The Royal Australasian
College of Physicians

From the President

2 June 2011

Dr Joanna Flynn
Chair
Medical Board of Australia
GPO Box 9958
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Via email: medboardconsultation@ahpra.gov.au

Dear Dr Flynn

The Royal Australasian College of Physicians (RACP) welcomes the opportunity to comment on the draft document *Guidelines for medical practitioners and medical students infected with blood-borne viruses*. Please find our submission included at Attachment A for your consideration.

If you could like to discuss the contents of this submission in more detail please do not hesitate to contact Ms Lucy Hartland, Senior Policy Officer.

Yours sincerely

John Kolbe

Attachment A: Submission draft *Guidelines for medical practitioners and medical students infected with blood-borne viruses*

The Royal Australasian College of Physicians

Guidelines for medical practitioners and medical students infected with blood-borne viruses

Submission by The Royal Australasian College of Physicians June 2011

The Royal Australasian College of Physicians (RACP) welcomes the opportunity to provide feedback on the draft *Guidelines for medical practitioners and medical students infected with blood-borne viruses*

General Statement

Generally, in spite of certain high profile cases, there is a low risk of transmission of blood borne infections from medical practitioners to patients.[1] This is partly because of the characteristics of the viruses themselves and partly because of existing infection control measures.

Guidelines for the management of medical practitioners who are infected with blood borne viruses are a part of infection control. These should be drafted in a way that reinforces and supports good infection control and management of infected medical practitioners, recognising that they too are patients.

Medical practitioners do not have the right to put patients at unnecessary risk of harm, however significant community investment has gone into the training of medical practitioners. Where it is necessary to control or limit the scope of practice of infected medical practitioners, these practitioners should be encouraged and assisted to use their training and experience in ways that do not pose a risk to training.

The guidelines should recognise that they are only part of the strategy to prevent the transmission of blood borne infection in health care settings. Patients have acquired blood borne viruses by way of uninfected health care workers who do not carry out good infection control.[2] Further, there will always be infected medical practitioners who do not know they are infected, including some who are unaware that they have been at risk of infection.

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[1] See discussion Gostin O, *A Proposed National Policy on Health Care workers Living with HIV/ AIDS and other Blood-Borne Pathogens* (2000) JAMA 284: 1965; Centers for Disease Control and *Prevention Occupational HIV Transmission and Prevention among Health Care Workers*, February 2011; Outbreaks of Hepatitis B and C reported at http://www.cdc.gov/hepatitis/Statistics/Outbreaks2008.htm (viewed 3 May 2011). Low transmission is also indicated by lookback investigations, see eg, http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5753a3.htm (viewed 3 may 2011) (lookback on HIV infected surgeon's patients and editorial note).

[2] See eg, Centers for Disease Control and Prevention. Hepatitis C Virus Transmission at an Outpatient Hemodialysis Unit — New York, 2001–2008. MMWR 2009; 58:189-194 (outbreak of Hepatitis C in a dialysis unit)

Questions for stakeholders

Comments against the questions posed in the consultation paper follow for consideration.

Question 1
Should medical practitioners with any level of viraemia be permitted to perform exposure prone procedures? If you believe that they can safely perform exposure prone procedures in some circumstances, define the circumstances (for example, which viruses and what maximum level of virus?)

This is a complex area that is not amenable to a simple guideline. As a preliminary matter, a “level of viraemia” can only refer to what is actually detectable on testing. In respect of the different viruses there are various tests that indicate viraema, each with different sensitivities. Thus, in the absence of a specific method of determining viraemia, the expression “any level of viraemia” is imprecise. A qualification such as "a level of viraemia below the limit of detection of most sensitive nucleic acid amplification testing (NAAT)[3] assay currently commercially available to the person tested" would provide an objective standard. It should be noted that testing for hepatitis B viraemia using HBV DNA is expensive and there are restrictions on the number of HBV DNA tests that can be ordered in a twelve month period.

Because of the limitations of the available tests, a person known to be infected with a virus may have no detectable virus by NAAT but still have viraemia, although that would be at extremely low levels. The minimum level of virus required for transmission is not known. With undetectable virus, however, the risk must be extremely low. Certainly, in other jurisdictions, for example Israel, HIV positive medical practitioners have been permitted to continue performing exposure prone procedures.[4]

Exposure prone procedures also vary. The NHMRC *Australian Guidelines for the Prevention and Control of Infection in Healthcare* (AGPS, 2010) recognises three categories of exposure prone procedure, based on the risk of exposure to the health practitioner’s blood and the likelihood of immediate detection and management of that exposure. Individual procedures within those categories vary in the level of risk of exposure, for example, whether solid or hollow bore needle is involved.

Given the variance in practice between medical practitioners and variance between different individual scenarios, the decision on whether a particular medical practitioner should perform exposure prone procedures in particular circumstances is best left to the treating specialist.

[3] Sometimes referred to as NAA testing or nucleic acid testing (NAT).
[4] The case of a HIV positive surgeon is described here: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5753a3.htm. Conditions of practice included: 1) instruction by infection-control personnel at the surgeon's hospital regarding safe practices, including adherence to standard precautions and hand hygiene requirements, double-gloving during all surgery, and immediate reporting of any cuts in gloves or finger sticks, plus agreement by the surgeon to abide by these practices; 2) routine health-care follow-up at 3-month intervals, including measurement of CD4 T-cell count and HIV RNA; and 3) adherence to a prescribed antiretroviral regimen, maintenance of good health, and continued CD4 T-cell level >200 cells/μL, with HIV RNA below the threshold of detection.

Question 2
Is it reasonable to expect that medical practitioners and medical students infected with a blood-borne virus will comply with the Board's guidelines and their treating specialist doctors' advice, or should they have conditions imposed on their registration that prevent them from performing exposure prone procedures?

Most medical practitioners and medical students infected with a blood-borne virus will comply with the Board's guidelines and their treating specialist doctors' advice. This is consistent with medical practitioners' medical knowledge and training, and their professional ethics. It must, however, be acknowledged that there will be individuals who will not do so.

In considering whether conditions on registration should be imposed on all infected medical practitioners, the following needs to be taken into account:

1. **The compulsory imposition of practice conditions on all medical practitioners infected with blood borne viruses will effectively disclose their condition publicly.** This is so even though there would need to be no explicit mention of the reason for the imposition of a practice condition. A restriction against performing exposure prone procedures has few, if any, explanations other than infection with a blood borne virus.

   Such a disclosure is inconsistent with the treatment of others infected by blood-borne viruses, which is generally governed by privacy and public health legislation. It would expose these medical practitioners to the risk of stigmatisation both in professional and other contexts.

   This is entirely unnecessary for infected medical practitioners who do not perform exposure prone procedures and for those whose specialists have determined do not pose a risk to patients.

2. **The practice conditions may contradict treating specialists' advice that specific infected medical practitioners could carry out certain exposure prone procedures.** Accordingly, the conditions would be more onerous than necessary to protected patients.

3. **The conditions and likely negative consequences will encourage under reporting of needlestick injuries and other incidents that put the medical practitioner at risk.** Needlestick injuries are known to be significantly unreported.[5] This is a situation that needs to be addressed and anything measure that decreases the likelihood of reporting is undesirable. A medical practitioner who fails to report an injury misses out on intervention regarding proper technique to prevent infection, such as, for example, the correct handling of sharps. If actually infected, the medical practitioner also misses out prophylaxis and misses out on knowing that they are now infectious. This is especially serious in the case of HIV where the immediate post infectious viral load is high.

4. **The imposition of conditions will not guarantee that those in denial about their status or are recklessly indifferent to their status won't practice procedure prone procedures.** Unfortunately in the past, medical practitioners have breached conditions of their registration.[6] Some doctors also have other impairments which indicated that they cannot practice safely. A more targeted approach is needed to identify and deal with these medical

[5] See e.g., J. C. Trim and T. S. J. Elliott *A review of sharps injuries and preventative strategies* Journal of Hospital Infection Volume 53, Issue 4, April 2003, Pages 237-242
[6] See e.g., *Re Dr Swapan Chowdhury* [2010] NSWMT 13.

practitioners, as these are the ones who actually pose a risk to patients. This includes those who are known to be infected but who are not under the care of a specialist physician and those who are known to have a history of generally poor infection control. This is no different to the management of any other potential impairment to safe practice.

Taking the above into consideration, imposing conditions would be counterproductive and is not supported.

Question 3
Should these guidelines include details about the management of practitioners who appear to have cleared the HBV or HCV, whether that is the result of treatment or whether it is spontaneous? Should that be left to the treating specialist doctors' discretion?

The guidelines should include details about the management of practitioners who appear to have cleared the HBV or HCV. This may be simply to advise the Medical Board of Australia that they are no longer prevented from exposure prone procedures after 'clearance' from their treating specialist.

Question 4
Which of the following groups of medical practitioners infected with a blood-borne virus should be monitored by the Board and if so, how? For example, should they be required to provide regular results of tests to the Board?

a. all registered medical practitioners; or

b. only registered medical practitioners who perform exposure prone procedures; or

c. only registered medical practitioners that may place the public at risk of harm because of their practice.

Who should be monitored?

Infected medical practitioners who perform exposure prone procedures should be monitored.

Monitoring all infected medical practitioners including those who don't perform exposure prone procedures (depending on the definition of exposure prone procedures), beyond requiring infected practitioners to annually declare whether or not they perform exposure prone procedures, may be counterproductive, depending on the numbers involved. Effort spent monitoring those who pose no risk may detract attention from those who do.

As an aim of monitoring is to identify "registered medical practitioners that may place the public at risk of harm because of their practice", aiming to monitor only this group is not sufficient, however once identified, this subgroup will require additional measures.

Form of monitoring

An approach to monitoring could be that the medical board require an annual report from the treating doctor of each infected registered medical practitioner. This would require these medical practitioners to:

1. be under the care of an appropriate medical practitioner;
2. have an at least annual test; and

3. provide accurate information to the treating doctor on the nature of their practice, so that a proper risk assessment can be made.

Although these obligations are not required of an ordinary person, they are reasonable requirements under the circumstances.

Reporting would also be required if there was any significant change to the medical practitioner's status, including where the medical practitioner seeks to perform additional exposure prone procedures with a greater risk. Those who were formerly not carrying out exposure prone procedures at all but who wish to gain clearance to do so would also need to provide a report from the treating doctor on the level of risk.

This kind of monitoring would be distinct from what would be required of "problem" medical practitioners, such as those who have breached requirements, where the Board would need an immediate update on their clinical status.

Question 5
Are there any other measures the Board should put into place (within the scope of its powers) to protect the public from potential infection by medical practitioners with a blood-borne virus?

The RACP would support reasonable additional measures by the Board as long as these did not unnecessarily increase the risk of a breach of privacy of affected medical practitioners or have unintended consequences. A breach of confidentiality regarding health care workers and their blood borne virus status has a massive negative impact on the person concerned and on the community.

Comments on specific parts of the guidelines

3. Summary of these guidelines

> ***... Medical practitioners who perform exposure prone procedures should be voluntarily tested for blood-borne viruses prior to the commencement of practice, following potential exposure to a blood-borne virus and on an annual basis.***

The implication of the wording above, notwithstanding the word "voluntarily" is that a person could be in breach of the guidelines simply for not having an annual test. Annual testing should be recommended or considered but not required as an essential part of practice. If a medical practitioner poses no risk to a patient, annual testing is unnecessary.

5. Responsibilities of all medical practitioners and medical students

> ***... Medical practitioners and students should be immunised against blood-borne viruses where a vaccine is available.***

The words "safe and effective" vaccine should be added, noting that vaccination for Hepatitis C and HIV may become available in the future.

> ***... It is not necessary for practitioners to stop performing exposure prone procedures after the exposure, unless they are found to have become infected with the blood-borne virus.***

Consideration should be given to whether this applies to all exposure prone procedures before confirmation of diagnosis, noting that some exposure prone procedures pose a greater risk to patients than others. The period before seroconversion is associated with a high risk of transmission.