HIV infection and hospital doctors

POLICY STATEMENT

PWG PERMANENT WORKING GROUP OF
EUROPEAN JUNIOR HOSPITAL DOCTORS

Foreword I

Blood borne infection has always been a threat to the medical profession, but it was not until HIV entered the scene that the potential problems for infected health care workers were widely discussed. Due to the moral and ethical issues involved irrational fear and prejudice have complicated further the professional response to this challenge. Several years ago the Permanent Working Group of European Junior Hospital Doctors (PWG) saw the need for a clear evidence based policy regarding the question of HIV and other blood borne infections in health care workers, and a working party was established. The present policy document is the result of this work, which has been achieved to a large extent because of the contribution of the British Medical Association Foundation for AIDS. It has been a pleasure to take part in the development of this document, and I want to thank all the members of the working party, and the various national delegations who provided data from their country. Hopefully, the policy statements can help on a national level to prevent unnecessary fear or problems, and to ensure both future patients and health care workers their rights and security.

Guttorm Brattebø MD
Chairman of working party

Foreword II

It is incumbent on all professionals to keep themselves updated on everything that influences the safety of the practice of their profession. So also with physicians and other health workers. This Policy Statement is an important document towards that end, and especially since the production of it was conceived by junior doctors themselves.

International health authorities, and national authorities in most countries, may not, because of the relative small risks involved for exchange of blood between health workers and patients, have found it cost-beneficial to have used time and resources yet on reviewing the problem and expressing a policy and strategy for coping with the questions it raises. Since in excess of 80 per cent of HIV-infection worldwide is caused by sexual transmission, such an attitude may be explicable. However, to health workers their own safety and the safety of their patients are of paramount importance, as is, of course, their legal rights in those few, but not less tragic, causes when transmission may be traced to professional exposure.

This PWG Policy Statement on HIV Infection and Hospital Doctors is a model of clarity and applicability. An added benefit is that it is equally applicable to other blood-borne infections such as the hepatitis viruses.

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Introduction and basic principles

The Permanent Working Group of European Junior Hospital Doctors (the PWG) is an association of European national organisations representing postgraduate trainees in hospital medical specialities and general practice. Its aims include improving and protecting standards of health care and furthering the professional interests of junior doctors in Europe. In line with these aims, when considering issues related to the employment and careers of doctors who may be infected with HIV the PWG acknowledges the need to ensure the highest standards of safety and welfare for patients, while seeking to ensure doctors' rights to privacy and freedom from unwarranted discrimination on the basis of actual or presumed HIV infection status.

A basic principle is that patients are entitled to know that effective policies and practices are in place to protect them from infection risks, but they are not entitled to know details regarding the personal health status of doctors or other health professionals. Health workers who have HIV infection are entitled to the same rights to confidentiality as any other patients.

The risk of transmission of HIV infection in health care settings is low, provided routine infection control procedures are observed. Worldwide, only one case of a health worker transmitting HIV to patients has been reported, that of the Florida dentist. Although the exact mode of transmission from the dentist remains obscure, it is known that he did not observe all recommended precautions. Other studies of large numbers of patients treated by HIV positive health workers have shown no evidence of transmission.

The risk to patients undergoing invasive surgical procedures from HIV positive health workers can be compared with that to health workers from infected patients. Even after a skin puncture with a needle contaminated with infected blood, the risk to a health worker of acquiring HIV is less than one in 200. This is much lower than for other infections such as hepatitis B (HBV), and illustrates that a significant transfer of blood or other infectious bodily fluid is needed for HIV to be transmitted. In most documented cases where health workers have become infected with HIV, this has resulted from skin puncture with a hollow needle containing blood. Incidents in which patients are exposed to comparable volumes of the blood of health care workers are likely to be very unusual.

This statement is intended to assist national organisations in formulating policies and guidance to protect the interests both of health workers and the public, in the light of the fact that workers are considerably more likely to acquire HIV infection from their patients than to transmit it.

Prevention of transmission of HIV infection between health workers and patients

Employers, doctors and other health care employees share a responsibility for health and safety in the workplace, including the prevention of parenteral exposures to blood and potentially infectious body fluids. The key to avoidance of transmission of HIV and other blood borne infections in health care settings is to maintain high standards of infection control at all times and in all circumstances, regardless of whether any individual patient or worker is known or suspected to be infected with HIV.

The PWG recognises that doctors have a professional obligation to keep abreast of techniques to reduce the risks of cross infection and to apply all reasonable precautions to protect their patients, themselves, and their colleagues. They must comply with legal requirements for reporting of actual or suspected exposure incidents. Failure to adhere to

appropriate standards of infection control practice may render a doctor liable to disciplinary action.

Employers should provide all necessary equipment, facilities and training to enable appropriate precautions to be followed, and must require incidents of parenteral exposure to blood or potentially infectious body fluids to be reported, through mechanisms to be agreed in consultation with staff representatives and in conformity with EC Council Directive 90/679/EEC of 26 November 1990.

All health care staff should have ready access to specialist occupational health services led by a consultant in occupational medicine, at no charge to the employee. Such services should be arranged in conformity with recognised principles of ethics in occupational medicine, whereby personal health information is not transmitted to the employer without the consent of the person to whom it relates. Health service occupational health services should be encouraged to develop appropriate services and policies for prevention of transmission of bloodborne infections and for the care of employees who have been exposed to potentially infectious body fluids (eg 24-hour "needlestick hotlines") as well as those who are HIV positive.

Restrictions on the practice of HIV infected doctors

Despite the fact that no doctor is known to have infected a patient with HIV, the PWG accepts that some invasive surgical procedures may entail a remote but finite risk that a patient could be exposed to a sufficient quantity of the operator's blood for HIV infection to be transmitted. Such exposure could only occur if an HIV-infected operator suffered an injury during the procedure and this led to bleeding into a patient's exposed tissues or body cavity. This theoretical risk is confined to procedures which require insertion of (part of) the operator's hand(s) into the patient in the presence of sharp instruments, bone spicules, teeth or foreign objects such as broken glass. Such procedures are referred to as "exposure prone".

All other clinical procedures can be safely performed by staff who are infected with HIV, including invasive procedures such as venepuncture where there may be a risk of "needlestick" incidents in which the operator might be exposed to the patient's blood but not vice versa.

Some national authorities may take the view that the risk of transmission of infection is so remote, even during "exposure prone" procedures, that it does not justify restricting the practice of HIV positive doctors in any way. However, subject to national circumstances and policies, the PWG accepts that it may be necessary for doctors who know themselves to be HIV positive to refrain from performing some or all "exposure prone" procedures. Any such restrictions should be kept to the minimum necessary, and if they are to be applied then the following criteria should be in place:

> The policy should be based upon voluntary self-identification of infected doctors, in accordance with agreed ethical principles, including the highest standards of confidentiality.
>
> A competent national expert body should be established, in consultation with relevant professional organisations, to advise employers and infected health workers or their personal medical advisors about precisely which techniques and procedures may and may not be safely performed by infected workers.

All possible measures should be taken to protect the training and career prospects of doctors who are obliged to modify their work patterns because of HIV infection (see below).

Restrictions should be confined to individuals who are known to be HIV positive. If a doctor has been exposed to the blood of an HIV positive patient, he or she should not be required to cease performing "exposure prone" procedures during the period of follow-up while the doctor is undergoing testing but has not been confirmed as HIV infected.

The PWG recommends that doctors who believe they may have been at risk of HIV infection should seek advice in confidence from a suitably qualified specialist such as a consultant in occupational medicine, and should undergo voluntary HIV testing where this is recommended as a matter of professional ethics and/or national policy. Where necessary, such a specialist can seek guidance on behalf of the doctor without disclosing his or her identity and can act as his or her advocate.

In view of the very low risk of transmission of HIV in health care settings, it is unnecessary for doctors to seek routine HIV testing unless they have reason to believe they may have been at risk. The PWG would strongly oppose any move, whether on the part of employers or national authorities, to require doctors to undergo compulsory HIV testing as this would be an unjustifiable infringement of the human rights and privacy of those concerned.

Employment, training and professional advancement

Employers and relevant national authorities should take all necessary steps to preserve the employment and career prospects of doctors who need to alter their working practices because of HIV infection. Any change in duties should be the minimum necessary to avoid performing exposure prone procedures. Adequate resources, careers advice and retraining should be provided to enable the redeployment of those whose current speciality is so dominated by exposure prone procedures (eg some surgeons) that they cannot continue to practise it. Where re-deployment is needed, it should ordinarily be to an alternative clinical speciality unless the individual prefers to enter a non-clinical role. Dismissal cannot be justified on grounds of HIV infection alone. National policies and regulations may need to be developed to promote good employment practice in relation to doctors with HIV and similar infections, and coordinated action may be desirable to facilitate redeployment where this involves a transfer between different employers.

Subject to national conditions, it may be necessary to allocate resources specifically for the purpose of retraining doctors who are seeking to change their speciality because of a physical or mental health condition. HIV infected individuals unable to pursue a surgical career would be among those eligible to benefit from such provision.

Provision for suitable retraining and redeployment is desirable even in countries where national policies do not require HIV positive doctors to restrict their practice in any way, because some individuals may wish to cease performing exposure prone procedures voluntarily out of concern for the welfare of their patients.

To the greatest extent possible, training programmes and requirements for specialist accreditation should provide flexibility to accommodate individuals who are unable to follow the standard training model for reasons of health. For example, where doctors are ordinarily

expected to perform exposure prone procedures during early post-qualification training, a requirement to observe such procedures might be substituted in the case of an individual with HIV or a similar infection to enable him/her to proceed to more specialised training towards a non-surgical career.

Asymptomatic HIV infection should have no bearing on the employment, training or professional advancement of doctors whose work does not involve performing exposure prone procedures. Flexible working arrangements, sickness benefits, and early retirement on health grounds may be required by doctors who develop symptomatic HIV disease, on an identical basis to those with other chronic progressive illnesses. National policies, including legislation if appropriate, should be developed to combat HIV-related discrimination in employment, including medical employment and training.

Medical confidentiality should be maintained in arranging altered working practices, retraining and redeployment for HIV positive doctors. The specialist in occupational medicine plays a crucial role in advocating on behalf of the affected individual while keeping medical details confidential.

Support for affected doctors

Diagnosis of HIV positivity inevitably causes significant stress, in view of its implications for personal health and future sexual and family relationships. For doctors, concerns about possible employment and career implications may create an additional burden of anxiety. Professional organisations should ensure that suitable services are available to advise and support doctors who find themselves to be HIV positive, and where necessary to assist them in negotiations with employers or training authorities. Procedures should be in place to ensure the confidentiality of doctors seeking the support of their professional organisations.

Occupationally acquired and non-occupationally acquired HIV infection

In accordance with national arrangements for compensation in respect of occupational diseases and injuries, doctors should be entitled to seek redress for disability and loss of income where this is due to occupationally acquired HIV infection. In establishing the validity of claims for compensation, it is acceptable to examine the work practices of the doctor concerned to assess the probability of his or her having been in contact with the blood of patients with HIV infection. Where such a probability exists, the claim should be accepted without subjecting the doctor to intrusive questioning regarding his or her private behaviour. Parenteral exposures to blood may sometimes occur without being noticed, so compensation should be payable on balance of probability in cases where there has been no specific documented exposure but the doctor's work has involved performing invasive procedures on patients likely to be infected with HIV.

The route by which an HIV positive doctor acquired the infection is irrelevant to his/her future employment and training. It is inappropriate for anyone involved in selection processes for re-training and redeployment to enquire as to how the doctor might have become infected.

Patients who may have undergone exposure prone procedures performed by an infected worker

When a doctor is found to be HIV positive, concerns may arise regarding the welfare of patients on whom he or she has performed exposure prone procedures in the past, between the probable date of acquiring the infection and its being diagnosed. The question arises as to whether it is necessary to inform patients in these circumstances and to offer them counselling and HIV testing if they wish it, ie to perform a "look back" patient notification exercise. The PWG's view is that, given the very low risk of transmission involved, it is not necessary or appropriate *routinely* to notify patients who have undergone exposure prone procedures performed by doctor who has been found to be HIV positive. There are a number of drawbacks associated with "look back" patient notification exercises, including:

Substantial costs and diversion of staff resources for contacting and counselling patients and dealing with media enquiries;

Risk of promoting public anxiety and fostering misconceptions about the level of risk involved;

Significant risk that the infected doctor's privacy will be infringed if his or her identity can be deduced.

There may be individual cases where "look back" patient notification is judged necessary, for example if procedures have been performed which are thought to carry an unusual risk of patient exposure to the worker's blood, or if a potential lapse in infection control precautions is known to have occurred. Even in such cases, however, the infected doctor should be consulted where possible and every effort should be made to prevent deductive disclosure of his or her identity. Guidance regarding "look back" exercises should be developed at the national level in consultation with relevant professional bodies, to assist local public health authorities, employers and consultants in occupational medicine in the management of individual cases.

Summary of key conclusions

Health professionals are entitled to the same rights to confidentiality regarding their personal health status as any other patients.

The key to avoidance of transmission of HIV and other blood borne infections in health care settings is to maintain high standards of infection control at all times and in all circumstances.

Employers should provide all necessary equipment, facilities and training, and must require incidents of parenteral exposure to blood or potentially infectious body fluids to be reported.

All health care staff should have ready access to specialist occupational health services led by a consultant in occupational medicine.

Subject to national circumstances and policies, it may be necessary for doctors who are HIV positive to refrain from performing some or all "exposure prone" procedures (see definition). Any such restrictions should be kept to the minimum necessary, and applied in accordance with criteria set out above.

Doctors who believe they may have been at risk of HIV infection should seek advice in confidence from a suitably qualified specialist such as a consultant in occupational medicine, and should undergo voluntary HIV testing if appropriate.

It is unnecessary for doctors to seek routine HIV testing unless they have reason to believe they may have been at risk.

The PWG would strongly oppose any move, whether on the part of employers or national authorities, to require doctors to undergo compulsory HIV testing.

Employers and national authorities should take all necessary steps to preserve the training, employment and career prospects of doctors who need to alter their working practices because of HIV infection. Dismissal cannot be justified on grounds of HIV infection alone.

National policies, including legislation if appropriate, should be developed to combat HIV-related discrimination in employment, including medical employment and training.

Professional organisations should ensure suitable confidential services are available to advise and support doctors who are HIV positive, and where necessary to assist them in negotiations with employers or training authorities.

Doctors should be entitled to redress for disability and loss of income in respect of HIV infection where, on balance of probabilities, this is occupationally acquired.

It is not necessary *routinely* to notify patients who have undergone exposure prone procedures performed by a doctor who has subsequently been found to be HIV positive, and there are a number of drawbacks associated with doing so.

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Annex 2: PWG questionnaire on bloodborne pathogens in health professionals: summary of responses

This paper sets out the results of a survey carried out during 1993. It is attached as an annex to the PWG Policy Statement on HIV Infection and Hospital Doctors, as it provides useful background information.

As agreed at the May 1993 meeting of the PWG, the UK delegation circulated a questionnaire to appointed members of 15 national delegations on behalf of the working party on HIV/AIDS and bloodborne pathogens. Responses were requested by 1 August 1993; a number of delegations took longer to respond, because of the work involved in compiling the information, and a number did not respond at all. Some responses were very detailed, whereas it was clear from others that areas covered in the questionnaire are only beginning to be discussed.

The following information is based on the responses from the following national delegations:

Austria, Denmark, Finland, France, Germany, Iceland, Ireland, Italy, Latvia, Netherlands, Norway, Slovenia, Sweden, Switzerland, UK.

Extent of the problem

The extent of infection among doctors, either with HIV or HBV, is difficult to gauge, as in many countries there are no separate data. France is the exception, as HIV is a notifiable disease. By 31.03.92 there were 153 doctors or medical students reported HIV positive and 356 other health professionals (149 nurses, 107 care auxiliaries, 40 domestic staff, 28 dentists, 20 laboratory staff and 12 physiotherapists). Of these, 8 cases were **proven** to have been acquired at work (all nurses) and 28 **presumed** to have been so acquired (including 3 doctors, 1 house officer and 2 medical students). There were no exact figures for HBV infection among doctors, but the number of cases was reduced (divided by 15) between 1981 and 1991.

The UK has no system for reporting HIV infection among doctors or other health professionals, but a number of cases had been reported in the media. One doctor and 5 other health professionals were reported as having acquired HBV infection in 1992.

Among other countries giving figures, Denmark estimated HBV infection at 0-2 among doctors and 0-5 among other health professionals. Figures for HIV infection were unknown, but less than 10 and less than 100 respectively. In Finland, 5-10 doctors and 10-15 health professionals were known to be infected with HIV (none acquired occupationally). Slovenia had one doctor reported HIV positive, and 3 other health professionals. Iceland had one case of HIV infection in each category. Norway had one health professional reported HIV positive. Italy had "very few" (possibly 5-6) known cases of HIV infection among doctors and 15 among other health professionals.

There was no overall pattern as regards the disciplines in which doctors worked at the time of diagnosis. Ophthalmology, obstetrics and gynaecology, general practice, general surgery, paediatrics, anaesthetics, radiology were all cited.

The level of debate within the medical profession was high in the UK, Ireland, Germany, Switzerland and Latvia. Elsewhere it seemed relatively low, although in Sweden there was discussion about how to minimise the risk of transmission of infection, and in Norway the issue had been discussed among surgeons in particular. In France, debate among both doctors and the public had been dominated by recent scandals over contaminated blood for transfusion.

Media coverage of HIV infection among doctors had undoubtedly been greatest in the UK,although this did not necessarily mean that there was genuinely high public awareness or understanding of the problems. The Irish media were described as having dealt sensitively with the issue, which had certainly not been the case in the UK. Latvia also reported public awareness, and there had been some discussion in Italy. The media in other countries (Austria, Finland, Norway) had reported on cases in the UK and USA.

The UK and Ireland seemed to be the only countries in which identifiable details of infected doctors had been made public, although the Irish response suggested that the details were those of British doctors. This had now happened in the cases of doctors suffering from HIV and HBV in the UK.

Ethical guidelines

Delegations were asked whether their regulatory bodies had published ethical guidelines on the responsibilities of doctors infected with HIV or HBV. Where there were guidelines, most delegations did not specify whether these applied to doctors infected with HIV or HBV or both, although the principles involved were similar. Some respondents interpreted the term "ethical" rather broadly.

Once again, the issues seemed to have been addressed in the greatest detail in the UK, where the government had produced guidance on the responsibilities of doctors with HIV and HBV infection (the latter published very recently) and the professional regulatory body for doctors with HIV infection. The Irish Medical Council had published guidelines for doctors with AIDS/HIV. Latvia and Switzerland also had guidelines, and guidance was currently being drawn up in Norway. Denmark and Austria had procedural, rather than ethical, guidelines. Some hospitals in Finland had their own guidance, and the situation in the Netherlands was described as being governed by "gentlemen's agreement", whereby infected doctors would appear before a committee of "wise men/women" to discuss their cases.

Ethical guidance had been produced by other bodies in the following countries:

> ***UK*** - medical association
> ***Germany*** - medical association; medical publisher; health ministry (general information)
> ***Sweden*** - assumed to be medical association
> ***Italy*** - national AIDS advisory board
> ***Latvia*** - HIV medical association; department of health protection
> NB: In ***France***, a working group under the authority of the health minister was examining the risks involved in exposure to blood.

Some delegations included copies of, or details from, their guidelines, but not all did so.

Where applicable, guidelines seemed to be generally accepted by the medical profession. The exception was the UK, where guidelines produced by professional bodies (the regulatory body and the medical association) were well-accepted, but those produced by the government had been controversial. The Swiss response pointed out that some senior doctors in the older generation objected to campaigns for safer sex etc and wished to test all patients before treating them.

Where doctors were required, or advised, to disclose infection, this was as follows:

> ***UK*** - Specialist advice to be sought, probably from consultant in occupational health, infectious diseases or public health. Governmental guidance requires those who have been involved in invasive procedures to inform their employers, probably through a senior occupational physician.
> Ireland - Information given to professional colleagues
> ***France*** - HIV notifiable disease. Notification normally through occupational physicians or by hospital doctors if the infected person is hospitalised.
> ***Finland*** - all HBV and HIV infections notified by doctors to "provincial and state officials" (i.e. no special requirement for doctors).
> ***Austria*** - initials only given to the national health board.
> ***Germany*** - hospitals may ask job applicants about their HIV status, and may ask them to undergo HIV tests if they are to work in certain areas where there is a high risk of transmitting infection.
> ***Sweden*** - infected doctors advised to inform their heads of department (consultants).

Italy - heads of departments
Latvia - Department of Health Protection and HIV Medical Association
Netherlands - Committee of "wise men/women" described previously (no formal requirement)
Switzerland - infection at work dealt with by occupational physicians. Positive cases notified to national health board on anonymous basis.

Policy

There was no clear pattern as regards screening or vaccination. Notes on individual countries are as follows:

UK - No screening for HIV. All health care workers performing high-exposure procedures to be immunised against HBV. Until recent guidelines were published, there was a voluntary vaccination programme, but there were problems with funding, and its distribution was uneven.
Ireland - no governmental policy
France - no screening, but compulsory vaccination against HBV, diphtheria, tetanus, TB and polio for all those exposed to risk of infection via their work (includes medical students)
Denmark - doctors training to become surgeons or pathologists, certain laboratory staff and other health professionals considered to be at risk of infection should be screened for HBV and vaccinated if necessary.
Finland - screening for TB and rubella immunity only
Slovenia - no screening, but vaccination programme for all health professionals (and students) who may be exposed to HBV
Austria - screening and vaccination only mentioned for TB
Iceland - no compulsory screening. HBV vaccination offered to health professionals at moderate to high risk and to medical students
Norway - HBV vaccination programme for health professionals in casualty departments or dialysis units
Latvia - Compulsory screening twice a year for medical students, doctors and other health workers for HIV, HBV and other diseases. No information about vaccination programmes.
Netherlands - HBV vaccination not compulsory, but strongly recommended and paid for by health authorities
Switzerland - All doctors supposed to be vaccinated against HBV, if possible as medical students. Vaccination depends on the individual taking the initiative when vaccination sessions are organised by hospitals (usually once a year). Occupational exposure to HIV governed by recommendation, rather than by government policy. It should be followed by immediate testing, repeated after 3 and 6 months. Prophylaxis with zidovudine to be considered in serious cases.

Retraining of infected doctors had been discussed only in the UK, Denmark, Norway, Latvia, the Netherlands and Switzerland. Discussions seemed to be at an early stage, and almost no specific action had been taken. In the Netherlands, there had been discussions about finding alternative placements for infected surgeons, but it was not known whether or not any action had been taken. In Switzerland, there was no recommendation to bar doctors with HIV infection from invasive work. It would be considered paradoxical to ask doctors to treat HIV-positive patients but to exclude them from their professional activities when they became infected themselves.

Financial compensation for infected doctors and their families was very limited. The UK offered compensation to doctors who suffered injury or infection in the course of their work (NHS Injury Benefit Scheme - 85% of normal salary); HBV was on a list of prescribed diseases which would normally be assumed to be due to exposure at work, but it would be extremely difficult to prove the origin of HIV infection. France would compensate salaried doctors for accidents at work if it could be proven according to strict scientific criteria that they had been infected at work; doctors in "liberal" practice had to take out their own insurance. Germany offered a compensation scheme for inability to work which covered both HBV and HIV.

Only the medical associations of the UK, Ireland, Germany and Sweden had policy on the areas covered in the questionnaire. British Medical Association policy and publications were extensive and either had been, or would be, made available to the PWG working party. The Irish Medical Organisation had called for HIV infection to be a notifiable disease and had urged health boards to assign protected resources to treat it. The Marburger Bund (Germany) supported guidelines drawn up by the Bundesärztekammer and German Hospital Association (available in German). It strictly opposed any screening policy, especially where doctors were concerned. The Swedish junior doctors' organisation did not support pre-employment HIV screening.

The only additional comments came from sources in the UK. They pointed out that, although media attention and debate - at least in the UK - had been directed primarily at risks associated with HIV infection, HBV was more infectious and posed a greater risk to health professionals. They also pointed out that consideration of the needs of infected doctors needed to go beyond retraining. Issues such as redeployment, employment protection, confidentiality and protection against discrimination should be considered.

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