

Ethical issues of sexually transmitted infections (stis)



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Identify a specific situation, from your own experience in practice, where an ethical issue arose. With regard to confidentiality, outline the situation and explore the issues involved. Using appropriate ethical theory/principles, analyse the situation and the action taken to resolve the problem.

In this essay we shall consider the case of Mrs. P., a 39 yr. old married mother of three who attended at a gynaecology clinic with menorrhagia. She was investigated and was found to have, amongst other things, a chlamydial infection.

She was horrified. On questioning, she was initially incensed and stated that the path lab must have made a mistake and that such a thing “ simply was not possible”, she denied any knowledge of how such an infection could have been contracted and asked the staff if it meant that her husband had been unfaithful. It was about half an hour after the news had been broken and the rest of her problems had been dealt with, that the staff moved onto the delicate matter of contact tracing.

It was only then that Mrs. P. eventually confided that she had had a number of clandestine relationships without her husband knowing. One of these relationships was with her husband’s best friend from his work (Mr. H). She was adamant that neither he nor her husband should be told, as she could not face the consequences from the inevitable fall out. The clinic staff were also told that Mr and Mrs H were desperate to have a baby and that Mrs H was about to consider going for referral for infertility investigations.

There are many ethical issues in this small clinical encounter and they represent, as a generalisation, issues that are typical of many ethical difficulties that present to healthcare professionals in the UK on a daily basis.

The subject of medical ethics has evolved over a huge length of time and is, in part, dependent on the circumstances and environment in which it is applied. (Veitch RM 2002). In this essay we shall consider these ethical difficulties as they pertain to Mrs. P., but before we consider them in detail, let us consider the overriding ethical principles that should guide the actions of those concerned.

We can start with a historical note. If we consider Hippocrates' often quoted dictum "first do no harm", (Carrick P 2000), we will see that it underpins the first guiding principle of ethics, that of Non-Maleficence. This means "no malice". It places an implied burden on any healthcare professional to not only avoid doing harm to a patient, but also to take active steps to make sure that harm does not occur through accident or negligence.

The Principle of Beneficence takes the argument further with an expectation of doing good or "goodness" as a quality. As we have suggested earlier, this quality is variable and is judged in the circumstances in which it occurs. This is particularly relevant in questions relating to consent which again, is central to the case of Mrs. P. (McMillian J 2005)

The third principle of ethics that is relevant to our considerations here is the Principle of Deontology which places an expectation on the healthcare professional to act in a way that means that decisions are made in the

patient's best interests and are not in any way influenced by other considerations such as cost or expediency. (Tännsjö T 2005)

There is then the consideration of autonomy. In the case of Mrs. P. this effectively means that she is allowed to make her own decisions based on her own free will and is not forced (either figuratively or expressly) into a situation where she feels pressurised into decisions against her will. She should be allowed to consider what is right for her, in her current circumstances, without feeling that she is being coerced by any form of outside influence.(Mill JS 1982)

It clearly follows from this statement that Mrs. P. can only make such a decision if she is in full possession of all of the relevant facts relating to her circumstance and this then opens up another field of debate, one relating to the role of the healthcare professional as an information resource. It is incumbent on the healthcare professionals advising Mrs. P. that they would ensure that she has available to her (in a form that she can understand) all of the information necessary to allow her to make up her own mind on the issues presenting themselves. (Sugarman J & Sulmasy 2001)

Chlamydia

In order to appreciate the full implication of the decisions and dilemmas facing Mrs. P., we should firstly consider the issues of the pathophysiology of chlamydia. It is commonly accepted that a large proportion of what was previously called NSU or even undiagnosed genital discharge, was probably infection due to chlamydia. It currently ranks as being responsible for

numerically the greatest number of sexually transmitted diseases in the UK in the present day. (Duncan 1998)

The actual incidence of detected chlamydia varies between different sociological groups and is dependent on the study. Adams (et al 2004) produced a huge meta analysis of UK data and suggested that the incidence varies from 8.1% of the under 20 age group to 1.4% of the over 30 group

Equally it can be seen that other studies, (Piementa et al 2003), put the incidence in the under 20 group as high as 17% and in antenatal clinics (whole population) at 12%. There is no merit in debating the statistical validity of these figures, they are presented to underline the point that Mrs. P.'s dilemma is not a rare one.

If we take an overview of the whole chlamydia issue we can cite the opinion of National Institute for Clinical Excellence (NICE) who quote that, in their rationale for a national screening programme, chlamydia:

Is the commonest Sexually Transmitted Infection (STI) in England

Is an important reproductive health problem ~ 10-30% of infected women develop pelvic inflammatory disease (PID).

In a significant proportion of cases, particularly amongst women, are asymptomatic and so, are liable to remain undetected, putting women at risk of developing PID.

Screening may reduce incidence of PID and ectopic pregnancy.

These points are presented as underlining the argument that we will make later in this essay, that a diagnosis of chlamydial infection – although commonly asymptomatic (especially in men), is actually far from trivial and therefore should not be taken lightly or dismissively.

Discussion

With specific reference to Mrs. P. we should note that there are two important factors that should influence our discussions here. One is the relevance to Mr H. and his wife and the possible implications to their apparent infertility, and the second is effectively the contact tracing arguments and the degree that the healthcare professional should be involved in making Mr H. aware of the possibility that he may have the chlamydial infection.

Let us begin by considering an excellent and informative paper by Cassell (et al 2003) on the issue of partner notification. The authors are of the opinion that, due to factors such as the explosion in the numbers and the evolution of the Health Service, that the thorny issue of partner notification, which had previously largely fallen into the domain of the GUM clinic nurse, had now evolved to involve General Practice staff, obstetric and gynaecology clinic staff as well as many others. The corollary of this is that this role has lost some of its efficiency in skill resources and time. (D of H 2002).

The paper itself is very informative, but if we restrict ourselves to a consideration of those aspects which are directly referable to our considerations here. With regard to the issue of patient confidentiality and contact informing, only 40% of the healthcare professionals questioned <https://assignbuster.com/ethical-issues-of-sexually-transmitted-infections-stis/>

thought that partner notification was actually their role. The remaining 60% took the view that it was their role to inform the patient of what they saw was their responsibility to inform their own partners.

The reason that we make this point is that over at least the last two decades, there has been a noticeable and welcome shift to the general acceptance of evidence based medicine (Berwick D 2005). The point is therefore made that if this evidence is accepted, then we could assume that the majority of healthcare professionals believe that their responsibility to inform the patient's partner ends with their discussion of the matter with the patient. This is relevant if one considers the Bolam principal which has been the foundation of the legal view of matters of medical negligence. The Bolam test, when applied to this type of situation states that:

A healthcare professional is not negligent if he or she acts in accordance with practice accepted at the time by a responsible body of medical opinion.

In other words, if one acts in accordance with the rules that govern normal medical and nursing practice. In these circumstances it would appear that the majority medical opinion is that one's burden of responsibility is limited to telling the patient that they should tell their own sexual partners of their infection.

To a degree, this view is at odds with other ethical considerations, as one might consider that one has an obligation both to Mrs. P.'s husband who may clearly be at risk from chlamydial infection and complications, and also Mr. H and his partner, who may even already be suffering from complications, as they are considering being investigated for infertility. In these eventualities
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one has to consider if one is breaching any or all of the three principles that we have already outlined above. On the face of it, it would appear that all three principles are being compromised by this course of action.

Non-maleficence – because of the implied failure to take active steps to protect Mrs. P.'s partners from potential harm.

Beneficence because of Mrs. P.'s failure to agree to consent to anyone telling her partners on her behalf

Dentology because it could be argued that a suggestion that the healthcare professional should tell Mrs. P.'s partners means that decisions are being made on the grounds of expediency rather than necessarily in Mrs. P.'s best interest (as Mrs. P. sees it).

The only principle that appears to be upheld with this particular view is that of Mrs. P.'s autonomy.

We can explore this issue further. Mrs. P.'s refusal to inform her partners may be, at first sight, understandable. But there are other issues that we must consider before passing moral judgement on her. If we consider a paper by Duncan (Duncan B et al 1998). This provides a very informative insight into the issues that confront women in this situation and she cites a common finding of equating a perception of “being dirty” or promiscuity with a positive test. There is also the issue of both men and women feeling embarrassed to get tested, although, with the advent of General Practice based testing and testing away from the stigma of the GUM clinics, this may well be less of a problem.

It also follows from this study finding that there is a major Public Health Education paradox here. If it is true that the majority of healthcare professionals actually believe that it is the responsibility of the patient to tell their partner and this fact is augmented by the discovery that another study found that nearly 20% of respondents actually chose to treat chlamydia with a dose of antibiotic which is less than the currently recommended therapeutic level recommended by the Central Audit Group for Genitourinary Medicine, (Stokes et al 1997), it is perhaps not a surprising observation that the level of chlamydial infection is apparently as high in the community as it is.

It follows from this that the authors of another study in a similar area can make the comment:

If testing in primary care continues to increase without adequate support for partner notification, much of the resource used in testing women will be wasted. (Griffiths et al 2002)

To provide a balanced view on the subject we should observe that the converse of our argument so far is put by other workers in the field (EHC 1999), who argue for the enhancement of the contact tracing facilitators and facilities in order to “ properly maximise a reduction in the risk of both personal re-infection and the level of infection in the community”

The central importance of this argument is exemplified in an excellent paper by Patel (HC et al 2004). This looked at the reliability of contact tracing mechanisms. The paper itself is both long and involved. It followed up over 250 patients over a five year period. in short, the authors reported that if the <https://assignbuster.com/ethical-issues-of-sexually-transmitted-infections-stis/>

infected patient had a regular partner, they were likely to turn up for treatment in about 53% of cases, whereas if there was an extramarital partner only about 13% would receive treatment. The implication is clearly (although it is obviously admitted that there are significant confounding factors), that an infected patient is far more likely to tell their marriage partner than an extramarital sexual partner.

Conclusions and suggestions for practice.

In order to help with such considerations we note that the main professional bodies issue their own comprehensive guidelines. They are issued jointly by both the BMA and RCN for all healthcare professionals (Dimond. B. 1999). The documents themselves are unsurprisingly enormous, and offer outline guidance on virtually every major issue and they follow the principles that we have already set out. They equally make the point that not every eventuality can either be predicted or catered for, and in these circumstances the healthcare professional is left to make their own judgement based on their interpretation of the underlying principles and circumstances.

In our interpretation of these principles, it would appear that the overriding consideration in the case of Mrs. P. is that of autonomy. There may well be a substantial evidence base that we could point to which would suggest that Mrs. P.'s refusal to tell either her husband or sexual partner could have serious and possibly long lasting adverse effects on their health. But in the last analysis, Mrs. P. has the right of consent to her personal details being divulged - either explicitly or by inference and implication - to any other

person. If that consent or permission is withheld then the healthcare professional would be expected to respect that right, even if they had personal difficulty with it themselves.

There is an implicit obligation on healthcare professional not only to enhance the patient's autonomy but also to take as many steps as possible to ensure that any decision reached by the patient is truly autonomous. The professional guidelines suggest that one of the best ways of doing this is primarily by the giving of as much information as possible, particularly that information which is judged to be of importance in assisting them in making their decisions (Williamson C 2005)

This view seems to be echoed by the legal profession who have pointed to the fact (in case law) that each adult has a right to their own autonomy. (Donaldson L 1993). The guiding pronouncement in this type of issue is that a legally competent adult has the right to agree or to disagree with any form of treatment or opinion offered by a healthcare professional and does not have to justify the reason for their action to anyone else.

It is clearly incumbent on the healthcare professional to try to provide the Public Health information to help the patient make an informed and considered decision. It may even be considered acceptable to suggest or persuade the patient to " do the honourable thing", but this clearly must not be interpreted as placing undue pressure on the patient otherwise all of the underlying ethical principles discussed so far will be completely undermined (Hendrick, J. 2000).

We should also note that the same professional guidelines cited above also make the suggestion that the nature of the conversation and the topics discussed should be clearly recorded in the patient's notes and if a decision is made to allow healthcare professionals to contact the other potential partners, then a consent form recording the decision should ideally be signed by the patient. In many instances we acknowledge that it is common practice to advise and take whatever action is perceived to be in the best interests of the patient, but in terms of our ever more litigious society, it appears to be good advice to get written consent for virtually every action however seemingly minor. (Yura H et al 1998),

If we had to sum up the thrust of this essay in a sentence it would be that there is no excuse - either ethically, or for that matter in law - for making unfounded assumptions about what the patient wants or will permit. (Gillon. R. 1997).

References

Adams EJ , A Charlett, W J Edmunds, and G Hughes 2004 Chlamydia trachomatis in the United Kingdom: a systematic review and analysis of prevalence studies *Sex. Transm. Inf.*, October 1, 2004; 80(5): 354 - 362.

Berwick D 2005 Broadening the view of evidence-based medicine *Qual. Saf. Health Care*, Oct 2005; 14: 315 - 316.

Carrick P 2000 *Medical Ethics in the Ancient World* Georgetown University press 2000 ISBN: 0878408495

Cassell JA , M G Brook, R Slack, N James, A Hayward, and A M Johnson 2003
Partner notification in primary care *Sex. Transm. Inf.*, June 1, 2003; 79(3):
264 – 265.

Dimond. B. 2001 *Legal Aspects of Consent* Salisbury.: Quay Books 2001

D of H 2002 Department of Health. *The national strategy for sexual health
and HIV: implementation action plan.* London: DoH, 2002.

Donaldson L 1993 in *Re T (Adult: Refusal of Treatment)* [1993] Fam 95 5

Duncan B, Hart G. 1998 *Screening for Chlamydia trachomatis: a qualitative
study of women’s views.* *Prevenir* 1998; (suppl 24): 229.

EHC 1999 *Effective Health Care. Getting evidence into practice.* York:
University of York, 1999.

Gillon. R. 1997. *Autonomy* London: Blackwell 1997

Griffiths C, Cuddigan A. 2002 *Clinical management of chlamydia in general
practice: A survey of reported practice.*

J Fam Plann Reprod Health Care 2002; 28: 149-52.

Hendrick, J. (2000) *Law and Ethics in Nursing and Health Care*, London.
Stanley Thornes 2000

McMillan J 2005 *Doing what’s best and best interests* *BMJ*, May 2005; 330:
1069 ;

Mill JS 1982 *On Liberty*, 1982, Harmondsworth: Penguin, p 68.

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Patel HC, Viswalingham ND, Goh BT 2004

Chlamydial ocular infection: efficacy of partner notification by patient referral. Int. J. STD AIDS 2004 Jul-Aug; 5(4): 244-7.

Stokes T, Bhaduri S, Schober P, et al. 1997 GPs' management of genital chlamydia: a survey of reported practice. Fam Pract 1997; 14: 455-60

Sugarman J & Sulmasy 2001 Methods in Medical Ethics Georgetown Univeristy Press 2001 ISBN: 0878408738

Tännsjö T 2005 Moral dimensions BMJ, Sep 2005; 331: 689 – 691 ;

Veitch RM 2002 Cross-cultural perspectives in medical ethics

Jones & Bartlett 2002 ISBN: 0763713325

Williamson C 2005 Withholding policies from patients restricts their autonomy BMJ, Nov 2005; 331: 1078 – 1080 ;

Yura H, Walsh M. 1998 The nursing process. Assessing, planning, implementing, evaluating. 5th edition. Norwalk, CT: Appleton & Lange, 1998.

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