



## Criminal prosecution for HIV transmission

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## Editorials

An increased risk of congenital malformations provides another reason for recommending that any pregnancy in subfertile couples, whether achieved naturally or through infertility treatment, is carefully monitored by a fetal medicine specialist, with detailed antenatal imaging. Given the possible link between infertility treatment and anomalies, counselling of affected couples in relation to future pregnancies may be more complex and require detailed input from clinical geneticists.

Finally, what are the possible genetic causes of subfertility in a parent that are associated with congenital anomalies in a baby? Constitutional chromosomal rearrangements, including reciprocal and robertsonian translocations, and inversions are all well known causes of reduced fertility, miscarriages, and a whole spectrum of birth defects in offspring who inherit a chromosomal imbalance.<sup>11</sup> In the presence of a normal

karyotype, the possibility of a subtelomeric rearrangement or interstitial chromosomal deletions and duplications must also be considered.<sup>12</sup> Another possibility is gonadal mosaicism in a parent for these chromosomal alterations,<sup>13</sup> or other currently unknown monogenic defects. Future research should focus on establishing the mechanisms of these associations and, hence, provide improved risk assessment and counselling.

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## Criminal prosecution for HIV transmission

### *A threat to public health*

The Crown Prosecution Service for England and Wales has issued, for public consultation, new guidance on criminal prosecution for the “sexual transmission of infections which cause grievous bodily harm.” It is likely to be used mostly in relation to HIV. Although this attempt to introduce standardised criteria for prosecutions is welcome, we have serious concerns about the public health impact of using the law to criminalise disease transmission.

People infected with HIV who are taking antiretroviral treatment are able to live relatively healthy lives, but those whose infection remains undiagnosed still face serious illness and death. There has never been a stronger imperative to encourage individuals at risk to come forward for testing so they can access treatment. In the face of a rapidly rising prevalence of HIV infection, there is an equally strong imperative for preventing transmission. This includes support for those infected, helping them work out how to avoid exposing their sexual partners to infection and dealing with the challenges this may involve.

The government has made it a policy priority to increase uptake of HIV testing<sup>2,3</sup> and is funding prevention programmes in England for the population groups most at risk. Services around the country offer

voluntary testing, confidential partner notification, and education and support for affected individuals and their partners. Crucially, these measures rely on a relationship of trust and confidence between patients and healthcare professionals.

The sustainability and success of this approach are threatened by the policy of criminal prosecution. While those living with HIV infection or at risk of infection have had many reasons to be fearful about the impact of HIV, the possibility of appearing in a court of law followed by imprisonment had not until recently been one of them. However, 2001 saw the first successful prosecution in Scotland for “reckless injury,” followed by some in England and Wales for “reckless transmission” of HIV, under the 1861 Offences Against the Person Act. According to the Terrence Higgins Trust, more cases are in the pipeline.

Already there are indications that this use of the criminal law is having unintended negative consequences. Awareness is spreading among those infected with HIV that they face the threat of criminal prosecution. Media coverage has vilified those convicted as “AIDS assassins,” exacerbating the stigma already associated with infection. No wonder those unlucky enough to become infected often choose to keep their status a secret.

*BMJ* 2006;333:666-7

Individuals in this situation need help and support to plan how and to whom they will disclose their status, and to find strategies for protecting others from infection. With a spouse or long term partner, suddenly refusing to have sex or requiring the use of condoms without explanation is unlikely to be effective, but disclosure of HIV status may lead to rejection, physical violence, and financial destitution. If word gets out into the community, perhaps through a sexual partner, individuals with HIV risk being ostracised, with their families taunted and their employment and entire existence under threat. Health professionals can advise and assist, but their patients, if fearful of prosecution, may be unwilling even to tell them if they are having difficulties avoiding unprotected sex.<sup>4</sup>

An estimated 20 000 people in the United Kingdom have HIV infection that is still undiagnosed.<sup>5</sup> There is a clear disincentive to testing when prosecution relies on defendants knowing they are infected. Meanwhile, those who do take the test may not agree to their partners being notified for fear of legal repercussions, thereby jeopardising essential public health control efforts. In addition, the threat to the confidentiality of data posed by criminal investigations may deter participation (or honesty) in the sexual behaviour research which provides an essential evidence base for HIV prevention.

Doctors need guidance on whether the potential for criminal prosecutions changes their legal and ethical duty of confidentiality, and how to advise their HIV positive patients, who may become "victims" or "defendants" if a prosecution occurs. A briefing paper to inform clinicians is in preparation, a draft of which can be obtained from the British HIV Association.<sup>6</sup>

Research evidence on the public health impact of criminal prosecutions for reckless transmission of HIV is limited,<sup>7</sup> and there is an urgent need for further research. Rates of uptake of HIV testing in groups at highest risk should be monitored to see whether criminalisation may be leading to reductions.

In the short term, there is the opportunity to respond to the Crown Prosecution Service consultation. The draft guidance includes advice on how to

apply the Code for Crown Prosecutors, which states that a prosecution will usually take place "unless there are public interest factors tending against prosecution which clearly outweigh those tending in favour." Putting aside the difficulties in attributing who infected whom, we would argue that, in the case of criminal prosecution for reckless transmission of HIV, the public interest is not best served by pursuing justice against the few at the expense of the health of the many.

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## Commissioning health education in primary care

*Primary care trusts must give all patients timely access to relevant, high quality health information*

In the United Kingdom most people acknowledge personal responsibility for their own health,<sup>1</sup> and 87% say they have to be "really ill" to visit the doctor.<sup>2</sup> Yet most general practitioners who responded to a study in *Family Practice* said that they are often consulted about illnesses or symptoms that they consider to be minor.<sup>3</sup> Meanwhile, people with chronic conditions that are treatable continue to present late to their general practitioners.<sup>4</sup> How can we explain these apparent contradictions? Most general practitioners regularly provide education and information to patients, but the message and style of this information is often not optimal. A *Reader's Digest* survey in

2005 found that more than four fifths of the population rely on information from their general practitioners and over half use health leaflets from their surgery or pharmacy. Even so, market research conducted for the policy group Developing Patient Partnerships found that nearly three quarters of respondents would be less likely to visit their general practitioner if they had more information about managing common ailments.

A recent international study that compared data from Australia, Canada, New Zealand, United States, and Germany with the four UK nations, showed that British patients are the least likely to receive advice