diagnostic screening measures? The only difference in this context between HIV positivity and leukaemia is that the latter carries a more probable fatal outcome. This does not prevent us from carrying out screening processes without specific consent and being prepared to counsel our patients as appropriate. Why should we have two opposing ethics merely because of the possible social stigma attached to one condition? It would seem that those members of the profession unwilling to grasp this nettle have sought to strengthen their case by seeking supportive legal opinion but the opinion presented would appear to be based on such specious case history and argument as to render it wide open to challenge.

Ray Outwin,
Chairman

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