BMA

Needlestick injuries and blood-borne viruses: decisions about testing adults who lack the capacity to consent

Guidance from the British Medical Association

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Summary of key points

- Where the patient is expected to regain capacity before a decision on testing is needed, testing should not take place until consent has been obtained.
- If the patient lacks capacity, doctors should determine whether the patient has a valid and applicable advance decision to refuse treatment (ADRT) or whether there is anyone with legal authority to make the decision (eg in England and Wales, an attorney with the relevant decision-making authority or a court-appointed deputy; in Scotland a welfare attorney, a sheriff-appointed guardian or a person authorised under an intervention order).
- Where a patient is not expected to regain capacity before a decision needs to be made, and there is no ADRT, attorney or appointed deputy/guardian etc, doctors are entitled to make a decision whether to test the patient without consent and must do so in accordance with the law in that jurisdiction.
- The doctor must make that decision by assessing whether testing is in the best interests of the patient (in England, Wales and Northern Ireland) or will benefit the patient and is reasonable in the circumstances to safeguard or promote the physical or mental health of the patient (in Scotland). The doctor **must** follow a structured decision-making process in making the decision, including seeking views from the patient and consulting a range of parties including relatives and those caring for the patient.
- All relevant circumstances need to be considered by any doctor making that decision but where there is a potential clinical benefit to the patient, it is highly likely that ultimately the 'balance sheet' will indicate that testing should be undertaken (and the potential clinical benefit is highly likely to be a 'factor of magnetic importance' that has a decisive influence on the outcome of the best interests assessment).
- In England, Wales and Northern Ireland, where there is no potential clinical benefit, in the absence of evidence to the contrary it is legitimate for doctors to assume that the patient would want to 'do the right thing' and that this factor weighs in favour of testing.
- In Scotland where there is no potential clinical benefit to the patient, it is not clear that testing would comply with the legislation and so we advise against testing.
- Where a decision is taken that it is lawful and appropriate to test and a recent existing sample is available that is suitable for testing, this should be used in preference to taking a new sample.
- Testing should be undertaken on a pseudonymised basis.
- If the patient regains capacity, the patient should be informed that the test has been undertaken and given sufficient information to make an informed decision about whether to receive the results of the test.
- If the patient opts not to know the result, no information about the test should be included in the medical record.

1. Introduction

1.1 In the period between 2004 and 2013, there were 3,396 reported cases of needlestick injuries in the UK where the source patient was known, or thought, to be hepatitis B surface antigen (HBsAg) positive (HBV), hepatitis C virus (HCV) antibody positive and/or HIV antibody positive.[1] The actual number of needlestick injuries is likely to be considerably higher when non-reported cases,[2] and those where the infection status of the patient was unknown, are included.

1.2 Standard procedures for the clinical management of needlestick injuries[3] include identifying from the patient's medical record whether there is any information about the patient's hepatitis C, hepatitis B and HIV status. If no test has been undertaken, or recorded on the record, the patient should be asked to consent to testing in order to inform the future management of the healthcare worker. In some cases, however, the patient lacks the capacity to give consent. Guidance from the GMC (General Medical Council) states that testing that is 'solely for the benefit of the healthcare worker' is unlawful[4] and that testing may only take place where it is in the best interests of the patient.[5] The MPS (Medical Protection Society) similarly states that testing of incapacitated adults following a needlestick injury may only take place where testing is in the best interests of the source patient.[6] Neither set of guidance expands on how 'best interests' should be assessed in this context. This guidance fills that gap by focussing specifically on this issue. In the absence of any clear legal rulings on this issue, this guidance sets out a proportionate and ethical basis for testing within the different legal jurisdictions around the UK. Based on our assessment of the relevant laws we believe that, in the majority of these cases it will be appropriate and lawful to test; this guidance sets out in some detail the reasons for that conclusion and the process that should be followed. It should be noted that the situation in Scotland is more restrictive, in terms of testing, than in the rest of the UK.

1.3 As part of their duty of care to the health professionals they employ, we strongly encourage all employers of healthcare staff to develop their own protocols based on this guidance, stating that in these cases, where it is not possible to seek consent, it will usually be appropriate to test the source patient.

2. Why is testing important?

2.1 Health professionals who sustain a needlestick injury in the course of their duties are at risk of contracting a serious blood-borne virus. This has significant implications for the individual in terms of their own health, concern about the potential risk of exposing partners to the virus and any professional implications for those carrying out exposure-prone procedures as part of their work.

2.2 The implications of sustaining such an injury are different for each blood-borne virus.

2.2.1 Hepatitis B: Most health professionals will have been immunised against hepatitis B virus and their immunity can be checked, if necessary, post-exposure with expert advice taken on interpretation of the results if necessary. Where they have not completed the course of hepatitis B vaccine or are known non-responders, and the source is HBsAg positive, they require post-exposure prophylaxis in the form of hepatitis-B immunoglobulin as soon as possible and no later than 48 hours after the incident. They also need a booster dose of hepatitis B vaccine. If they have not been previously vaccinated they need an accelerated course of hepatitis B vaccination at 0, 1, 2 and 12 months.

2.2.2 HIV: Post-exposure prophylaxis is available which can reduce the chance of transmission of HIV, but this is not an easy option. Although the treatment recommended in the UK is generally well-tolerated,[7] there are side-effects and these can be severe, including acute renal failure, diarrhoea, nausea and vomiting. The post-exposure prophylaxis should be started as soon as possible, and no later than 72 hours after exposure, and continued for 28 days.

2.2.3 Hepatitis C: No vaccination or post-exposure prophylaxis is available for hepatitis C. Early diagnosis permitting prompt access to treatment can be effective.

2.3 Those who have sustained a 'high risk injury' (which includes some needlestick injuries), are advised to use barrier contraception and to avoid blood or tissue donations, pregnancy and breast feeding 'especially during the first six to 12 weeks after exposure'.[8] Advice from occupational health is also required to determine whether any changes to their activities are required to prevent the risk of onward transmission.

2.4 All of these infections have a long incubation period, meaning that the healthcare worker must live with the uncertainty about their status for a period of up to 6 months. The psychological impact of this should not be underestimated. A study of 370 health professionals who had received a needlestick injury in Germany, found that more than 80% of respondents reported high levels of anxiety regarding the injury.[9] A study published in 2013 found that 12% (9/77) of the UK trainee doctors in the study who had experienced a needlestick injury had post-traumatic stress reactions (compared with 3% in the general population).[10]

2.5 Early access to information about the infection status of the source individual can significantly reduce the anxiety and risk associated with needlestick injuries either by providing reassurance or by informing future management of the healthcare professional, including the steps that need to be taken, where appropriate, to reduce the risk of infection. Nevertheless, we recognise that testing without consent is a very significant step requiring careful justification and consideration of the rights and interests of the individual concerned.

3. Patients who are expected to regain capacity within a short space of time

3.1 If the patient lacks capacity to consent to testing at the time of the needlestick injury but is expected to regain capacity before a decision on testing is needed, for example because he or she is under an anaesthetic, it is difficult to imagine circumstances where it is justifiable to test the patient before the patient has regained capacity.

3.2 If the patient regains capacity, the same approach should thereafter be taken as is taken for a patient who has had capacity at all times. An explanation should be given to the patient about the needlestick injury and the implications of this; consent should be sought for testing for blood-borne viruses and the disclosure of the results to the injured individual and the occupational health service. Over recent years there have been moves to normalise testing for blood-borne viruses and there is no longer perceived to be a need for complex pre-test counselling; it is sufficient to mention that a blood-borne virus test would include hepatitis B, hepatitis C and HIV. Any questions should be answered. This discussion should not be undertaken by the exposed individual as this could put pressure on the patient which could undermine the validity of the consent. Experience shows that the vast majority of patients are willing for blood to be tested in these circumstances but if the patient has capacity to consent to testing and refuses to consent, the test cannot proceed.

4. Adults who lack capacity to consent – England and Wales

4.1 Decisions for adults who lack capacity to consent to medical treatment in England and Wales are covered by the Mental Capacity Act 2005 ('the Act').[11]

4.2 If the patient has a valid and applicable ADRT (advance decision refusing treatment) this must be respected and testing cannot take place.

4.3 Where a decision is made on behalf of the patient, that decision must be made in the patient's best interests. If the patient has an attorney or a deputy with the legal authority to make treatment decisions for him or her, that person can give consent to testing on behalf of the patient. A 'next of kin'[12] who is neither a decision maker under a health and welfare lasting power of attorney nor a court-appointed deputy cannot give consent on behalf of a patient.

4.4 Where there is no valid and applicable ADRT and no one who can take a lawful decision on behalf of the patient, the doctor will be the decision maker as to whether testing is in the best interests of the patient. The doctor must follow the structured decision-making process set out in section 4 of the Act.

4.5 Assessing best interests

4.5.1 When carrying out a best interests analysis it is appropriate for doctors to adopt the 'balance sheet' approach which has been adopted by the courts in assessing best interests. The 'balance sheet' approach requires any factors of benefit to the patient to be set out on one side of the balance sheet and any dis-benefits to the patient to be set out on the other side. As part of this process any 'factors of magnetic importance' should be identified; these are factors that might have a decisive influence on the outcome. Testing should only be undertaken if the 'balance sheet' comes out in favour of doing so.

4.5.2 When carrying out this assessment all relevant circumstances must be considered, including (but not limited to):

(i) the patient's past wishes and feelings (in particular, any written statement made by the patient when he or she had capacity);
(ii) the patient's present wishes and feelings (which might include any altruistic wishes or feelings)[13]
(iii) the beliefs and values that would be likely to influence the patient's decision if he or she had capacity (including beliefs and values such as altruism);
(iv) other factors that the patient would be likely to consider if he or she were able to do so. Factors which might be relevant include the effect of the decision to give or withhold consent on the health professional concerned and the duties of a responsible citizen.[14]

4.5.3 If the views of the patient can be ascertained, these can have great importance in making a best interests decision. In Wye Valley NHS Trust v B (Rev 1) the court said 'a conclusion that a person lacks decision-making capacity is not an *'off-switch'* for his rights and freedoms. To state the obvious, the wishes and feelings, beliefs and values of people with a mental disability are as important to them as they are to anyone else, and may even be more important. It would therefore be wrong in principle to apply any automatic discount to their point of view'.[15] Hence the views of a patient who lacks capacity but has sufficient understanding to indicate that he or she agrees to testing can be a powerful factor in favour of a best interests decision to test.

4.5.4 If it is practicable and appropriate to consult the following, their views as to what would be in the patient's best interests and as to the points listed at paragraph 4.5.2, must be taken into account:

(i) anyone named by the individual as someone to be consulted on such matters;
(ii) anyone engaged in caring for the patient or interested in his or her welfare;
(iii) anyone appointed as a lasting power of attorney;
(iv) any court-appointed deputy.

4.5.5 It is clear from the code of practice to the Act, and from the relevant court decisions, that 'best interests' can go beyond the patient's direct and immediate clinical benefit. The fact that the primary beneficiary of a decision is a third party does not prevent the decision being in the best interests of a patient, particularly if there is some indirect benefit and very little (if any) dis-benefit for the patient.

4.5.6 When the legislation was being debated in Parliament we lobbied extensively for explicit provision to be made to permit minimally invasive procedures that would not harm the incapacitated individual but would have significant benefit for a third party; testing incapacitated patients for blood-borne viruses in the event of a needlestick injury was the main example used. The Minister, Lord Warner, made clear that the Government was rejecting the amendment because it considered it to be unnecessary: under the Bill as it stood, the government's view was that testing could already go ahead in these circumstances. The following statements were made by the Minister:

> *'Our view is that an amendment to the Bill of the kind proposed is unnecessary. We consider that as it currently stands, the Bill would allow for acts the primary purpose of which would be to benefit a third party, provided that those acts are in the person's best interests. That is the critical point which is at stake.*
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> *As was said in another place, I can confirm that the Bill will not prevent a genetic test for a familial cancer, for example, that might not be essential to the person's medical care, but would provide considerable benefit to some other family member. Similarly HIV testing would be lawful if there were a needlestick injury to a nurse involved in the person's care, and if timely diagnosis of HIV status would be in the person's best interests so that treatment could be started.*
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> *I am pleased to be able to say that we will make it clearer in the code that in such cases the possible wider benefit that accrues from testing that has been endorsed in legal judgements – those legal judgements are critical – will continue to be an important factor in determining best interests... Certainly our legal advice is that the kind of circumstances mentioned by the noble Earl, Lord Howe, [and the noble, Baroness, Lady Barker] would be covered under the Bill as it is currently drafted."*[16]

4.5.7 In the event, the Code of Practice was not as explicit as we would have liked and uses the example of genetic testing for the benefit of a family member, rather than needlestick injury. Nevertheless, the relevant section of the Code reinforces the general principle that testing can proceed where it is undertaken primarily for the benefit of another person:

> *'5.47 Section 4(6)(c) of the Act requires decision-makers to consider any other factors the person who lacks capacity would consider if they were able to do so. This might include the effect of the decision on other people, obligations to dependants or the duties of a responsible citizen.'*
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> *'5.48 The Act allows actions that benefit other people, as long as they are in the best interests of the person who lacks capacity to make the decision. For example, having considered all the circumstances of the particular case, a decision might be made to take a blood sample from a person who lacks capacity to consent, to check for a genetic link to cancer within the family, because this might benefit someone else in the family. But it might still be in the best interests of the person who lacks capacity. 'Best interests' goes beyond the person's medical interests.*
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> *For example, courts have previously ruled that possible wider benefits to a person who lacks capacity to consent, such as providing or gaining emotional support from close relationships, are important factors in working out the person's own best interests. If it is likely that the person who lacks capacity would have considered these factors themselves, they can be seen as part of the person's best interests."*[17]

4.6 Clinical benefit

4.6.1 Where the test would potentially bring clinical benefit to the patient this must be entered on the side of the balance sheet in favour of testing, although all other relevant circumstances must also be considered. Whilst testing is not routinely offered to all patients with capacity, it is arguably in the best interests of all patients to be aware of whether they suffer from a blood-borne condition such as hepatitis B, particularly if that condition is asymptomatic at some stages in the development of the condition and/or can be effectively treated or managed.[18] The potential clinical benefit could, for example, be to rule out the possibility of serious disease or, if a condition is detected, to allow treatment to be started earlier; the information might also be helpful in interpreting test results or in making treatment decisions. These potential clinical benefits arise equally for those with and without capacity. The fact that testing would benefit the health professional does not prevent the testing being in the best interests of the patient. The fact that the test was not contemplated before the needlestick injury occurred does not undermine the argument for clinical benefit.

4.6.2 The best interests assessment is not whether the test is immediately clinically necessary but whether, all things considered, having the test is in the individual's best interests, judged holistically. Where testing has the potential to result in a clinical benefit to the patient (for example, by ruling out the possibility that the patient has unsuspected conditions or permitting earlier diagnosis), it is highly likely that ultimately the balance sheet will indicate that it is in the best interests of the patient to be tested. We consider that the potential (albeit unanticipated) benefit to the patient of ascertaining whether he or she is suffering from one or more asymptomatic blood-borne conditions is highly likely to be a 'factor of magnetic importance' that has a decisive influence on the outcome of the best interests assessment. It is likely to be an exceptional case in which the potential clinical benefit is outweighed by considerations on the 'do not test' side of the balance sheet. Nevertheless, the law requires *all* relevant circumstances to be considered.

4.7 Broader best interests

4.7.1 In a very small number of cases obtaining the clinical information which would be generated by testing might be of no potential clinical benefit to the patient (for example where it is anticipated that the patient will die in the very near future and so treatment would not be started in the event of a positive test result). However, in that situation the conclusion that testing is not in the patient's best interests is not inevitable.

4.7.2 The Act requires that the views of certain people should be sought (see paragraph 4.5.4). In this case, therefore, the situation should be explained to those who need to be consulted and their views sought about what would be in the patient's best interests.

4.7.3 In addition, there is legal support for the argument that 'in the absence of clear evidence to the contrary' it is legitimate to assume that the patient would want to 'do the right thing'[19]. In our view, when considering what is 'the right thing' in this context the following points are relevant:

(i) the vast majority of patients with capacity give consent in the circumstances in question;
(ii) the relationship between the patient and health professionals is important to the patient and is supported by testing;
(iii) there is a strong moral argument from reciprocity: that since the health professional has been injured providing care to the patient, the patient has some responsibility to assist the health professional if doing so is not contrary to his or her best interests;
(iv) all patients benefit from health professionals being protected, enabling them to continue to provide treatment;
(v) the duties of a 'responsible citizen'[20] in these circumstances.

4.7.4 As part of the best interests assessment, the Act requires that the decision maker should take account of the individual's 'beliefs and values' and of any other factor that the patient would be likely to consider if he or she were able to do so. When considering those points, in the absence of evidence to the contrary it is legitimate to assume that the above factors would influence the patient towards giving consent.

4.7.5 Support for the above view can be found in the code of practice to the Act which refers to the relevance, of:

> '*the effect of the decision on other people, obligations to dependants or the duties of a responsible citizen*'.[21]

4.7.6 It also says that

> '*...if it is likely that the person who lacks capacity would have considered these factors themselves, they can be seen as part of the person's best interests.*' [22]

4.7.7 It is therefore entirely appropriate, and consistent with the Act, to take into account the effect of the decision on other people to the extent that the source patient would have done so him or herself. In this particular context, our view is that all patients benefit from having health professionals protected so that they can continue to provide treatment to others. We also believe that all individuals benefit from being part of society and from the receipt of safe and effective healthcare.

4.7.8 The principle that best interests decisions can include decisions that benefit others was confirmed in a 2010 legal case (Re G (TJ)[23]) which considered the factors to take into account in assessing best interests under the Act. The case concerned whether an order should be made authorising life-time gifts to be made to Mrs G's adult daughter, C. Granting the order, Mr Justice Morgan explored in some detail how 'best interests' is to be interpreted in the Act, concluding:

> *'the word "interest" in the best interests test does not confine the court to considering the self-interest of P. The actual wishes of P, which are altruistic and not in any way, directly or indirectly self-interested, can be a relevant factor. Further, the wishes which P would have formed if P had capacity, which may be altruistic wishes, can be a relevant factor.'*[24]

4.7.9 In discussing how best interests should be interpreted in the Supreme Court decision in Aintree University Hospitals NHS Foundation Trust v James, Baroness Hale referred back to the Law Commission's report on mental incapacity on which the Act was based, as follows:

> *'But the best interests test should also contain "a strong element of substituted judgment" (para 3.25), taking into account both the past and present wishes and feelings of the patient as an individual, and also the factors which he would consider if able to do so (para 3.28). This might include "altruistic sentiments and concern for others" (para 3.31).'*[25]

4.7.10 In line with these statements, where there is no potential clinical benefit to testing, whilst all relevant circumstances must be considered in assessing the benefits and dis-benefits of testing, in the absence of any evidence that the patient would not give his or her consent if he or she had capacity, it is legitimate for doctors to assume that the patient would want to 'do the right thing' and that this factor weighs in favour of testing.

5. Patients who lack capacity to consent – Northern Ireland

5.1 The Mental Capacity (Northern Ireland) Act 2016 was passed by the Northern Ireland Assembly in March 2016. Until the Act comes into force, decisions on behalf of those who lack capacity continue to be governed by the common law. In England and Wales the Mental Capacity Act 2005 (see above) built on the common law and subsequent case law has provided further legal clarity about how best interests should be interpreted and how such decisions should be made. Decisions of the Supreme Court are binding on courts in Northern Ireland and those of the Court of Appeal attract significant weight. Although the Mental Capacity Act 2005 does not extend to Northern Ireland, it is therefore nevertheless likely that courts in Northern Ireland will give significant weight to the relevant English and Welsh case law. The guidance above about best interests decision making by doctors – including the process for making those assessments – should therefore also be followed by those working in Northern Ireland. This guidance will be updated to refer specifically to the capacity legislation in Northern Ireland once it comes into force.

6. Adults who lack capacity to consent – Scotland

6.1 Decisions for adults who lack capacity to consent in Scotland are covered by the Adults with Incapacity (Scotland) Act 2000 and any interventions must benefit the patient. An 'advance directive' specifically refusing relevant treatment/categories of treatment is likely to be binding.[26] Where there is a sheriff-appointed guardian, welfare attorney or person authorised under an intervention order to make decisions on behalf of the patient, that person must be consulted and can give or withhold consent to testing subject to the dispute resolution provisions set out in the Act.[27] Where there is no valid and applicable advance directive and no such person exists, medical treatment that benefits the patient and is 'reasonable in the circumstances' to 'safeguard or promote the physical or mental health' of the patient may be provided under the general authority to treat.

6.2 Assessing benefit

6.2.1 We consider that when assessing 'benefit' it will be appropriate for doctors to adopt the 'balance sheet' approach discussed above, setting out any factors of benefit to the patient of testing on one side against the dis-benefits on the other. When carrying out this assessment, as far as is reasonable and practicable, account should be taken of:

(i) the patient's past and present wishes so far as they can be ascertained;
(ii) the views of the nearest relative and individual's primary carer;
(iii) the views of any guardian, continuing attorney or welfare attorney;
(iv) the views of any person whom the sheriff has directed to be consulted; and
(v) the views of any other person who has an interest in the welfare of the adult or in the proposed intervention.

6.3 Clinical benefit

6.3.1 Where there is potential clinical benefit to testing the patient for blood-borne viruses, for example because it would enable treatment to be started, or if it could help with interpretation of test results or inform the patient's future management, this should be entered onto the benefit side of the balance sheet. As discussed above in relation to England and Wales, in our view the potential (albeit unanticipated) clinical benefit to the patient of knowing whether he or she is suffering from an asymptomatic blood-borne condition is highly likely to be a 'factor of magnetic importance' that has a decisive influence on the outcome of the assessment of benefit, although we consider that all relevant circumstances need to be taken into account. As discussed in paragraph 4.6.1 above, the fact that testing was not contemplated before the needlestick injury occurred does not undermine the argument for clinical benefit. It is likely to be an exceptional case in which the potential clinical benefit is outweighed by considerations on the 'do not test' side of the balance sheet.

6.3.2 We also believe that where there is potential clinical benefit to testing, the requirement that the intervention be 'reasonable in the circumstances' to 'safeguard or promote the physical or mental health' of the patient is highly likely to be satisfied.

6.4 Broader benefit

6.4.1 In a very small number of cases obtaining the clinical information which would be generated by testing might be of no potential clinical benefit to the patient (for example if the patient is expected to die in the near future and so no treatment would be started). A decision is then needed about whether testing, in the absence of potential clinical benefit, would be consistent with the legislation.

6.4.2 Unlike in England and Wales there was no discussion about this scenario when the legislation was debated and there have been no formal statements from the Scottish Government about its position. There are clear indications that the definition of 'benefit' is intended to go beyond direct and immediate clinical interests[28] and therefore, in the absence of evidence to the contrary, testing could be seen to benefit the patient in a broader sense (see the discussion above in relation to England and Wales). Nevertheless, the 2000 Act also requires that any intervention is reasonable in the circumstances to '*safeguard or promote the physical or mental health'* of the patient. In the absence of any relevant case law on how the scope of safeguarding the 'mental health' of the patient should be interpreted, we have doubts about whether testing in this way, where there is no potential clinical benefit to the patient, would be lawful in Scotland. There is some suggestion that an expansive approach should be taken towards the interpretation of this requirement; the 2000 Act's Code of Practice says that 'the Act is designed to ensure that as far as possible adults with any incapacity have equality of treatment and choice with adults with capacity'[29] but this is not sufficient to make a clear definitive statement on the legality of such action. In such circumstances, therefore, we would advise against testing. Doctors may, however, wish to seek advice from the Scottish Government and consider making an application to the Sheriff Court for a declaration to clarify this point.

7. Use of existing samples

7.1 Once a decision has been taken that it is lawful and appropriate to test without consent, consideration should be given to the least invasive method of achieving this. Where there is a recently stored sample that is suitable for testing, this should be tested in preference to the taking of a new sample. Similarly, if blood is being taken for clinical purposes, additional blood should be taken for testing at the same time, rather than requiring an additional invasive procedure. Testing should be undertaken on a pseudonymised basis.

8. Informing the patient

8.1 Once the patient regains capacity, he or she should be advised of the needlestick injury and that a test was undertaken for blood-borne viruses. In some cases treatment will have commenced while the patient lacked capacity and so the patient should be informed of this and consent should be sought for the treatment to continue. Where that is not the case, information should be provided to allow the individual to make an informed decision about whether to receive the test result.

8.2 Information should be provided to all patients (irrespective of the result) about the implications of being told about either a positive or a negative test result, for example:

- if they received a test result that revealed they were HIV, hepatitis B or C positive:
  - there would be significant benefit to starting treatment as soon as possible; and
  - they could take steps to prevent the infection being spread; but
  - they would need to reveal the information in future insurance applications.
- if they received a test that revealed they were not HIV, hepatitis B or C positive:
  - they would be reassured and not have to live with the uncertainty of not knowing.

Some patients will want to know the results, preferring not to live with uncertainty, others will prefer not to receive the information; the individual's views should be respected.

9. Recording information on the medical record

9.1 Given that the test was not undertaken as part of the patient's treatment and nor was it undertaken solely for the patient's clinical benefit, the individual should be given the option of whether or not information about the test should be recorded in the medical record.

9.2 If the patient is content for information about the test to be recorded on the medical record this should include the justification for testing without consent and the patient's decision about whether to know the test result. The result itself should only be included if the individual has opted to know the information and has agreed to have that information recorded.

British Medical Association
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Endnotes

1 Woode Owusu M, Wellington E, Rice B, Gill ON, Ncube F & contributors. *Eye of the Needle United Kingdom Surveillance of Significant Occupational Exposures to Bloodborne Viruses in Healthcare Workers: data to end 2013*. December 2014. Public Health England, London.

2 Lang S, Rapid response: Management of sharps injuries in the healthcare setting, *BMJ* 2015; 351;h3733.

3 Riddell A, Kennedy I, Tong CYW. Management of sharps injuries in the healthcare setting, *BMJ* 2015; 351:h3733 doi: 10.1136/bmj.h3733.

4 General Medical Council (undated) *Update to Serious Communicable Diseases*, GMC, London.

5 General Medical Council (2008) *Consent patients and doctors making decisions together*, GMC, London, para 76.

6 Medical Protection Society (2015) *Needlestick Injuries*, MPS, London.

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8 Riddell A, Kennedy I, Tong CYW. Management of sharps injuries in the healthcare setting, *BMJ* 2015; 351:h3733 doi: 10.1136/bmj.h3733.

9 Wicker S, Stirn AV, Rabenau HF, *et al*. Needlestick injuries: causes, preventability and psychological impact. *Infection* 2013: DOI 10.1007/s15010-014-0598-0.

10 Naghavi SHR, Shabestari O, Alcolado J. Post-traumatic stress disorder in trainee doctors with previous needlestick injuries. *Occup Med (Lond)* 2013; 63(4): 260-265.

11 For more information about the Mental Capacity Act see British Medical Association (2016) *Mental Capacity Act toolkit*. 2nd edition, BMA, London.

12 The term "next of kin" is often used to describe a near relative for a patient but it has no legal standing.

13 Re G (TJ) [2010] EWHC 3005 (COP).

14 Department for Constitutional Affairs (2007) *Mental Capacity Act 2005 Code of Practice*, The Stationery Office, London: paras 5.47; Law Commission (1995) *Report 231, Mental Incapacity*, HMSO, London: para 3.31; Aintree University Hospitals NHS Foundation Trust v James and Others [2013] UK SC 67, para 24.

15 Wye Valley NHS Trust v B (Rev 1) [2015] EWCOP 60 at 10.

16 House of Lords, *Hansard*, 1 February 2005, col 196.

17 Department for Constitutional Affairs (2007) *Mental Capacity Act 2005 Code of Practice*, The Stationery Office, London: paras 5.47- 5.48.

18 With conditions such as HIV, for example, there are clear advantages to earlier diagnosis. See, for example: MEDFASH (2015) *HIV for non-HIV specialists,* 2nd edition. MEDFASH, London; and Halve It. Position Paper: *Early testing saves lives*, available at:www.halveit.org.uk (Accessed 8 March 2016).

19 Re Jones [2014] EWCOP 59. Although that quotation was limited to doing the right thing for family and loved ones, it is sensible to extend the principle to a person being assumed to do the right thing for healthcare workers who are providing care and support to the patient.

20 Department for Constitutional Affairs (2007) *Mental Capacity Act 2005 Code of Practice*, The Stationery Office, London: para 5.47.

21 Department for Constitutional Affairs (2007) *Mental Capacity Act 2005 Code of Practice*, The Stationery Office, London: para 5.47.

22 Department for Constitutional Affairs (2007) *Mental Capacity Act 2005 Code of Practice*, The Stationery Office, London: para 5.48.

23 Re G (TJ) [2010] EWHC 3005 (COP).

24 Re G (TJ) [2010] EWHC 3005 (COP) para 56.

25 Aintree University Hospitals NHS Foundation Trust v James and Others [2013] UK SC 67, para 24.

26 Scottish Executive (2010) *Adults with Incapacity (Scotland) Act 2000. Code of Practice (third edition) for practitioners authorised to carry out medical treatment or research under part 5 of the Act* SG/2010/57, para 2.30.

27 Adults with Incapacity (Scotland) Act 2000 s. 50.

28 This includes the justification for opting for 'benefit' rather than 'best interests' in Law Commission of Scotland (1995) *Report on Incapable Adults, Scottish Law Commission Report No.151*. Para 2.50 http://www.scotlawcom.gov.uk/files/5013/2758/0994/rep151_1.pdf (accessed 9 May 2016); In addition, *Adults with Incapacity (Scotland) Act 2000 Explanatory Notes*, para 7 (http://www.legislation.gov.uk/asp/2000/4/notes/division/2/1/1 (accessed 9 May 2016); Great Stuart Trustees Ltd v Public Guardian [2014] CSIH 114; T, Applicant, Sheriff Court of Glasgow and Strathkelvin at Glasgow, 2005, SLT (sh Ct) 97; Ward A, *Adults with Incapacity Legislation*, W Green, Edinburgh, p. 13.

29 Scottish Executive (2010) *Adults with Incapacity (Scotland) Act 2000. Code of Practice (third edition) for practitioners authorised to carry out medical treatment or research under part 5 of the Act* SG/2010/57, para 2.35.

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