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Is the UK Morally Responsible for Providing Healthcare for Failed Asylum Seekers with Chronic HIV Related Health Problems?

Case Report

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The guidelines for dealing with health related issues in failed asylum seekers are often confusing and conflicting for UK healthcare providers [1] and there are a significant number of patients living with HIV/AIDS who fall into this category. I present a case which demonstrates the 'perfect storm' of dealing with such complex medical issues leading to an ongoing risk of further healthcare issues due to a lack of continuity of care.

A 27 year old man from Ghana was diagnosed with advanced HIV infection and immunosuppression in 2012 after initially presenting with cerebral Toxoplasmosis and pneumonia. The former was diagnosed by a brain biopsy and despite recovering from this with aggressive antibiotic therapy; he was left with severe epilepsy as a result of post-infective organic brain damage probably due to a combination of cerebral Toxoplasmosis and advanced HIV infection and severe immunosuppression. He had limited family in the UK having 2 cousins who were nominated as next of kin as his ex-wife and 2 children lived in France. After specialised care in a regional tertiary centre, he was transferred back to our city as he resided here. He was enrolled in specialised rehabilitative physiotherapy as well as speech and language therapy and a subsequent cognitive assessment suggested profound short term and long term memory deficit. Unfortunately, due to being at home for long periods of time with limited memory loss, he often missed doses of his anti-epileptic medication which led to multiple admissions to our Intensive Care Unit (ICU) with loss of consciousness due to status epilepticus. It was even suggested by the specialised ICU team to make this gentleman a 'not for resuscitation' order due to the potential poor prognosis but it was refused on the grounds that the prognosis was uncertain despite repeated admissions. It was around this time, he had a fall whilst on the ward which led to a fracture of the neck of femur leading to a total hip replacement. His carers admitted difficulties in looking after him despite their initial best intentions citing full time employment and having families of their own to care for. His carers also admitted that his UK student visa had expired and if deported back to Ghana, there were no relatives there to look after him and a lack of specialised rehabilitative care. He was also unable to register with many GP practices due to his immigration status and one failed court case appeal. He was unable to obtain an NHS number to be reviewed by a neurologist and acquire the much needed anti-epileptic treatment. I was able to prescribe his HIV treatment as he was in the UK for more than 6 months in accordance with the recent HIV treatment guidelines changes [2]. We applied to the UK Border Agency for an exemption certificate to allow him as an illegal immigrant to have full access to NHS health and social care and this was granted as a 'temporary measure'. Despite us applying and finding a fully funded specialised neurorehabilitation unit locally, he was discharged after just 1 month due to a 'lack of further funding' and was still unable to register with a community General Practitioner (GP).

Currently this gentleman is residing with friends and is complying with his HIV medication and has improved immunity status. He still has profound memory problems and is unable to access a GP, specialist neurological care and obtain anti-epileptic treatment. We in the Blood Borne Virus unit are currently still prescribing his anti-epileptic treatment as a monthly prescription which goes against our current guidelines for non-antiretroviral treatment. He is currently clinically depressed and this is likely to be exacerbating his current cognitive stateand we are unsure in where we go from here. Thus with this case, one can see a number of medical, psychosocial and legal ethical issues arising:

[a]. Failed asylum seeker with chronic health problems and the lack of an immediate family or carers – Although there is more clarity on the rights and access to asylum seekers awaiting a court case (or appeal) [3], there is still uncertainty on those awaiting deportation and whether checks are made to see if adequate healthcare support exists in the country

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of origin. Some HIV units issue 'deportation packs' which constitute enough medication, advice, contact numbers etc to when they leave the UK to attempt seamless care [4].

[b]. Inability to register with GP or obtain access to specialised acute care in NHS [4] – This is dependent on the GP practice discretion but very few accept this cohort without appropriate documentation. This stance can further isolate patients needing care and hence can lead to difficulties in patients engaging with healthcare due to isolation and mistrust of the system. It has been shown that the risk behaviour of passing on HIV is higher in the effect of migration from another country [5] which is further exacerbated by social isolation [6].

[c]. Repeated admissions to a costly intensive care due to inability to obtain neurological expertise in anti-epileptic treatment or neurorehabilitation – This is a classic example of inefficient chronic disease care in the community leading to expensive, sometimes inappropriate admission to an acute care hospital [7].

[d]. Failure of a specialised, tertiary centre to provide long term specialised input due to lack of funding. Is it the responsibility of a specialist centre of excellence to organise specialist out-patient care when a referring District General Hospital (DGH) lacks the resources to provide adequate follow-up care? Although multi-disciplinary teams in specialised units are costly, they can be very cost effective in the long term if organising long term care for local referrers. Networks for clinical care are crucial in terms of having a specialised centre of excellence to deal with the more complex cases but this demonstrates how a lack of clear guidelines in referrals to such units can fail a patient.

[e]. Inability to obtain NHS funded long term care for specialised care and treatments – Despite obtaining a legal permit from the UK Border Agency allowing access to NHS care, local funding was not secured despite repeated appeals. This disparity in national and local guidelines leaves healthcare professionals in a very difficult situation to provide care as this only applies to those with an outstanding application for refuge and not those who have a failed status despite court appeals [8].

[f]. Reluctance of carers of the patient or the patients themselves to be deported back to the country of origin due to lack of a named carer or specialised resources. The UK rightly prides itself foremost on being a humanitarian country providing sanctuary and refuge to those fleeing persecution and torture. In this instance, the carers had realised that if our patient was deported back to Ghana, there would be no-one there to care for him let alone the existence of a healthcare infrastructure system to take on this complex case in a resource limited country.

[g]. Inability to self-care due to profound neurocognitive defects hence leading to a need for perhaps lifelong supervised care and direct observed therapy administration. This gentleman is depending on the generosity of friends in the Ghanaian community as well as our local HIV charity and it is assumed that he is compliant with his HIV and anti-epileptic treatment. The risk for falls and a potential head injury remains if doses of the latter are omitted.

I suspect we are not alone in this country or discipline with this type of cohort and I welcome any constructive suggestions to move forward. A national debate is needed at a political level in a sensible way to discuss the long term care of such cases.

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