Dear Sir / Madam,

Management of HIV-infected Healthcare Workers: A paper for Consultation

The British Medical Association (BMA) is a voluntary, professional association that represents doctors from all branches of medicine all over the UK; It is also an independent trade union, with a total membership of almost 150,000 including more than 3,000 members overseas and over 19,000 medical student members.

BMA Cymru Wales represents some 9,000 members in Wales from every branch of the medical profession.

BMA Cymru Wales welcomes the report of the tripartite working group’s publication on the management of HIV infected healthcare workers. We believe it lays out a sufficient evidence base for changing national guidance which also brings the UK into line with the stance taken by other countries. We believe the tripartite group contains appropriate representatives of the relevant stakeholders.

BMA Cymru Wales considers there should be more specific and detailed guidance on the support which employers should offer to doctors (and others) in the rare event of doctor to patient transmission.

Yours sincerely,

Dr Stefan Coghlan
Chair - BMA Welsh Council
Response to the Welsh Government consultation on the management of HIV infected healthcare workers

Consultation question 1: Do you agree with the tripartite working group’s assessment of the risk of HIV transmission from an infected healthcare worker to a patient during exposure prone procedures?

Yes, we agree with the working group’s assessment.

Consultation question 2: Do you have any comments on the assessment of overall risk of HIV transmission to a patient having an exposure prone procedure of the most invasive type from any healthcare worker? Do you consider it more likely that healthcare workers who think that they are at risk of infection may come forward for HIV testing, if the tripartite working group’s recommendations were implemented, and do you have any evidence for this?

We consider the risk estimate to be reasonable. Healthcare workers would be more likely to come forward for HIV testing if the recommendations were implemented. This would also apply to those who already know that they were HIV positive but haven’t declared it. The attitude change might well be greater in those groups who work outside managed environments (private sector for example) or have only emergency Exposure Prone Procedures (EPP) contact (ambulance staff, some dental nurses).

Consultation question 3: Are the tripartite working group’s main recommendations supported by the available evidence about risk?

Yes, we believe the main recommendations are supported.

Consultation question 4: Does the suggested implementation framework strike an appropriate balance between protecting patient safety and acknowledging the rights and responsibilities of HIV-infected healthcare workers, and is it feasible?

We believe an appropriate balance is struck. The rare situation of a healthcare worker not on combination antiretroviral drug therapy (cART) but who nevertheless maintains a low viral load needs to be addressed in this policy. As it stands, the policy could be seen as pressuring healthcare workers to start cART before it was deemed clinically necessary, in order to perform EPPs. This undermines the principle of treatment according to need.

Consultation question 5: What adjustments will occupational health services need to make to support HIV-infected healthcare workers affected by these recommendations?

Guidance should also be given to occupational health departments on appropriate handling of results of HIV tests – including the identification and protection of confidentiality in a healthcare setting. This may be different from the procedures adopted in GUM clinics. For those individuals affected - albeit they will be few in number - enhanced support and testing is going to have to be implemented. This will be quite onerous as has already been demonstrated by the situation with certain Hepatitis B antigen positive healthcare workers. 3 monthly call-ups and blood testing will be burdensome for all concerned and have a cost. Nevertheless, those healthcare workers who are potentially affected and who have previously been banned from certain work will no doubt be pleased to co-operate. Others will elect to have their practice restricted.

Consultation question 6: Is referral of all cases of HIV-infected healthcare workers infected with HIV who wish to perform exposure prone procedures whilst on combination antiretroviral drug
therapy (cART) to UKAP necessary to ensure consistency in the application of the policy and to help promote best practice? If so, for how long should this continue?

We believe it is unnecessary to refer all cases to the UK Advisory Panel. Instead we would suggest that there needs to be an expectation of better communications and exchange of information between occupational physician and treating HIV specialist, where the patient is in accord. Occupational physicians working in departments who have regular contact with HIV positive healthcare workers will have no difficulty in implementing these procedures. Those who are unfamiliar with such scenarios (on account of a paucity of cases) can always contact their colleagues or the UK Advisory Panel for healthcare workers infected with blood borne viruses (UKAP) for advice.

Consultation question 7: Do you agree that, if the tripartite working group’s recommendations are implemented, patient notification exercises should only routinely take place in connection with untreated HIV-infected healthcare workers, as advised in current national guidance, unless patients may have been at risk of infection e.g. because of an increase in a healthcare worker’s viral load?

Yes, we would agree that patient notification exercises should take place as outlined above.

Consultation question 8: Is national monitoring of policy implementation at the NHS frontline necessary? If so, how should it be done most effectively and proportionately, and what might be the cost implications? Is it appropriate or feasible for local occupational health services to submit local information about HIV-infected healthcare workers to the Health Protection Agency to allow national surveillance of policy?

We think it eminently feasible for local services to submit local information to the HPA to allow national surveillance in much the same way as they report body fluid exposures routinely – however not all areas of the UK are covered by the HPA. We believe that the use / creation of a more appropriate national health protection surveillance body within Wales should be one of the considerations given to national monitoring mechanisms.

Consultation question 9: Does the estimate of the number of healthcare workers who may be affected by the policy seem reasonable? Is there further information that consultees can provide and/or are there further sources of information that the Welsh Government should consult?

This seems a reasonable estimate.

Consultation question 10: Does the consultation impact assessment accurately reflect the possible costs and benefits of the policy, were it to be implemented? Is there further information that consultees can provide and/or are there further sources of information that the Welsh Government should consult?

It seems reasonable. Costs will naturally disproportionately fall on areas where HIV prevalence is high.

Consultation question 11: Does the draft equality analysis adequately assess equality issues in this context? Is there further information that consultees can provide and/or are there further sources of information that the Welsh Government should consult which may be relevant to the draft equality analysis?

We broadly agree with the draft equality analysis.