

AIDS / HIV INFECTED HEALTH CARE WORKERS:

GUIDANCE ON MANAGEMENT OF INFECTED HEALTH
CARE WORKERS AND PATIENT NOTIFICATION:

A CONSULTATION

A Consultation Paper

**AIDS/HIV Infected
Health Care Workers:**

**Guidance on the Management of
Infected Health Care Workers and
Patient Notification**



SCOTTISH EXECUTIVE

Health Department

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Dear Colleague

HIV INFECTED HEALTHCARE WORKERS: CONSULTATION ON GUIDANCE ON THE MANAGEMENT OF HIV INFECTED HEALTH CARE WORKERS AND PATIENT NOTIFICATION

I would welcome your comments on the enclosed draft guidance which, subject to responses, will replace the version published in 1998 (issued under cover of MEL(1999)29). It describes a range of key changes in recommended practice. We realise that there are several references to the new organisational arrangements in England and we will consider which of these needs to be amended at the conclusion of this consultation.

This new draft guidance updates advice on the need for, and scope of, patient notification exercises when a healthcare worker is found to have been infected with HIV. This reflects the new policy agreed by Ministers following expert advice from the Expert Advisory Group on AIDS (EAGA) and UK Advisory Panel for Health Care Workers Infected with Blood-borne Viruses (UKAP). They concluded that it is no longer necessary to notify every patient who has undergone an exposure prone procedure by an infected healthcare worker because of the low risk of transmission and the associated anxiety experienced by such patients and, indeed, the wider public.

This draft guidance recommends that the decision on whether a patient notification exercise should be undertaken should be assessed on a case-by-case basis using a criteria based framework. Directors of Public Health (DsPH), supported in Scotland by the Scottish Centre for Infection and Environmental Health (SCIEH), will be responsible for deciding whether a patient notification exercise is necessary, taking account of the criteria set out in this guidance. UKAP will be available to provide advice, if required, across the UK.

The guidance should help DsPH and other relevant health professionals in:

- quantifying the level of risk associated with clinical procedures that are classified as exposure prone; and



- providing clear criteria to use when assessing the need for, and nature of, any patient notification exercise.

I would welcome any general comments on the scope and content of the guidance and on whether you consider that there are gaps in the information provided. I would be particularly interested in your views on:

- section 8 (“When a patient notification exercise should be conducted”); and
- section 11 (“Practical guidance on notifying patients”).

I would welcome replies by **22 November 2002**.

Comments should be sent to Wendy McKendrick, Public Health Division – 1, Area 3E(S), St Andrew’s House, Regent Road, Edinburgh, EH1 3DG (e-mail to wendy.mckendrick@scotland.gsi.gov.uk).

Yours sincerely



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Deputy Chief Medical Officer



To:

General Managers of NHS Boards
Chief Executives of NHS Trusts

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Directors of Public Health
CADO's
Trust Directors of Nursing
Health Board Aids Co-ordinators
Health Board Directors of Nursing
Director, Scottish Centre for Infection and Environmental Health (SCIEH)
Deans of Medical/Dental Schools
Academic Heads of Depts of Nursing
Directors of HIV Regional Virus Labs
General Manager, CSA
General Manager, State Hospital
Chief Executive, HEBS
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- General Practitioners
- Midwives
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Faculty of Public Health Medicine
British Dental Association
British Medical Association
Medical and Dental Defence Union for Scotland
Scottish Prison Service
Scottish General Practitioners Council
National Voluntary organisations working in HIV/AIDS field
Public Health Institute for Scotland
UNISON
Scottish Practice Nurse Association
Scottish NHS Officer and Joint Chair, Scottish Partnership Forum
Nursing Research Institute of Scotland
Community & District Nursing Association
Scottish Health Visitors Association
Scottish Civic Forum
NHS Education for Scotland



SUMMARY

This guidance is intended to replace the previous version published in 1998 and includes updated advice on patient notification exercises. The advice reflects the new policy (announced in November 2001) on the need for patient notification exercises when a health care worker (HCW) is found to be infected with HIV. It follows expert advice from the Expert Advisory Group on AIDS (EAGA) and UK Advisory Panel for Health Care Workers Infected with Blood-borne Viruses (UKAP). They advise that it is no longer necessary to notify every patient who has undergone an exposure prone procedure by an infected HCW because of the low risk of transmission and the anxiety caused to patients and the wider public.

It is recommended that the decision on whether a patient notification exercise should be undertaken should be assessed on a case-by-case basis using a criteria based framework. Directors of Public Health (DsPH) of Primary Care Trusts/NHS Boards in Scotland will be responsible for deciding whether patient notification is necessary, although UKAP will be available to provide advice.

The guidance document aims to assist Directors of Public Health and relevant health professionals in:

- quantifying the level of risk associated with clinical procedures that are classified as exposure prone; and
- providing clear criteria to use when assessing whether a patient notification exercise is warranted, and if so, its extent.

We should be grateful for comments in general on:

- the scope and content of the guidance;
- whether there are gaps in the information provided.

And, in particular, on:

- section 8 (When a patient notification exercise should be conducted);
- section 11 (Guidance on notifying patients).

Please note that responses to this consultation may be made public unless a respondent requests that their views be kept confidential.

Any comments should be sent to Wendy McKendrick, Scottish Executive Health Department, Public Health Division –1, 3E(S) St Andrew's House, Edinburgh EH1 3DG or by e-mail to wendy.mckendrick@scotland.gsi.gov.uk by **22 November 2002**.

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KEY POINTS AND RECOMMENDATIONS

Management of infected health care workers

1. These guidelines apply to all health care workers in the NHS and private sectors, including visiting health care workers and students. **(Paragraph 1.1)**
2. All health care workers are under ethical and legal duties to protect the health and safety of their patients. They also have a right to expect that their confidentiality will be respected and protected. **(Paragraph 1.4)**
3. Provided appropriate infection control precautions are adhered to scrupulously, the majority of procedures in the health care setting pose no risk of transmission of the human immunodeficiency virus (HIV) from an infected health care worker to a patient. **(Paragraph 1.5)**
4. The circumstances in which HIV could be transmitted from a health care worker to a patient are limited to exposure prone procedures in which injury to the health care worker could result in the worker's blood contaminating the patient's open tissues ("bleed-back"). HIV infected health care workers must not perform any exposure prone procedures. **(Paragraphs 1.6 and 3.4)**
5. The Expert Advisory Group on AIDS recommends that, as far as is practicable, patients should only be notified if they have been at distinct risk of bleed-back from the particular exposure prone procedures performed on them by an HIV infected health care worker. Such patients should be contacted and encouraged to have pre-test discussion and HIV antibody testing. **(Paragraph 1.7)**
6. The decision on whether a patient notification exercise is undertaken should be made on a case-by-case basis using risk assessment. It is anticipated that in most cases this decision will be made locally by Directors of Public Health (DsPH) of Primary Care Trusts (PCTs)/NHS boards in Scotland, supported as necessary by Regional Epidemiologists, Regional Directors of Public Health or in Scotland, the Scottish Centre for Environmental Health (SCIEH)). Where there is still uncertainty, the United Kingdom Advisory Panel for Health Care Workers Infected with Blood-borne Viruses (UKAP) may also be approached for advice. **(Paragraph 1.8)**
7. HIV infected health care workers must not rely on their own assessment of the risk they pose to patients. **(Paragraph 4.6)**
8. A health care worker who has any reason to believe they may have been exposed to infection with HIV, in whatever circumstances, must promptly seek and follow confidential professional advice on whether they should be tested for HIV. Failure to do so may breach the duty of care to patients. **(Paragraph 4.7)**

9. Examples of how a person in the UK may have been exposed to HIV infection include if they have:
- engaged in unprotected sexual intercourse between men;
 - shared injecting equipment whilst misusing drugs;
 - had unprotected heterosexual intercourse in, or with a person who had been exposed in, a country where HIV transmission through sexual intercourse between men and women is common;
 - engaged in invasive medical, surgical, dental or midwifery procedures in parts of the world where infection control precautions may have been inadequate;
 - had a significant occupational exposure to HIV infected material in any circumstances.
10. Additionally, a person who is aware that they had unprotected sexual intercourse with someone in any of the above categories may also have been exposed to HIV infection. **(Paragraph 4.8)**
11. Health care workers who are infected with HIV must promptly seek appropriate expert medical and occupational health advice. If no occupational physician is available locally, consideration should be given to contacting one elsewhere. Those who perform, or may be expected to perform, exposure prone procedures must obtain further expert advice about modification or limitation of their work practices to avoid exposure prone procedures. Procedures which are thought to be exposure prone must not be performed whilst expert advice is sought. **(Paragraph 4.9)**
12. If there is uncertainty whether an HIV infected worker has performed exposure prone procedures, a detailed occupational health assessment should be arranged. The UKAP can be consulted by the occupational health physician, the health care worker or a physician on their behalf if there is doubt. The health care worker's identity should not be disclosed to the UKAP. **(Paragraph 4.10)**
13. If it is believed that any exposure prone procedures have been performed and that a patient notification exercise needs to be considered, the infected health care worker or their chosen representative (e.g. the occupational or HIV physician) should inform the Director of Public Health (DPH) of the relevant Primary Care Trust/NHS board in Scotland on a strictly confidential basis. The DPH or a delegated colleague (e.g. the Consultant in Communicable Disease Control (CCDC) or the Consultant for Public Health Medicine (CPHM) (CD & EH in Scotland) will in turn make an appraisal of the situation to decide whether a patient notification exercise is necessary, consulting Regional Epidemiologists, Regional Directors of Public Health or in Scotland, SCIEH, and UKAP, if necessary. The medical director of the employing trust should also be informed in confidence at this stage. **(Paragraphs 4.11 and 4.12)**

14. HIV infected health care workers who do not perform exposure prone procedures but who continue to provide clinical care to patients must remain under regular medical and occupational health supervision. They should follow appropriate occupational health advice, especially if their circumstances change. **(Paragraph 4.14)**
15. Health care workers who know or have good reason to believe (having taken steps to confirm the facts as far as practicable) that an HIV infected worker is practising in a way which places patients at risk, or has done so in the past, must inform an appropriate person in the infected worker's employing authority (e.g. a consultant occupational health physician) or, where appropriate, the relevant regulatory body. The DPH should also be informed in confidence. The UKAP can be asked to advise when the need for such notification is unclear. Such cases are likely to arise very rarely. Wherever possible the health care worker should be informed before information is passed to an employer or regulatory body. **(Paragraph 4.17)**
16. All employers in the health care setting should ensure that new and existing staff (including agency and locum staff and visiting health care workers) are aware of this guidance and of the professional regulatory bodies' statements of ethical responsibilities, and occupational health guidance for HIV/AIDS infected health care workers. **(Paragraph 5.1)**
17. Medical, dental, nursing and midwifery schools, colleges and universities should draw students' attention to this guidance and the relevant professional statements. **(Paragraph 5.2)**
18. Where an employer or member of staff is aware of the health status of an infected health care worker, there is a duty to keep such information confidential. **(Paragraph 5.3)**
19. Employers should assure infected health care workers that their status and rights as employees will be safeguarded so far as is practicable. Where necessary, employers should make every effort to arrange suitable alternative work and retraining opportunities, or where appropriate early retirement, for HIV infected health care workers, in accordance with good general principles of occupational health practice. **(Paragraph 5.4)**
20. All matters arising from and relating to the employment of HIV infected health care workers should be co-ordinated through a specialist occupational health physician. **(Paragraph 6.1)**
21. Patient safety and public confidence are paramount and dependent on the HIV infected, or potentially infected, health care worker observing their duty of self-declaration to an occupational physician. Employers should promote a climate which encourages such confidential disclosure. It is extremely important that HIV infected health care workers receive the same rights of confidentiality as any patient seeking or receiving medical care. **(Paragraph 6.7)**

Patient notification exercises

22. Notification of patients identified as having been exposed to a risk of HIV infection by an infected health care worker is considered necessary:
 - To provide the patients with information about the nature of the risk to which they have been exposed;
 - To detect HIV infection, provide care, and advice on measures to prevent onward HIV transmission;
 - To collect valid data to augment existing estimates of the risk of HIV transmission from an infected health care worker to patients during exposure prone procedures. **(Paragraph 8.1)**
23. The need for patient notification should be decided on a case-by-case using three risk assessment criteria: evidence of possible HIV transmission, nature and history of the infected health care worker's clinical practice and other relevant considerations (e.g. evidence of poor clinical practice in relation to infection control or physical/mental impairment as a result of symptomatic HIV disease). **(Paragraph 8.4)**
24. Exposure prone procedures have been classified into three levels of risk of bleed-back (categories 1-3 of increasing risk). Where there is evidence of HIV transmission from infected health care worker to patient, notification of all patients who have undergone exposure prone procedures by that health care worker should take place. In the absence of evidence of HIV transmission, all patients who have undergone category 3 procedures by an HIV infected healthcare worker should be notified. When only category 1 or 2 procedures have been carried out, patient notification will not be necessary, unless the other relevant considerations suggest that it is. **(Paragraphs 8.5-8.8 and 8.13)**
25. The decision about the need for a patient notification exercise should rest with the DPH, supported as necessary by the Regional Epidemiologist and the Regional Director of Public Health or, in Scotland, SCIEH. When a patient notification exercise is to be undertaken the DPH or delegated colleague (e.g. CCDC) should inform the UKAP. If more than one Primary Care Trust is involved, it will be appropriate for the Regional Epidemiologist(s) or in Scotland, SCIEH, to become involved at this stage. If there is doubt about the need for patient notification, UKAP should be consulted. **(Paragraphs 8.15-8.16)**

Confidentiality

26. Every effort should be made to avoid disclosure of the infected worker's identity, or information that would allow deductive disclosure. This may include the use of a media injunction to prevent publication or other disclosure of a worker's identity. **(Paragraph 10.2)**

27. The duties of confidentiality still apply even if the infected health care worker has died, or has already been identified publicly. **(Paragraph 10.5)**

1. INTRODUCTION

- 1.1 These guidelines apply to all health care workers in the NHS and private sectors, including visiting health care workers in any health care setting and students in training for whom there may be implications for future career options.
- 1.2 The guidelines are intended to replace the version issued in December 1998, *AIDS/HIV Infected Health Care Workers: Guidance on the Management of Infected Health Care Workers and Patient Notification*. They reflect changes in NHS structures, experience of patient notification exercises and the recommendations of a joint working group of the Expert Advisory Group on AIDS (EAGA) and the United Kingdom Advisory Panel for Health Care Workers Infected with Blood-Borne Viruses (UKAP), which has recently reviewed the policy for notifying patients exposed to HIV infected health care workers.
- 1.3 This guidance continues to endorse the ethical guidance in the statements from the professional regulatory bodies, clarifies the duties of HIV infected health care workers, their medical advisers and employers, and outlines the procedures which should be followed if a patient notification exercise is being considered.
- 1.4 All health care workers are under ethical and legal duties to protect the health and safety of their patients. They also have a right to expect that their confidentiality will be respected and protected.
- 1.5 Provided appropriate infection control precautions are adhered to scrupulously, the majority of procedures in the health care setting pose no risk of transmission of the human immunodeficiency virus (HIV) from an infected health care worker to a patient.
- 1.6 The circumstances in which HIV could be transmitted from an infected health care worker to a patient are limited to exposure prone procedures in which injury to the health care worker could result in the worker's blood contaminating the patient's open tissues. This is described as "bleed-back" in this guidance. HIV infected health care workers must not perform any exposure prone procedures. The majority of health care workers do not perform exposure prone procedures.
- 1.7 The EAGA recommends that, as far as is practicable, patients should only be notified if they have been at a distinct risk of bleed-back from the particular exposure prone procedures performed on them by an HIV infected worker. Such patients should be contacted and encouraged to have pre-test discussion and HIV antibody testing.

- 1.8 The decision on whether a patient notification exercise is undertaken should be made on a case-by-case basis using the risk assessment criteria developed by the EAGA/UKAP Working Group. It is anticipated that, in most cases, this decision will be made locally by Directors of Public Health (DsPH) of Primary Care Trusts (PCTs)/NHS board in Scotland, supported as necessary by Regional Epidemiologists, Regional Directors of Public Health, or in Scotland, SCIEH. Where there is still uncertainty, the UKAP may also be approached for advice.
- 1.9 The recommendations in this guidance reflect the need to protect patients, to retain public confidence and to safeguard the confidentiality and employment rights of HIV infected health care workers.

2. CURRENT ESTIMATES OF THE RISK OF TRANSMISSION

- 2.1 Documented cases of hepatitis B and hepatitis C infections have occurred in patients operated on by hepatitis B or C infected health care workers. It is plausible that HIV could be transmitted under similar circumstances, although the risk of HIV transmission has been shown to be considerably less than for hepatitis B or hepatitis C following needlestick injuries.
- 2.2 Worldwide, there have been two reports of possible transmissions of HIV from infected health care workers performing exposure prone procedures: a French orthopaedic surgeon and a Florida dentist. Although genetic relatedness was demonstrated in both cases, only in the case of the French orthopaedic surgeon was the route of transmission clear.^{1,2}
- 2.3 All other retrospective studies worldwide of patients exposed to the potential risk of transmission of HIV during exposure prone procedures have failed to identify any patients who have become infected by this route.
- 2.4 The data available from patient notification exercises supports the conclusion that the overall risk of transmission of HIV from infected health care workers to patients is very low. Between 1988 and 2001 in the UK, there were 22 patient notification exercises. However, there was no detectable transmission of HIV from an infected health care worker to a patient despite about 7,000 patients having been tested.
- 2.5 The Public Health Laboratory Service's (PHLS) Communicable Disease Surveillance Centre (CDSC) and, in Scotland, SCIEH actively follow-up newly diagnosed HIV infections to establish the likely route of transmission. There have been no inexplicable infections, which might otherwise have been potentially linked to exposure prone procedures.
- 2.6 The evidence indicates that there is a far greater risk of transmission of HIV from infected patients **to** health care workers than **from** infected workers to patients. Up to June 1999, there had been 102 cases worldwide of health care workers in whom seroconversion was documented after occupational exposure to HIV from patients. Five of these were cases in which transmission occurred in the UK.³
- 2.7 The Department of Health, EAGA and UKAP will continue to evaluate the epidemiological evidence on the risks of transmission, informed by results from properly documented patient notification exercises when these are considered necessary.

3. GENERAL PRINCIPLES OF BLOOD-BORNE VIRUS INFECTION CONTROL AND EXPOSURE PRONE PROCEDURES

- 3.1 The Health Departments published guidance for clinical health care workers on protection against infection with blood-borne viruses in 1998 (see box).⁴ This guidance should be followed to minimise the risk of blood-borne virus transmission to health care workers from patients. The measures recommended will also minimise the risk of transmission from infected workers to patients, and from patient to patient.

General measures to prevent occupational transmission of blood-borne viruses

1. Apply good basic hygiene practices with regular hand washing, before and after contact with each patient, and before putting on and after removing gloves. Change gloves between patients.
2. For **all** clinical procedures, cover existing wounds, skin lesions and all breaks in exposed skin with waterproof dressings, or with gloves if hands extensively affected.
3. Health care workers with chronic skin disease such as eczema should avoid those invasive procedures which involve sharp instruments or needles when their skin lesions are active, or if there are extensive breaks in the skin surface. A non-intact skin surface provides a potential route for blood-borne virus transmission, and blood-skin contact is common through glove puncture that may go unnoticed.
4. Use protective clothing as appropriate, including protection of mucous membrane of eyes, mouth and nose from blood and body fluid splashes. Avoid wearing open footwear in situations where blood may be spilt, or where sharp instruments or needles are handled.
5. Prevent puncture wounds, cuts and abrasions and if present, ensure that they are not exposed (see 2).
6. Avoid sharps usage wherever possible and consider the use of alternative instruments, cutting diathermy and laser.
7. Where sharps usage is essential, exercise particular care in handling and disposal, following approved procedures and using approved sharps disposal containers.
8. Clear up spillages of blood and other body fluids promptly and disinfect surfaces.
9. Follow approved procedures for sterilisation and disinfection of instruments and equipment.
10. Follow approved procedures for safe disposal of contaminated waste.

- 3.2 All breaches of the skin or epithelia by sharp instruments are, by definition, invasive. Most clinical procedures, including many which are invasive, do not provide an opportunity for the blood of the health care worker to come into contact with the patient's open tissues. Provided the general measures to prevent occupational transmission of blood-borne viruses are adhered to scrupulously at all times most clinical procedures pose **no** risk of transmission of HIV from an infected health care worker to a patient, and can safely be performed.
- 3.3 Those procedures where an opportunity for health care worker to patient transmission of HIV **does** exist are described as exposure prone and must not be performed by a health care worker who is HIV infected.
- 3.4 **Exposure prone procedures** are those invasive procedures where there is a risk that injury to the worker may result in the exposure of the patient's open tissues to the blood of the worker (bleed-back). These include procedures where the worker's gloved hands may be in contact with sharp instruments, needle tips or sharp tissues (e.g. 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. However, other situations, such as pre-hospital trauma care and care of patients where the risk of biting is predictable (e.g. such as with a disturbed and violent patient or a patient having an epileptic fit) should be avoided by health care workers restricted from performing exposure prone procedures.
- 3.5 Procedures where the hands and fingertips of the worker are visible and outside the patient's body at all times, and internal examinations or procedures that do not involve possible injury to the worker's gloved hands from sharp instruments and/or tissues, are considered not to be exposure prone provided routine infection control procedures are adhered to at all times. Examples of such procedures include:
- taking blood (venepuncture);
 - setting up and maintaining intravenous lines or central lines (provided any skin tunnelling procedure used for the latter is performed in a non-exposure prone manner);
 - minor surface suturing;
 - the incision of external abscesses;
 - routine vaginal or rectal examinations;
 - simple endoscopic procedures.

Examples of UKAP's advice on which procedures are and are not exposure prone are attached at **Annex A**.

- 3.6 The final decision about the type of work that may be undertaken by an infected health care worker should be made on an individual basis, in conjunction with a specialist occupational physician, taking into account the specific circumstances including working practices of the worker concerned. The occupational physician may wish to consult the UKAP.
- 3.7 The decision whether an HIV infected worker should continue to perform a procedure which itself is **not** exposure prone should take into account the risk of complications arising which might necessitate the performance of an exposure prone procedure. Only reasonably predictable complications need to be considered in this context.
- 3.8 The likelihood of injury to the health care worker and consequent possible risk to the patient depends on a number of factors which include not only the type and circumstances of the procedure, but also the skill and fitness to practise of the health care worker and patient circumstances (e.g. if the patient is restless or agitated).

4. THE DUTIES AND OBLIGATIONS OF HEALTH CARE WORKERS WHO ARE OR MAY BE INFECTED WITH HIV

- 4.1 The current statements of the General Medical Council, General Dental Council and the Nursing and Midwifery Council about the ethical responsibilities of health care workers towards their patients are set out at **Annex B**. These responsibilities are equally applicable to all other professional groups not covered by these regulatory bodies.
- 4.2 All doctors, dentists, nurses, midwives, health visitors and other professionals who have direct clinical care of patients, have a duty to keep themselves informed and updated on the codes of professional conduct and guidelines on HIV infection laid down by their regulatory bodies and any relevant guidance issued by the Health Departments.
- 4.3 In addition, students should be made aware of the implications of these statements and of the contents of this guidance (**see also Paragraphs 1.1 and 5.2**)
- 4.4 All health care workers are under ethical and legal duties to protect the health and safety of their patients. Under the Health and Safety at Work etc. Act 1974, health care workers who are employees have a legal duty to take reasonable care for the health and safety of themselves and of others, such as colleagues and patients, and to co-operate with their employer in health and safety matters.
- 4.5 Self-employed health care workers have general duties to conduct their work so that they and others are not exposed to health and safety risks. The Employment Medical Advisory Service of the Health and Safety Executive (HSE) is able to act as a liaison point between health care employers and their employees, and HSE. It may also be approached by infected health care workers wishing to seek advice on health and safety issues.
- 4.6 HIV infected health care workers must not rely on their own assessment of the risk they pose to patients.
- 4.7 A health care worker who has any reason to believe they may have been exposed to infection with HIV, in whatever circumstances, must promptly seek and follow confidential professional advice on whether they should be tested for HIV. Failure to do so may breach the duty of care to patients.
- 4.8 Examples of how a person in the UK may have been exposed to HIV infection include if they have:
- engaged in unprotected sexual intercourse between men;
 - shared injecting equipment whilst misusing drugs;

- had unprotected heterosexual intercourse in, or with a person who had been exposed in, a country where transmission of HIV through sexual intercourse between men and women is common;
- engaged in invasive medical, surgical, dental or midwifery procedures in parts of the world where infection control precautions may have been inadequate;
- had a significant occupational exposure to HIV infected material in any circumstances.

Additionally, a person who is aware that they had unprotected sexual intercourse with someone in any of the above categories may also have been exposed to HIV infection.

- 4.9 HIV infected health care workers must promptly seek and follow appropriate expert medical and occupational health advice. If there is no occupational health physician available locally, consideration should be given to contacting one elsewhere. Those who perform or who may perform exposure prone procedures must obtain further expert advice about modification or limitation of their working practices to avoid exposure prone procedures. Procedures which are thought to be exposure prone must not be performed whilst expert advice is sought (see **Section 6**).
- 4.10 If there is uncertainty whether an HIV infected worker has performed exposure prone procedures, a detailed occupational health assessment should be arranged. The UKAP can be consulted by the occupational health physician, the health care worker or a physician on their behalf if there is doubt. The health care worker's identity should not be disclosed to the UKAP (any correspondence must be anonymised or pseudonyms used).
- 4.11 If it is believed that any exposure prone procedures have been performed and that a patient notification exercise needs to be considered, then the infected health care worker or their chosen representative (e.g. the occupational health physician or the HIV physician) should inform the DPH of the relevant PCT/NHS Board in Scotland on a strictly confidential basis.
- 4.12 The DPH or a delegated colleague (e.g. Consultant in Communicable Disease Control (CCDC) or CPHM in Scotland) will in turn make an appraisal of the situation to decide whether a patient notification exercise is warranted, consulting Regional Epidemiologists, Regional Directors of Public Health or in Scotland, SCIEH and UKAP, if necessary. The medical director of an employing trust should also be informed in confidence at this stage (see **Section 8**).

- 4.13 The health care worker, the occupational health physician or the HIV physician should not make the decision about whether a patient notification exercise needs to be considered.
- 4.14 HIV infected health care workers who do not perform exposure prone procedures, but who continue to provide clinical care to patients must remain under regular medical and occupational health supervision. They should follow appropriate occupational health advice, especially if their circumstances change (see **Section 6**).
- 4.15 Once any health care worker has symptomatic HIV disease, closer and more frequent occupational health supervision is necessary. As well as providing support to the worker, the aim of this is to detect at the earliest opportunity any physical or psychological impairment which may render a worker unfit to practise, or may place their health at risk.
- 4.16 HIV infected health care workers applying for new posts should complete health questionnaires honestly. HIV infection is a medical condition about which an occupational physician should be informed, verbally if preferred. Details will remain confidential to the occupational health department, as for other medical conditions disclosed in confidence to occupational health practitioners (see **Paragraphs 6.7 and 6.8**).
- 4.17 Health care workers who know or have good reason to believe (having taken steps to confirm the facts as far as practicable) that an HIV infected worker is practising in a way which places patients at risk, or has done so in the past, must inform an appropriate person in the health care worker's employing authority (e.g. an occupational health physician) or, where appropriate, the relevant regulatory body. The DPH should also be informed in confidence. The UKAP can be asked to advise when the need for such notification is unclear. Such cases are likely to arise very rarely. Wherever possible, the health care worker should be informed before information is passed to an employer or regulatory body.

5. THE RESPONSIBILITIES OF EMPLOYERS AND COMMISSIONING BODIES

- 5.1 All employers in the health care setting should ensure that new and existing staff (including agency and locum staff and visiting health care workers) are aware of this guidance and of the professional regulatory bodies' statements of ethical responsibilities, and occupational health guidance for HIV/AIDS infected health care workers. This may include issuing regular reminders. Commissioners may wish to stipulate this when placing service agreements with NHS Trusts. This advice is also applicable to the private sector. Under the Control of Substances Hazardous to Health (COSHH) Regulations 1999, employees must receive suitable and sufficient information, instruction and training on the risks and precautions to be taken.⁴
- 5.2 Medical, dental, nursing and midwifery schools, colleges and universities should draw students' attention to this guidance and the relevant professional statements. Each training establishment should identify a nominated officer with whom students may discuss their concerns in confidence. In addition, all students should be appropriately trained in procedures and precautions to minimise the risk of occupational blood-borne virus transmission. All these issues should be addressed before there is clinical contact with patients.
- 5.3 Where an employer or member of staff is aware of the health status of an infected health care worker, there is a duty to keep any such information confidential. They are not legally entitled to disclose the information unless that individual consents, or in exceptional circumstances (see **Section 10**). A decision to disclose without consent should be carefully weighed as authorities or persons taking such action may be required to justify their decision.
- 5.4 Employers should assure infected health care workers that their status and rights as employees will be safeguarded so far as practicable. Where necessary, employers should make every effort to arrange suitable alternative work and retraining opportunities, or where appropriate, early retirement for HIV infected workers, in accordance with good general principles of occupational health practice.
- 5.5 The Disability Discrimination Act 1995 makes it unlawful to discriminate against disabled persons including those with symptomatic AIDS or HIV infection in any area of employment, unless the employer has justification because of a material and substantial reason. The restriction of such a worker for the purpose of protecting patients from risk of infection, such as the requirement to refrain from performing exposure prone procedures, would justify discrimination. However the employer who knows that the worker is disabled has a duty to make reasonable adjustment, e.g. by moving the worker to a post, if available, where exposure prone procedures could be avoided. Asymptomatic HIV infection does not currently bring the worker within the protection of the Disability Discrimination Act 1995.

- 5.6 The NHS Injury Benefits Scheme (or HPSS Injury Benefits Scheme in Northern Ireland) provides temporary or permanent benefits for all NHS employees who lose remuneration because of an injury or disease attributable to their NHS employment. The scheme is also available to general medical and dental practitioners working in the NHS. Under the terms of the scheme it must be established whether on balance of probabilities the injury or disease was acquired during the course of NHS work.
- 5.7 Although HIV is not a prescribed disease under the Social Security Acts, health care workers who have acquired HIV infection because of exposure to HIV infected material in the workplace may be able to claim Industrial Injuries Disablement Benefit where there has been an accident arising out of and in the course of employment, e.g. a needlestick injury.

6. THE ROLE AND RESPONSIBILITIES OF THE OCCUPATIONAL HEALTH SERVICE AND HIV PHYSICIANS

- 6.1 All matters arising from and relating to the employment of HIV infected health care workers should be co-ordinated through a specialist occupational health physician.
- 6.2 The HIV physician providing the necessary regular care to an infected worker should liaise with the occupational health physician and preferably they should jointly manage the case.
- 6.3 Occupational health services which do not employ a specialist occupational physician should refer individuals to such a physician in another unit. The Association of National Health Service Occupational Physicians (ANHOPS) has issued guidance to its members and has given a list of specialist occupational physicians who can be contacted by those working in occupational medicine in the field (see **Annex D**). The close involvement of occupational health departments in developing local procedures for managing HIV infected health care workers is strongly recommended.
- 6.4 If such arrangements do not exist, the Faculty of Occupational Medicine or ANHOPS will also put independent contractors and other non-NHS staff in touch with a specialist occupational health physician. Alternatively, the physician looking after the worker may contact the UKAP for advice.
- 6.5 Whilst the occupational health physician has responsibility for occupational medical management and assessment, if a physician is not immediately available, some infected health care workers may initially seek advice from an occupational health nurse. The nurse should make every effort to arrange for the health care worker to see the occupational health physician as soon as possible. If necessary the occupational health nurse should seek confidential advice directly from the UKAP. As for any other referral to the UKAP, identification of the worker should be avoided.
- 6.6 Patient safety and public confidence are paramount and dependent on the HIV infected, or potentially infected, health care worker observing their duty of self-declaration to an occupational physician. Employers should promote a climate that encourages such confidential disclosure. It is extremely important that HIV infected health care workers receive the same rights of confidentiality as any patient seeking or receiving medical care. Occupational health practitioners, who work within strict guidelines on confidentiality, have a key role in this process, since they are able to act as an advocate for the health care worker and adviser to the employing authority. They should adopt a proactive role in helping health care workers to assess if they have been at risk of HIV infection and encourage them to be tested for HIV if appropriate (see **Paragraphs 4.7-4.9**).

- 6.7 Occupational health records are held separately from other hospital notes and can be accessed only by occupational health practitioners, who are obliged ethically and professionally not to release records or information without the consent of the individual. Conversely, occupational health practitioners do not have access to hospital notes. There are occasions when an employer may need to be advised that a change in duties should take place, but HIV status itself normally would not be disclosed without the health care worker's consent. However it may be necessary in the public interest for the employer and the DPH to have access to confidential information where patients are, or may have been, at risk.
- 6.8 Occupational physicians are well placed to act as advocates for the worker on issues of retraining and redeployment, or, if indicated, medical retirement. Occupational health departments have a key role to play in developing local policies for the management of infected health care workers' future employment.

7. THE ROLE OF THE UK ADVISORY PANEL FOR HEALTH CARE WORKERS INFECTED WITH BLOOD-BORNE VIRUSES (UKAP)

- 7.1 Details of UKAP's general remit and contact details are provided in **Annex C**.
- 7.2 UKAP advises as a committee and is available to be consulted through its Secretariat:
- when the general guidelines in this document cannot be applied to individual cases;
 - when assistance is required to help decide if a patient notification exercise is warranted;
 - when health care workers or their professional advocates dispute local advice;
 - if advice is needed about modification of working practices to avoid exposure prone procedures prospectively;
 - where special circumstances exist.
- 7.3 The UKAP can also advise individual health care workers or their professional advocates on how to obtain guidance on working practices.
- 7.4 Those seeking the advice of the UKAP should ensure the anonymity of the referred health care worker and should avoid the use of personal identifiers.

8. WHEN A PATIENT NOTIFICATION EXERCISE SHOULD BE CONDUCTED

Purpose of patient notification

8.1 Notification of patients identified as having been exposed to a risk of HIV infection by an infected health care worker is considered necessary:

- to provide the patients with information about the nature of the risk to which they have been exposed;
- to detect any HIV infection, provide care to the infected person and advice on measures to prevent onward HIV transmission;
- to collect valid data to augment existing estimates of the risk of HIV transmission from an infected worker to patients during exposure prone procedures.

8.2 The overall objective of patient notification is to identify the patient population at a distinct risk of exposure to the infected health care worker's blood during exposure prone procedures. These patients should be contacted, offered counselling and encouraged to have an HIV antibody test. The decision on how far to look back should be taken by the DPH on a case-by-case basis after a criteria-based risk assessment has been carried out.

Risk assessment of need for patient notification

8.3 EAGA has advised that it is not necessary any longer to notify automatically **every** patient who has undergone **any** exposure prone procedure by an HIV infected health care worker because the overall risk of transmission is very low.

8.4 Instead, EAGA has recommended that the decision on whether a patient notification exercise should be undertaken should be made on a case-by-case basis using three risk assessment criteria. These are:

- evidence of possible HIV transmission; if found, a patient notification exercise should always be carried out and **all** exposed patients contacted;
- the nature and history of the clinical practice of the health care worker; this would take into account the clinical speciality and the level of risk of various exposure prone procedures performed (**see Paragraph 8.6**);
- other relevant considerations, for example
 - evidence of poor clinical practice (e.g. poor infection control and frequent needlestick injuries);

- evidence of physical or mental impairment as a result of symptomatic HIV disease (or any other disease) which could affect the HIV infected health care worker's standard of practice. Examples include visual impairment, neurological deficit and dementia.
- other relevant medical conditions, e.g. skin diseases such as weeping eczema.

8.5 The definition of exposure prone procedures given in paragraph 3.4 embraces a wide range of procedures, in which there may be very different levels of risk of bleed-back (injury to the health care worker resulting in the worker's blood contaminating the patient's open tissues - **see Paragraph 1.6**). A risk-based categorisation of clinical procedures has been developed including procedures where there is negligible risk of bleed-back (non- exposure prone procedures) and three categories of exposure prone procedures with increasing risk of bleed-back.

8.6 The definitions and examples of categories 1, 2 and 3 are:

Category 1

Procedures where the hands and fingertips of the worker are usually visible and outside the body most of the time and the possibility of injury to the worker's gloved hands from sharp instruments and/or tissues is *slight*. This means that the risk of the health care worker bleeding into a patient's open tissues should be *remote*.

Examples: *local anaesthetic injections in dentistry, removal of haemorrhoids.*

Category 2

Procedures where the fingertips may not be visible at all times but injury to the worker's gloved hands from sharp instruments and/or tissues is *unlikely*. If injury occurs it is likely to be noticed and acted upon quickly to avoid the health care worker's blood contaminating a patient's open tissues.

Examples: *routine tooth extractions, appendicectomy.*

Category 3

Procedures where the fingertips are out of sight for a significant part of the procedure, or during certain critical stages, and in which there is a *distinct* risk of injury to the workers gloved hands from sharp instruments and/or tissues. In such circumstances it is possible that exposure of the patient's open tissues to the health care workers blood may go unnoticed or would not be noticed immediately.

Examples: *hysterectomies, caesarean sections, open cardiac surgical procedures.*

8.7 A comprehensive categorisation of the most common clinical procedures depending upon the relative risk of bleed-back is being developed with the assistance of the Royal Colleges and their specialist associations. This will be available from the Department of Health in Autumn 2002.

8.8 In assessing the “other relevant considerations” criterion, the following information will be helpful:

- the health care worker’s current or past health;
- any information to suggest that the infection could have affected his or her working practices, e.g. visual impairment, neurological deficit or dementia;
- whether the health care worker has a skin condition (e.g. weeping eczema);
- the employment history of the health care worker;
- any evidence of the health care worker not following recommended infection control practices;
- any direct evidence available that might suggest that the health care worker was at higher risk of transmitting HIV, e.g. reported episodes of needlestick injuries.

Additional information for risk assessment and deciding length of patient notification

8.9 In carrying out a risk assessment and deciding on how far back patient notification should go, the following information will also be needed. The co-operation of the health care worker will be needed, and should be sought in as sensitive a manner as possible, preferably by his or her own physician:

- confirmation of the date of diagnosis. Steps should be taken to ensure that there is no doubt that the worker is HIV infected, including repeat testing in a UK laboratory if appropriate;
- any information to suggest when the health care worker was infected. For example:
 - evidence of a possible seroconversion illness;
 - previous documented negative HIV tests;
 - presence of symptomatic HIV disease;
 - having worked in a country with a high prevalence of HIV infection;
 - other risk factors, e.g. injuries, blood transfusion etc.

- whether there any stored sera that could be tested (with informed consent) to obtain further information;
- a carefully documented clinical history (including dates, places and results of tests for HIV antibody, HIV viral load, and CD4 cell counts) to assemble a record of the course of HIV infection;
- the interval between the health care worker being diagnosed as HIV positive and reporting this to an occupational health physician or to public health officials; what recommendations were made then and were they documented; did the health care worker continue to practise during this time;
- the nature of the duties performed while likely to have been HIV infected;
- whether the health care worker is willing for his or her medical adviser(s) to provide information on all/any of the above;
- after first seeking specialist virological advice on specimen collection and processing, specimens suitable for HIV isolation and gene sequencing should be obtained from the worker and securely stored in anticipation of a possible need for investigation at a later date.

8.10 Ideally, the bulk of the clinical history should be obtained from the health care worker. If for any reason this is not possible or appropriate, the history may require reconstruction or supplementation from other data sources after appropriate consent has been obtained. These may include hospital in-patient or out-patient notes, general practice records and the health care worker's partner and family.

8.11 Although it is unlikely that the date of the **onset** of the worker's infection with HIV will be known, in some cases the clinical history may indicate when this was likely to have occurred.

8.12 Where the duration of infection is unknown, where a clinical history cannot be obtained or if the health care worker has AIDS or has died, it is currently recommended that in the first instance patients who have undergone relevant exposure prone procedures during the preceding **10** years be notified, where records are still available. If there is evidence of transmission of HIV from the health care worker to a patient during this time then patient notification should be extended for as long as is possible.

Deciding whether patient notification should take place

8.13 Where there is evidence of HIV transmission from infected health care worker to patient, all patients who have undergone exposure prone procedures by that health care worker should be notified, counselled and offered an HIV test. In the absence

of evidence of HIV transmission, all patients who have undergone category 3 procedures by an HIV infected healthcare worker should be notified, counselled and offered an HIV test. Notification of patients who have undergone procedures placed in categories 1 or 2 is **not** necessary unless information gathered under the other relevant considerations criterion suggests that it is.

- 8.14 If a DPH is informed by an HIV infected health care worker or their advocate that exposure prone procedures may have been performed, he or she should make a careful appraisal of the facts, seeking relevant specialist advice (e.g. occupational health, epidemiological and virological advice). It may be helpful to review some records of those treated by the infected health care worker to assess the range of procedures performed. As mentioned already, the need for patient notification will depend on the specific circumstances of each case and the perceived risk of bleed-back. Specialist epidemiological and virological advice can also be sought. This process should involve as few other people as possible, on a strictly confidential "need to know" basis.
- 8.15 The decision about the need for a patient notification exercise should rest with the DPH, supported as necessary by the Regional Epidemiologist and the Regional Director of Public Health, or in Scotland, SCIEH. The DPH is best placed to assess all the contributing factors and to guide PCTs, NHS trusts and others as to appropriate action needed. When a patient notification exercise is to be undertaken the DPH or delegated person (e.g. CCDC, or CPHM in Scotland) should inform the UKAP. If more than one PCT is involved, it will be appropriate for the Regional Epidemiologist(s) to become involved at this stage.
- 8.16 The UKAP should be consulted if there is doubt about the need for a patient notification exercise. This may arise if there is difficulty in reaching a conclusion locally about the categories of procedures performed by the health care worker or the application of the other criteria. UKAP should also be informed in writing of incidents where it is concluded that a patient notification is not warranted.
- 8.17 When it has been decided that a patient notification exercise is necessary, a small incident team should be set up locally. The DPH or delegated person (e.g. CCDC, or CPHM in Scotland) should promptly notify in confidence the DPH covering any other employing authority involved in the exercise. They should also inform the regional epidemiologist, who can assist in facilitating liaison and co-ordinating activities across boundaries, the PHLS Communicable Disease Surveillance Centre (for cases in England, Wales and N.Ireland) or the Scottish Centre for Infection and Environmental Health (see **Annex D**). Consideration should be given also to the need for a multi-PCT incident team. The lead PCT should be identified, and the roles of members of local as well as multi-PCT teams should be clarified at the outset.
- 8.18 The number of individuals who know the identity of the infected worker should be kept to a minimum at all stages. It may not be necessary for all members of the team(s) to be aware of the identity of the infected worker. The consent of the infected worker to disclosure should be obtained where possible.

9. CARE OF THE HEALTH CARE WORKER

- 9.1 The interests of the health care worker and their family are very important. Where possible, the health care worker should be kept informed of decisions about the patient notification exercise. With their family, they may need immediate practical or psychological support including measures to protect privacy. If the health care worker has been only recently diagnosed as HIV infected, access to counselling and specialist medical advice will be needed, including a consideration of antiretroviral drug therapy.
- 9.2 It is important to make every effort to keep the health care worker's confidence during the assessment period and afterwards. Assurances should be given about measures to protect their identity, and that an injunction to prevent publication of their name will be sought on their behalf as necessary (see **Paragraphs 8.18, 10.2 and 11.40**).
- 9.3 The worker or their family may wish to seek their own independent legal advice. If they do seek legal advice it will be helpful for the authority's legal advisers to keep in regular contact with those representing the health care worker.
- 9.4 Infected health care workers who normally perform exposure prone procedures as part of their duties will need to modify their practice or seek retraining or redeployment. Advice on the former can be obtained in the first instance from a specialist occupational health physician who may wish to take advice from the UKAP. The Trust's director of human resources and/or the regional postgraduate dean should be approached for advice on retraining and redeployment issues or alternative careers.
- 9.5 It is important that staff who are involved in managing the incident, particularly the DPH, do not act as personal advisers or advocates for the health care worker. A specialist occupational health physician may be the most appropriate person to represent the workers' interests (see **Section 6**).

10. CONFIDENTIALITY CONCERNING THE INFECTED HEALTH CARE WORKER

- 10.1 There is a general duty to preserve the confidentiality of medical information and records. Breach of this duty is very damaging for the individuals concerned and it undermines the confidence of the public and of health care workers in the assurances about confidentiality which are given to those who come forward for examination or treatment. In dealing with the media, and in preparing press releases where necessary, it should be stressed that individuals who have been examined or treated in confidence are entitled to have their confidence respected.
- 10.2 Every effort should be made to avoid disclosure of the infected worker's identity, or information which would allow deductive disclosure. This should include the use of a media injunction as necessary to prevent disclosure of a health care worker's identity (see **Paragraph 11.40**). The use of personal identifiers in correspondence and requests for laboratory tests should be avoided and care taken to ensure that the number of people who know the worker's identity is kept to a minimum (see **Paragraph 8.18**). Any unauthorised disclosure about the HIV status of an employee or patient constitutes a breach of confidence and may lead to disciplinary action or legal proceedings. Employers should make this known to staff to deter open speculation about the identity of an infected health care worker.
- 10.3 The duty of confidentiality, however, is not absolute. Legally, the identity of infected individuals may be disclosed with their consent or without consent in exceptional circumstances where it is considered necessary for the purpose of treatment, or prevention of spread of infection. Any such disclosure may need to be justified.
- 10.4 In balancing duty to the infected health care worker and the wider duty to the public, complex ethical issues may arise. As in other areas of medical practice, a health care worker disclosing information about another health care worker may be required to justify their decision to do this. The need for disclosure must be carefully weighed and where there is any doubt the health care worker considering such disclosure may wish to seek advice from his or her professional body.
- 10.5 The duties of confidentiality still apply even if the infected health care worker has died or has already been identified publicly.

11. GUIDANCE ON NOTIFYING PATIENTS

Identification of exposed patients

- 11.1 Patient identification should be conducted as swiftly as practicable. However, there may be circumstances where it is considered advantageous to adopt a more measured approach to patient identification, and involve fewer personnel. This approach may help to reduce the risk of attracting attention of staff who are not involved, and possibly of the media to unusual activity. For example, if a major public holiday is imminent it may be prudent to postpone embarking on the patient identification process until immediately afterwards. A balance should be sought between conducting patient notification quickly and risking unnecessary public anxiety.
- 11.2 The patient identification process will require the assistance of the medical records officer and setting up a small team who, in some circumstances, may need to work out of hours and over weekends. There may be practical difficulties in tracking medical records, whether manual or computer based, as well as inaccuracies or omissions within the records themselves. If at all possible, patient identification should be complete before any public announcement is made to reduce unwarranted public anxiety. In practice, particularly when large numbers of patients are concerned and if the media have become aware, this may not be possible.
- 11.3 The number of people who need to know the identity of the worker should be kept as small as possible, even though a larger number of people may need to know that there is an incident. In some cases, for example, it may be possible for staff who do not know the worker's identity to perform a preliminary search of records for particular exposure prone procedures. These records may then be searched for procedures performed by the infected worker by those who know the worker's identity.
- 11.4 Depending on the particular circumstances, patient identification may include:
- checking operating theatre, delivery room, accident and emergency department records, dental records, and hospital or departmental computer records. It will often be necessary to use several sources, and data will require amalgamation and cross-checking;
 - abstracting the following patient details: full name, date of birth, hospital number or other identifier, last known address/telephone number, date of death if known to have died, name, address and telephone/fax number of GP, date(s) and type and full name/description of procedure(s) performed by the health care worker, and the role played;
 - further examination of records of patients known to have died, including review of death entry records.

- 11.5 When more than one PCT is involved, these activities should take place according to a timescale agreed by the multi-PCT incident team. The Regional Epidemiologist(s) or in Scotland, SCIEH, will play an important role in co-ordination and facilitation of liaison.
- 11.6 At the start of the patient notification exercise the procedures which the health care worker is known to have performed (or is likely to have performed) should be reviewed and categorised according to level of risk of bleed-back (categories 1 to 3). If category 1 or 2 procedures have been carried out, the need to notify patients should be assessed taking account of the other two risk assessment criteria.
- 11.7 It is important that procedures are described in sufficient detail to allow their categorisation by risk of bleed-back. Any abbreviations should be used with care to avoid misinterpretation.
- 11.8 Once patient identification is complete, a list of patients' names and procedures should be given in confidence to the incident team.

Contacting patients

- 11.9 In deciding how best to contact patients and the information to be given, the following factors should be borne in mind:
- the numbers likely to be involved;
 - the profile of the patients who may require notification;
 - the type of operation or procedures undertaken;
 - whether children are involved.
- 11.10 As a general principle, it is preferable for patients to be personally contacted by a counsellor, health adviser or other relevant health professional before any press announcement is made and every effort should be made to do so.
- 11.11 However, in large-scale patient notification exercises it may be judged neither reasonable nor practicable to contact exposed patients personally, in which case they should be contacted by other means such as by letter.
- 11.12 For elderly or other more vulnerable patients, for example, those receiving psychiatric care (who may be disproportionately worried by receiving a letter), it may be preferable to write to the GP first, asking them to decide whether it is appropriate to inform the patient. However not all such cases are likely to be recognisable during the patient identification process.

Writing to patients

- 11.13 If possible, letters to patients should be sent so that they arrive before or on the day of any planned press statement. The addresses should be checked and letters sent by first class post marked strictly private and confidential. If letters are sent directly to patients, it is suggested that local GPs are written to at the same time to inform them that a patient notification exercise is underway, and to advise them which of their patients, if any, are involved.
- 11.14 It is helpful to enclose a pre-paid envelope and reply slip for the patient/GP to return, to confirm they have received the letter. This assists with the documentation and further handling of the incident.
- 11.15 The letters should give details of a dedicated confidential helpline number. Patients receiving a letter may be very anxious to discuss the situation or arrange to have an HIV test at the earliest opportunity. Details of the local general helpline number and the National AIDS Helpline number should also be included (see **Paragraphs 11.21-11.22**).
- 11.16 Most patients' addresses should be available from the case notes, but more up to date addresses may be obtained from the PCT, NHS Board in Scotland or health and social services board, although identifying a new address when the patient has moved out of the area can take some time. Where the PCT or board has no record of a particular patient they may possibly be traced through the NHS Central Registry at Southport or Edinburgh, or the Central Services Agency in Northern Ireland.

Staff in the hospital(s) involved in the patient notification exercise

- 11.17 Staff in the hospital(s) involved may also be worried and concerned about the issues surrounding HIV or AIDS, the effect of the exercise on their relationships with patients, or because they know or worked with the health care worker. They may also be contacted by worried patients. It is recommended that appropriate staff are briefed by the incident team about the exercise, initially on a strictly need to know basis, or more widely if details have entered the public domain or are likely to do so. The identity of the infected worker should not be revealed or discussed.

General security and confidentiality of records

- 11.18 The general conditions applying to confidential information about patients are equally valid in patient notification exercises. This includes not only the names of patients being contacted, but also the names of those who have phoned the helplines. It therefore is important to restrict access to the local incident room or to any other place where confidential records may be held. In addition, general heightened security measures will be necessary as there may be unauthorised attempts to gain access to this information.

11.19 Documents which include details that can directly identify the health care worker or patients ideally should not be left on the hard disk of an unattended computer. If they are, they should be protected by passwords which should be changed regularly. All hard copy files and diskettes must be properly locked away in a secure place when not in use, and access to these should be limited to as few people as practicably possible.

11.20 If there is any doubt about security during electronic transmission, this route should not be used.

Telephone helplines

11.21 If details about an infected health care worker incident have entered or are likely to enter the public domain, PCTs/NHS Trusts should consider setting up a general helpline in addition to the specific helpline offered to patients contacted in the lookback. This will help avoid the hospital switchboard becoming jammed. It may be appropriate to contract existing local HIV helplines or *NHS Direct* to help provide such a service. The National AIDS Helpline can also provide more general help and advice. Any local helpline should also take account of the particular needs of people whose first language is not English.

11.22 If establishing a local helpline, it is useful to bear the following in mind:

- the telephone company should be contacted immediately the decision to set up a general helpline has been made;
- large numbers of telephone lines can take 24-48 hours to establish. If necessary, start with as many lines as can be made available at the time and then introduce more, once available. Lines can be decommissioned as demand subsides;
- the number of calls can be very large. At the start of larger incidents in the past, helplines often have had to deal with 300-400 calls an hour. This may, in part, have been due to the public alarm provoked by the widespread publicity given to their existence;
- the desirability of publicising a general helpline number should be balanced against the possibility that this may provoke needless alarm and that members of the public may feel they ought to contact it;
- lines should ideally operate from 8am to midnight in the first instance and over the weekend. An answerphone with a reassuring message, including the National AIDS helpline number, should be in operation overnight;
- helplines should not be routed through the main hospital switchboard, otherwise they will become jammed;

- staff manning any helpline will need briefing and discussions with the incident team, so that they are able to reassure callers that any patient who is considered to have been placed at risk of HIV infection will be notified individually, counselled, and offered testing. Depending on the complexity of the case finding process, this may not be until after an evaluation phase has been completed;
- when patient identification is not complete callers should be told that they will be contacted, if appropriate, once their records have been checked;
- if patient identification is complete and a patient calls a helpline insisting that they have been treated by the worker whose identity is in the public domain but there is no record of this, their views must be respected;
- in the event that helplines are continually blocked, experience has shown some people telephone or come directly to the hospital. Switchboard and reception staff may require briefing and should know where to refer them. Such patients should be seen by a well briefed staff member on site as soon as possible.

Pre-test discussion and testing of patients

- 11.23 Patients who are contacted as part of a patient notification exercise should be informed that they may have been exposed to a low risk of HIV transmission from an infected health care worker and should be counselled and offered an HIV test.
- 11.24 People considering whether to have an HIV test may require reassurance concerning any effect this may have on their insurance. The Association of British Insurers has recommended to its members that for life insurance proposals and proposals for other types of insurance where health or lifestyle questions are asked, they no longer ask whether the applicant has had counselling or a negative test for HIV infection. Insurers continue to be entitled to ask about any positive HIV test result in connection with a life insurance application.
- 11.25 Arrangements should be in place for voluntary confidential HIV testing of patients who have undergone exposure prone procedures. Staff responsible for pre-test discussion will need to explain that occasionally a second specimen may be needed and that this does not necessarily indicate that HIV infection is present.
- 11.26 A large number of patients may decide to be tested for HIV infection. Such testing must be undertaken by an accredited laboratory with the facilities and experience to handle a heavy demand for testing, and which participates in a quality assurance scheme for HIV testing. The laboratory director should be consulted before any local arrangements are made. The laboratory director will also arrange for confirmatory testing and HIV gene sequence investigations where these are required.

- 11.27 If the patient's exposure prone procedure occurred less than three months earlier, the HIV test should be repeated at least three months following the procedure. This is because of the "window period" between infection with HIV and appearance of HIV antibody.
- 11.28 The results of the test must be made available to the patient as soon as possible, ideally by the person who provided pre-test discussion.
- 11.29 Depending on circumstances, it may be helpful if the laboratory forms accompanying patients' specimens are marked with an agreed code. This will allow any peripheral laboratories to recognise tests which relate to a particular incident and will facilitate the rapid reporting of results. Ideally these should all go through the same laboratory.
- 11.30 Any initially reactive test results should be discussed with a reference laboratory as a matter of urgency so that confirmatory HIV tests can be rapidly completed.
- 11.31 Laboratories should report relevant HIV test results to the incident team for incorporation into the patient notification database.

Further investigation of HIV positive results

- 11.32 In any exercise of this nature it is possible that unrelated positive test results may be obtained because of risk factors other than treatment by the infected health care worker. A repeat blood specimen should be collected from such patients and tested in a reference laboratory (see **Annex D**).
- 11.33 If the presence of HIV infection is confirmed, the patient should promptly be referred to a specialist HIV physician for clinical management. The following investigations should also be undertaken:
- the senior investigator should personally undertake a detailed record review to document the exposure prone procedure and to confirm that the HIV infected patient was exposed to the HIV infected worker. Copies of the relevant records should be made and securely stored;
 - if the patient received any blood or blood products, the National Blood Service should be asked to investigate the donors;
 - the infected patient should be interviewed by an experienced clinician or counsellor in order to obtain a detailed history of risk factors for HIV infection;

- specimens suitable for HIV isolation and HIV gene sequencing should be obtained from the infected patient and securely stored;
- consideration should be given to offering HIV testing to the patient's sexual partner(s);
- specialist epidemiological and virological advice on further investigation should be sought.

Dealing with the media

- 11.34 A nominated press officer should be part of the incident team from the start of the exercise. If at all possible, he or she should have experience of working with the national media and should liaise with both the Directorate of Health and Social Care press officer and the Department of Health press officer, if appropriate (see **Annex D**).
- 11.35 External pressure should be resisted and should not be permitted to prompt inappropriate action in haste, although it is accepted that public concern may influence the speed with which the case finding process is undertaken. Unnecessary or inappropriate notification (e.g. patients who have not undergone an exposure prone procedure) can cause unjustifiable distress, and detract from the value and acceptability of properly targeted patient notification exercises.
- 11.36 In the event of media interest or other external enquiries during the period of evaluation prior to a patient notification exercise, the DPH should acknowledge that a case is being investigated. If necessary the media should be told that when the evaluation is complete anyone who is considered to have been at risk will be notified individually, counselled and offered HIV testing. At the same time, an assurance should be given that the overall risk is considered very low.
- 11.37 A public announcement can give rise to unnecessary public alarm and may result in the loss of confidentiality for exposed patients and the infected health care worker. In some incidents involving small numbers of patients no such announcement has been made. An announcement may be necessary if, for instance, wide knowledge of the incident within a hospital or Trust means that it is likely to become known to the media and public. Although desirable, it is often not possible to complete patient identification or to contact patients before any public announcement is made. This needs to be decided on a case by case basis as local circumstances may vary.
- 11.38 A media statement should be held in readiness at all times, reviewed regularly, for use in the event of media enquiries.
- 11.39 An ideal scenario exists when all exposed patients have been identified and contacted, so that if necessary a press statement could be used to confirm, if the media enquire, that all patients exposed to risk have been informed and others need have no cause for concern.

11.40 If, however, a proactive public announcement is judged necessary, it will normally be made through a press release. This should be as informative as possible to avoid unnecessary public anxiety, whilst avoiding the inclusion of information which could lead to deductive disclosure of the health care worker's identity. The health care worker should not be named. It should:

- refer to "a health care worker" unless more explicit information about the worker's profession has already entered the public domain;
- include details of arrangements which are being or have been made to contact patients;
- reassure that all patients who may have been exposed to risk will be or have been contacted individually, and offered HIV testing as appropriate.

In addition, the "Notes for Editors" might state that a media injunction will be sought and invoked if necessary, to prevent any publication or other disclosure of the worker's identity. If a media injunction is sought, careful consideration should be given to how restrictive it needs be. A very restrictive media injunction may result in greater public alarm than one which allows a limited disclosure of information that would not lead to deductive disclosure of the health care worker's identity.

11.41 If details of an incident are in the public domain, NHS and other relevant authorities may consider that in order to deal effectively with the potentially large number of media enquiries, they should hold a press conference. A medically qualified person, usually the DPH or a deputy, should be present, along with senior managers and the incident team's nominated press officer. Public announcements should not be delayed if it proves difficult to assemble all relevant persons for a press conference. Press conferences may need to be held more than once if there is further media interest.

11.42 If it is known that an HIV infected worker has worked for a number of different authorities, any public announcements should ideally be made by all the authorities concerned at the same time. The multi-PCT incident team should issue a statement which covers all PCTs, or if separate communications are necessary, ensure that the content and timing of these are consistent.

Reviewing the outcome

11.43 Once the incident is over, the head of the incident team should correlate the master list of patients, appropriately coded, and details of the procedures undergone with the HIV antibody test results. The completed dataset should be archived at the PHLS CDSC or the Scottish Centre for Infection and Environmental Health (see **Annex D**). This will be collated with data from all similar patient notification exercises to assist in further epidemiological assessment.

- 11.44 In all cases it is helpful, when the exercise is complete, to evaluate how it was managed, identify pressure points or problems and refine the local action plan accordingly.
- 11.45 The Department of Health would be grateful if the heads of incident team would consider sending summary datasets and/or final reports to the UKAP secretariat to assist in the further development of this guidance (see **Annex B**).

ABBREVIATIONS

ANHOPS	The Association of NHS Occupational Physicians
BBV	Blood-borne virus
CCDC	Consultant in communicable disease control
CDSC	Communicable Disease Surveillance Centre
COSHH	Control of Substances Hazardous to Health Regulations 1999
CPHM	Consultant in Public Health Medicine (Scotland)
DPH	Director of Public health
EAGA	Expert Advisory Group on AIDS
EPP	Exposure prone procedure
HCW	Health care worker
HIV	Human immunodeficiency virus
HSE	Health & Safety Executive
PCT	Primary Care Trust
PHLS	Public Health Laboratory Service
SCIEH	Scottish Centre for Infection and Environmental Health
UKAP	UK Advisory Panel for Health Care Workers Infected With Blood-borne Viruses

REFERENCES

1. Lot F, Séguier J-C, Fégueux S, Astagneau P, Simon P, Aggoune M et al. Probable transmission of HIV from an orthopaedic surgeon to a patient in France. *Ann Int Med* 1999; **130**: 1-6.
2. Ciesielski C, Marianos D, Ou C-Y, Dumbaugh R, Witte J, Berkelman R et al. Transmission of human immunodeficiency virus in a dental practice. *Ann Int Med* 1992; **116**: 798-805.
3. PHLS AIDS and STD Centre at the Communicable Disease Surveillance Centre and Collaborators. Occupational transmission of HIV: summary of published reports. December 1999 edition, data to June 1999. London: PHLS, 1999.
<http://www.phls.co.uk/facts/HIV/hivoctr99.pdf>
4. UK Health Departments. Guidance for clinical health care workers: protection against blood-borne viruses. London: Department of Health, 1998.
<http://doh.gov.uk/chcguid1.htm>

EXAMPLES OF UKAP ADVICE ON EXPOSURE PRONE PROCEDURES

1. The UKAP has been making recommendations about the working practices of health care workers (HCWs) infected with HIV since the end of 1991, and HCWs infected with other blood-borne viruses (BBVs) since September 1993. Advice for occupational physicians arises from individual queries, cases or general issues which have been referred to the UKAP since its inception.

Exposure prone procedure criteria

2. Judgements are made by occupational physicians, or in conjunction with the UKAP where doubt or difficulty exists, about whether any procedure is or is not exposure prone against the following criteria:

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.

3. Occupational physicians and others who need to make decisions about the working practices of infected HCWs may find the advice helpful. In some cases this advice may help clarify matters, and in others may direct the reader to seek further specific advice about the individual case under consideration.

Cautionary note

4. Until now, the UKAP has not favoured issuing guidance about what areas or particular procedures of medical, nursing or midwifery practice involve exposure prone procedures. This is because individual working practices may vary between hospitals and between HCWs. Advice for one HCW may not always be applicable to another. This list must therefore be interpreted with caution, as it provides examples only and is not exhaustive.

Examples of advice given by UKAP

5. The following advice has been given by UKAP in relation to specialities and procedures:

5.1 Accident and Emergency

A + E staff who are restricted from performing EPPs should not provide pre-hospital trauma care (see **Paramedics**).

These staff should not physically examine or otherwise handle acute trauma patients with open tissues because of the unpredictable risk of injury from sharp tissues such as fractured bones. Cover from colleagues who are allowed to perform exposure prone procedures would be needed at all times to avoid this eventuality.

Other exposure prone procedures which may arise in an A + E setting would include rectal examination in presence of pelvic fracture, deep suturing to arrest haemorrhage and internal cardiac massage. In addition, situations where risk of biting of health care workers' fingers is considered significant (such as a violent patient or during an epileptic fit) should be avoided where possible unless the EPP restricted worker is the only person available to provide an immediate life saving intervention. Mouth to mouth resuscitation should not be withheld if the EPP restricted worker is the only immediately available person competent to provide this, but ideally should be delegated to a colleague not restricted from performing EPPs. (see **Resuscitation**).

5.2 Anaesthetics

Procedures performed purely percutaneously are not exposure prone, nor have endotracheal intubation nor the use of a laryngeal mask been considered so. Arterial cutdown involving tissue dissection has been considered exposure prone. Skin tunnelling (used in some pain control procedures) may or may not be exposure prone depending on whether the operator's fingers are at any time concealed in the patient's tissues in the presence of a sharp instrument. It is considered possible to perform a skin tunnelling procedure in a non-exposure prone manner.

5.3 Bone Marrow transplants

Not exposure prone.

5.4 Cardiology

Percutaneous procedures including angiography/cardiac catheterisation are not exposure prone, provided cutdown is not performed to obtain vascular access. Arterial cutdown involving tissue dissection is considered exposure prone. Implantation of permanent pacemakers (for which a skin tunnelling technique is used to site the pacemaker device subcutaneously) may or may not be exposure prone. This will depend on whether the operator's fingers are or are not concealed from view in the patient's tissues in the presence of sharp instruments during the procedure [see 5.2].

5.5 Chiropodists - see Podiatrists

5.6 Dentistry (including hygienists)

The majority of procedures in dentistry are exposure prone, with the exception of examination using a mouth mirror only.

5.7 Ear, Nose and Throat Surgery (Otolaryngology)

ENT surgical procedures generally should be regarded as exposure prone with the exception of simple ear or nasal procedures, and procedures performed using endoscopes (flexible and rigid) **provided fingertips are always visible**. Non-exposure prone ear procedures include stapedectomy/stapedotomy, insertion of ventilation tubes and insertion of a titanium screw for a bone anchored hearing aid.

5.8 Endoscopy

Simple endoscopic procedures (e.g. gastroscopy, bronchoscopy) have not been considered exposure prone but should be avoided by EPP restricted health care workers if a significant risk of biting of the worker's fingers is deemed to be present such as in a violent or fitting patient.

In general there is a risk that surgical endoscopic procedures (e.g. cystoscopy, laparoscopy - see below) may escalate due to complications which may not have been foreseen and may necessitate an open exposure prone procedure. The need for cover from a colleague who is allowed to perform exposure prone procedures should be considered as a contingency.

5.9 General Practice

Exposure prone procedures are rare in General Practice. Possible areas where they may be encountered are minor surgery, obstetrics and trauma situations. See relevant sections for procedures.

5.10 Gynaecology (see also Laparoscopy)

Open surgical procedures are exposure prone. Many minor gynaecological procedures are not considered exposure prone, examples include dilatation & curettage (D&C), suction termination of pregnancy, colposcopy, surgical insertion of depot contraceptive implants/devices, fitting intrauterine contraceptive devices (coils), and vaginal egg collection provided **fingers remain visible at all times when sharp instruments are in use**.

Performing **cone biopsies** with a scalpel (and with the necessary suturing of the cervix) would be exposure prone. Cone biopsies performed with a loop or laser would not in themselves be classified as exposure prone, but if local anaesthetic was administered to the cervix other than under direct vision, i.e. with fingers concealed in the vagina, then the latter would be an exposure prone procedure.

5.11 Haemodialysis/Haemofiltration

See **Renal Medicine**.

5.12 Laparoscopy

Mostly non-exposure prone because fingers are never concealed in the patient's tissues. Exceptions are, exposure prone if main trochar inserted using an open procedure, as for example in a patient who has had previous abdominal surgery. Also exposure prone if rectus sheath closed at port sites using J-needle, and fingers rather than needle holders and forceps are used.

In general there is a risk that a therapeutic, rather than a diagnostic, laparoscopy may escalate due to complications which may not have been foreseen necessitating an open exposure prone procedure. The need for cover from a colleague who is allowed to perform EPPs should be considered as a contingency.

5.13 Midwifery

Simple vaginal delivery and the use of scissors to make an episiotomy cut are not exposure prone. Infiltration of local anaesthetic prior to episiotomy, suturing of an episiotomy and attaching sharp scalp electrodes to baby's head are considered exposure prone.

5.14 Minor Surgery

In the context of GP minor surgery and elsewhere: excision of lipomata and sebaceous cysts should not be performed by an EPP restricted HCW. Any more complex procedures which are occasionally performed in GPs' surgeries by doctors with appropriate experience, such as herniorrhaphy, are exposure prone also.

5.15 Needlestick/Occupational Exposure to HIV

Health care workers need not refrain from performing exposure prone procedures pending follow up of occupational exposure to an HIV infected source. The combined risks of contracting HIV infection from the source patient, and then transmitting this to another patient during an exposure prone procedure is so low as to be considered negligible. However in the event of the worker being diagnosed HIV positive, such procedures must cease in accordance with this guidance.

5.16 Nursing

General nursing procedures do not include exposure prone procedures. The duties of operating theatre nurses should be considered individually. See also sections on **Accident and Emergency, Resuscitation and Renal Medicine/Nursing**.

5.17 Obstetrics/Midwifery

See midwifery. Obstetricians may also perform other surgical procedures, many of which will be obviously exposure prone according to the criteria.

5.18 Operating Department Assistant/Technician

General duties do not normally include exposure prone procedures.

5.19 Ophthalmology

With the exception of orbital surgery which is usually performed by maxillo-facial surgeons (who perform many other EPPs), routine ophthalmological surgical procedures are not exposure prone as the operator's fingers are not concealed in the patient's tissues. Exceptions may occur in some acute trauma cases, which should be avoided by EPP restricted surgeons.

5.20 Orthodontics

Because of the presence of sharp wires on fixed orthodontic appliances which may cause injury to the orthodontist's fingers inside the mouth, and the need for oral examination which may involve the use of sharp instruments, it would be difficult for a worker unfit for EPPs to pursue a career in orthodontics. See also **Dentistry** as some orthodontists perform general dental procedures, the majority of which are exposure prone.

5.21 Paediatrics

Neither general nor neonatal/special care paediatrics has been considered likely to involve any exposure prone procedures, with the exception of cutdown to obtain vascular access (involving tissue dissection). Paediatric surgeons do perform EPPs.

5.22 Paramedics

In contrast to other emergency workers, a paramedic's primary function is to provide care to patients. Direct patient care including intravenous cannulation is not a risk to patients as it is not exposure prone; however, paramedics who are EPP restricted should not perform duties at emergency sites because of risk of injury due to the unpredictability of the situation.

5.23 Pathology

In the event of injury to an EPP restricted pathologist performing a post mortem examination, the risk to other workers handling the same body subsequently is so remote that no restriction is recommended.

5.24 Podiatrists

For podiatrists who are not trained in and do not perform surgical techniques, routine procedures are not exposure prone. EPP restricted podiatrists should not train in surgical techniques, nor should an EPP restricted surgical podiatrist continue to perform surgery. Prior to formalising criteria for exposure prone procedures, the UKAP agreed with a representative from the podiatry profession that there was risk that injury to a podiatrist could result in contamination of a patient's open tissues with the podiatrist's blood.

5.25 Radiology

Arterial cutdown involving tissue dissection should not be performed by EPP restricted workers. All percutaneous procedures, including imaging of the vascular tree, biliary system and renal system, drainage procedures and biopsies as appropriate, are not exposure prone procedures.

5.26 Renal Medicine

Obtaining vascular access at the femoral site in a distressed patient may constitute an exposure prone procedure as the risk of injury to the HCW may be significant. This is more likely to be a problem for haemofiltration (often performed in an emergency) than for haemodialysis (more likely to be instigated electively and patients less likely to be distressed than those who need haemofiltration).

The working practices of those staff who supervise haemofiltration and haemodialysis circuits do not include exposure prone procedures.

5.27 Resuscitation

Unless an equally competent colleague who is allowed to perform exposure prone procedures is present, EPP restricted HCWs **should** provide immediate life saving mouth to mouth resuscitation if they are competent so to do; potential benefit to the patient greatly outweighs the small risk of BBV transmission in these circumstances.

5.28 Surgery (see also Laparoscopy, Minor Surgery)

Open surgical procedures are exposure prone. This applies equally to major organ retrieval because of the risk of contamination of the organ during the procedure and the potential risk to the recipient.

REGULATORY BODIES' STATEMENTS ON PROFESSIONAL RESPONSIBILITIES

1. GENERAL MEDICAL COUNCIL

The GMC Statement, *HIV Infection and AIDS: the Ethical Considerations*, was first sent to all registered medical practitioners in August 1988, and in April 1991 was sent to those who had obtained full registration since 1988. A revised version was sent in June 1993, and this was re-circulated to doctors as part of the series of booklets *Duties of a Doctor* in 1995.

In 1997, it was superseded by the booklet *Serious Communicable Diseases*. This term applies to any disease which may be transmitted from human to human and which may result in death or serious illness. It particularly concerns, but is not limited to, infections such as HIV, tuberculosis and hepatitis B and C.

Excerpts relevant to health care workers with HIV/AIDS are as follows:

Responsibilities of doctors who have been exposed to a serious communicable disease

29. *If you have any reason to believe that you have been exposed to a serious communicable disease you must seek and follow professional advice without delay on whether you should undergo testing and, if so, which tests are appropriate. Further guidance on your responsibilities if your health may put patients at risk is included in our booklet Good Medical Practice.*

30. *If you acquire a serious communicable disease you must promptly seek and follow advice from a suitably qualified colleague - such as a consultant in occupational health, infectious diseases or public health on:*

- *Whether, and in what ways, you should modify your professional practice;*
- *Whether you should inform your current employer, your previous employers or any prospective employer, about your condition.*

31. *You must not rely on your own assessment of the risks you pose to patients.*

32. *If you have a serious communicable disease and continue in professional practice you must have appropriate medical supervision.*

33. *If you apply for a new post you must complete health questionnaires honestly and fully.*

Treating colleagues with serious communicable diseases

34. *If you are treating a doctor or other health care worker with a serious communicable disease you must provide the confidentiality and support to which every patient is entitled.*
35. *If you know, or have good reason to believe, that a medical colleague or health care worker who has, or may have, a serious communicable disease, is practising, or has practised, in a way which places patients at risk, you must inform an appropriate person in the health care worker's employing authority, for example an occupational health physician, or where appropriate the relevant regulatory body. Such cases are likely to arise very rarely. Wherever possible you should inform the health care worker concerned before passing information to an employer or regulatory body.*

2. GENERAL DENTAL COUNCIL

Extract from *Maintaining Standards Guidance to dentists on professional and personal conduct*. November 1997.

This guidance was sent to all registered dental practitioners in December 1997 and replaces the guidance entitled *Professional Conduct and Fitness to Practise*.

Dealing with Cross-Infection

4.1 There has always existed the risk of cross-infection in dental treatment. Therefore, a dentist has a duty to take appropriate precautions to protect patients and other members of the dental team from that risk. The publicity surrounding the spread of HIV infection has served to highlight the precautions which a dentist should already have been taking and which are now more important than ever. Detailed guidance on cross-infection control has been issued by the Health Departments and the British Dental Association, and is endorsed by the Council.

It is unethical for a dentist to refuse to treat a patient solely on the grounds that the person has a blood borne virus or any other transmissible disease or infection.

Failure to employ adequate methods of cross-infection control would almost certainly render a dentist liable to a charge of serious professional misconduct.

Dealing with Transmissible Disease

4.2 A dentist who is aware of being infected with a blood borne virus or any other transmissible disease or infection which might jeopardise the wellbeing of patients and takes no action is behaving unethically. The Council would take the same view if a dentist took no action when having reason to believe that such infection may be present.

It is the responsibility of a dentist in either situation to obtain medical advice which may result in appropriate testing and, if a dentist is found to be infected, regular medical supervision. The medical advice may include the necessity to cease the practice of dentistry altogether, to exclude exposure prone procedures or to modify practice in some other way.

Failure to obtain such advice or to act upon it would almost certainly lead to a charge of serious professional misconduct.

3. UNITED KINGDOM CENTRAL COUNCIL FOR NURSING, MIDWIFERY AND HEALTH VISITING (UKCC) - NOW NURSING AND MIDWIFERY COUNCIL

Extract from: Registrar's Letter 4/1994 Annex 1 *ACQUIRED IMMUNE DEFICIENCY SYNDROME AND HUMAN IMMUNO DEFICIENCY VIRUS INFECTION (AIDS AND HIV INFECTION) The Council's Position Statement.*

The Council's Code of Professional Conduct

- 2. The 'Code of Professional Conduct for the Nurse, Midwife and Health Visitor' is a statement to the profession of the primacy of the interests of patients and clients. Its introductory paragraph states the requirement that each registered nurse, midwife and health visitor safeguard the interest of individual patients and clients. It goes on to indicate to all persons on the register maintained by the Council that, in the exercise of their personal professional accountability, they must 'act always in such a manner as to promote and safeguard the interests and well-being of patients and clients'.*

The Responsibility of Individual Practitioners with HIV Infection

- 13. Although the risk of transmission of HIV infection from a practitioner to a patient is remote, and, on the available evidence much less than the risk of patient to practitioner transmission, the risk must be taken seriously. The Department of Health in England have commissioned a study to evaluate this risk. It is incumbent on the person who is HIV positive to ensure that she or he is assessed regularly by her or his medical advisers and complies with the advice received.*
- 14. Similarly, a nurse, midwife or health visitor who believes that she or he may have been exposed to infection with HIV, in whatever circumstances, should seek specialist medical advice and diagnostic testing, if applicable. She or he must then adhere to the specialist medical advice received. Each practitioner must consider very carefully their personal accountability as defined in the Code of Professional Conduct and remember that she or he has an overriding ethical duty of care to patients.*

UK ADVISORY PANEL FOR HEALTH CARE WORKERS INFECTED WITH BLOOD-BORNE VIRUSES: BACKGROUND INFORMATION

1. Remit and Tasks of the UKAP

The UK Advisory Panel was set up originally under the aegis of the UK Health Departments' Expert Advisory Group on AIDS in 1991, and in 1993 its remit was extended to cover health care workers infected with all blood-borne viruses.

The tasks of the UKAP are:

- . to establish and update as necessary, criteria on which local advice on modifying working practices may be based;
- . to provide supplementary specialist occupational advice to physicians of health care workers infected with blood-borne viruses, occupational physicians and professional bodies;
- . to advise individual health care workers or their advocates how to obtain guidance on working practices;
- . to advise directors of public health on patient notification exercises where these are indicated of patients treated by health care workers with other blood-borne viruses as appropriate;
- . to keep under review the literature on transmission of blood-borne viruses in health care settings and advise the Expert Advisory Group on AIDS and the Advisory Group on Hepatitis on the need for revision of guidelines as necessary.

2. Membership of the UKAP

The Panel is chaired by a lay (non-medical) person.
The following specialities are represented:

Anaesthetics
Dentistry
Epidemiology
General Practice
Hepatology
HIV Disease
Midwifery
Nursing
Obstetrics and Gynaecology
Occupational Health
Public Health
Surgery
Virology

Lay members in addition to the Chairman are also appointed.

The Secretariat is provided by the Health Protection: Communicable Diseases Branch of the Department of Health.

3. Contact with the UKAP

Directors of public health, regional epidemiologists, physicians, occupational health practitioners and others wishing to obtain the UKAP's advice should contact the Medical Secretary by letter, or by telephone if urgent. Any information which may identify the infected health care worker should be withheld. Confidentiality of all information concerning individual referrals will be maintained by the secretariat and members of the UKAP.

Cases are considered by selected members of the UKAP according to the health care worker's area of work. Experts from other specialties not represented on the UKAP are co-opted to advise as necessary.

Address of Secretariat

Department of Health

Room 635B

Skipton House

80 London Road

London SE1 6LH

Telephone: 020- 7972-1533 (Medical Secretary)

020-7972-5684 (Administrative Secretary)

SOURCES OF ADVICE AND SUPPORT

1. **The PHLS Virus Reference Division** at the Central Public Health Laboratory, 61 Colindale Avenue, London NW9 5HT (020-8200 4400) can:
 - . provide facilities for rapid confirmatory testing of specimens initially reactive for anti-HIV antibody;
 - . advise on the collection of specimens for HIV gene sequencing and make provision for the long term storage of specimens;
 - . arrange for any necessary molecular investigations to be conducted in collaboration with other experts.
2. **The PHLS Communicable Disease Surveillance Centre (CDSC)**, 61 Colindale Avenue, London NW9 5EQ (020-8200-6868) and/or Regional Epidemiologists can provide:
 - . background scientific information on the outcome of patient notification exercises which have been conducted;
 - . field advice and support to any incident team established to manage such an incident, including help with drafting model letters and information sheets for GPs and exposed patients;
 - . facilities for collating HIV test results from widely scattered laboratories and forwarding them to the incident team co-ordinating a patient notification exercise;
 - . advice on the investigation of HIV infected persons in whom risk factors for infection have not been identified;
 - . advice on the selection of suitable "control" HIV infected persons, should HIV gene sequencing investigations be considered necessary.
3. **The Scottish Centre for Infection and Environmental Health**, Clifton House, Clifton Place, Glasgow G3 7LN (Tel: 0141-300 1100) can provide similar advice to the above in Scotland.
4. **The National AIDS Helpline, Tel: 0800-567123**. This English language service offers confidential advice, information and referrals on all aspects of HIV and AIDS. The service is free and lines are open 24 hours a day, 7 days a week. Services are also available in other languages.

- 5. Faculty of Occupational Medicine**, Royal College of Physicians, 6 St Andrews Place, Regents Park, London NW1 4LB (Tel: 020-7487-3414).
- 6. Secretary to the Association of National Health Service Occupational Physicians (ANHOPs)**, c/o Sheffield Occupational Health Services, Northern General Hospital, Sheffield S5 7AU Tel: (0114-271 4161).
- 7. Department of Health Press Office**, Richmond House, 79 Whitehall, London SW1A 2NS (Tel 020-7210-5658).
- 8. Association of British Insurers**, 51 Gresham Street, London EC2V 7HQ (Tel 020-7600 3333).
- 9. NHS Pensions Agency**, Injury Benefits Manager, 200-220 Broadway, Fleetwood, Lancashire FY7 8LG.
- 10. Employment Medical Advisory Service (EMAS)/Health and Safety Executive (HSE)** For details of your local EMAS/HSE contact Health and Safety Information, (Tel: 0541-545500).

THE CONSULTATION CRITERIA

The criteria for all UK national public consultations is set out in the Code of Practice for Written Consultations¹ published by the Cabinet Office. This requires that:

1. Timing of consultation should be built into the planning process for a policy (including legislation) or service from the start, so that it has the best prospect of improving the proposals concerned, and so that sufficient time is left for it at each stage.
2. It should be clear who is being consulted, about what question, in what timescale and for what purpose.
3. A consultation document should be as simple and concise as possible. It should include a summary, in two pages at most, of the main questions it seeks views on. It should make it as easy as possible for readers to respond, make contact or complain.
4. Documents should be made widely available, with the fullest use of electronic means (though not to the exclusion of others), and effectively drawn to the attention of all interested groups and individuals.
5. Sufficient time should be allowed for considered responses from all groups with an interest. Twelve weeks should be the standard minimum period for a consultation.
6. Responses should be carefully and open-mindedly analysed, and the results made widely available, with an account of the views expressed, and reasons for decisions finally taken.
7. Departments should monitor and evaluate consultations, designating a consultation co-ordinator who will ensure the lessons are disseminated.

We confirm that these criteria have been, and will continue to be followed.

¹ Code of Practice on Written Consultation, Cabinet Office November 2000

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