Submission to Medical Board of Australia

Blood-borne virus guidelines

Personal submission of Dr Kerry Breen

General comments

There is a long and somewhat unsatisfactory history over the "ownership" of national guidelines in regard to infectious diseases in Australia, dating back at least to the 1996 guidelines issued jointly by the NHMRC and the Australian Council on Aids in 1996 (for the full guidelines, now rescinded, go to http://www.nhmrc.gov.au/publications/synopses/ic6syn.htm). Your draft identifies a forthcoming CDNA national standards document but does not mention the 2010 document issued jointly (after extensive public consultation) by the NHMRC and the Australian Commission on Safety and Quality in Health Care. This is titled "Australian Guidelines for the Prevention and Control of Infection in Health Care" and is accessible at http://www.nhmrc.gov.au/_files_nhmrc/file/publications/synopses/CD33_InfectionControlGuidelines2010.pdf . It would seem to me that NHMRC guidelines might take precedence over CDNA guidelines but you may wish to seek advice from the Federal Health Department. The NHMRC/ACSQHC document contains some very pertinent material (as identified where relevant below).

I presume this has been an accidental oversight, but the document needs a definition of "exposure prone procedures". There is an extended definition of exposure prone procedures commencing on page 211 of the Australian Guidelines for the Prevention and Control of Infection in Health Care (see http://www.nhmrc.gov.au/_files_nhmrc/file/publications/synopses/CD33_InfectionControlGuidelines2010.pdf).

I suggest that the issues for infected medical students (while they remain students) are different from those of practising doctors. It might be better to separate the two groups in the document. The Australian medical school deans have issued a detailed policy statement covering the issues for students and you may need to check that that document is aligned with the Board's final advice. It is available at http://www.medicaldeans.org.au/wp-content/uploads/Infectious-Disease-Policy.pdf .

There is probably a need to somewhere mention the relevant notifiable diseases legislation as this contradicts to a small extent the notion of total confidentiality for infected persons.

It may be desirable for the guidelines to address the responsibilities of treating doctors (for an example see page 178 of Good Medical Practice: Professionalism, Ethics and Law, published by Cambridge University Press in 2010).

Out of respect for the earlier work of various state and territory medical boards, I suggest that this document should make mention of these previous guidelines (I presume that until these new MBA guidelines are in place, the previous state medical board guidelines are informally still in effect). It would also be useful and respectful to reference the thoughtful and detailed advice the RACS gives to its Fellows.

Specific comments

Para 1 ***Introduction:*** The tone of the introduction (but not the later text) is surprisingly permissive and could be misinterpreted by the general public. It might read more clearly (and be better aligned with what follows if it were reworded along the lines of: "*The guide (or guidelines) provides advice and direction to registered medical practitioners and registered medical students who are or who may be infected with blood-borne viruses, specifically hepatitis B, hepatitis C and HIV. The guide outlines limits to the practise or study of medicine that may be needed in order to prevent transmission of infection to patients. In general, these limits will not prevent practise in most fields of medicine but will preclude infectious doctors from undertaking a range of clinical procedures where patients may be put at risk (termed exposure prone procedures). In addition, the guide addresses the need for all medical students and medical practitioners to seek appropriate immunisation where available. The guide also addresses the need for infected doctors and students to remain under the care and direction of another medical practitioner with relevant expertise and experience.*

Para 2 ***Who needs to use these guidelines***: I suggest that this currently fashionable question is not needed in these guidelines as the title of the guidelines already make the first point of this paragraph clear. The need for treating doctors and employers to be aware of the guidelines might be better made in the introduction.

Para 3 ***Summary of these guidelines***: Depending upon the final length of the guide, it may be better not to have a summary, unless the summary covers every important point. Perhaps a box that highlights key points might work better than an attempt at summarising quite complex material. Much of what is in the current summary should appear within the main text of the guide. In relation to the existing text, I wonder whether the medical reader might be more clearly advised as to what type of specialist should be consulted as an "appropriately experienced, independent medical practitioner"? A diplomatic way of so advising might be words along the lines of "in general, this will be an infectious diseases specialist or (for hepatitis B or C) a hepatologist".

Para 4 ***Background:*** The clear link to the section of Good Medical Practice is appropriate and desirable but I suggest that this might be better made part of an expanded introduction, or part of the actual guideline. It does not quite fit the bill of being "background".

Para 5 ***Responsibilities of medical practitioners and medical students***: As mentioned earlier, I suggest you look again at how well the document works in striving to combine the issues for doctors with the issues for medical students.

The first sentence reads "Medical practitioners and medical students should know their HIV, HBV and HCV antibody status". This may be appropriate practice for medical students as it is relevant to career counselling but it seems inconsistent with current practice for all doctors. The ethical position up until now as I understand it has been that only doctors who undertake exposure prone procedures "should know their HIV, HBV and HCV antibody status". This is also an example of where it might be difficult to try to unify the guideline to simultaneously address the issues for students and practising doctors.

It is my understanding that the medical schools go further than just "strongly advising" testing. Unless MBA disagrees with the medical school policies, this section needs to be consistent with what

now happens with medical students (see http://www.medicaldeans.org.au/wp-content/uploads/Infectious-Disease-Policy.pdf).

This draft section refers to "post-exposure protocols" and summarises them. It might be useful to include a reference and a website link to the protocols. Are these protocols now identical around the nation or are they still subject to institutional variations? There is a description of post-exposure protocols at page 214 of the "Australian Guidelines for the Prevention and Control of Infection in Health Care" (see http://www.nhmrc.gov.au/_files_nhmrc/file/publications/synopses/CD33_InfectionControlGuidelines2010.pdf).

Para 6 ***Medical practitioners and students who are infected with a blood-borne virus***: Again, in seeking to cover the issues for both students and doctors, this section does not seem to me to work well. It is my understanding that medical students are highly unlikely to be involved in exposure prone procedures.

The paragraph is a little difficult to follow as the various tests for the three different viruses are intermingled. It might work better to have a separate paragraph for each viral infection.

Responses to questions:

Question 1: (re levels of viraemia). No, although some might argue that certain tests are not actual tests of "viraemia" or "infectivity".

Question 2: (re possibly imposing conditions). It will be sad day for the medical profession if conditions have to be applied to registration when it is very clear to the treating doctor and to professional colleagues that the unfortunately infected proceduralist has already altered his/her practice. Individual cases make bad law so please do not be swayed by a recent and yet to be fully investigated scandal. If there are other concurrent issues (eg drug dependence or mental ill-health), clearly there are existing processes for imposing any necessary conditions.

Question 3: (re doctors who may have cleared the virus). This needs expert input but you might want to consider what stance the doctor's medical indemnifier would take and what stance the College of Surgeons currently takes in this situation. I have already mentioned the desirability of having a section advising treating specialists of their responsibilities under these guidelines. Some specialists may find decision making and exercise of discretion very onerous and may want to be able to seek advice. I would not argue for an expert panel to be involved compulsorily for every infected doctor but it could help to have a panel to which a treating doctor could turn for advice.

Para 7 ***The role of the Board***: Perhaps you feel this paragraph is necessary as the document will eventually "stand alone" but coming at this point in the document, it seems oddly placed. If it is really needed in all your guidelines, I suggest you think about where it should be placed and then be consistent in every guideline. Perhaps it could be in a box at the start or end of each document (in my view, at the end would be preferable). For the majority of readers (who will mostly be doctors), it seems redundant.

Para 8 ***Notifications about an impairment***: This is tricky material under the present regressive legislation. It is possible to read into the draft that the Board is advising doctors to ignore the

legislation. I suggest that this section needs further thought. The preceding sections of the draft guide are in effect stating that an infected doctor is only regarded as a risk if he/she undertakes exposure prone procedures. Thus for those whose practice does not involve such procedures, it seems very unfair and probably untrue that such a doctor should be considered and labelled as impaired.

Question 4: (re monitoring by the Board). This question came as a considerable surprise given that para 6 had already implied that most infected doctors will be handled by an independent specialist. In line with a previous comment, I suggest that only doctors with additional impairments – those that might affect their insight and judgement – will need direct monitoring by the Board. If such a doctor is identified, then it is difficult to imagine how any form of medical (clinical) practice would be permitted.

Question 5: (re additional measures). No.

Final comment: I suggest that placing a timeline of "within three years" until a review is unwise, as in practice such timelines are rarely met. It might be wiser to say "will be reviewed and if necessary revised from time to time".

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