

Section D

Legal and professional framework

History of sexual health advising

Law & the sexual health adviser

Ethical issues in sexual health advising

Code of professional conduct

Leading a team of sexual health advisers

History of sexual health advising

HEATHER WILSON

A tradition of philanthropy and social work has co existed with efforts to control sexually transmitted infection. Working within the national clinic system, social workers had contact tracing and health promotion integrated into their role. After World War two, the job of contact tracer gradually became formalised and existed nationwide by the mid 1970's.

The combined tradition of social work and contact tracing has culminated in the sexual health adviser, with their core roles of partner notification, counselling and health promotion.

This chapter is reflects on the circumstances that led to the emergence of a unique profession.

INTRODUCTION

Sexual health and the treatment of sexually transmitted infection is a field of medicine that inspired a holistic approach, with the welfare of those affected being considered alongside the medical, moral and public health ramifications. The origins of the current system emerged from an alliance between the medical profession, moral campaigners and health promoters, which has occurred in the field of sexual health over the last 150 years.¹

THE MORAL - MEDICAL ALLIANCE

The venereal diseases were widely assumed to be associated with prostitution; it was believed that if prostitution could be eradicated, venereal diseases would follow. Indeed the suffragettes maintained that votes for women would see the end of prostitution, when women could pursue other types of work, and with it, the end of venereal disease.² Christian zeal and the ideals of eugenics were the springboard for the first non medical efforts to combat venereal diseases.

Thomas Scott, the assistant chaplain of the London Lock Hospital for Venereal Disease, established in 1792 an Asylum to protect prostitutes who had completed their treatment and wanted to be reformed. They were accommodated for two years and trained to go into service.³ Adler describes how the chaplain of the Middlesex Hospital in 1849 found “more fruit of (his) labours” on the female venereal disease ward than on any other, recommending that syphilitic women were confined to their rooms except for divine service on Sundays.⁴

The Contagious Diseases Acts 1864, 1866 and 1869 were an attempt to deal with the high prevalence of venereal disease amongst the Armed Forces. Modelled on the European system, they were implemented in specified garrison towns and allowed for the enforced medical examination and treatment of women suspected to be prostitutes, men and ‘respectable women’ were seen as inappropriate for genital examination.^{5 6} Known prostitutes could be examined fortnightly and if found to be infected, a woman could be detained for up to six months for treatment.⁷ Hospitals were established for this purpose, and it has been argued that the intention was for a supply of healthy prostitutes for the forces.⁸ The Association for Promoting the Extension of the Contagious Diseases Acts to the Civilian Population was formed. Dominated by the medical profession, it also had members from the Tory party and the clergy. They argued that medics, rather than moralists, had greater authority on social and environmental issues, and claimed great success for the legislation, testifying that people were now behaving in the proper manner and prostitutes were displaying “common decency and self respect”.⁹

This effort to extend the acts provoked the first organised opposition. In 1869 The National Association for the Repeal of the Acts was formed and they asked Josephine Butler to spearhead the campaign. Butler was well known as a campaigner who had published on the subject of the economic plight of women who needed to work. She had set up a home for working class girls and was involved with the Rescue Society, who rescued and reformed ‘fallen women’. The National Association was for men only so Butler and Elizabeth Wolstenholme formed the Ladies National Association to fight this campaign. She was an evangelical Christian, a vicars wife who believed that the repeal campaign was the divine mission that she had been waiting for.¹⁰ With the backing of influential women such as Florence Nightingale, the Association was able to use the language of evangelical religion to influence parliament. They published widely, attacking doctors for using legislation to flout basic moral principles, violate women and destroy civil liberties. Parliament was unable to cope with “the revolt of the women”.¹¹ The campaign was arduous; the women were referred to as “shrieking sisters” and encountered hostility from the public and the medical profession.¹² They were successful however, “despite vociferous protests from the medical establishment, many venereologists, *The Lancet* and the *British Medical Journal*.”¹³

The Liberal politician James Stansfield joined the campaign in 1876 and was able to garner support from other Liberals, he also formed the National Medical Association for doctors who favoured repeal. The House was persuaded that Butlers rescue strategy to deal with prostitution was effective; they became uncomfortable about the state sanctioning immoral behaviour, and paying for it. The Acts were repealed in 1886. Butler was able to use her evidence session in Parliament to emphasise her case for raising the age of consent for girls from 12 to 16. This was eventually successful.¹⁴

EUGENICS AND HEALTH PROMOTION

The state entered a period of inactivity in legislation, both in the regulation of prostitution, although this continued in Europe,¹⁵ and in the area of venereal diseases. Although there was pressure for a government inquiry into the problem, it had proved to be a political quagmire

and parliament preferred to believe that the diseases were in decline, and were anyhow best combated by moral and religious efforts.¹⁶

The Eugenics movement became influential in the early 20th century. Although some of the ideas contravened medical ethics, such as sterilising the unfit, the desire to eliminate ‘racial poison’ such as the venereal diseases, was so persuasive that many prominent doctors were supportive and a new moral medical alliance was forged which became the social hygiene movement. Various organisations were formed out of this including The National Council for Combating Venereal Disease (NCCVD), which consisted of doctors, eugenicists, feminists and moralists.¹⁷

The Royal Commission on Venereal Diseases (1913 – 1916) produced what Oriel describes as “an enlightened document” which became law, the Public Health (Venereal Diseases) Regulations 1916.¹⁸ The recommendations were radical, establishing a free, confidential, nationwide service for the provision of diagnosis and treatment of venereal disease. However, as discussed by Oriel¹⁹ and Adler²⁰, the commissioners were nervous about prevention and prophylaxis. They considered the need for health education and took evidence from schools about “hygiene” lessons and the role of the school as compared to parents.

“...any appeals that may be made to children should be moral appeals. I think you can appeal to them on the ground of morality or on the ground of God, whereas I do not think you will appeal to them very strongly on the ground of the physical risk they run.”²¹

In the end the task was delegated to the NCCVD, which received considerable funds as a result. The commissioners believed that education should be based on spiritual and moral principles, especially given the dilemma of prevention, which may encourage a man to “deliberately fornicate in the knowledge that he would be protected from the consequences of his action?”²²

The NCCVD campaign, which was aimed at troops during the First World War and civilians afterward, was very popular, reaching two and a half million people between 1914 – 1920. It consisted of literature, films and plays, with titles such as “Damaged Goods” These consisted of images of health, athleticism and nature, juxtaposed with sinister images of the city and the amateur prostitute.

This was typical eugenicist propaganda and fostered the belief that venereal diseases were to be caught casually in the urban underworld, public drinking fountains, doorknobs, towels, etc., were all suspected modes of transmission, even by physicians.²³ As Oriel observes, this campaign failed to reach those at actual risk of infection and instead led to “a flow of the worried well to clinics – as was to happen 60 years later after television programmes about AIDS”.²⁴ Nevertheless, the NCCVD remained the only organisation with Government backing but eventually diversified into other areas of health education, becoming the British Social Hygiene Council in 1925 and eventually being absorbed into the Health Education Council in 1943. By this time public interest in the subject had faded and there was little demand for the books and pamphlets published about venereal disease.²⁵

CONTACT TRACING AND THE NEW VD CLINICS

Meanwhile the staff at V.D clinics nationwide was carrying out one –to –one counselling and contact tracing. Colonel L. W. Harrison was appointed in 1919 as the first Adviser in Venereal Diseases to the Ministry of Health. He was the medical director of St Thomas’s clinic, which was built according to his design and run according to his rules. These emphasised high

standards of medical care, teaching and research, as well as confidentiality, ease of access and respect for the patients. His systems and clinic design were widely adopted across the country under his guidance as the Ministry Adviser.²⁶

Amongst his considerable achievements as a clinician had been the introduction of contact tracing methods during his military service. In India between 1902 – 1904 Harrison would ask soldiers if they could recognise the source of their infection. Then an identity parade would be held. During the First World War medical officers at the hospital for soldiers with V.D., outside Le Havre in France, were required by Harrison to take a description of the woman concerned as part of the medical history. French plain clothes police would then attempt to find the woman and take her into custody for examination.²⁷ Back in the UK after the War, clinicians were aware of the importance of examining contacts, with Harrison preferring the patients being encouraged to trace their own contacts, which he by then believed to be more effective.²⁸

The first clinic staff to be concerned solely with the social and psychological well being of patients were the almoners. Employed During the 1920's and 1930's, they were medical social workers whose role was primarily to assist with the financial and domestic problems of the patients. However they also undertook to persuade patients to bring their contacts to the clinics.²⁹

DORA 33B AND THE TYNESIDE SCHEME

Formal contact tracing began during the Second World War. The American system of disease control, designed by the epidemiologist Thomas Parran, was being successfully applied to US forces, but the epidemic in England was not being contained. Colonel Harrison planned and implemented the Defence of the Realm Act, Regulation 33b (DORA33B), which required clinic doctors to supply the Medical Officers for Health with names of any sexual contact suspected by two or more of their patients to be the source of an infection. Treatment was then obligatory.

This regulation failed in it's primary objective, due to small numbers of reports, although more success was achieved when unofficial follow ups to single reports were undertaken.³⁰ This regulation was repealed in 1947 but in the meantime "it stimulated and encouraged a considerable surge of activity in the field of contact tracing"³¹

In 1948 the Ministry of health issued instructions to borough medical officers of health and venereal disease specialists entitled "Expiry of Defence Regulation 33b. Suggested Methods of Continuing to trace sources of (Venereal) Infection." All clinics were sent a book of contact information forms. They would send the details of their patients and the contacts to the local authority medical officer for health, who would then ask their VD social worker to approach the contact.³²

Some medical officers used health visitors, who were already employed by them, to do the contact tracing. The benefit of using the health visitors was that they had local knowledge and were known within the community, thus a home visit by a health visitor wouldn't arouse suspicion. The almoners/social workers in this system worked within the clinic, they were regarded as the 'case holders,' while the health visitors were the 'case finders'. The "Tyneside scheme", which started as an experiment in 1943, had followed this approach.³³ In 1944 at a meeting of the MSSVD the social worker was described as an "indispensable member of the staff of the venereal diseases clinic".³⁴ After the success of this scheme, other local authorities followed and most larger clinics employed VD social workers, paid by the borough.

The use of contact tracing methods and their effectiveness is the subject of much of this manual and thus won't be reviewed here. The literature does feature some successes and describes very labour intensive detective work by the VD social workers and health visitors. Detailed contact sheets were developed, which contained descriptions of the person and where they were most likely to be found. Often there was no name and no address but the contacts were found anyway. The workers discuss how frustrating and time consuming this work was "one often has to spend hours on research going from one address to an other".³⁵ All patients with gonorrhoea and syphilis were interviewed, "except selected patients such as innocently infected wives and fiancées"³⁶

It is notable how important to the work the rapport between the worker and the patient is. This is commented on from the perspective of being persuasive and able to extract more information than medical staff from the patients and also to be able to persuade the reluctant contact to attend the clinic. "...I could suggest that they come to talk to me at the clinic and could then fairly easily inveigle them into a consulting room".³⁷

Nevertheless, it is very evident that the workers were conducting supportive interviews with these patients, often expressing concern about their welfare, in particular the ill treatment of prostitutes by their pimps. As Thin comments, these workers were able to: "listen, discuss, offer simple advice, and refer patients to the clinic doctor, to their general practitioner, or to other agencies as required."³⁸

FROM VD SOCIAL WORKER TO HEALTH ADVISER

In 1969, compulsory examination of those suspected to be infected with a venereal disease was considered again by parliament and rejected.³⁹ A report by The Chief Medical Officer in the same year stressed the importance of contact tracing and, in 1971, the Department of Health and Social Security recommended the appointment of contact tracers to every clinic in London. Subsequently, numbers of contact tracers employed in clinics increased nationwide.⁴⁰

With the reorganisation of the health service in 1974, some local authority services and staff, such as health visitors, transferred to the health service. An increase in the recruitment of nurses into the posts of contact tracer/ health adviser has subsequently led to the majority of currently employed health advisers having a nursing qualification. A recent survey put this at 77%.⁴¹

Contact tracing was regarded as a valuable activity: "Effective Contact Tracing and the treatment of carriers of infection requires great tact and perseverance but is an essential element in the control of the diseases".⁴² In 1980 the Health Education Council published "A Handbook on Contact Tracing in sexually transmitted diseases". This was the first textbook on the subject in the world.⁴³ It provides detailed advice and instructions on how to undertake contact tracing. It is a very practical document, advising on the wording of letters, and what to say on phone calls and visits, it even goes to the extent of advising how to dress and behave on a pub or disco visit.⁴⁴

In 1981 five day residential training courses were established for all health advisers, and discussions were held with the DHSS and then NHS Training Authority about developing more comprehensive training.⁴⁵ The developments in health advising practise and expansion of the role in the last two decades are discussed in the Introduction and elsewhere in this manual.

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Law and the sexual health adviser

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The sexual health adviser needs to be aware of the legal framework surrounding their work if they are to practice in a safe and competent manner.

INTRODUCTION

The work of the health adviser is influenced by a number of background legal and ethical factors that are not always readily compatible with one another. An understanding and acceptance of these may greatly assist the health adviser when addressing specific situations and assessing any proposed plans for action.

- **The Law** The law is the base line of all professional activity. To operate outside it runs the risk of instigating legal proceedings or being sued. It is important to have a basic awareness of the legal framework that addresses issues such as slander, defamation, minors and disclosure. It is also necessary to establish what support we can expect from professional organisations and employers
- **The ethos of the workplace** Custom and practice in the place of work can heavily influence professional activity. For example, legally it may be allowable for a health adviser to disclose an HIV positive diagnosis to a patient over the telephone, but the custom and practice of the clinic may say that only the consultant can do this
- **Personal ethics** Somewhere in the middle of the law and workplace ethos lies the ethical stance of the health adviser. Others may pay little attention to this but at times each person may have to confront situations that affect them at their level of conscience. For example; issues of contraception to under-16's; discussing and encouraging sexual practices which one may never engage in personally; withholding the 'truth' from partners

THE LEGAL SYSTEM

Laws emanate from basically two sources;

- Decided cases through the court system. Sometimes known as Case Law, Judge-Made Law or the Common Law
- Legislation. Established by Acts of Parliament (Statutes), directives and regulations. The European Community may in some circumstances be the legislative authority¹

Like most legal systems English law is divided into criminal law and civil law. At the lower levels, different courts administer the two types of law:

- **Criminal Courts:** 95% of criminal cases are dealt with in a Magistrates Court. Magistrates are usually lay people neither paid nor legally qualified and are assisted by the Clerk to the Justices, who is usually a qualified solicitor. The Crown Court deals with the more serious criminal cases and here the accused is tried by a professional judge sitting with a jury
- **Civil Courts:** A civil action can be brought in the County Court, or in the High Court. Higher damages can be awarded by the latter. Many civil cases are settled out of court (about 99% in personal injury cases)

The legal profession is divided into two branches, barristers and solicitors. The public rarely have direct access to barristers, who are called to ‘counsel’, and normally have to go through a solicitor, who briefs counsel. Barristers can argue cases in all higher civil courts and solicitors argue cases in lower courts.² This however is changing and there are moves to make them one profession.³

DECIDED LAW

This forms the basis and backbone of English Law and the English legal system and was developed by the Royal Judges from the Norman conquest to the present day. It is often called the common law because in medieval times it was the law common to the whole realm, as distinct from local customary laws.

The cornerstone of the common law is the doctrine of precedent, which means that once a case has decided a particular point of law, that decision must be followed in all subsequent cases involving that point of law, unless a higher court overrules it. Decisions of the House of Lords, which is the highest domestic court, bind all other courts below it, and decisions of the European Court of Justice can bind even the House of Lords. Health care practice is largely governed by the common law. Consent to treatment is almost entirely a matter for the common law.

LEGISLATIVE LAW

The problem of establishing a precedent is that it becomes rigid and may not reflect new fields of human activity or for that matter be in tune with the political climate of the current age. Under English law Parliament is sovereign, and can make or repeal whatsoever laws it wishes.

Primary legislation describes statutes passed by Parliament and formally approved by the Queen. This can be a lengthy process consisting of a ‘Green Paper’ to outline problems needing addressing, followed by a ‘White Paper’ with proposals for action. A bill is then drafted and introduced to Parliament. Before becoming an Act it must go through a number of hurdles such as a second reading, the Committee stage and the report stage. Once the final text is reached the Bill must be passed by both Houses (Commons & Lords). The process is

meant to generate well thought out legislation. The courts can and do interpret the Statutes (or Acts) which Parliament passes, and what is called the case law thus generated is often crucial in knowing what the law of England is. The 1967 Abortion Act as an example requires a registered medical practitioner to conduct a termination but in the case of Royal College of Nursing of UK v. DHSS (1981) it was decided in the House of Lords that the induction/prostaglandin method that requires a high level of nurse involvement, did not offend the requirement. When judge made law and statute law conflict the statute law prevails.

Secondary legislation is the making of regulations by statutory instruments. It is approved by Parliament but prepared by ministers and the details are not debated. They take up less Parliamentary time and can be amended more easily than Statutes. They commonly spell out details of plans more generally put in Statutes. Specific duties, standards and procedures are often the content of regulations. The Abortion Regulations 1991 by way of example can be more instructive to the professional than the Abortion Act 1967.

GUM is very familiar with the 1974 VD regulations and the newer NHS Trusts and Primary Care Trusts (Sexually Transmitted Diseases) Directions 2000 (see Appendix 2).⁴ These impose the same obligations of confidentiality on the members and employees of both NHS trusts and Primary Care Trusts.

THE LEGAL AID SYSTEM

The 1999 'Access to Justice Act' made sweeping changes to the legal aid scheme by establishing a Legal Services Commission to run publicly funded schemes that enable people in need to access legal services. It also paved the way for a more streamlined system dealing with litigation. One outcome was the establishment of a fee system based on the principle of a 'no win, no fee' agreement.⁵

THE LAW AND THE HEALTH ADVISER

The law impinges on health care professionals in the following ways:

Criminal Law. A crime is an offence committed against the State either in the performance of some act that the law forbids or in the omission of some act that the law requires. Laws are generally enforced through prosecutions brought by the Crown Prosecution Service. Other bodies such as the National Society for the Prevention of Cruelty to Children, the Health and Safety Inspectorate and Environmental Health Officers have powers to prosecute in certain circumstances. The outcome of a prosecution is dependant on the ability of establishing a standard of proof beyond reasonable doubt. This leads to a verdict of 'guilty' or 'not guilty' and the penalties vary from fines to imprisonment. The concept of criminal responsibility is important since the state presumes that every person committing an act is sane and is doing so voluntarily unless this is proved otherwise. Legally recognised reasons exist for acts committed which ordinarily would have been criminal such as the use of reasonable force in self-defence. Ignorance of the law is no defence.

Civil Law. Much of the professional's work is written in the framework of the civil law, particularly the part of it known as the law of torts. A tort is a civil wrong or transgression and results in a common law action for damages. Individuals can seek to remedy a civil wrong committed against them by another individual or organisation. Legal action taken by a private individual can result in monetary compensation being awarded though the process can be slow, expensive and cumbersome.

Negligence (duty of care brought into question), trespass to the person (assault and battery) and how legal defences of consent and necessity operate, is of relevance to the health adviser. A further tort of interest is defamation, either as libel (permanent form, usually in writing) or slander (spoken word). A breach of confidence (in England, Wales and Northern Ireland) can lead to a person being sued. The patient can sue the health adviser for defamation. For several reasons this is impractical and unlikely to succeed. First the material has to be of such a nature that the person is lowered in the eyes of 'right thinking' people. In the past allegations of venereal diseases or 'imputation of unchastity in a woman' would have been put into this category. However, a major defence is that the defamatory material is true. This usually prevents successful actions being taken unless the purpose of the breach was to bring the patient into disrepute. A second difficulty is the cost of taking legal action. As defamation cases are not covered by legal aid, this in practice rules out all but the very affluent from taking action.

Public Law. This deals with the relationship between citizens and the state. It concerns the limits of government power, including that of public bodies such as the Department of Health, health authorities, and NHS trusts.

Employment legislation. Codified Acts of Parliament now exist to deal with the increasing complaints of the work situation though much of the law relating to employment has its roots in civil law. Protection of the individual employee and industrial relations regulation are two major themes tackled by employment legislation. If an employer sacks an employee for taking time off for treatment, the employee will have no statutory remedy (a contractual remedy however may be available) unless s/he had been in employment with that employer for at one year or in certain specified situations can be as little as one month. ⁶ Health Professionals have an obligation to follow the lawful and reasonable instructions of their employers often set out in policies and protocols. They may be disciplined for failing to follow them and such action has legal backing. Professional judgement may well be exercised to depart from agreed rules and regulations if specific situations merit it and can be clearly argued. ⁷

Professional legislation. Professionals are regulated by codes of conduct, which are rules set by their colleagues.⁸ Breaching them constitutes a professional misconduct and can lead to penalties imposed, which in some circumstances can mean being removed from the register.

Since April 2002 the majority of health advisers fall under the jurisdiction of the Nursing & Midwifery Council. Their basic functions are laid down in the Health Act 1999 through detailed statutory instruments. Essentially they determine the rules for professional registration and investigate allegations of misconduct. Codes of professional conduct do not have the status of law but a professional duty is placed on all registered members to work within them. Failure to do so can mean a health adviser be legally prevented from practising thus the law and professional behaviour remain intertwined. The Society of Sexual Health Advisers is in the process of exploring all measures needed to establish and maintain a professional register.

Quasi-Law. The NHS generates circulars, guidance and executive letters instructing how to carry out work. These documents may not be legally binding but may have some legal force if not followed. It is common practice for the Department of Health to use guidance and encouragement rather than compulsion. The 'Guidelines for pre-test discussion on HIV testing' published in March 1996 are such an example. Mrs Gillick objected to a controversial circular in 1985 on contraceptive services for young people. This eventually led to a ruling in the House of Lords, which governs practice.

European Law. Much of this law is concerned with governing that economic activity is based on fair competition. European Community Law is rapidly growing with legislation made or proposed by the European Commission. Treaties, regulations and directives can in some instances have a direct or indirect impact on English law, individuals and authorities such as NHS trusts. A number of directives have been concerned with giving mutual recognition to professionals qualifying from other member states. Doctors and nurses have had their statutes changed to incorporate these directives. The European Court of Justice based in Luxembourg is a further source of European Community law which can examine alleged failures of governments and institutions to meet their legal obligations.

Human Rights Law. International agreements can influence health care law. The European Convention for the Protection of Human Rights and Fundamental Freedoms was originally drawn up by the Council of Europe in 1950 and influenced the European Social Charter of 1961. Until the publication of the Human Rights Act 1998⁹ the UK had no mechanism for the vindication of human rights. Frequent petitions from this country were made to the European Commission of Human Rights. The commission passed on any case to the court if a Convention breach was apparent. The UK Government undertook to agree to any decision made by the European Court of Human Rights.

The 1961 Social Charter makes only brief mention of rights to health and seeks to facilitate the activities of professionals more than limit them. However it does provide for the detention of those judged to be insane or threatening to infect others with disease.

The Human Rights Act 1998 specifically deals with interference by a public authority on the right to respect for private and family life. It is important that the actions of health advisers such as securing the attendance of sexual contacts are legal and backed by sound policies and procedures that clearly articulate their rationale and necessity. Any action taken, even if within policies and procedures, need should be justified for each individual case.

LEGAL ISSUES: SEXUAL HEALTH OF CHILDREN & YOUNG PEOPLE

The health adviser commonly has contact with young people and some attention is given to outlining some of the key legal issues that crop up when dealing with some of the concerns that they bring.

The Civil Law

In general, the consent of the child or young person can be obtained where:

a) The young person is over the age of 16 years. In these circumstances, so long as they are of sound mind, they have a statutory right to give consent under section 8 of the Family Law Reform Act 1969. Parental consent is not required.

or

b) The child or young person is under the age of 16 years, but is deemed capable of giving consent in certain circumstances.

Normally, no medical examination should take place if a child or young person is competent to consent but refuses to do so.

However, those with parental responsibility (e.g. natural or adoptive parents, or the local authority in possession of a care order) can override the refusal in some cases. It is important to take into consideration the refusal of consent from the child before making such a decision.

If consent is not available, doctors can only provide those elements of treatment that are immediately essential to secure the child or young person's welfare.

Fraser Ruling

In the case of *Gillick v West Norfolk and Wisbech Area Health Authority* (1985) 3 All ER 4092, the House of Lords reviewed the issue of consent with regard to young people under 16 years of age. It was held that the test to apply was whether the child had sufficient understanding and intelligence to enable full understanding for any proposed intervention.¹⁰ Parental rights are to yield to the young person's right to make their own decisions.¹¹ This became known as the Fraser Ruling though is still sometimes referred to as an assessment of 'Gillick competency'.

The Criminal Law

See Appendix 1 for summary of sex laws.

- ***Offences (females)***

In all offences perpetrated by a male upon a female, the Sexual Offences Act 1993 abolished the legal presumption that a boy under the age of 14 was incapable of sexual intercourse. All references to a man, therefore include reference to a boy.

Intercourse with a girl under thirteen It is a serious arrestable offence for a man to have sexual intercourse with a girl under the age of thirteen.

Intercourse with a girl under sixteen It is an offence for a man to have unlawful sexual intercourse with a girl under the age of sixteen in England, Scotland and Wales and under seventeen in Northern Ireland. It is no defence that the girl consented to the sexual intercourse.

It may be an exception to the offence of having intercourse with a girl aged under 16 (but not if she is under 13) if the man is under the age of 24, has not been previously charged with a like offence, and believes the girl to have been the age of sixteen or over, and that he has reasonable grounds for that belief.

- ***Offences (males)***

Homosexuality Consensual anal sex in private can now occur lawfully when the parties are over the age of sixteen.¹²

Sexual intercourse is deemed not to have taken place in private if more than two men are present, or if it takes place in an area to which the public have access.

Gross Indecency It is an offence for a man (otherwise than in the circumstances below) to commit an act of gross indecency with another man (either in public or private) or to be a party to the commission of such an act or to procure it.

- It is not an offence if the man is under the age of 16 and the other man has attained the age of 16
- No offence is committed if both parties are over the age of 16 and consent and the act takes place in private. In these circumstances there will be no offence of commissioning or procuring

▪ ***Offences (both sexes)***

Rape It is an offence for a man to rape a woman or another man. Rape is committed if a man has sexual intercourse (whether vaginal or anal) with a person who, at the time, does not consent to it, and he either knows that the person does not consent or is reckless as to consent. ('Recklessness' can be defined as indifference to the feelings and wishes of the victim and giving no thought to the possibility she might not be consenting).

Penetration is sufficient to constitute sexual intercourse; ejaculation is not necessary. Consensual sexual intercourse becomes rape if the participating party ceases to consent during intercourse.

The definition of rape was amended by the Criminal Justice and Public Order Act 1994 to include rape by a husband of his wife.

It is also an offence to aid, abet, procure or incite to commit rape.

Indecent Assault It is an offence for any person (man or woman) to make an indecent assault on either a man or woman.

Assault usually includes physical contact and can include acts such as touching or kissing as well as penetration (for example with a finger).

The test for indecency is what a right minded member of the public would consider to be indecent. Factors that should be considered when determining this include the relationship of the accused to the victim, how the accused has come to embark on this conduct, and why they are behaving in that way.

A boy or girl under the age of 16 is unable to consent to an act to prevent it being an indecent assault. Incompetent men and women are also unable to consent, although the accused will only be guilty if they knew the victim was incompetent or had reason to believe that they were.

Buggery Committing buggery with another person or an animal is a serious arrestable offence unless:

1. both parties are over 16 and are in a private place when the act takes place, or;
2. the person who commits buggery is under 16 and the person who it is committed with is over 16 (this ensures protection for minors who may be being abused).

An act will not be committed in private if it takes place in a lavatory which the public have access to, or more than two people take part or are present.

Buggery includes anal sex by a man with either a man or a woman. Less commonly the offence is also committed by either a man or a woman, in any manner, with an animal.

A man who procures another man to commit with a third man an act of buggery which is not an offence (i.e. in the circumstances above) commits an offence. It is also an offence to assault another person with intent to commit buggery.”

Incest It is an offence for a man to have sexual intercourse with a woman whom he knows to be his grand-daughter, daughter, sister or mother. It is immaterial whether the woman consented.

It is an offence for a woman of the age of 16 or over to permit a man whom she knows to be her grandfather, father, brother, or son to have sexual intercourse with her by her consent. A distinction is drawn between permission and submission.

For these purposes “sister” and “brother” include half sisters and brothers. Additionally any relationship imported between two people applies notwithstanding that it cannot be traced through lawful wedlock. The accused must be aware of the relationship existing at the time of the commission of the offence; a mistake of identity may be a defence.

Summary of offences

The law relating to these offences has been overhauled by the Sexual Offences Act 2003. The behaviour described above will still be an offence, but there are a number of new classifications in the Act which could make certain offences more wide-ranging. The Act also includes more protection for children, especially in relation to acts such as incitement to engage in sexual offences and grooming. The Act also contains added protection for those suffering mental disorders, and provides more detail on existing offences. The Act is not yet in force, meaning that the law as stated above still stands, but professionals should be aware that the updated provisions, which offer more avenues of protection and detailed explanation, will come into force in due course.

HEALTH ADVISER IMPLICATIONS

The health adviser owes the employers certain duties;

- To carry out their lawful instructions
- To render them faithful service
- Not to be absent from work without good cause
- Not to disclose confidential information obtained in the course of duty
- To perform duties with reasonable care
- To take reasonable care for the health and safety of others and to co-operate with your employer in this

Being sued for professional negligence is a great fear and can be done for giving either advice or treatment, which an ordinarily competent health adviser would not advise or do. Inexperience is no defence. The following tips should prove helpful:

- Always ensure advice is as accurate as possible
- Do not act beyond the scope of professional competence
- Be willing to take extra trouble in whatever is done
- Always try to maintain good relations with clients
- Keep notes and records which are adequate, legible, signed and dated
- Keep all correspondence and copies of letters sent
- Never admit liability, except on legal advice
- Do not release confidential information until the identity of the recipient has been confirmed (call back other GUM clinics) and clarify the use of this information
- Mark all confidential correspondence as 'Confidential' or 'For Addressee Only'¹³
- Professional indemnity insurance is desirable and most professional associations will provide it though it is unlikely the health adviser will need it because the employing authority is vicariously liable for any negligence committed in the course of employment. In practice it is usually the employer and not the individual worker who is sued

HYPOTHETICAL EXAMPLES

Case Study 1

Fiona, a newly appointed health adviser mentioned to her flat mate that she had seen a well-known footballer with gonorrhoea at the clinic. He was married but had picked up the infection by having oral sex with one of his team-mates. She asked her to keep quiet about it. Some weeks later an article appeared in the local press revealing the explicit details. The source of the information was traced back to her. What are the legal repercussions?

The trust between the patient and professional imposes a duty of care to protect confidentiality.¹⁴ The footballer could sue Fiona's employers for their vicarious liability though this is unlikely as such action could attract adverse publicity. If he had been aware of the intention to print the article prior to its release he would have grounds to take out a court injunction prohibiting publication.

Fiona could face disciplinary proceedings on a number of counts:

- Failing to comply with a term in her employment contract (explicit or implicit) that expects employees to respect the confidential nature of patient information. This may lead to dismissal
- Failing to respect her professional code of conduct. These will vary across professions though all will contain a clause requiring members protect patient confidentiality unless there were legal justifications to breach it

- Failing to comply with the statutory provision of the NHS (Venereal Diseases) Regulations 1974 and the NHS Trusts and PCT's (Sexually Transmitted Diseases) Directions 2000. These prevent the disclosure of any identifying information about a patient examined or treated for a sexually transmitted disease (including HIV and AIDS) other than to a medical practitioner (or to a person employed under the direction of a medical practitioner) in connection with and for the purpose of either the treatment of the patient and/or the prevention of the spread of the disease

Fiona could claim her friend had breached trust between them and could take legal action against her. This may be feasible if the friendship had broken down though may not be advisable if compensation costs would be difficult to recover. Even if this friend had been paid money for her story by the press the judge may not look favourably on Fiona benefiting from these profits.

Acceptable breaches of confidentiality do exist in the following circumstances: ¹⁵

- **Patient consent** Obtaining consent from a patient with a mental illness may not be straightforward due to the question of competency. If the patient is incompetent the presence of another colleague will not make their consent valid. The presence of the extra professional is a matter of good practice to assist in deciding whether the patient is competent. If the conclusion reached is that the patient is competent then their consent is valid. If the patient is incompetent they can be treated in their best interests.
- **Patient best interest** This covers giving information to other professionals. Implied consent is fraught with medico-legal difficulties though in practice it is widespread. It extends beyond the sharing of patient information with professional colleagues into tricky situations where the patient did not refuse consent but equally did not sanction it. For example, supplying verbal information to a GP who rings wanting to know details of his patients clinic visit when he had merely advised he attend without sending a referral letter. Similarly in Case Study 1 it would cover giving information to the Football club doctor if the player did not return to the department for treatment despite several attempts to contact him
- **Court order** If justice is to be served in courts of law, litigation and prosecutions a judge may waive the right of a patient to confidentiality. Before releasing information the health adviser should check with their employers legal department
- **Statutory requirements** Such as the Police & Criminal Evidence Act
- **Public interest** Serious criminal acts warrant disclosure. Suspicion of child abuse should waive any hesitation of protecting confidentiality.^{16 17} The VD regulations make provision to disclose information, against the wishes of the patient, to a relevant health care professional for prevention purposes.¹⁸ Significant harm to an identified individual would need to be demonstrated if the disclosure was not made. For each event a strong case would need to be made to argue that a breach in confidentiality was a legitimate action and proportionate to the seriousness of the concern. This is a complex area and the health adviser should take advice from other colleagues before proceeding further. Clear clinic policies outlining courses of action to be taken in common situations should be available

Case Study 2

Russell attended the GUM clinic as a result of a provider referral for gonorrhoea by contacting him at his place of work. He was a junior doctor working in Accident & Emergency. Epidemiological treatment was given and he took up the offer to have an HIV antibody test. Unexpectedly the result came back positive. The health adviser, Kenny saw him several times over the next few months and although Russell agreed to inform his employer he never seemed to get round to it. Does Kenny have a legal obligation to ensure full disclosure is made?

Health care workers infected with HIV have an ethical and legal duty to take reasonable care to protect the health and safety of their patients. An HIV infected worker must not perform procedures that are clearly described as exposure prone.

*Exposure prone procedures (EPPs) are those where there is a risk that injury to the worker may result in exposure of the patient's open tissues to the blood of the worker. These procedures include those where the worker's gloved hands may be in contact with sharp instruments, needle tips or sharp tissues (spicules of bone or teeth) inside a patient's open body cavity, wound or confined anatomical space where the hands or fingertips may not be completely visible at all times.*¹⁹

The General Medical Council as the regulatory body for doctors, places on Russell an obligation to take certain actions.²⁰ These include:

- Promptly seeking and following advice from a suitable qualified colleague. This should cover whom to tell – current, previous and prospective employers. Also what aspects of professional practice may need modification?
- Not to rely on self-assessment of risk to patients
- Arrange appropriate medical supervision
- If he persists in choosing not to follow this guidance he could in the future face disciplinary proceedings and possible dismissal

If Kenny has taken reasonable steps to advise Russell to inform relevant authorities about his status and yet believes that this advice has not been acted the on the 'Sexually Transmitted Disease Directions' provide grounds to inform an appropriate person in Russell's employing authority (e.g. an occupational health physician). In practice this is an action likely to be delegated to the GUM Consultant. Russell should be informed that this action is to be taken.

C O N C L U S I O N

This chapter has not intended to cover all eventualities and is merely intended to be a reference guide. Health advisers may need more detailed and specific legal advice on a matter from time to time to clarify issues. An employer has a duty to protect staff and could be approached when an uncertainty arises. Professional bodies or trade union organisations may also be of some assistance. Safe and competent practice will be more assured when the professional appreciates the legal parameters within which to operate.

Having a firm grasp of the legal framework underpinning the work of the health adviser may appear daunting. There are constant demands to respond effectively to patients sexual health needs. The potential for major upset is real. It is important therefore not to ignore legal

implications though at the same time it is worth reflecting on the fact that very few practitioners will fall foul of the law.²¹

USEFUL INTERNET RESOURCES

Brief explanations of the English legal system for non-lawyers.

Nicol N. Barrister & Mediator <http://www.niknicol.co.uk/English/english.html>

Centre for Criminal Justice Studies. UK Law Online <http://www.leeds.ac.uk/law/hamlyn/toc.htm>

Venereal Disease Regulations 2000 <http://www.doh.gov.uk/stdtdirections.htm> The latest version that governs practice within GUM clinics

Nursing & midwifery council. Code of professional conduct <http://www.ukcc.org.uk/cms/content/publications/>
Defines the standards which are required at all times from registered nurses, midwives and health visitors. This is the benchmark against which complaints of misconduct are judged and the source of all the other professional advice and guidance published by the UKCC

The Children Act 1989 http://www.hmsso.gov.uk/acts/acts1989/Ukpga_19890041_en_1.htm The Act brings together most private and public law about children, thereby replacing complex and fragmented legislation with a single statute.

Her Majesty's Stationary Office

<http://www.hmsso.gov.uk/legis.htm> UK Legislation since 1988 and Northern Ireland legislation since 1981

Sexual Offences (Amendment) Act 2000 <http://www.legislation.hmsso.gov.uk/acts/acts2000/20000044.htm> An Act to reduce the age at which certain sexual acts are lawful

The Lord Chancellor's Department: Justice - Rights – Constitution. <http://www.lcd.gov.uk/>

APPENDIX 1

Sex Laws at a glance

Heterosexual sex - The legal age of consent in England, Scotland and Wales is 16 years. It is 17 years in Northern Ireland. It is an offence to have sexual intercourse with a girl under 16, even if she consents.

No specific law exists to prevent an older woman having intercourse with a boy under 16. She could be charged with indecent assault. In either case, only the older person is guilty of an offence.

Heterosexual anal sex - The legal age of consent for a man and a woman in England and Wales is 16 years. It is 16 years in Scotland.

Anal sex between two men - The legal age of consent for in the UK is 16 years except Northern Ireland which is 17 years, provided both men consent.

Sex between two women - No specific law exists on the age of consent for lesbians. It may be implied in other laws that both women must consent and be over 16 years, except in Northern Ireland, where they must be over 17 years.

Incest – Sex is outlawed with a close blood relative: father, mother, sister, brother, grandfather and grandmother.

Sex in a public place – This is illegal. Includes toilets, places of entertainment and recreation.

Money for sex - You can't legally solicit or run premises and receive payment for sexual favours/services.

Abuse of trust – The person in the position of trust must be over 18 to commit the offence. The person abused must be under 18. It is a defence if the accused can show that they reasonably believed the other person was 18 or over, or that they were not aware they were in a position of trust with them.

A P P E N D I X 2

THE NATIONAL HEALTH SERVICE ACT 1977

The NHS Trusts and Primary Care Trusts (Sexually Transmitted Diseases) Directions 2000

Made - - - - 8th September 2000

Coming into force - - - - 15th September 2000

The Secretary of State for Health in exercise of powers conferred by sections 17 and 126(3) of the National Health Service Act 1977(a) and of all other powers enabling him in that behalf, hereby makes the following Directions:

Citation, commencement and extent

1. - These Directions may be cited as the NHS Trusts and Primary Care Trusts (Sexually Transmitted Diseases) Directions 2000 and shall come into force on 1st April 2000.
- (2) These Directions extend to England only.

Confidentiality of information

2. Every NHS trust and Primary Care Trust shall take all necessary steps to secure that any information capable of identifying an individual obtained by any of their members or employees with respect to persons examined or treated for any sexually transmitted disease shall not be disclosed except-

- (a) for the purpose of communicating that information to a medical practitioner, or to a person employed under the direction of a medical practitioner in connection with the treatment of persons suffering from such disease or the prevention of the spread thereof, and
- (b) for the purpose of such treatment or prevention.

Revocation

3. The National Health Service Trusts (Venereal Diseases) Directions 1991 are revoked.
8th September 2000

Signed by authority of the Secretary of State for Health

Marcia A Fry

Member of the Senior Civil Service

EXPLANATORY NOTE

(This note is not part of the Directions)

The National Health Service (Venereal Diseases) Regulations 1974 (S.I.1974/29) imposed on health authorities an obligation to secure that information about sexually transmitted diseases obtained by their officers should be treated as confidential. In 1991 Directions were made imposing the same obligations on trustees and employees of a National Health Service trust. These are now revoked in relation to England.

These new Directions, which apply only to England, impose the same obligations of confidentiality on the members and employees of both NHS trusts and Primary Care Trusts.

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- 5 Ibid
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Ethical issues in sexual health advising

GILL BELL

Ethical considerations are at the heart of all aspects of health advising, including partner notification, counselling and health promotion. This chapter offers a framework for understanding and managing ethical issues.

INTRODUCTION

Almost everything health advisers do has the potential to affect somebody's welfare, and as such may raise ethical issues. Simultaneous duties to the individual patient, their sexual contacts and the community as a whole create numerous dilemmas when the best interests of all cannot be fully accommodated. Choices have to be made about how best to serve a person's interests, or whose interests should receive priority, when there is conflict. Furthermore, the finite nature of resources requires decisions about which individuals, or groups, (if any) should benefit from restricted access sessions, outreach initiatives, or priority appointments.

The aim of this section is to clarify how an ethical issue might be identified and managed. The main ways of approaching an ethical issue are explained, and the key principles are discussed in relation to common dilemmas. There are no objectively right answers in ethics, but there are valid and non-valid arguments for and against a given action. Familiarity with the concepts and language of ethics will enable health advisers to make decisions, and explain them, with greater confidence.

1. APPROACHES TO ETHICS

DEONTOLOGICAL ETHICS: THE IMPORTANCE OF PRINCIPLES

Deontology is the study of duty. Deontological ethics start from the position that there are certain moral principles that we have a binding duty to uphold. Rules of behaviour that serve or enshrine these principles must be followed. Examples of moral obligations include the duty to tell the truth, keep promises, be fair, respect autonomy and treat people as ends rather than means. There are many more.

A situation is an ethical issue, in deontological terms, if potential actions, or inactions, might violate a moral principle. An action is considered to be right if the appropriate principles have been honoured. The consequences of an action are not necessarily relevant to the debate, unless certain outcomes are integral to a principle, such as beneficence (see below).

The concept of rights is an important aspect of deontological ethics. All individuals may be said to have certain fundamental human rights, for example to “life, liberty and estate”¹ that cannot normally be legitimately transgressed. In addition to these, some people have rights that are the result of particular circumstances where a tacit or explicit contract applies. For example, patients attending genitourinary medicine (GUM) have a right to free and confidential screening and treatment.

Rights are only meaningful if others are obliged to respect them. The rights of a person requiring a sexual health check therefore confer duties on the health care system and on individual health care workers to do whatever is necessary to honour these rights. Sometimes the duty is to do nothing – to refrain from interfering with the person’s right to autonomy.

Debate arises in duty-based ethics when there is conflict between principles, or confusion about the validity, relevance or meaning of a principle.

TELEOLOGICAL ETHICS: THE IMPORTANCE OF CONSEQUENCES

Teleology is the study of consequences. Teleological theories of ethics, such as utilitarianism, regard actions to be right if they produce desirable outcomes. ‘Extreme’² or ‘act’ utilitarians assert that each individual must consider the consequences of all possible actions before choosing the action that produces the best balance of good over harm. Moral rules may be useful as rules of thumb, but they are not sacrosanct, and should be disregarded if they are likely to result in an undesirable outcome in the instance.

By contrast, ‘restricted’³ or ‘rule’ utilitarians place more faith in moral rules than the judgement of the individual, who may lack the necessary knowledge, experience or wisdom to anticipate the full range of consequences. It is postulated that established moral rules have been created, and have survived, because they tend to lead to positive outcomes. Furthermore, rules offer security and protection: the ability to trust that individuals will behave in certain agreed ways is in everyone’s interest. For these reasons, rule-utilitarians believe that the most desirable outcome is more likely to result in the long term if moral rules are followed. The rule-utilitarian commitment to moral principles and rules is based on a perception of their utility, rather than the deontological position that they are intrinsically right.

Debates arise in teleological ethics when there is disagreement about which consequences are desirable, for whom they should be sought, and how they might be calculated reliably.

EXISTENTIALIST ETHICS: THE IMPORTANCE OF MORAL INTEGRITY (AUTHENTICITY)

For the existentialist, the primary moral duty is to be ‘authentic’, or true to oneself. The individual has a fundamental obligation to make a judgement about what is right in a given situation, and to act accordingly. The responsibility to be a conscious moral agent, and make choices, is inescapable: in this sense we are “condemned to freedom”⁴.

Inherited moral rules are not binding, and are of limited use, because they apply to the general, while moral dilemmas are always unique and specific. The individual must also choose which consequences are desirable. An action is right only if the person has acted in ‘good faith’⁵: that is, in accordance with his or her own personally constructed values.

The relevance of this doctrine to the ethics of health care is that it “explodes the myth that a professional is somehow different from a non-professional...[A] person should be true to himself in every situation in which he finds himself, and being a professional for a time is just one more situation in which this authenticity is necessary”⁶.

From an existentialist perspective, health care workers should not hide behind their professional role or allow themselves to be guided blindly by professional codes of conduct. There is no escape from the duty to think for oneself: it is a form of moral dereliction, or ‘bad faith’, to pretend to be enslaved.⁷

In hierarchical organisations like the health service it is sometimes difficult to avoid bad faith, because there is great pressure to follow the instructions or advice of senior colleagues, regardless of one’s own view of what is right.

PROFESSIONAL ETHICS: THE IMPORTANCE OF ROLE

Having considered that, from the existentialist perspective, blind adherence to received rules amounts to an utter failure to be moral, how is it possible to advocate a code of conduct that prescribes professional behaviour? One reason is that subjective individual judgements would be variable, unpredictable and sometimes unacceptable to the majority. They may be guided by self-interest, warped by prejudice or hampered by the difficulty of grasping moral thinking. All professionals have a contract with society to meet certain requirements. The public therefore has a right to be reassured that duties will be performed in full, in an acceptable way, notwithstanding the idiosyncrasies of individual practitioners. Furthermore, practitioners need some guidance: it is unreasonable and unrealistic to expect that we all have the time and capacity to strip down an ethical issue and ‘invent’ an acceptable response many times each day, without a clear map. Besides, from many ethical perspectives it is part of the nature of morality that we are bound by rules we have not chosen.

Health advisers have particular ethical duties attached to their professional role, outlined in the ‘Code of Professional Conduct for Sexual Health Advisers’.⁸ Specifically, they have a duty to:

- Safeguard and promote the interests of patients
- Safeguard and promote the sexual health of those at risk of sexually transmitted infection
- Serve the interests of society
- Justify public trust and confidence

PERSONAL V PROFESSIONAL ETHICS

Personal ethics may conflict with designated professional duties in important ways. For example, it may be difficult to offer supportive and non-judgemental care to a person who is known to be seriously abusive to others; the duty to protect confidentiality may oblige a health adviser to be deceitful, or collude with the deception of others; a possible conviction that

abortion is wrong is at odds with the obligation to offer impartial counselling to a patient who is considering a termination. An individual health adviser may find a team decision on an ethical dilemma to be personally unacceptable – for example, a decision about whether to refer a young person to social services, against their wishes. There may also be occasions where duties attached to other social roles conflict with professional duties.

These conflicts may give rise to debilitating levels of tension and anxiety. It is important for health advisers to have a safe and supportive arena, such as supervision, where these issues can be ventilated and explored.

AN ECLECTIC APPROACH

Even though each of the above approaches to ethics appear to offer a comprehensive, mutually exclusive system, there is much overlap. Some principles, such as beneficence, are consequentialist by nature; consequentialist theories recognise the importance of rules; our professional ethical code⁹ contains both rule and goal based elements; all approaches require individuals to make personal decisions about what is right in a given situation. In practice, an eclectic approach is required. It is not possible to address an ethical issue adequately without considering all elements: prima facie principles, consequences, professional obligations and personal integrity.

2. PRINCIPLES OF HEALTH CARE

Beauchamps and Childress¹⁰ propose an ethical framework for health care based on four prima facie principles: autonomy, beneficence, non-maleficence and justice.

These are described and discussed in relation to a range of ethical choices encountered by health advisers. The importance of confidentiality will also be considered.

AUTONOMY

Having autonomy means being in control. It also means accepting responsibility for one's choices, actions and welfare. An autonomous person is a rational being who is free to make decisions and act, or permit actions on his/her behalf, accordingly. Autonomy is of central importance to most schools of ethical thought. For some deontologists, such as Kant and Sartre, it is a requirement of moral agency, and therefore intrinsic to the core value of persons. "Moral value is something that springs into being only when there is an actual moral agent deciding what to do, and doing it".¹¹ In other words, one of the qualities that make persons valuable is the ability to make moral choices. A person who lacks autonomy therefore potentially has less status as a human being. For this reason, it cannot be violated or surrendered: autonomy is both a right and a duty. Utilitarians have also stressed the importance of autonomy because it enables individuals to pursue their own goals. The assumption here is that the individual is the best judge of what will maximise his or her well-being.

The following table summarises the ways in which health advisers might facilitate, respect or promote autonomy.

<i>Respect for autonomy means that:</i>
Truthful, accurate information needed to make informed choices about care is given promptly, in a way that can be readily understood
Informed consent, freely given, is sought prior to any action that carries a risk for the patient (Examples include partner notification; HIV or hepatitis testing; sharing of information with others)
Patients are empowered to make and sustain positive behaviour/lifestyle changes of their choice (for example, through risk-reduction interventions)
Health is restored where possible, thereby removing physical and psychological barriers to independence
Confidentiality is maintained. The patient understands the limits of confidentiality, and is warned of necessary disclosures
Choices are respected
Persons are treated as ends in themselves, not means to an end

Ethical dilemmas in relation to autonomy

Difficulties arise in relation to autonomy when:

- **There is conflict between the autonomy of one person and the welfare, rights or autonomy of another**
 This conflict would arise if, for example, a woman with chlamydia did not want her ex-partner to be notified. There would be some duty to encourage her to change her mind, even though this challenges her autonomy, because he is entitled to information that will allow him to protect his health, and that of future partners.
- **The person wishes to surrender autonomy**
 For example, a patient who is having difficulty deciding whether to have an HIV test might ask the health adviser to decide for him (“What would you do?”). The health adviser might be tempted to ‘help’ the patient make the ‘right’ choice. However, such paternalism (see *Paternalism*, below) would weaken his autonomy by allowing him to avoid responsibility for the decision.
- **The decision appears to be against the person’s interests**
 Legally competent patients cannot be obliged to undergo interventions against their wishes, regardless of the potential benefits for themselves. However, situations arise where a patient makes a fully informed choice that appears to be against his or her interests. Take the example of an HIV contact whom refuses testing to protect his partner from guilt, should the test be positive. The dilemma for the health adviser is whether to accept the patient’s choice without comment, or to challenge the decision. Any attempt to encourage, persuade, cajole or pressurise a person into making a particular choice violates autonomy to some degree.

- **The person's stated wishes are not autonomous**

This may be because the capacity for reason or understanding is impaired, or under-developed. For example, an intravenous heroin user might request a test for hepatitis C while heavily sedated by drugs and/or alcohol. In this condition, s/he would not be able to make an autonomous decision because the capacity to reason would be temporarily impaired, and consent would not be valid.

B E N E F I C E N C E

Beneficence means doing good. The assertion that an action is right if the consequences are beneficial is central to utilitarian ethics. As health advisers we have a professional duty to seek certain benefits for certain people. Primarily, there is a duty to promote the sexual health of the patient, the control of infection and the wider community. Regarding patients, there is an additional duty to safeguard and promote broader aspects of health and well-being.

N O N - M A L E F I C E N C E

Non-maleficence means not causing harm. As health advisers we have a duty to minimise the damage we do to patients, contacts or the community in the process of trying to do good, given that “whenever we try to help others we inevitably risk harming them”.¹² There is also a wider duty to avoid harming other people, even if we do not have a professional duty to create benefits for them.

Table 23.2

<i>Beneficence/non-maleficence depends upon:</i>
Concern for the welfare of the patient/contact/client/community
Respect for dignity and privacy
Respect for autonomy
Professional competence
A safe environment
Disclosure of unsafe practice
Evidence-based practice, informed by research findings and local audits
Adherence to agreed protocols
Clinical and counselling supervision
Effective liaison with other members of the care team
Awareness of services that may be helpful to patients

Ethical dilemmas in relation to beneficence/non-maleficence
 Difficulties regarding beneficence/non-maleficence arises when:

- **Doing the most good and/or least harm for a patient requires their autonomy to be violated**

Sometimes health care workers believe they are better able to decide what is in the patient's interests than the patient. Such views are paternalistic.

Paternalism involves denying a person autonomous control in order to protect them from harm. In health care this may take the form of giving only selective information, or overriding stated wishes, or doing things for the patient that they ought to do for themselves.

The implication behind paternalism in the context of health care is that ultimate responsibility for the patient's health rests with the professional rather than the patient. Paternalism is problematic because it violates one fundamental principle of health care – autonomy – to fulfil another – beneficence.

The justification for paternalistic acts is that they serve the best interests of the person by protecting them from harms that are more damaging than the temporary loss of autonomy. The danger of paternalism is that it may erode a sense of personal control and responsibility for health. This may discourage health-seeking behaviour in future and/or diminish a person's ability to avoid risk. The damage to the person is compounded by the subtle loss of status that accompanies loss of autonomy.

However the capacity to act autonomously and take due care of physical health can be compromised by many factors, including addiction, sickness, depression, distress, limited understanding or a chaotic lifestyle. In such circumstances the patient may not be able to fully protect him or herself, and require assistance.

Consider the following example of a 16-year-old girl with untreated chlamydia: she has been informed that she needs medication; that her abdominal pains could be the result of her infection, and that failure to get treatment as soon as possible may result in more serious illness, or infertility. She promises to attend the next day, but fails to do so. Should the health adviser keep contacting her until she finally attends, or should the girl be left to take responsibility for herself, given that she has been fully informed? Is it harassment, a violation of autonomy, to keep pursuing her? Or is it more injurious to her autonomy in the long run to abandon her to the risk of infertility, which will restrict her life choices in the future?

- **Bringing benefits to some might harm others**

There is often a conflict of interests between parties in partner notification. A typical scenario might involve an HIV positive patient who is reluctant to inform a partner of his status because he fears the relationship may break down; there is reason to believe the partner, whose identity is known, is at ongoing risk.

If the partner were to be informed of his risk by the clinic (against the patient's wishes) he could protect himself from future exposure, or gain access to medication if already infected. The patient, on the other hand, may suffer as a result of damaged relationships with the partner and the clinic.

- **The balance of benefits and harms is difficult to estimate**

Many actions result in a ripple of far reaching consequences. The variety of short and long term benefits and harms for all interested parties can be difficult to calculate. Research findings may provide clues (this is the main rationale for research) but there may be a lack

of research in a particular area, or findings from one study in one time and place may not be transferable. In the absence of reliable guidance, a crude calculation of harms and benefits has to be attempted.

Consider the question of whether antibiotics should be delivered to the home of a sex worker who has failed to return for treatment for gonorrhoea, despite having been informed. There is reason to suspect that she sometimes has unprotected sex with clients. In the short term the consequences would be favourable: the risks of complications and onward transmission could be halted. In the long term the net benefits might not be so clear: the woman may be discouraged from taking responsibility for her own health in future; she might expect that treatment will be brought to her on all future occasions, putting a strain on resources, and leading to delayed treatment if staff cannot be released; other sex workers may expect the same service, or feel unfairly treated if they do not get it.

J U S T I C E

Justice, in this context, means fairness. The difficulty of treating everyone fairly rests on the paradox that individuals are at once equal and unequal. On the one hand, all people have equal fundamental value as human beings, and are entitled to be treated with the same degree of consideration and respect. On the other hand there are many inequalities that put some individuals at an unfair disadvantage. Sexual health can be adversely affected by many factors, including young age, female gender, social deprivation, black ethnicity and ^{13 14} homosexuality.¹⁵ In view of these inequalities, “people can be treated unjustly if they are treated equally”.¹⁶ Being fair may mean attempting to make individuals more equal, by favouring the disadvantaged. For this reason, justice requires us to “treat equals equally and unequals unequally”.¹⁷

The three concepts of justice below¹⁸ all influence the ways in which people gain access to GUM services.

- **Justice as ‘to each according to his rights’**

All service users share basic rights that ensure the same minimal standard of care for everyone. The open access ethos of GUM services rests on the principle that all individuals have an equal right to request a sexual health check. There is no obligation to demonstrate need: a person does not have to be symptomatic, or to be a known contact of infection, in order to book an appointment. Other rights include the right to be seen within half an hour of the appointment time¹⁹ the right to free treatment and the right to confidentiality.²⁰

- **Justice as ‘to each according to his need’**

This concept of fairness aims to redress existing inequalities. It usually underpins the allocation of health care resources.²¹ An example in GUM is the triage system, whereby patients in need of urgent medical attention can be seen without delay. Others may be given preferential access if they are disadvantaged by the appointment system because, for example, they cannot predict when discreet absence from home, work or school will be possible.

- **Justice as ‘to each according to what he deserves’**

The idea that health care might be allocated as a reward for good behaviour, or compensation for an injury, does not immediately appear fair at all. However, there are occasions when patients may be given preferential access to the service for this reason.

Take the example of a young gay man who calls in without an appointment because he happens to be passing and his hepatitis B vaccine is due. He does not have a need or a right to be seen urgently. However, this man was extremely co-operative with partner notification a couple of months earlier, when he presented with primary syphilis. He went to a great deal of trouble to track down casual partners, and to bring identifying details for the health adviser to locate others. He also used his influence with local gay saunas to allow health promotion materials to be displayed. There is a sense in which this man deserves a reciprocal favour as a reward for all his help, which may have averted a local outbreak of syphilis.

Table 23.3

Justice depends upon:
Adherence to agreed protocols
Equal respect for persons, with consideration for the balance of benefits and harms for all affected individuals
Equal access for equal need
Non-discrimination on the grounds of personal characteristics that do not relate to need, such as age, ethnicity, class, status, sexuality, values, beliefs
Respect for rights (human, contractual, legal)
Priority access given on the basis of need
Targeting prioritised on the basis of need
Information given on the basis of need

Ethical dilemmas in relation to justice
Difficulties arise in relation to justice when:

- **There is conflict between competing claims for justice**
The finite nature of health care resources inevitably leads to competition between interested parties: the rights or needs of one individual, or group, may be met at the expense of others. Special arrangements may be made to give more equal access to those who may otherwise be deterred from using the service. Examples include restricted access sessions that are only available to certain groups, such as teenagers, or sex workers, or gay men. Similarly, there may be fast-tracking arrangements for certain patients. The difficulty here is that others may have their access restricted, or waiting times increased, as a result.
- **There is conflict between the principle of justice and other principles of health care**
The concepts of justice considered here are protective of the individual, rather than the community.²² Health advisers have a professional duty to protect the sexual health of the community as well as of individuals: they would therefore need to consider justice in the context of other principles, such as beneficence.

Consider the ethics of a pilot scheme that offered financial incentives (£10 travel expenses) to street-workers who were playing a significant role in the local transmission of

gonorrhoea, but whose uptake of clinic services was poor due to the overriding demands of drug addiction that made sexual health a low priority for the women.²³ Objections to the policy might be that it is unjust to offer financial rewards to some patients and not others. It may also have violated the women's autonomy by exploiting their desperate need for money. Furthermore, it might be seen to support, or collude with, illegal drug use by financing the purchase of heroin. On the other hand, the initiative resulted in sexual health benefits for the women and the community. Previously undiagnosed sexually transmitted infections (STIs) were treated in 5/27 (19%), preventing further complications or onward transmission.

CONFIDENTIALITY

Confidentiality is central to all the above principles of health care. Moreover, it is of fundamental ethical importance to sexual health services because of the particularly private nature of sexual behaviour, the stigma that accompanies sexual disease, and the damage to relationships if infidelities are exposed. Without a promise of confidentiality, people may be less likely to seek treatment for infections, or co-operate with partner notification. The sexual health of the community would suffer as a result.

Table 23.4

<i>Management of confidentiality requires:</i>
Protection of patient privacy within the clinical area. Discussions or examinations would not be overheard or observed by anyone who is not involved in the delivery of care, unless the patient has given prior consent
Protection of patient records (paper or electronic). These would only be available to staff involved in the delivery of care. They would be stored in locked cabinets when the clinic is closed
Protection of the identity of service users. Appointment lists would not be visible to other service users. Enquirers would not be told whether an individual has an appointment, or is attending
Protection of data or photographs capable of identifying an individual patient. These would not be used for teaching, research, epidemiological surveillance or publications, without consent
Protection of patient information. Details of a named patient's sexual history, diagnosis or care would not be shared with a third party outside the care team unless requested by the patient, or required by law
Patients to understand the limits to confidentiality
Negotiation of an acceptable means of contacting each patient, should the need arise
Discretion when encountering a third party in the process of partner notification or patient recall

Ethical dilemmas in relation to confidentiality
 Difficulties arise in relation to confidentiality when:

- **Confidentiality is against the patient's interests**

Breaches of confidentiality might be justified if this is necessary in order to protect a patient from harm. For example, if a patient with an untreated STI fails to return for treatment and cannot be located, it may be appropriate to inform the GP, who might see the patient in future and give the antibiotics. This would only be justified if the benefits of receiving treatment outweighed the potential harms incurred, such as the perceived damage to the GP/patient relationship.

- **Patient confidentiality is harmful to others**

Health advisers sometimes have to choose between protecting a patient's confidentiality and protecting others from harm. An acute dilemma of this kind might involve an HIV positive patient who does not intend to inform his regular partner of his diagnosis, but who continues to have unprotected sex with that partner.

Arguments for warning the partner might be that she has a right to know so she can protect herself, and that the health adviser has a professional duty to prevent the transmission of infection, where possible. An alternative view might be it is ultimately the duty of the patient, not the health adviser, to inform the partner.

Breaching confidentiality could be very damaging to the patient, who may lose his relationship with the partner as a consequence. He could also find it hard to access health services in the future if trust has been destroyed. The duty of care to a patient makes it very difficult to take a course of action that inflicts harm. Some would therefore argue that the health adviser has a greater duty to protect the interests of patients than of other citizens.

There is also the consideration that breaching confidentiality may be detrimental to sexual health in the long term if infected individuals were discouraged from seeking care or giving any information about partners.

- **Confidentiality requires other moral principles to be breached**

In some situations confidentiality cannot be fully protected unless the health adviser is prepared to lie, or collude with lies told by patients. For example, a health adviser may consider posing as a friend or work colleague to allay the suspicion of a third party encountered during provider referral.

The justification for this lie might be that it protects the patient and honours the trust placed in the service, without appearing to harm anyone else. This overriding commitment to confidentiality may benefit the sexual health of the wider community by making services more accessible.

On the other hand it could be regarded as unprofessional to tell lies - a breach of public trust that health care workers will tell the truth. This may undermine confidence in services and jeopardise the public standing of health professionals.

<i>Guidelines for managing an ethical dilemma</i>
Identify all possible courses of action
Identify the moral principles at stake, for each action. These will include the rights of all affected individuals
Clarify your particular professional duties in the situation
Consider the potential consequences of each action, for all individuals that might be affected. This might include the patient, a contact, the community or a health care worker
Clarify any facts that might influence the decision
Discuss with other health advisers. Ensure you have the professional support of at least one other health adviser before committing to a course of action
Discuss with other members of the multidisciplinary team. Seek a consensus of support for any action
Work within all relevant codes of professional conduct. An individual health adviser may be bound by the Nursing and Midwifery Council Code of Professional Conduct for Nurses, or the British Association for Counselling and Psychotherapy Ethical Framework for Good Practice in Counselling and Psychotherapy, in addition to the Code of Professional Conduct for Sexual Health Advisers (See Ch. 24)
Avoid actions that breach the law. Seek a legal opinion if you, or the law, are not clear. Legal advice may be available from the trust solicitor. Alternatively, a medical colleague may approach the Medical Defence Union, or the Medical Protection Society
Document key points of the discussion, personnel involved and the decision reached in the patient's notes

C O N C L U S I O N

Health advisers face many ethical dilemmas in the course of their work. The principles of *autonomy*, *beneficence*, *non-maleficence*, *justice* and *confidentiality* can guide reasoned moral choices. It is good practice to discuss ethical difficulties with colleagues, and to document such discussions.

Further examples of ethical issues are discussed elsewhere in the manual:

- Ethical issues in partner notification, Ch. 5
- Ethical issues in pre and post-test discussion, Ch. 15
- Ethical issues in patient recall, Ch. 10
- Ethical issues in outreach work, Ch. 28
- Ethical issues in health promotion Ch. 30

- Ethical issues in triage, Ch. 12

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Code of professional conduct

THE SOCIETY OF SEXUAL HEALTH ADVISERS

The purpose of the *Code of Professional Conduct for Sexual Health Advisers* is to clarify the professional and ethical standards of conduct required of sexual health advisers.

1. THE ROLE OF THE SEXUAL HEALTH ADVISER

There are three core aspects to the role:

- 1.1 To ensure, wherever possible that contacts of sexually transmitted infections (STIs), including HIV, are offered medical services through partner notification.
- 1.2 To reduce the transmission of STIs, including HIV, through health promotion initiatives.
- 1.3 To support individuals affected by STIs, including HIV.

2. SEXUAL HEALTH ADVISERS HAVE A DUTY TO:

- 2.1 Safeguard and promote the well-being of individual patients/clients.
- 2.2 Safeguard and promote the sexual health of the wider community.
- 2.3 Serve the interests of society.
- 2.4 Justify public trust and confidence.
- 2.5 Uphold and enhance the reputation of the profession.
- 2.6 Adhere to the law.

To achieve these aims, sexual health advisers will:

3. RESPECT THE INDIVIDUALITY OF PATIENTS/CLIENTS

- 3.1 Sexual health advisers will safeguard and promote the interests of all patients and clients irrespective of age, gender, ethnicity, sexuality, ability, lifestyle, socio-economic status, culture, religion, values and beliefs.
- 3.2 Sexual health advisers will ensure:
 - 3.2.1 Interventions are tailored to meet the needs of the individual.
 - 3.2.2 Communications are as clear and effective as possible.
 - 3.2.3 Personal beliefs and values that may adversely affect the quality of care are addressed in supervision.

4. RESPECT THE AUTONOMY OF PATIENTS/CLIENTS

- 4.1 Individuals have the right to be informed and make choices about their health and care. Sexual health advisers will ensure:
 - 4.1.2 Patients are offered as much information as they may require about their current health, treatments, choices, prognosis and services available.
 - 4.1.3 Information given is accurate, truthful and clear.
 - 4.1.4 Valid consent is obtained for all procedures or communications that carry a risk for the patient.
 - 4.1.5 Valid consent would be:
 - Informed
 - Freely given
 - Given by a legally competent person, capable of sufficient understanding to make an informed choice.
 - 4.1.6 If valid consent cannot be obtained, the multidisciplinary team will decide how to serve the patient's best interests. This may involve wider consultation with the patient's significant others and/or professional bodies.
 - 4.1.7 If a legally competent person refuses consent, this will be respected, unless a third party is thereby placed at avoidable risk of significant harm. Such situations will be discussed with the multidisciplinary team.

5 . P R O T E C T C O N F I D E N T I A L I T Y

- 5.1 Information obtained in a professional capacity will not be disclosed beyond the multidisciplinary care team except:
 - 5.1.1 To another medical practitioner or person working under the direction of a medical practitioner for the purposes of treatment and/or prevention of an STI. (VD Regulations 1974).
 - 5.1.2 With valid consent.
 - 5.1.3 By law or court order.
 - 5.1.4 To protect the individual, or another, from the risk of significant harm.
- 5.2 Sexual health advisers will take all reasonable steps to ensure that:
 - 5.2.1 Individuals are aware of the limits of confidentiality.
 - 5.2.3 Personal information is protected from unauthorised access.
 - 5.2.4 Consent for disclosures is always sought.
 - 5.2.5 Disclosures are limited to the amount of information that is necessary to achieve the legitimate purpose.

6 . E N S U R E F I T N E S S T O P R A C T I S E

- 6.1 Sexual health advisers will:
 - 6.1.1 Ensure they have the knowledge and skills to perform all aspects of the role safely and effectively, based upon current evidence.
 - 6.1.2 Demonstrate commitment to ongoing professional development.
 - 6.1.3 Adhere to professional guidelines from The Society for Sexual Health Advisers.
 - 6.1.4 Be guided by all relevant government directives.
 - 6.1.5 Work within the limits of their professional ability. Where the practitioner lacks confidence, experience or appropriate training, the support and guidance of competent colleagues will be sought. The direct line manager will be informed of the need for additional training or support.
 - 6.1.6 Seek regular managerial and clinical supervision.
 - 6.1.7 Ensure their workload is manageable. The direct line manager will be informed if an excessive workload jeopardises professional standards or places an unreasonable strain on practitioners.

- 6.1.8 Ensure they are physically, psychologically and emotionally able to undertake duties without risking harm to themselves or patients/clients/contacts. Concerns will be brought to the attention of the direct line manager.

7. WORK CONSTRUCTIVELY WITH OTHER MEMBERS OF THE CARE TEAM

- 7.1. Sexual health advisers will:
 - 7.1.2 Recognise, respect and support the contribution of others to the care of the patient. This may include medical and nursing colleagues, social workers, psychologists, counsellors, physiotherapists, occupational therapists, dieticians, pharmacists, youth workers and voluntary agencies, as well as partners, relatives and friends.
 - 7.1.3 Ensure the patient is offered access to any professional or non-statutory services that may be beneficial.
 - 7.1.4 Endeavour to communicate effectively with those involved in the patient's care. Information that allows others to do their best for the patient will be shared promptly, subject to patient consent. Sexual health advisers will take all reasonable steps to ensure that they, or a delegated colleague, can be contacted for case discussion. A record of care given and discussions with other carers will be recorded promptly in the case notes.
 - 7.1.5 Support the professional development of colleagues by sharing knowledge and skills appropriately.
 - 7.1.6 Ensure other carers understand the role of the sexual health adviser.
 - 7.1.7 Work within their specified role.

8. PROTECT PATIENTS/CLIENTS/CONTACTS FROM HARM

- 8.1 In addition to the above measures, sexual health advisers will:
 - 8.1.2 Remove or report hazards in the physical environment.
 - 8.1.3 Protect patient dignity and privacy.
 - 8.1.4 Report concerns that a colleague may be unfit to practise, due to incompetence, poor health, or inappropriate behaviour.
 - 8.1.5 Advocate on behalf of patients, clients, contacts and the wider community to ensure that all have fair access to care.
 - 8.1.6 Establish clear professional boundaries with patients or clients to minimise the risk of abuse or exploitation. All aspects of the relationship should focus exclusively on the needs of the patient or client, and must not be detrimental to

their welfare in any way. Embarking upon a sexual relationship with a patient is forbidden.

- 8.1.7 Refuse offers of gifts, favours or hospitality that may be perceived as an attempt to secure preferential treatment or build an inappropriate relationship.
- 8.1.8 Never ask for, or accept, a loan from patients, clients or their associates.
- 8.1.9 Document sign and date all aspects of care in the patient record.
- 8.1.10 Take all reasonable steps to ensure that the patient has access to alternative support at times when the sexual health adviser is not available.
- 8.1.11 Declare any interests or conscientious objections that may prejudice advice or treatment.

Leading a team of sexual health advisers

DORINDA THIRLBY

A forward planning team can greatly benefit from using specific evaluative tools to make strategic advances. These are presented.

If the core roles of the health adviser are to be strengthened then good relationships are needed with the wider clinic team members.

Annual formal individual performance appraisals can be viewed negatively by some staff. They can however, along with more regular management supervision, enhance the contribution an individual makes to team objectives as well as promote professional development.

INTRODUCTION

Management courses are often available to managers in the NHS by NHS Trust training departments, for example on performance review and on leadership styles, which would complement this chapter. Management is concerned with looking beyond oneself and "exercising formal authority over the activities and performance of other people" ¹

Many health advisers may be managed by a senior health adviser who has health advising experience themselves. Others in smaller teams may be managed by a senior nurse/ matron or an operational manager, but all need to be managed so as to have direction in their work and role. This chapter will look at managing a health adviser team through business planning and setting objectives for the team, and how these are translated into individual performance reviews. This links in with Trusts' clinical governance frameworks, to ensure competence in practice.

It is often difficult for health advisers in a team to see beyond being 'on call' or 'covering' the clinical work, and at the mention of business planning many will fear being given additional work to do. The manager's role will encompass influencing the morale of the team, and the individuals' motivation, job satisfaction and performance. It is important to take into account

the expectation of colleagues such as consultants, nurses and managers within the GUM /HIV setting and keep them informed of the work being planned by the team.

Many of the systems within the NHS and GUM are based on historical systems, which have developed alongside the speciality. Business management is about forward planning, it is important to look at the health adviser role, and look at whether there is a need to change and how the role may be best developed. There needs to be some foresight of change in the role the profession and responsiveness to change. It is important to take stock of how the team is working, day-to-day and look at whether change (within financial constraints) can be made.

When looking at the development or planning for the team it is also important to review the need for change in the core prescribed roles as well as looking at both the internal and external pressures on the team and their role.

This chapter will look at:

- Considering the core roles of the health adviser team
- Predicting what a team may need to consider in the next five years by identifying potential pressures on a health adviser team through the uses of a Political, Economic, Social-cultural and Technological changes tool (PEST)
- Developing a team “Strengths, Weaknesses, Opportunities and Threats” (SWOT) analysis to enable the team to come up with team objectives for the next 5 years and for the next year
- Delegating the objectives to an individual health adviser
- Individual performance reviews/ plans
- Guidance for management supervision including reviewing the health adviser’s objectives

CORE ROLES OF THE HEALTH ADVISER TEAM

Prior to setting aims or objectives it is important for the senior health adviser/ manager to look internally at the needs of the team and define the health adviser team goals or 'core' roles of the team. These are the areas of work where the team are clinical experts, and therefore can lead local discussions and developments: in the clinic / hospital/ community / nationally.

The following headings show the possibilities for the team and serve as a checklist, although this will vary from service to service. The senior health adviser/ manager will influence in which direction the team works and it is therefore important to ask what a progressive health adviser team needs to be undertaking/ developing.

These suggestions are examples, and are therefore not exhaustive but may be used to focus on the team’s issues:

a) Leading partner notification. It is recommended all health adviser teams take a clinic and local lead in developing partner notification:

in the team - consider:

- Looking at the recommendations standards from this manual
- What could the team be doing to improve partner notification?

in the clinic - consider:

- What facilitates partner notification
- Do the receptionists need training? For example what to do with a contact slip, how are they attached to the notes? how are the notes then cross referenced?
- What would facilitate the health adviser's role?

out of the clinic - consider:

- How can partner notification be facilitated for contacts of STIs? For example women with PID in the gynaecology department?
- How can the team facilitate partner notification in primary care settings? Will this require more staffing?
- Funding issues. What low cost suggestions are there? For example phone advice for patients with an STI

b) Lead HIV testing. It is recommended all health adviser teams take a clinic and local lead in HIV testing:

in the team - consider:

- How does the on call system work? Could it be improved?
- What is good documentation?

in the clinic-consider:

- How does HIV testing get offered in the clinic?
- Who gets referred to the health adviser? Is there a protocol?
- How does the team measure uptake?
- Could uptake and testing access be standardised?
- What training/ facilitation is required?
- Do clinical notes prompts need to be updated?

out of the clinic - consider:

- What testing is happening in the rest of the hospital and the community?
- Is there a clear guidance or evidence based protocol?

- Is there a training need?

c) Lead sexual health promotion. It is recommended all health adviser teams take a clinic and local lead in sexual health promotion undertaken:

in the team - consider:

- How are people referred for work re risk reduction?
- What models of working do the health advisers each use?
- Are there experts in the team for internal referral or informal supervision?
- How can documentation be improved in the clinic notes?

in the clinic - consider:

- What clinic resources are there?
- The team needs to be taking a lead in the health promotion being undertaken in the clinic, for example does the team take an active role in assessing relevant leaflets for patients attending the clinic?
- Could sexual health promotion discussions be improved?
- Is there a need for a multidisciplinary team meeting on health promotion messages/ resources being used in the clinic? For example access to condoms and information about correct usage

out of the clinic – consider:

- Health adviser involvement in the local sexual health strategy and teenage pregnancy planning meetings
- Look at the possibility of developing the MSSVD STIF courses for local GPs/ practitioners.

d) Manage recall / results management. It is recommended all health adviser teams take a clinic and local lead in the management of infection recall.

in the team - consider:

- Does the recall protocol need to be improved and are there any gaps?
- Are there fail-safe systems in place and is this audited?
- How can documentation be improved in the clinic notes?

in the clinic - consider:

- Are the rest of the clinic aware of the protocols and are they circulated?

- Could an audit be undertaken which could be presented to the clinic, giving examples of cases so that people understand the complexities of recall?

out of the clinic - consider:

- What sexually transmitted infection recall is happening in the hospital and community?
- Is there a clear guidance or evidence based protocol?
- Is there a training need?

e) Counselling and access to other psychological services. It is recommended all health adviser teams take a lead in counselling undertaken in the clinic.

in the team - consider:

- What is the skill mix of the team?
- What counselling training do health advisers have?
- Is counselling supervision in place?
- What appropriate counselling work could be undertaken by the team?
- Could this be expanded/ or cut back?
- How are people referred for counselling?
- What models of working do the health advisers each use?
- Are there experts in the team for internal referral or informal supervision?
- How can documentation be improved in the clinic notes?
- What is the health adviser's role with patient advocacy?
- Do they take a lead in representing the patient's needs?
- Health advisers have an important role in maintaining patient perspective in decisions about clinic protocols and practice, for example maintaining access, improving waiting times, assessment and fast tracking 'at risk' patients
- Helping to ensure that there is a system for patients to make comments about the service (positive and negative)

in the clinic - consider

- Are there ways to make the professional counselling work of the team more visible to the rest of the clinic? For example documentation or presenting cases/ models at the clinic meetings.
- Would it be a good idea to write a protocol? For example for urgent assessments

- Who can the team refer onto? is this explicit to the team?

f) Teaching. It is recommended all health adviser teams take a clinic and local lead in teaching.

in the clinic - consider:

- What are the team be doing in terms of teaching?
- Are the health advisers involved in the teaching programmes?

out of the clinic - consider:

- Medical/ nursing schools, schools teaching?

g) Visibility of the role. It is recommended that health advisers consider the visibility of their role.

in the team - consider:

- Is the role visible or explicit and does work need to be done to make it more explicit?
- Is the role understood- i.e. why people are referred?
- Is it clear who is on call?
- Are they in the clinical area?
- The importance of documentation, does documentation need to be improved?
- Is the team's documentation standardised or consistent?
- Is it clear from the documentation what the patient gained from seeing a health adviser?
- Does documentation facilitate additional work? For example when seen again by another health adviser, or referred onto a psychologist who sees the patient for a similar issue.

in the clinic - consider:

- Is the role understood? i.e. why people are referred?
- Nurses/ doctors sit in to understand the role better?
- Are there clear referral protocols?
- Is there representation at the relevant departmental meetings?
- Can the team be more accessible without compromising quality?

- Look at how the team's activity is recorded and how the work is measured. Many GUM software systems have simply inserted look up trees where the team can record the work and time taken. For example see appendix 1

h) Audit/ Clinical governance. The team needs to ensure that the health advisers' work is evaluated and that national standards are met where they apply.

in the team - consider:

- What audits need to be undertaken?
- Representation at clinical governance meetings
- Development of the appropriate protocols

POLITICAL, ECONOMIC, SOCIAL-CULTURAL AND TECHNOLOGICAL (PEST)

A team of health advisers do not work in isolation, and the role is influenced by a number of external pressures. It is therefore useful to consider with the team what the clinic, trust, local, regional and national pressures are by brainstorming the political, economic, social-cultural and technological influences. A P.E.S.T. analysis helps the team to look externally and examine future opportunities and challenges to try to predict potential changes that could impact on the role.²

Ideally the manager needs to undertake the PEST exercise with the health adviser team as a warm up to doing the objectives planning. If time is limited then the senior/ manager may undertake the exercise and circulate their thoughts for comment. It may be undertaken with a flip chart. Set an hour aside with the team (or as many as can be there- missing team members can be circulated with a copy to add their thoughts, so that they are included in the team process.) Looking at these areas will help the manager and team think conceptually.

Simply using individual flip charts or headings on a computer projector ask the team the following questions about potential changes (These suggestions are examples, and are therefore not exhaustive but may be used to focus on the team's issues)

The political future. There needs to be team foresight into possible political influences on the organisation and team. It may help to focus on:

- What is happening nationally For example change of government, proposed closure or development of the service- how will this impact on the health adviser service? Will the team be expected to work differently?
- Any new legislation proposed which may have an impact on the health adviser service?
- Local- how the sexual health strategy will be developed locally- who will take the lead: the PCT, family planning, GUM or health advisers. What will health advisers be expected to do? For example involvement in partner notification for chlamydia in primary care.

- What about clinic politics (negative or positive)?- and look at the impact on the team?

The economic future. Explore what may be about to change (negative and positive) in the next few years which may affect the team. NHS funding is often undergoing change, and HIV/ GUM funding has undergone significant changes in the past few years, how could this affect the role:

- Changes to funding formulae. For example what is the current belief on the HIV / GUM funding For example what are plans locally re HIV prevention monies? How is the team funded? Will there be changes in funding as a result of sexual health strategy/ teenage pregnancy initiatives?
- What is happening with local PCT funding, what are the financial links with GUM?
- It is important to know how the Trust is planning to achieve its cost pressures (or spend its underspend). The senior needs to be aware of the meetings/ forums where finance is discussed so that the health advisers are represented
- Are there local investment or development plans that are relevant?
- Are there any development monies that could be bid for?
- What budget lines do the health advisers oversee? Could there be any change to these?

The social-cultural future. It is important to focus on social or cultural changes and what the implications there are for the health adviser team:

- Are different cultural groups beginning to access the service? How does the health adviser need to respond to this change in the service For example to facilitate access to care and treatment for 'at risk groups'?
- Implications of changes in lifestyle identified in reports, that may affect the way the team works
- How to manage an increasing workload of patients and how to prioritise the workload
- What are the health and education needs of the attendees?

The technological future. There needs to be foresight into possible technological changes on the organisation and team. It may help to focus on:

- What will the impact of new screening tests be? For example, changing to more sensitive chlamydia screening tests so that more patients with chlamydia are diagnosed. How will the clinic cope with the increase in work and referrals or requests for advice from the community?
- How will information technology (IT) impact on the clinic and the team? It is important to meet with the IT department who will be able to give insight into proposed developments to the system, and what it will be possible to develop, for

example using computers for all recall management, letter generation or for managing partner notification

- Possible research findings and impact, for example moving to regular resistance assays

The P.E.S.T analysis helps the health adviser/ manager (and the team) think about the future and look at potential changes and formulate a picture of what the team needs to be working on.

STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS

Using a team “Strengths, Weaknesses, Opportunities and Threats” brainstorming exercise to enable the team to come up with team objectives for the next year/ 5 years.

The SWOT is a tool to help the team and manager focus on the strengths, weaknesses, opportunities and threats for the team which informs the strategic change³, or what the team are planning to do in the next one to five years. The senior s be mindful of the team’s core roles (partner notification, HIV testing, health promotion, counselling, recall/ results management, teaching, MDT team work) and introduce them as prompts under each of the SWOT headings. The senior must be mindful not to censor people’s responses and write all of the suggestions down. Let the team think laterally, and say what they think. The senior can also introduce their ideas (without it meaning that everyone has to do what the senior thinks). The SWOT does not need to be circulated beyond the team, only the final objectives.

Again this exercise can be done in an hour (but may be better in two). If time is limited to an hour, circulate the PEST to get the team in the mood again. Then divide the time to 10 minutes on each SWOT, 10 minutes on 5 year plan, 10 minutes on what the team needs to do this year, and then open up the discussion for ten minutes on who might lead on each of the objectives.

Using individual flip charts or headings on a computer projector ask the team the following questions.

Strengths:

- What are the team’s distinct strengths, attributes or competencies?
- ‘What does the health adviser team do well?’
- ‘What are the health advisers respected for in the clinic? And in the community?’
- ‘What would fall apart if the health advisers were not here?’
- ‘What does nobody else do as well as health advisers? (in the clinic and out of the clinic)’
- Consider the strengths in partner notification, HIV testing, health promotion, counselling, recall/ results management, teaching, MDT team work.

Weaknesses:

- This is looking at the negative aspects or deficiencies of the team, including resources, image
- ‘What are the health advisers not doing? (or could improve on)?’
- ‘What are the health advisers failing at?’ for example recording activity, returning contact slips
- Consider weaknesses in partner notification, HIV testing, health promotion, counselling, recall/ results management, teaching, MDT team work

Opportunities:

- What is favourable for the team?
- ‘What would the team love to do given the time and money?’
- ‘What could the team be doing much better?’ For example triage, outreach and schools work’
- Consider the opportunities in partner notification, HIV testing, health promotion, counselling, recall/ results management, teaching, MDT team work

Threats:

- This is the opposite of opportunities; it is unfavourable situations which may arise from environmental conditions.
- ‘Who might take a part of the role on?’
- ‘Is there an individual who is seen as a threat?’
- Consider the threats in partner notification, HIV testing, health promotion, counselling, recall/ results management, teaching, MDT team work

A 5-year plan. At the end of this exercise another sheet of paper can be used entitled ‘a 5 year plan’ and the team asked to brainstorm the next 5 years. Introduce the brainstorming session as ‘What would the team ideally like to do in the next five years?’

List the core team roles and brainstorm what the team’s aims are, making sure partner notification, HIV testing, health promotion, counselling, recall/ results management, teaching, MDT team work are all covered.

Questions such as ‘What could the team improve on in each of these areas in the next five years?’ and ‘What does the team need to improve on?’

The next year? It is important to focus the 5 year work plan into what could ideally be achieved in this coming year. Using the 5 year list ask the team to come up with the ten (5-20 dependant on the size of the tasks and the size of the team) things the team need to do.

Setting objectives. Objectives are about what the team is striving to accomplish. Once the goals are identified, this gives a focus for the team. The objectives are best written after writing the PEST and considering the team's core roles.

The objectives: ⁴

- Standardise the performance of the health advisers
- A structure for producing the teams goals for planning and management control
- Allows the team to move forward with their visions
- Gives guidance for decision making (and a defence against criticism)
- Documents a clear focus for purposeful behaviour (in work that can be a bit 'jack of all trades- where the team can define what the trade is)
- May influence the structure and the working of the team
- Provide a motivation and reward
- Show what the team is really trying to provide (makes the work explicit)

It is the senior's/ manager's responsibility to clarify the goals especially where there are conflicting view points. The manager needs to integrate the organisational or team goals with personal goals of the individual health adviser.

- As a senior health adviser/ manager it is important to look at the following expectations:
- What does the senior wish the team to achieve?
- What does the organisation want the team to achieve?
- The PEST may raise most of these issues, but it is important to know what the consultants, doctors, nurses and managers want from the team
- What does each individual health adviser want to do?
- What courses are health advisers going to do, and how does their learning fit into the role?
- What are the core roles of the team?
- Are the objectives SMART enough?

SMART is about making sure that the objectives are achievable. Are they:

- **Specific?** Are they quantifiable and testable? Is it possible to measure whether the objective has been achieved?
- **Manageable?** Are they genuinely within the health adviser's control or influence?

- **Attainable?** Are they realistic about the scale of what can be achieved? Is it within their remit to do the objective or does it rely on others?
- **Resourced?** Is it possible within manpower and financial constraints?
- **Time-bounded?** When do they have to be done by? Is it achievable in the year?

DELEGATING THE OBJECTIVES

This can be discussed in the meeting and staff may offer to work on an objective they are interested in. These discussions can also continue out of the meeting.

The objectives need to be delegated to all members of the team including the senior. It is also important for the manager to look at what support/ training needs/ appropriate supervision and support will need to be given to the health adviser so that they can do their task.

It is important to:

- Write up the exercise promptly and circulate to the team (see example fig.1)
- Identify who will be doing each objective and agree this with the individuals concerned
- It may be appropriate to discuss the SWOT with the clinic manager/ the senior health adviser's manager. This will help inform the manager of the teams plans for development and may improve the visibility around the health adviser's role. It may be a good way of selling the potential of the team, their good ideas, and it helps managers understand what the team is trying to achieve. There may need to be some censorship if there are people named in the SWOT
- Produce the list of 5-year objectives. 1-year objectives (priorities) and who is doing what within a few days. (Check that they are SMART enough-see below) see (example 1)
- The objectives need to be discussed with other senior members of the clinical team so there is cohesion for the clinic's overall objectives and strategic direction

Obstacles to achieving the objectives. Objective setting needs to be an annual process so it is important that the senior health adviser/ manager looks at ways that the process could be sabotaged by the team or themselves:

- **Sabotage:** Individuals may try to sabotage the process. It is important to think about what's going on in the team. Consider speaking to anyone who is likely to sabotage the process to minimise any possible disruption
- **Negativity:** It is important that the senior leads this process, is not too negative, is enthusiastic and thinks about how the session will be run. This process is about developing the team year upon year. It is a continually evolving process
- **Time:** It is important the team have protected time. Give plenty of warning of when the SWOT will be, expect all of the team to attend and make this explicit to them, for

example they need to be there unless there is a personal disaster/ ill health so no double booking. Lay the boundaries down. The meeting has to start on time and the senior makes sure that the health advisers are reminded

- Creativity: It is important to think laterally. It is important that the senior/ manager avoids being dictatorial and motivates the team to develop their ideas

Table 25.1

Example of an agreed team objectives: (based on 1 Fulltime HA (HA1) and 2 part time: HA2/3)		
<u>Annual HA team objectives & who to take lead</u>		
<u>HIV</u>	Adherence work/ HA assessment audit:	HA1
	PN	SHA
<u>PN</u>	HIV PN*	SHA
	GC/CT PN	HA1
	Telephone HA	SHA
<u>Counselling</u>		
	Review and develop protocols:	Team
	HA counselling/ referral/ assessment	Team
	Protocols	
	women sex dysfunction	HA2
	Triage	HA1
	Hep C	SHA
	Counselling/ referral	HA2
	Condom	SHA
	Telephone HA	SHA
	Web protocol	Team
	Rape/sexual assault	HA2
	?counselling leaflet	Team
<u>Sexual Health promotion/HIV prevention</u>		
Who will take the lead/ represent:		
	Young people	HA3
	Gay men	SHA
	African	SHA
	Sex workers	HA2
	IVDU	SHA
	Boards/ leaflets	HA1/3
	Library (web protocol)	HA1
<u>Promoting HA role</u>		
Audit	HSV audit	HA3
	PN audit	HA1
	Counselling audit	HA2
	↑Community links +PN (C4a)	Team

INDIVIDUAL PERFORMANCE REVIEWS/ PLANS

From the team objectives- it is important to look at who is best suited to lead on an objective, based on the particular skills of the health adviser, what the individual health adviser wants to do, and what is best for the team and the service.

Most NHS Trusts will have guidance on performance review. Most managers will be expected to attend a study day on performance reviews and there are often corporate forms to be used and interview assessment tools.

Often performance reviews are viewed negatively by staff and may even be seen as a threat. It is important to address people's concerns about their purpose, and should be much more about keeping track of someone's performance, and can be used to celebrate the health adviser's success/ hard work.

The person's individual objectives are used as a focus of the individual's work performance. It is the Senior health advisers task to annually set them carefully making sure they are SMART and to review them through the year in supervision to detect problems. For example with lack of time or support, early on rather than discovering the tasks have never been started (see management supervision session). Once the individual performance plan has been set and agreed then it needs to be reviewed regularly as part of the health adviser's supervision.

Setting individual objectives may be facilitated by an individual appraisal (see Appendix 2, an example of a health adviser questionnaire/ interview tool).

Using the tool set out before or a Trust questionnaire, this may need slight modification so it is relevant to the role.

Some health advisers may be part of a performance related pay structure. The questionnaire is a start point, a clarification or review tool for the health adviser, which asks the health adviser what targets or objectives they would suggest for themselves (see question 11). The health adviser can be helped to make SMART objectives from their team objective. (See appendix 3, an example of a health advisers annual objectives developed from the team objectives, appendix 2)

Time needs to be set aside for the health adviser to go through the questionnaire, ideally before meeting the senior/ manager. This can be completed directly onto a computer template. If there is some resistance then meet with the individual and go through the questions with them making a note of the answers.

Meet and talk through the questions and discuss what issues they raise. Going through the questionnaire and discussing possible objectives may take 60-90 minutes. If the session goes on longer it is best to rebook the finalising of the objectives. After the session the health adviser will need time to update their questions and develop their objectives. A further meeting can be arranged to set and agree the objectives.

GUIDANCE FOR MANAGEMENT SUPERVISION

This is to include reviewing the health adviser's objectives (it is not counselling or clinical supervision)

- Find protected time/space for 60 minutes (although may only be 30-40 minutes depending on need). Do not cancel the sessions, and do not let people interrupt the session, the time needs to be respected
- It is important to meet regularly and have fixed meetings, ideally every month – to six weeks, (more often if there are performance/ support/ training issues)
- The senior/ manager needs to prepare before meeting and think about any thoughts or comments that need to be made. Review objectives prior to the meeting

- The senior/ manager needs to have the relevant leave forms/ rotas at hand to look at annual or study leave requests
- The senior/ manager needs to have the relevant paperwork, for example their objectives to hand

Checklist

- **How are things?** What does the health adviser want to say? Are there any specific problems? 'How is it all going?'. Does the senior/ manager have any concerns about the health adviser's work or performance in the team, for example lateness. If there is an issue the senior/ manager needs to give clear guidance/ boundaries on what their concern is and what is expected to change and why
- **Any concerns in the health adviser team or clinic team?** Similarly are there any concerns for the health adviser or their manager? If there are it is important to make it clear what the managers perspective is, giving guidance/ boundaries of what is acceptable and what is not. Decide on any action that needs to be taken and if so make it explicit what needs to be done by the health adviser to achieve the action
- **Discuss their patients.** Review the individual's patient workload, for example how many ongoing patients and how many sessions, whether the cases are being supervised and whether there are any management issues that the manager needs to be aware of. It is important to be clear about the differing roles and boundaries between the role of the clinical supervisor and that of the manager, for example the management session need not spend time focusing on a patient. If there are specific patient management issues, for example when the clinical supervisor has suggested that the health adviser discuss an ethical dilemma with the manager to get their viewpoint, then it is important to arrange a separate time to focus on the issue
- **Leave.** Review annual leave/ study leave and where time owing is allowed that this is reviewed and managed
- **Study leave.** Chance to raise review development. Review an individual's development portfolio
- **Reviewing annually set objectives.** Revisit and review objectives, going through each objective and look at how the work is progressing. Identify if there are any difficulties in achieving the objective. If it is not being achieved- is this reasonable- how can they get back on track. Giving clear guidance about what is expected
- **Anything else**
- **Set the next date**

A P P E N D I X 1

Measuring health adviser activity An example of the Roehampton Clinic FMI computer software look up tree, where the team can record the work and time taken, as they see the patients.

1. Interview Reason look up Maintenance
 - **HIV pre test counselling – health adviser**
 - Pre test disc – test performed
 - Pre test disc – test declined/deferred
 - Pre test disc – information only
 - **HIV post test counselling – health adviser**
 - Post test disc – negative result
 - Post test disc – equivocal result
 - Post test disc – positive result
 - **STD advice**
 - Std Advice – gonorrhoea
 - Std Advice - Hepatitis B
 - Std Advice - Hepatitis C
 - Std Advice - Herpes
 - Std Advice - NSU/chlamydia, PID
 - Std Advice - Other
 - Std Advice - Syphilis
 - Std Advice - warts
 - **Other counselling**
 - Abuse counselling
 - Bereavement counselling
 - Dealing with complaint
 - Condoms supplied / discussion
 - Contraception discussion
 - Cervical cytology & colposcopy disc
 - General counselling
 - Pregnancy
 - Top counselling
 - Psychosexual counselling
 - Rape / serious sexual assault
 - Triage of patient
 - Worried well
 - Triage RUSH/ under 16 (young persons clinic)
 - **HIV**
 - HIV positive on-going counselling
 - Introduction of HA
 - HIV one off
 - Discussion with relative/ significant other
 - **Telephone discussion**
 - Abuse
 - Contraception
 - NSU, Chlamydia & PID
 - Gonorrhoea
 - General information
 - Hepatitis B
 - Hepatitis C
 - Herpes
 - Discussion with HIV + patient
 - HIV information
 - Other telephone discussion
 - Pregnancy
 - TOP counselling
 - Rape / serious sexual assault counselling
 - General STD discussion
 - Syphilis
 - Warts & HPV
 - Cervical cytology & colposcopy

- **Liaison performed by health adviser**
 - Liaison with counsellor
 - Liaison with Dietician
 - Liaison with Other independent agency
 - Liaison with Psychiatry
 - Liaison with Psychologist
 - Liaison with HA / Sexual medicine
 - Liaison with Social worker
 - Visit to patient by health adviser
 - Ward visit by health adviser

A P P E N D I X 2

An example of a HA questionnaire/ interview tool

Name:

Date of discussion:

1. Does your job description accurately describe your main duties and responsibilities? If no, explain why? Has your job changed in the last twelve months? If so, how?
2. Which aspects of your present job give you the greatest satisfaction and why? What tasks do you feel you perform particularly well and why?
3. Did you achieve all last years objectives? Which did you find most rewarding? Most difficult? What constraints were there? (This section may not be applicable for the first review of performance)
4. What are your key job skills and areas of strength?
5. Do you feel your knowledge, abilities, and skills are being fully used in your present job? If not, why?
6. How well does your present job fit in with your immediate and longer term career plans? Have you made any plans? Should you be making plans?
7. What extra help or guidance do you feel you need to do the present job more effectively or prepare for future development?
8. Have you attended, or given any training courses this year? What did you gain from them?
9. Do you feel the need for any further training in any particular area? Think not only of your present job but what would you like to be doing over the next five years.
10. Which work-related tasks interest you the least or seem particularly difficult? Why?
11. Can you suggest any improvements in work systems, staff deployment etc, which could assist to make the service more efficient?
12. What targets or objectives would you suggest for yourself for your own development this coming year? Which ones would be most rewarding? Most difficult? What constraints may there be?
13. Do you wish to mention any other things, personal problems, anxieties or achievements to your manager?

A P P E N D I X 3

An example of a health adviser's annual objectives, a real example (taken from the team objectives) and all of the objectives were achieved

Key objectives for review period	Action required
1. Would like to manage the gonorrhoea and chlamydia PN audit work	(a) Update the PN sheet for use in RC notes (May) (b) Define what should be documented on the notes(May) (c) Define what should be documented on the computer(October) (d) Get list once a month of GC/ CT +ve results(May) (e) Give notes to relevant HA for PN review (monthly) (f) Produce summary of info on contacts (September/December/ March) (g) Review PN sheet design based on December audits findings(Jan) (h) Present to clinic at clinic meeting (Jan)
2. Update the recall policy	(a) Update old policy to include new computer codes (June) (b) Get 'X's completed work on sending out letters, visits and put in document (June) (c) Circulate policy to other HA's and get comments(July) (d) Update (July) (e) Circulate to nurse 'xx' & Drs 'xx' in clinic for their comments(August) (f) Send copy to 'x' (Senior HA in same Trust) for comments(Sept) (g) Submit for clinical governance to whole of GUM in Trust (2 clinics)(Oct)
3. To be clinic 'Patient information/ resources manager'	(a) Sort out the patient library (June) (b) Update patient information files(June) (c) Put relevant up to date literature out in the patient waiting room for HIV clinics (every two months review what is being put out) (d) Remove medical books/ magazines to specialist registrars room(June) (e) 'X' to do teaching on Publisher(July) (f) 'X' Teaching on using the scanner(August) (g) Look at producing specialist displays For example BV(September) (h) Change display boards every 6 weeks
4. Revisit the health adviser policies for clinical governance	(a) Review the health adviser policies and decide with HA team which ones we will each review For example provisionally 'x' to do B1,C4a, Triage (meeting in June) (b) Get relevant 'x' Trust (other clinic in Trust's) policies(August) (c) Rewrite/ update policies(September) (d) Meet regularly with rest of HA team and present these policies(Feb) (e) Submit for clinical governance to whole of GUM in Trust (2 clinics)(March)
5. Look at applying to do xx MSc next year	(a) Re discuss with supervisor (b) Approach x, x and x organisation to find out relevant courses (c) Discuss with 'x' at supervision in September (or in 2 weeks if decide to go for this academic year) (d) Look at applying and getting study leave funding/ support by completing Trust forms (October)

R E F E R E N C E S

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- 1 Mullins, I.J. Management and organisational behaviour, 5th Edition, Financial Times Pitman Publishing. 1999, p.166.
 2 Ibid.p.101
 3 Ibid.p.132
 4 Ibid.p.117