AUSTRALIAN DOCTORS' FUND

HAZARDS AND RISKS FACED BY HEALTH PROFESSIONALS IN THE MANAGEMENT OF HIV POSITIVE PATIENTS

"ON KEEPING OUR PERSPECTIVES"

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The Hon Justice M D Kirby CMG*

INVOLVEMENT IN AIDS

I speak to this conference not as a judge but as a former law reform commissioner, a present trustee of the AIDS Trust of Australia and recently appointed member of the Global Commission on AIDS. This body comprising 25 members, has been appointed by the Director-General of the WHO (Dr Hiroshi Nakajima) to provide guidance to that organization on the strategies to be adopted, within the overall framework of the activities of WHO, by the Global Programme on AIDS. That programme provides the principal focus of the international effort to respond to the great challenge posed by the advent of Human Immunodeficiency Virus (HIV). Members of the Commission include Professors Robert Gallo and Luc Montagnier, who first isolated the HIV virus. The chairman of the Commission is Professor Lars Kallings of Sweden. I was elected rapporteur of the first meeting.

I became involved in AIDS because, in the work of the Australian Law Reform Commission, I was concerned in many

projects with the interface of law and medicine. An early successful report of that Commission was on Human Tissue Transplants. It showed the value of close consultation between lawyers and health professionals in the development of laws concerned with health issues. But it also demonstrated the importance of involving in the design of laws and policies, where relevant, moral philosophers, representatives of closely affected groups and the community generally. There is always a danger in inter-professional discussions of myopia and self-concern.

Because of my involvement in medico-legal issues I was invited to address the first Australian Conference on AIDS. My paper on the legal issues raised by AIDS was later published in the Australian Law Journal.[1] This led on to invitations to participate in the Washington International Conference on AIDS and to sum up the Stockholm Conference on AIDS.

Necessarily, the focus of my concern tends to be legal. In this regard, the difficulties of securing behaviour modification (necessary to stem the epidemic of AIDS) must be faced squarely by lawyers and law-makers. That is not to say that laws are not needed to support useful strategies and as symbols of acceptable and unacceptable behaviour, so far as the spread of the epidemic is concerned. But it is important to face squarely the limited capacity of the law to achieve behavioural modification in a society such as ours, particularly where the behaviour to be

modified is so intimate as sexual activity and drug taking.

PUTTING THE RISK IN CONTEXT

I have just returned from the first meeting of the Global Commission on AIDS in Geneva. Following my return I went once again to Europe for another meeting on AIDS organised by the Mérieux Foundation at Annecy, France. This was attended by some of the Global Commissioners but also by other noted experts from both sides of the Atlantic. The fabled Jonas Salk was there, together with some of the top researchers of the Pasteur Institute and of relevant American institutes concerned, at the front line, with research on AIDS and public health policies connected with it.

It is true that during the discussions, both at the Global Commission and at the meeting at Annecy, the risks faced by health professionals in the management of HIV positive patients were mentioned. However, it is appropriate to note that the consensus of the experts when this issue was raised was that, of the many problems presented by the HIV/AIDS epidemic, it is, fortunately, one of the least pressing.

To say this is not to exhibit indifference to the legitimate health concerns of health professionals involved in the daily management of HIV positive patients. Nor is it to show insensitivity to those concerns which are proper and understandable on their part. Still less is it to suggest that there is no need for a high level of vigilance by all health care workers involved in the management of HIV

positive patients and particularly in contact with their blood. A members of my family is a health care worker. She is involved in the care of terminally ill patients, doubtless some of whom are HIV antibody positive. Naturally, her health and well-being is of the closest concern to me.

My statement is made simply to put the concern of health professionals in the global perspective of the management of this epidemic. As Professor June Osborn, Professor of Public Health at the University of Michigan and noted expert on public health policies on AIDS repeatedly says, in confronting this epidemic it is essential that we ground our policies in sound data. Good ethics arise from good data. AIDS is already replete with the potential for discrimination, prejudice, emotion and loathing. There is a clear risk of the alienation of unfortunate patients for whom medical science can at this stage offer no cure but only help, support, encouragement and a return to the healing arts.

The available data suggests that casual exposure to blood of HIV infected patients on the part of health professionals involves little risk of their seroconversion.[2] It also suggests that even needle-stick injuries, cuts with sharp objects, open wound contamination and the other hazards of health care management involve relatively low risks of seroconversion.[3] Because of the high level of morbidity in HIV positive patients, even low risks must be guarded against. Stringent precautions and

strict procedures must be followed. Health care workers must be instructed, trained and supervised in those procedures. There are no simple answers which guarantee total protection. For example, because of the nature of the antibody test and the "window period", universal testing of patients, including surgical patients, provides no guarantee of isolating all HIV antibody positive patients. On the contrary, it could produce a false sense of security and reduced vigilance which must now be demonstrated to all patients, e.g. in surgical procedures. Furthermore, it would bring in its train risks of prejudice and discrimination which could be disproportionate to the occasional benefit secured of extra vigilance in the case of the patient shown to be HIV+. At the present rate of seroconversions by needle-stick and other injuries - which involve not a single Australian health care worker operating in a hospital, laboratory or other like environment - the risks demonstrated on present data would not warrant the expense and risk of alienation and discrimination involved in a universal policy of mandatory testing of all patients. Furthermore, such a policy could discourage some persons with a legitimate call on the health care system from seeking its assistance. It is not necessary to refer once again to the risks of serious discrimination which can follow the gossip that attends a positive report on a HIV test. It is obvious.

THE REAL CHALLENGES TO MEDICAL PRACTICE

There is another matter to be considered in this context. At a meeting at WHO headquarters for World AIDS Day on 1 December 1988 Dr John Dawson of the British Medical Association expressed a new concern. It was that the health professionals who had, in this generation, become so used to the availability of miracle drugs and heroic surgery, would react adversely to a new predicament in which there were no miracle drugs or vaccines available to them or in prospect. Dr Dawson pointed out that in all previous generations, health care workers had taken very great risks. Even in recent times, risks of infection, including of fatal infection from tuberculosis, poliomyelitis and other infectious or contagious conditions were accepted by health professionals as part of the risks which their calling required them to face. It was for this reason that religious orders previously played such a high part in the provision of health care, as they still do with notable charity in attending to HIV antibody positive patients. The record of St Vincent's Hospital in Sydney needs to be mentioned here. It is an example to other hospitals of grounding hospital policy upon objective scientific data and not prejudice, emotion or fear.

At the meeting in Annecy one of the most important papers was delivered by Dr Anthony J Pinching, senior lecturer in clinical immunology at St Mary's Hospital Medical School in London.[4] His thesis was that HIV/AIDS had produced a new and less paternalistic approach to medical

care of a serious illness. This had occurred because of the comparative youth of most patients, the limited range of therapies available to health professionals, the courage and open-mindedness of the early medical pioneers of treatment and the very serious health consequences of infection, often leading to death. Pinching asserts that it is essential for health care workers dealing with HIV antibody positive patients to adopt a relationship of close physical proximity conveying warmth and a sense of involvement, including by touch and other nonverbal signals. This is not sentimentalism. It is part of the total management of the patient. Moreover, it involves no risk to the health care worker as it is now authoritatively established that casual contact and such proximity does not involve any risk of transmission of HIV.

BASING POLICIES ON SOUND DATA

HIV/AIDS is already an isolating, frightening and alienating condition for those affected, their families and loved ones. Suggestions for further isolation, particularly coming from health care workers, are therefore to be discouraged. Suggestions of special hospitals, intrusive inquiries, mandatory tests, space-suit surgical gear and the general atmosphere of fear of HIV positive persons will accelerate their isolation, reinforce community apprehension and impede the limited health care that health professionals can at this stage offer. Such policies can therefore only be justified if grounded in scientific data which justifies such

drastic precautions. The epidemic is now established. Its patterns and modes of transmission are well documented. Had there been a high risk of transmission to health care workers, it is undeniable that many more would have presented with HIV/AIDS than the current very small figures recorded in the literature. I know of no respected public health figure who supports the alarmist opinions of Dr Lorraine Day. Those opinions are not, in my opinion, based upon sound scientific data but upon unconvincing anecdotal material. They are rejected by the most knowledgeable observers of this epidemic.[5] Whilst open-mindedness to error is the hallmark of proper scientific enquiry, I do not believe that the figures now available bear out the alarmist message which Dr Day brings. She has expressed an opinion that the numbers of infected persons in the United States have been significantly underestimated. But if this is so, it makes the paucity of evidence of seroconversions in health care workers all the more significant. Given the very large number of persons infected in the United States and the numerous surgical and operative procedures involving them and exposing health workers to their blood, it would have been reasonable to expect very much higher number of health workers presenting with HIV from work related exposure, had the virus been readily acquired in that environment. Fortunately, it is not. Extrapolations from hepatitis-B or the wart virus are simply not justified in the case of HIV upon presently available scientific data.[6]

DON'T BECOME PART OF THE PROBLEM

To sum up, there is a risk to the health of health care professionals treating patients who are HIV antibody positive. Fortunately, however, the risk is very small indeed, particularly when compared with other viruses which present risks to such workers. The greatest risk is from needle-stick. Such risks should be reduced by sound management and clinical procedures. The risk does not arise from casual contact or from caring attention. In the management of HIV antibody positive patients, such attention is essential. In the present state of limited medication and therapies, health care workers are being taken back to pre-technological arts in the management of patients with a very serious condition for which there is no ready cure. Already, there is evidence of the development of appropriate and novel responses on the part of health care workers to this new and unprecedented challenge to their skills.

It would be a misfortune if Australian health professionals today were to prove less caring, and more self-concerned, than their predecessors in earlier generations and in other lands who confront other more infectious epidemics with caring, compassion and courage. Particularly would this be a misfortune in AIDS/HIV because the available scientific data demonstrates the very low risk to health professionals, especially if standard precautions are observed. In the current state of the HIV antibody test and because of the window period, such a test does not

provide a reliable criterion for adopting high and low precautions, including in surgery. Vigilance at all times is required. It is essential that policies for the protection of health care workers should be based on vigilance. It is in the interests of patients, including those HIV antibody positive, that health care workers should not themselves become infected. Clearly, it is also in the interests of those workers and their families and of society. But the strategies for the protection of health care workers should be based on sound data related to the modes of transmission and the levels of risk. They should not be based on anecdotal stories and fear which can drive HIV antibody positive patients into further alienation and the risk of discrimination and stigmatization. If this were to happen, because of responses of health care workers to the epidemic, those workers, far from helping their patients and treading in the footsteps of their honourable predecessors, would become part of the AIDS problem.

FOOTNOTES

* President, Court of Appeal, Supreme Court of New South Wales, Sydney, 1984-. Commissioner, World Health Organization Global Commission on AIDS 1989-. Trustee, AIDS Trust of Australia, 1987-. Formerly, Chairman of the Australian Law Reform Commission 1975-84.

1. M D Kirby, "AIDS Legislation - Turning Up The Heat?" (1986) 60 Aust L J 324.

2. See R Marcus and the CDC Co-operative Needle-Stick Surveillance Group, "Surveillance of Health Care Workers Exposed to Blood from Patients Infected with the Human Immunodeficiency Virus", New England J Medicine 1118 (1988) 318.

3. J L Gerberding, "Occupational Health Issues for Providers of Care to Patients with HIV Infection". In Medical Management of AIDS, Infectious Disease Clinics of North America, vol 2 no 2, June 1988, 321.

4. A J Pinching, "Aspects of the Clinical Model of Care for AIDS Patients", Paper for a Conference on AIDS/HIV at Annecy, France, 22-23 April 1989, unpublished.

5. J L Gerberding and David K Henderson, "Design of Rational Infection Control Policies for Human Immunodeficiency Virus Infection", J Infectious Diseases, vol 156, no 6, December 1987, 861.

6. See B Tindall, D A Cooper, B Donovan and R Penny, "Primary Human Immunodeficiency Virus Infection, Clinical and Serological Aspects" in Medical Management of AIDS (ob cit) 329.