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30 October 2006

Mr S Wells
Consultations Coordinator
Department of Health
Skipton House
80 London Road
London
SE1 6LD

Dear Mr Wells

Re: BHIVA reply to Department of Health policy consultation on confidentiality and disclosure of patient information: HIV and sexually transmitted infections

Thank you for asking the British HIV Association (BHIVA) to consider the Department of Health (DOH) policy consultation on disclosure of information and sexually transmitted infections (STIs), including HIV.

BHIVA acknowledges that the DOH is trying to provide clarification to the process of confidentiality and disclosure on HIV and STIs but wishes to share clinicians and patients concerns that this process is running in parallel with the Crime Prosecution Service (CPS) consultation on reckless transmission and this is leading to significant anxiety and confusion. Clarification on the separate nature of these processes would be helpful and clearly each may inform the other. As a consequence this reply should be read alongside the BHIVA document on *HIV transmission, the law and work of the clinical team*, which is available at the BHIVA website on www.bhiva.org.

This reply is structured around the nine questions posed in the consultation document. In addition BHIVA has considered the BMA's response to this consultation and endorses its views, but expanded some of the responses.

- i) *Do you agree that where a health care professional believes their patient's sexual behaviour is putting individuals at risk of serious harm, and, the identity of those at risk is known, the health care professional should consider taking steps to inform known contacts, even if the patient does not consent, or consent cannot be obtained, and the patient cannot be persuaded to tell the individual(s) themselves?*

Individual BHIVA members are guided by the GMC on this matter, but BHIVA wishes to iterate that a therapeutic relationship with a patient needs to be maintained and time is often required to facilitate patient directed disclosure. This is vital to prevent the patient feeling alienated and further contact being lost, to maintain the wellbeing of the partner, and in the interests of maintaining public health.

- ii) *What might those steps be if the identity of the person at risk is known but they are not a patient of the treatment centre treating the index patient?*

The usual processes of partner notification apply.

- iii) *Are there circumstances when a health care professional may choose not to disclose to a known partner even though that partner might be at risk?*

Where such disclosure may result in the patient being potentially exposed to domestic violence or coercion

- iv) *Where does final responsibility for decisions on disclosure rest? For example, does responsibility lie with the Caldicott Guardian or are such decisions the duty of only the appropriate Doctor in consultation with peers if necessary (GMC Guidance annex 2)*

Clinicians seek to empower patients overtime to disclosure. Ultimate responsibility is covered by GMC guidance adequately.

- v) *Given the provisions of the common law of confidence and the NHS Code on Confidentiality, what additional safeguards do the current Regulations/Directions on STIs provide in practice? Are these additional safeguards necessary? Are they too restrictive?*

The additional regulations provide a framework for clinicians to work within, which help highlight the complexity of the issues under consideration. Removal of these will only confuse clinicians and patients and undermine the whole basis of STI/HIV provision in terms of the control of infection.

- vi) *If you consider that disclosure to the known sexual partner is appropriate in any circumstances, do you consider it to be appropriate for the healthcare professional to inform the partner directly that they can report their partner to the police for reckless transmission of HIV or other serious STI? Would this be likely to deter people from using sexual health services?*

BHIVA does not consider that professionals have a duty to inform patients that they can report to the police. However, in the context of facilitating patient directed disclosure, it may be necessary to inform the index patient of the potential illegality of his/her current actions.

- vii) *Do you agree? Other than for child protection in what circumstances might a health care professional, need to consider disclosure to someone other than a known sexual contact. When answering this question, please consider what the recipient of the information would be expected to do, or could do, in practice in response to receiving such information.*

In the context of a health care worker employed in an area where exposure prone procedures are likely to, or have been, performed, it would be correct practice to tell the patient to cease this practice and, with the patient's consent, inform EAGA on an anonymous basis initially for their advice. In the unlikely event of a HCW continuing to practice against the advice of the relevant professionals (HIV specialist, Occupational Health, their professional society etc) then there would be a need to inform the appropriate manager in confidence, in conjunction with the Occupational Health physician.

viii) *Do you agree that the added confidentiality provided by the Regulations/Directions applies wherever STI services are provided? (i.e. it is not limited to GUM services)? This may require sharing of information, in line with locally agreed protocols in settings providing integrated STI and contraceptive services in order to provide a seamless service to patients (e.g. avoid duplication of questions).*

BHIVA agrees that the added confidentiality should apply outside of GUM settings and seeks to assist in facilitating this. However, it is important that patients with HIV are encouraged to inform their GP of their status and for it to be managed similarly to other chronic long-term conditions but with the individual patient having the right to opt-out of record sharing.

ix) *Do you agree that policy on confidentiality should not prohibit the provision of non-identifying data and information for local and national surveillance?*

BHIVA agrees with this statement.

In summary it is BHIVA's view that new legislation is not required as the issues are well covered by existing guidance from the DOH and GMC. However, as DOH policy beginnings to shift clinical care of STIs and HIV away from GUM services and HIV becomes a long-term condition there is a clearly a need to maintain the enshrined confidentiality in non-GUM settings and this requires training for all staff. However, BHIVA believes that patients with HIV should be encouraged to disclose their status to their GP with records to be integrated with the primary care clinical notes. Additionally the new National Programme for IT in the NHS must support the same levels of confidentiality. Finally there is a significant need for education amongst all clinical staff and patients to understand the constraints and protections of current legislation. BHIVA recognises its role in contributing to this process.

We hope our comments are of value and look forward to hearing from you with the outcome of the consultation in due course.

Yours sincerely

A handwritten signature in black ink that reads "Margaret Johnson". The signature is written in a cursive, flowing style.

Professor Margaret A Johnson
Chair
British HIV Association (BHIVA)