AIDS-HIV infected health care workers : practical guidance on notifying patients recommendations of the Expert Advisory Group on AIDS / prepared by Department of Health.

UK HEALTH DEPARTMENTS

AIDS - HIV INFECTED HEALTH CARE WORKERS: PRACTICAL GUIDANCE ON NOTIFYING PATIENTS

RECOMMENDATIONS OF THE
EXPERT ADVISORY GROUP ON AIDS

APRIL 1993

AIDS-HIV INFECTED HEALTH CARE WORKERS

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SUMMARY

This booklet contains practical guidance for the implementation of a patient notification exercise, where patients may have been exposed to a risk of transmission of the Human Immunodeficiency Virus (HIV) during an exposure prone invasive procedure performed by an infected health care worker.

It is strongly recommended that employing authorities, NHS trusts, FHSAs, and directors of public health develop contingency plans for the management of such an exercise based on the guidance contained in this booklet and EL(93)24 which advises when such exercises should be carried out.

1. INTRODUCTION

1.1 The advice in this booklet is based on practical experience on how to notify patients when it is considered that they may have been exposed to a risk, however small, of transmission of the Human Immunodeficiency Virus (HIV), during an exposure prone invasive procedure performed by an infected health care worker. It should be read in conjunction with EL(93)24 which contains guidance about when such an approach should be undertaken. It will be helpful to keep this booklet together with EL(93)24 or its replacement once published.

1.2 The Expert Advisory Group on AIDS (EAGA) has set up a UK Advisory Panel on HIV Infected Health Care Workers which is also available to provide expert advice on when such an exercise should be undertaken.

1.3 The risk of transmission from health care worker to patient during an exposure prone invasive procedure is remote. There is a greater and well documented risk of transmission from an infected patient to a health care worker. Nevertheless, until the risk of transmission from health care worker to patient can be estimated more accurately, EAGA recommends that patients who have been exposed to this risk should be notified, offered reassurance and counselling, and an HIV antibody test on request. EL(93)24 outlines the specific circumstances in which such an approach may be required.

1.4 In order to confirm the risk of transmission of HIV from an infected health care worker to patient is remote, the Department of Health will be commissioning a detailed epidemiological assessment, the results of which will guide EAGA and the Department in the formulation of further guidance in due course.

1.5 The recommendations in this guidance reflect the need to protect patients, retain public confidence and provide safeguards for the confidentiality of the HIV infected health care worker. Health care workers have the right to expect that medical information about them remains confidential, and every effort must be made during the notification process to avoid public identification either directly or by deduction.

1.6 Look-back exercises should be undertaken with due care, but it is recognised that their scope may be unavoidably limited by the availability of relevant information and the extent to which resources can be properly devoted to the task. These limitations will need to be addressed by the local Director of Public Health and the responsible authority or trust on a case by case basis.

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5.2 The following should also be informed:

- The District and/or Regional Chairman as appropriate
- The Regional Director of Public Health
- The Regional Infectious Disease Epidemiologist
- The Director of the appropriate Family Health Service Authority (as necessary)
- The Department of Health – contact Dr Gwyneth Lewis or deputy 071-972 3355.

6. MANAGEMENT OF THE HEALTH CARE WORKER

6.1 Whilst public reassurance is paramount, the interests of the health care worker and their family are also very important. Once a decision is taken that will result in a public announcement the worker must be informed and they and their family will need immediate practical and psychological support. Often they will wish to move out of the public eye, particularly if other family members or children are involved, and sensitive and confidential arrangements for this should be made on request.

6.2 The worker or their family may wish to seek their own legal advice and no obstacle to this should be presented. If they do seek legal advice it will be helpful for the employing authority's legal advisors to keep in regular contact with those representing the health care worker. If the health care worker wants their name to remain confidential then this wish should be respected subject to the provisions in Section 2 of this guidance.

6.3 Infected health care workers who have undertaken invasive procedures will need to modify their practice or seek retraining or redeployment. Advice on the former may be obtained in the first instance from the local or nearest specialist occupational health physician who may wish to seek advice from the UK Advisory Panel. The local Director of Personnel and/or the Regional Postgraduate Dean will be able to offer advice on retraining, redeployment or alternative careers.

6.4 It is important that staff who are involved in managing the incident, particularly the Director of Public Health, do not also act as personal advisors or advocates for the health care worker. A specialist occupational health physician may be the best placed person to provide this advice.

6.5 In order to assist in the management of the look-back exercise, it will be very helpful if the following investigations can be carried out. They require the co-operation of the health care worker and this should be sought in as sensitive a manner as possible, preferably by his or her own physician:

- confirmation of the date of diagnosis. If uncertainty exists about whether the worker is infected or not, antibody tests should be repeated in a reference laboratory (see 13.11);
- the clinical history of the disease including any history of peripheral neuropathy, dementia or encephalopathy, retinopathy, thrombocytopenia or other bleeding disorders, dermatitis or other open lesions of the hands and the timing of any anti-viral therapy. A record of the course of HIV infection should be assembled from the clinical history including the dates and results of tests for immunological markers of progression;
- in anticipation of a possible need for further investigations, such as HIV gene sequencing, specialist virulogical advice should be sought from an experienced local consultant or from the PHLS Virus Reference Division (see 13.11);
- the existence of any previously stored specimens should be investigated. Testing of these may be useful for dating the onset of infection or, should the health care worker have died, may be of value for further investigations; and
- the onset of HIV infection should be estimated after appraisal of information from various sources including previous HIV tests, risk factor history, and clinical history including any indications of acute retroviral infection or sero-conversion illness.

7. CASE FINDING

7.1 Case finding must be conducted rapidly and as far as practicable. This will require the assistance of the Medical Records Officer and setting up a small team who may need to work out of hours and over weekends as necessary. If at all possible the case finding should be complete before any public announcement is made to reduce unwarranted public anxiety. In practice, particularly when large numbers of patients are concerned, this may not be possible, but case finding should be completed as rapidly as possible.

7.2 Depending on the particular circumstances case finding may include:

- checking the operating theatre or delivery room records. Noting whether sole or a main operator. In the case of deliveries note the type of delivery and any surgical intervention required;
- checking case notes for invasive exposure prone procedures or minor surgery that may have been undertaken in the accident and emergency department, out-patient department or elsewhere outside an operating theatre. Such procedures do not include the taking of blood or the giving of injections where the worker's hands are visible at all times. Routine examinations, including vaginal, rectal and endoscopic examinations, also pose no risk unless sharp instruments have been used.

In cases of doubt the UK Advisory Panel will be able to advise on whether a particular procedure should be regarded as invasive or not.

7.3 There may be practical difficulties in tracking medical records, whether manual or computer based, as well as inaccuracies or omissions within the records themselves. Case finding should be therefore undertaken as far as is considered reasonable and practicable.

7.4 Once case finding is complete, the list of patients' names and procedures should be given in confidence to the incident team and local helpline operators and counsellors to help them identify those callers who may need to be offered particular reassurance and counselling. If a caller to the helpline insists they have been treated by the worker but there is no record of this, the caller's views must be respected.

8. CONTACTING PATIENTS

8.1 In deciding how best to contact patients a number of factors need to be borne in mind:

- the numbers likely to be involved;
- the profile of the patients who may require notification; and
- the type of operation or procedure undertaken.

8.2 As a general principle it is preferable for patients to be personally contacted by a counsellor, health advisor or other relevant health professional before a press announcement is made and every effort should be made to do so.

8.3 In large scale look-back exercises where it is not possible to personally contact patients, they will need to be informed by other means. For example by:

- writing to patients;
- informing the patients' GPs and asking them to contact the patients in question with due regard to the caveats in 8.6;
- appropriately briefed health visitors or community midwives in the case of women who may have been delivered by an infected worker, as they have the advantage of already knowing the family.

Helplines should become operational at the same time as patients are informed as it is wise to assume that once patients have been contacted the wider local public will become aware of the exercise.

Suggested draft letters to patients and GPs can be found at Annex 3.

8.4 In incidents where it has not been possible to complete the case finding before a public announcement becomes necessary, some health authorities have chosen to write only to those patients treated by the worker who had not contacted the helpline. This method may be particularly appropriate when large numbers of patients are involved.

Specific circumstances that may require an individual approach

8.5 For elderly or other 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 or not to inform the patient. However not all such cases are likely to be identified during the case search.

8.6 Due regard to the confidentiality of patients who may not wish their family or GP to know, for example women who have had termination of pregnancy, requires that these patients be personally contacted by an appropriate professional. Letters should not be sent to their home or place of work or to the GP.

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9. GENERAL SECURITY AND CONFIDENTIALITY OF RECORDS

9.1 The general conditions applying to confidential information about patients are equally valid in these cases. 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 helpline 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. 24-hour security guards are strongly recommended.

9.2 Details that can directly identify the health care worker or patients should not be left on the hard disc of an unattended computer, and passwords to computer documents should be changed regularly. All hard copy files and diskettes must be properly locked away in a secure place when not required, and access to these should be limited to as few people as practicably possible.

10. TELEPHONE HELPLINES

10.1 Many patients may be poorly informed about HIV infection and AIDS, and be concerned, perhaps for the first time, about how this might affect them, their partners and their families. Patients will, above all, need reassurance about the very low risk of acquiring HIV during invasive procedures. They will therefore often want urgent and immediate access to services which can advise them on their concerns.

Local telephone helplines

10.2 Local telephone helplines can meet this need by:

- helping allay immediate concerns;
- providing a valuable first step in the counselling process;
- offering patients personal and private advice; and
- linking with other health care services (eg further counselling, testing).

10.3 Health authorities should, at the earliest opportunity, consider establishing a dedicated local helpline service. It may be appropriate to contract existing local HIV helplines to help provide such a service. Early contact with the National AIDS Helpline is advisable (see 10.6). Local helplines should also take account of the particular needs of people whose first language is not English.

10.4 In establishing local helplines it is useful to bear the following in mind:

- the telephone company should be contacted immediately the decision to inform patients has been made;
- widespread publicity regarding helpline numbers is essential;
- large numbers of helplines 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;
- the number of calls can be very large. At the start of larger incidents helplines have often had to deal with 300–400 calls an hour;
- the number of lines needed will be dictated to some extent by the scale of the problem but 20 helplines are recommended as a minimum and 40 for incidents involving significant numbers. Extra second line phones will be required for counsellors. Some lines can always be decommissioned as demand subsides;
- 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 switchboard. Otherwise it will become jammed;
- staff manning the helpline will need briefing and discussions with the incident control team about the issues likely to be raised and the local protocol for arranging further counselling. General guidelines are given in Annex 5; and
- helpline staff need frequent breaks and easy access to refreshments etc. A rota is essential. If the helpline is established in a building without a canteen, catering facilities will be required. This is also true for the incident control office.

10.5 Depending on the number of patients likely to phone in and the staff available it may be helpful to establish a system of triage (see Figure 1) ie:

- first calls to the helpline should be screened by the operator to ascertain if the caller has been treated by the worker, and if not, to be counselled and reassured;

- people who may have been treated by the health care worker should be transferred to second line, more highly skilled, counsellors who can then offer more detailed advice and reassurance as well as an opportunity for a personal meeting. These counsellors will need a second bank of phone lines;

- when case finding is not complete then the first line operator should tell callers that they will be phoned back once their records have been checked. This must be done as soon as possible. If they have been treated by the health care worker the second line counsellors should phone back;

- it is helpful to give a different helpline number in the letter to patients so that they can immediately call an experienced counsellor;

- when helplines are continually blocked experience has shown some people phone or come directly to the hospital. Switchboard and reception staff require briefing and should know where to refer them, and such patients should be seen by a counsellor on site as soon as possible.

National AIDS Helpline (NAH)

10.6 Advice on setting up local helplines can be obtained from staff at the National AIDS Helpline (NAH) (see 10.10). They can help:

- in an emergency whilst the local helpline is being set up (health authorities should forewarn the NAH first);

- by giving their number in press releases or other publicity as a back-up service; and

- on telephone answering machine messages for callers who ring the local helpline outside operating hours, or on 'all lines busy' messages.

10.7 The NAH can thus support and complement local helpline services by:

- helping to absorb overspill at busy periods;

- giving details of any special local services; and

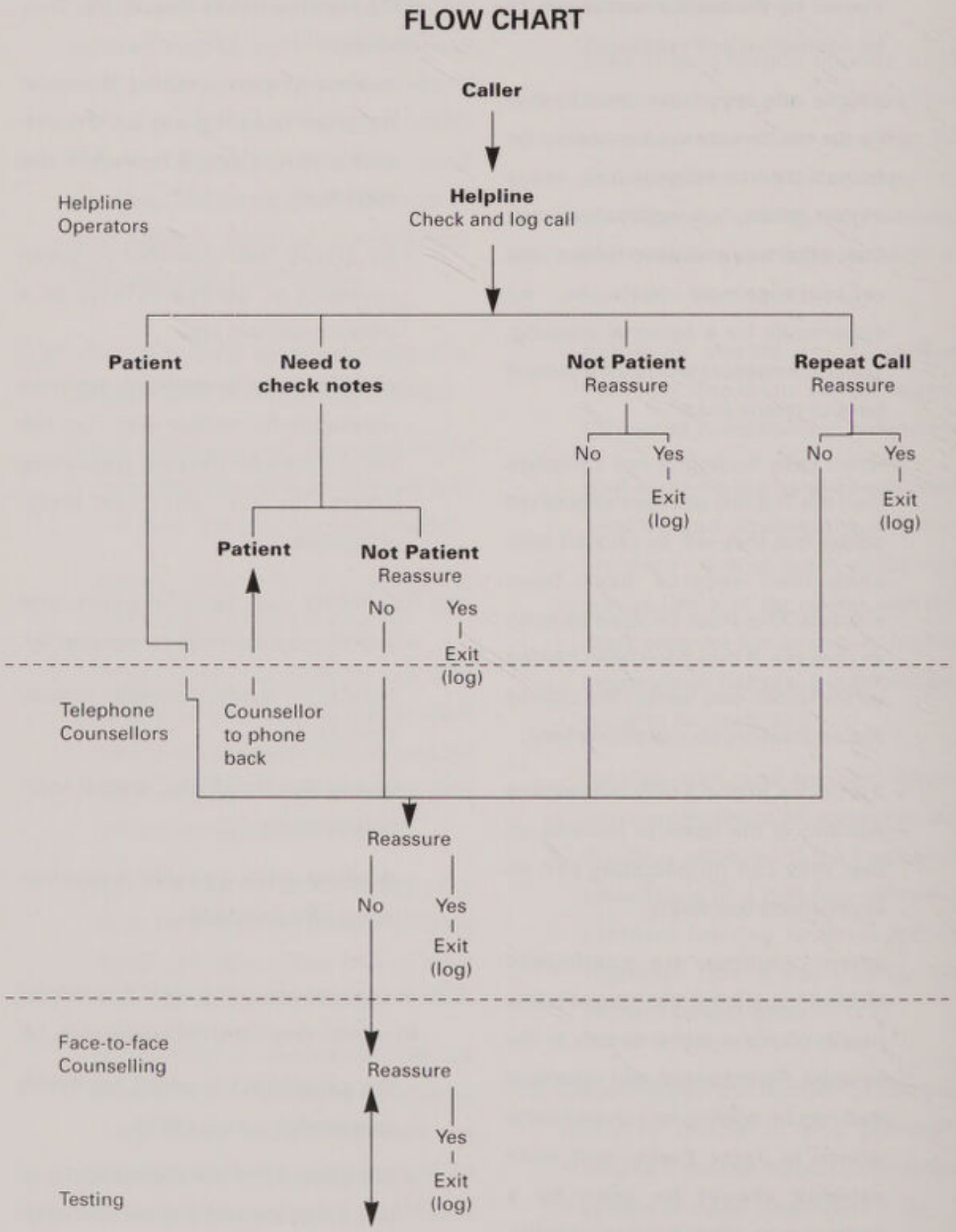
- dealing with general enquiries about HIV and AIDS.

10.8 In order to assist the NAH it is helpful to inform them in strict confidence, of:

- the area/district in which the health care worker was working;

- the name(s) of the institution(s) in which they worked, and the speciality;

FIGURE 1: HELPLINE – COUNSELLING



- how far back in time patients' are being notified; and

- details of specialist local helplines or services.

10.9 Health authorities should note that the NAH cannot provide a substitute local service. It may, exceptionally and provided any costs are met by the health authority, be able to provide trained staff for local helplines.

10.10 **Contacting the National AIDS Helpline**

Helpline: 0800 567 123. 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.

Administration

PO Pox 1577
LONDON NW1 3DW
Project Director – Alan Jamieson
Office telephone 071-387 6900: Office fax 071-380 0925 (can also advise on minority language helpline services)
or
PO Box 5000
GLASGOW G12 9JQ
Project Manager – Alan Paterson
Office telephone 041-357 1774
Office fax 041-334 0299

11. CHOICE OF SITE FOR COUNSELLING SERVICES

Sites for the provision of additional counselling sessions should be chosen with care, and with due attention paid to patient privacy and confidentiality. Such sites will need to be accessible by public transport and consideration should be given to operating evening or weekend sessions if enough staff are available. They should have facilities on site for taking blood for HIV antibody tests.

12. STAFFING COUNSELLING AND HELPLINES SERVICES

12.1 It is important to use the staff available appropriate to their skills. In many districts the number of counsellors, health advisors, psychologists and other professionals trained to provide such a service will be limited. The District HIV prevention co-ordinator and local GUM physician may also be able to identify further suitably trained staff. It may be possible to call on staff from neighbouring districts. The work is stressful and demanding, and a rota system with adequate time off is essential.

12.2 In all but the smallest of incidents it may therefore be preferable to have sensible well-briefed generalist staff answering the initial telephone calls. These may include nurses, health visitors and other health professionals. Patients who have been treated by the health care worker, or callers who are unduly concerned can then be passed on to specialised counsellors who will provide more specific reassurance and offer a meeting if so desired. Some counsellors will need to be available to see patients, including those who come to the hospital directly rather than phoning the helpline.

12.3 In preparing action plans for a possible notification exercise it may be useful to train other local staff who could provide a similar service in the future. For example authorities may wish to consider the possible roles of GPs and other medical staff, nurses, district nurses, community psychiatric nurses, health visitors and community midwives and train them appropriately.

13. TESTING FOR HIV ANTIBODY

13.1 The primary purpose of testing for HIV is to reassure worried patients of the remote nature of the risk. They should not be pressured into taking a test as this can give a false message as to the degree of risk of transmission, but neither should requests for tests be discouraged. The results of such tests, apart from reassuring patients, are also valuable in adding to the body of epidemiological knowledge on the degree of risk of transmission.

13.2 **Laboratory arrangements**

A large number of patients may wish to be tested for HIV infection. Such testing must be undertaken by a laboratory with both the facilities for and experience in handling a heavy demand for testing, and which participates in an HIV testing quality assurance scheme. The local PHLS or teaching hospital laboratory is usually best placed to offer such testing and its Director should be consulted before any local arrangements are made. He/she will also arrange for confirmatory testing and HIV gene sequence investigations where these are required.

Testing of patients

13.3 For patients who wish to be tested following counselling, arrangements should be in place for voluntary confidential HIV testing. Ideally this should be available on the same site as the counselling services. Counsellors will need to explain that occasionally a second specimen may be needed and that this does not necessarily indicate that HIV infection is present.

13.4 If the time when the patient's invasive procedure occurred was less than three months ago, the HIV test should be repeated at least three months following the procedure.

13.5 The results of the tests must be made available to the patient as soon as possible, and by the pre-test counsellor if available.

13.6 The laboratory forms accompanying patients' specimens should clearly indicate the reason for the test eg "Z Health Authority HIV exposed patient notification exercise". This will allow peripheral laboratories to recognise tests which relate to a particular incident and facilitates the rapid reporting of results to the Incident Team.

13.7 In a situation where the background prevalence of HIV infection is low it is to be expected that most initially reactive HIV test results will be shown by confirmatory testing to be false positives. Therefore any initially reactive test results should be discussed with a reference laboratory (see section 13.12) as a matter of urgency so that confirmatory HIV tests can be rapidly completed.

13.8 Laboratories should report relevant HIV test results to the Incident Team for incorporation into the patient notification database.

Further investigation of HIV Positive results

13.9 In any study of this nature it is possible that unrelated positive test results may be obtained. This has occurred in several studies in the United States, but further investigation revealed significant other risk factors for HIV and viral DNA sequencing ruled out the possibility of infection by the health care worker. Therefore, should a patient have a positive HIV test the following investigations should be performed:

- to confirm the presence of HIV infection another blood specimen should be collected from the HIV-infected patient and tested in a reference laboratory; (See 13.11)

- a detailed record review should be undertaken to document the invasive procedure and to confirm that the HIV-infected patient was exposed to the HIV-infected worker;

- if the patient received any blood transfusions, the Blood Transfusion Service should be asked to investigate the donations;

- 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; and

- consideration should be given to arranging for HIV testing of the patient's sexual partner(s).

13.10 Following the initial assessment of available information on the HIV-infected patient, a decision should be made on the need to compare HIV strains obtained from the health care worker and any infected patients and partners using gene sequencing techniques. Appropriate control specimens from other HIV-infected persons should be included as part of these investigations and co-operation may be sought in collecting these in the locality where the incident occurred (see para 13.12). Conclusive results are unlikely to become available for several months.

Sources of advice and support

13.11 The PHLS Virus Reference Division at the Central Public Health Laboratory, Colindale (081-200 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; and

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14. THE MEDIA

14.1 A nominated press officer should be part of the Incident Team from the start of the exercise. If at all possible the press officer should have experience of working with the national media. They should liaise with both the Regional Press Officer and the Department of Health Press Officer if appropriate (071-210 5229).

14.2 It is often not possible to complete the case finding or to contact patients before a public announcement is made, although in incidents involving small numbers of patients this has proved feasible. This needs to be decided on a case by case basis as local circumstances may vary but public announcements should be made as soon as practical.

14.3 The announcement will normally be made through a press release, which should contain as much information as possible. It should include:

- details of when and where the worker came into contact with patients;
- what action has been taken by the worker, their colleagues and the responsible authority;
- what arrangements have been made to contact patients; and
- what arrangements have been made to provide further information to patients and the general public, including the numbers of helplines and the hours they are open, and the availability of counselling and testing facilities.

14.4 Authorities, Trusts, 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. Public announcements should not be delayed if it proves difficult to convene the right people for a press conference. Press conferences may need to be held more than once if there is further media interest.

14.5 Where a worker waives his or her right to confidentiality, authorities should take great care to prevent further information about his or her whereabouts being made generally known.

14.6 If it is known that an HIV-infected worker has worked for a number of different authorities, information about all his/her contacts with patients should ideally be made public by all the authorities concerned at the same time.

15. REVIEWING THE OUTCOME

15.1 Once the incident is over the programme manager should correlate the master list of patients and their operative procedure with the HIV antibody test results. A summary of these results should be sent to the PHLS AIDS Centre at CDSC (see 13.12) and to the secretariat of the UK Advisory Panel (see Annex 1). This will be collated with data from all similar look back studies to assist in further epidemiological assessment.

15.2 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.

15.3 The Department of Health would be grateful if Incident Team Leaders would consider sending final reports to the AIDS Unit to assist in the further development of this guidance. Please contact:

Dr Gwyneth Lewis
Principal Medical Officer
Department of Health
Friars House
157–168 Blackfriars Road
LONDON SE1 8EU

ANNEX 1

USEFUL TELEPHONE NUMBERS

1. **Department of Health's AIDS Unit**

   Friars House
   157–168 Blackfriars Road
   London SE1 8EU
   Tel. 071-972 3319

2. **UK Advisory Panel on HIV Infected Health Care Workers**

   Secretariat
   Friars House
   Room 211
   157–168 Blackfriars Road
   London SE1 8EU
   Tel. 071-972 3330

3. **Department of Health Press Office**

   Richmond House
   79 Whitehall
   London SW1A 2NS
   Tel. 071-210 5229

4. **Public Health Laboratory Service (PHLS)**

   AIDS Centre at the Communicable Disease Surveillance Centre (CDSC)
   61 Colindale Avenue
   London NW9 5HT
   Tel. 081-200 6868

   PHLS Virus Reference Division

   Central Public Health Laboratory
   61 Colindale Avenue
   London NW9 5HT
   Tel. 081-200 4400

5. **National AIDS Helpline**

   Alan Jamieson
   Project Director
   PO Box 1577
   London NW1 3DN
   Helpline Number. 0800-567 123

6. **Association of British Insurers**

   Aldermary House
   Queen Street
   London EC4N 1TT
   Tel. 071-248 4477

ANNEX 2

UK ADVISORY PANEL FOR HIV INFECTED HEALTH CARE WORKERS

1. Remit and tasks of Panel

The UK Advisory Panel has been set up under the aegis of the UK Health Departments' Expert Advisory Group on AIDS.

The tasks of the Panel are:

1.1 To establish and update as necessary, criteria on which local advice on modifying work practices can be based.

1.2 To provide supplementary specialist occupational advice to physicians of HIV infected health care workers, occupational physicians and Professional Bodies.

1.3 To advise individual health care workers how to obtain guidance on working practices.

1.4 To advise Health Authorities and NHS Trusts on what action to take in respect of patients treated by HIV infected health care workers.

1.5 To keep under review the literature on occupational transmission of HIV and revise guidelines as necessary.

2. Constitution of Panel

The Panel is chaired by a lay person.

The following specialties are represented:

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

Two lay members are also appointed.

The Secretariat is provided by the Department of Health's AIDS Unit.

3. Contact with the Panel

3.1 Physicians, occupational physicians and others wanting specialist occupational advice should write to the Secretariat at the address at para 3.3. The worker's identity should not be revealed in any way.

Confidentiality of all information concerning individual referrals will be maintained by the Secretariat and members of the Panel.

3.2 Cases will be considered by selected members of the Panel, including an occupational physician, depending on the worker's speciality.

3.3 **Address of the Secretariat**

Department of Health
AIDS Unit
Room 211
Friars House
157–168 Blackfriars Road
London SE1 8EU
Tel. 071-972 3330

ANNEX 3

SUGGESTED MODEL LETTER TO PATIENTS

Strictly Private and Confidential

Dear

It has come to my attention that a (profession) who worked at (institution(s)) has the Human Immunodeficiency Virus which causes AIDS. It appears from our records that this health care worker was involved in your care. From close examination of the procedures that were carried out in your particular case there is virtually no risk that the virus could have been passed to you during your treatment. I want to inform you directly about this to avoid causing you any unwarranted anxiety as you might otherwise have heard through a media announcement.

The purpose of this letter is to give you the opportunity to discuss any concerns you might have. A special telephone line has been set up with the freephone number .....
The lines will be open from (am pm) each day for the next few weeks with staff who are trained and informed about this particular situation to answer your questions.

If you want further help after speaking to the staff on the helpline a special counselling appointment can be arranged for you within .... days. You can then discuss your concerns and HIV testing can be offered should you wish for this additional reassurance.

(I have also written in confidence to your general practitioner about this matter and you may wish to contact him/her.)

I need to be sure that you have received this letter and would be grateful if you could sign the attached form and return it in the enclosed stamped addressed envelope.

SUGGESTED MODEL LETTER TO GPs

Dear Dr

I am writing to inform you that a (profession) who worked in the (speciality) department of (institution) in 19.. has recently been discovered to be HIV positive.

The risk of any patient being infected by a health care worker is extremely remote. Nevertheless we believe it is important to contact each patient to reassure them of this very small risk and to offer them counselling and a test if desired. Although there are no recorded cases worldwide of a health worker infecting patients in hospital or general medical practice, an American dentist with AIDS infected a very small number of his patients during treatment, possibly by the use of contaminated equipment.

This case may well give rise to public anxiety, which we are seeking to address in a number of ways, including this letter and the attachments. You may find it reassuring to know that following similar situations in the past none of the patients who sought testing were found to be infected.

You may be contacted by anxious patients and to help you to respond we have prepared an information leaflet for those patients who have not received a letter but who continue to be worried can phone the local helpline for reassurance and the National AIDS Helpline freephone 0800-567 123 can provide confidential counselling and advice on the wider aspects of HIV infection.

I thank you in anticipation of your assistance in dealing with public anxieties and in respecting the medical confidentiality of the health worker and other patients involved.

Yours sincerely

INFORMATION FOR PATIENTS

HIV (the Human Immunodeficiency Virus) causes AIDS (the Acquired Immune Deficiency Syndrome). The virus damages the body's defence system so that it cannot fight certain infections or other diseases.

In the UK HIV is transmitted from one person to another in three main ways:

- through unprotected sexual intercourse (anal or vaginal)
- by injecting drug users sharing equipment including used syringes and needles
- from an infected mother to her baby, before, or during birth, or via breast feeding.

In the past, some people came into contact with HIV through being given infected blood or blood products. This may still happen in some areas of the world – but it is extremely unlikely in most developed countries, including the UK, where all blood donations have been screened and blood plasma products specially treated since October 1985.

HIV is **NOT** passed on through ordinary, everyday contact at home or at work. For example sharing eating or cooking utensils, towels, stationery equipment etc is safe. So are hugs, kisses and handshakes with a person infected with HIV or with AIDS.

What is the test?

When people become infected with HIV, they produce antibodies to the virus. The test looks for these antibodies in their blood.

What does the test involve?

The test will only be performed with your consent and after you have been counselled about it.

A doctor or nurse will take a sample of blood usually from your arm – and send it to a laboratory for the HIV antibody test. The laboratory has to process the test so the result is normally available after a few days. Under the present circumstances we are offering a speedier service for anyone deciding to go ahead with the test.

What does the result mean?

Negative result

A negative result means that the antibodies to HIV have not been found and indicates that almost certainly infection with the virus has not occurred. However it can take 2–3 months, and sometimes longer, from the time of infection for antibodies to show up in a blood test. So rarely it may be necessary to repeat the test 3 months after the date of possible infection.

Positive result

A positive result would mean that antibodies to HIV had been found and that infection with HIV had occurred.

But remember, the risk of infection from HIV positive health care workers is extremely low. No case has ever been reported of a doctor, nurse, or midwife infecting patients throughout the world. So the chances of being infected with HIV or an HIV-related infection by the worker concerned, are very remote.

What to do if you are concerned

If after reading this information you would still like to discuss your concerns, telephone the confidential helpline set up to respond to patient's queries.

Telephone number:

Operating times:

What will happen if I call the Helpline?

Skilled helpline operators will take your call and offer you a choice:

1. If you wish to give your name and other details for identification they can tell you if you were attended by the staff member in question. If you require further information or advice the operator will put you through to a trained counsellor who will discuss your concerns in detail.
2. If you prefer not to give your name, the operator will still put you through to a counsellor who will talk through your concerns with you. Remember, if you choose this option the operator or counsellor will not be able to tell you if you were attended by the worker in question.

In either case, all information you give will be treated in the strictest confidence.

If at the end of this telephone conversation with the counsellor you still have anxieties, or you wish to have an HIV antibody test, you will be given an appointment to see a counsellor preferably within 24 hours, and if applicable to have blood taken for a test. You may prefer to attend your local Genito-Urinary Medicine clinic, in which case the counsellor will give you relevant details, or your GP.

Test results will only be given face to face, and only to the person being tested. As far as possible, they will be available within 24 hours of the blood being taken.

All counselling and testing are offered free of charge and are totally confidential. No permanent records of results will be kept, and no information will be sent to your GP unless you specifically request it.

ANNEX 4

POINTS FOR HOSPITAL STAFF

1. As you may know, a health care worker in this District has been found to be infected with HIV, the virus that causes AIDS.

   The purpose of these notes is to allay your fears about HIV infection, to help you deal with enquiries you may receive from patients and the public and to advise you on how to deal with the media.

2. Two guiding principles should be borne in mind:

   - a health care worker with HIV infection is entitled to exactly the same privacy about their condition as any other person (see paragraphs 6 & 7 on confidentiality); and that

   - the risk of infection from HIV positive health care workers is extremely low. No case has ever been reported of a doctor, nurse, or midwife infecting patients throughout the world. So the chances of being infected with HIV or an HIV-related infection by the worker concerned, are very remote.

3. You may get HIV enquiries from anxious members of the public who have been patients in your department/hospital in the past.

   Telephone callers should be advised to ring the confidential helpline.
   Helpline Telephone No:

   People coming into your department should be given an "INFORMATION FOR PATIENTS" sheet and advised to contact the helpline for further discussion of their concerns. **DO NOT** enter into such discussions. **DO NOT** offer any reassurances or information in this regard.

4. You may get enquiries from the media. These should all be referred to (name of Press Officer)
   Media Telephone No:

   Any persistence should be answered with a decisive "no comment" and refusal to enter into discussion. Remember, reporters will not always identify themselves, and will often pose as anxious patients/family members/friends. In this instance they should be treated like any other member of the public and referred to the helpline.

5. You may have personal HIV-related anxieties in the light of recent events. Any matters in this regard may be discussed in the first instance, if you so wish, with your Head of Department, or alternatively with (name of chief counsellor). You may prefer to talk to someone outside this District. In this case, details can be obtained without any need to identify yourself, from the helpline operators.

   Telephone No:

   Be assured that, whatever option you choose, your queries will be dealt with sensitively and in the strictest confidence.

6. You are reminded of your obligations as an employee of [ ], with regards to confidentiality. All health professionals owe patients a common law duty of confidentiality and additionally within Health Authorities and Trusts are bound by the duties of confidentiality imposed under the NHS (Venereal Disease) Regulations 1974 and the National Health Service Trust (Venereal Disease) Directions 1991 which apply to all Health Authorities and Trust clinics.

7. Any unauthorised disclosure of information on a patient's or employee's HIV status constitutes a breach of confidence and is a disciplinary matter which may lead to dismissal and/or legal proceedings.

ANNEX 5

ADVICE TO HELPLINE OPERATORS

- Introduce the helpline and yourself and ask how you can help. e.g. "Hello, you're through to ( ) HIV Helpline. How may I help you?"
- Inform caller of the options available before they start to give any specific details about their identity etc. Tell them they may either:

OPTION 1 Give their name, address and date of birth and date of admission to hospital so that you can check if they were attended by the person in question and then see if they wish to discuss anything with a counsellor.

OR

OPTION 2 Choose not to give their name, in which case you will still put them through to a counsellor. Point out that the list cannot be checked without their name, but that the Counsellor will be happy to discuss their concerns in a general way.

- If the caller chooses **OPTION 1**:

a) Check your lists to see if they were attended by the staff member in question. If the list is not complete inform them that someone will phone them back once the records have been checked.

b) **IF THEY WERE NOT ATTENDED BY THIS WORKER** inform the caller to this effect, assure them the helpline is still available if further clarification is needed immediately or at a later point.

c) Thank them for calling.

d) Log details of the call.

e) **IF THEY WERE ATTENDED BY THIS WORKER**, check the details they gave against the information on your sheet. Inform them the worker did care for them. Offer to put them through to a Counsellor to discuss matters further.

f) Log details of the call.

- If the caller chooses **OPTION 2**:

Proceed as directed earlier. Log details of the call.

If all Counsellors' lines are busy, offer the caller the possibility of:

- hanging on
- calling back later

- leaving a contact number for the Counsellor to call them. Reassure them the Counsellor will ask for them in person and without disclosing why they have called to anyone else.

POINTS TO REMEMBER EVERY TIME:

DO:

- **ALWAYS** respond in a warm, supportive and helpful fashion to callers
- **ALWAYS** follow the procedure exactly as described
- **ALWAYS** log calls immediately after each call
- **ALWAYS** get the I.D. as instructed before giving any information from patient lists
- **ALWAYS** register against the name of callers who identify themselves
- **ALWAYS** refer to a supervisor-counsellor in case of doubt
- **ALWAYS** refer to the staff member involved as "the worker", "the staff member", "the employee" concerned

NEVER:

- offer reassurance or advice or enter into non-essential conversation;
- give information to anyone except the patients themselves (not even to a partner or family member, or friend);
- give any information about the staff member involved (e.g. name, age, gender, nationality, duty rotas, where they worked, or any other details);
- enter into **ANY** discussions with members of the press. Be aware that the press will not always identify themselves;
- give any details about other callers/clients/staff members;
- leave recorded information unattended or in any way visible/accessible to those outside the team;
- discuss queries with colleagues in the hearing of a caller OR other person who is not a member of the team;
- give your name to any caller;
- discuss any details of this work with colleagues, friends, or family. You are reminded that all health professionals owe patients a common law duty of confidentiality and additionally, within Health Authorities and Trusts are bound by the duty of confidentiality imposed under the NHS (Venereal Disease) Regulations 1974 and the National Health Service Trust (Venereal Disease) Directions 1991 which apply to all Health Authority and Trust clinics.

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