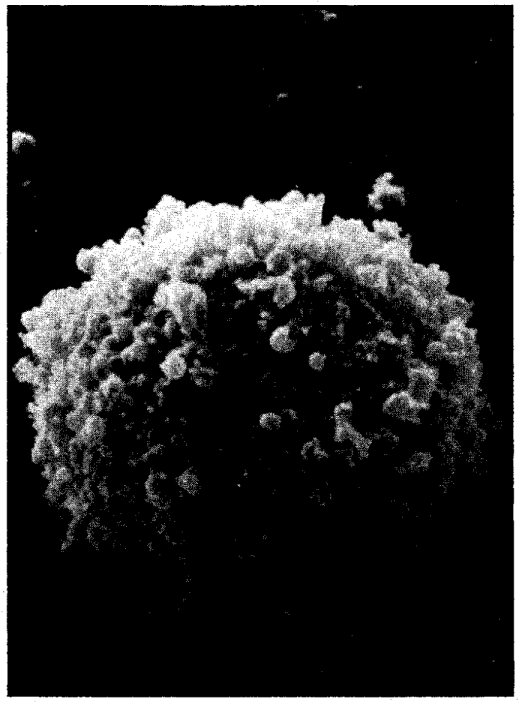
BRITISH MEDICAL ASSOCIATION

Third BMA Statement on AIDS



Report of the British Medical Association

Printed December 1986
Reprinted April 1987

Published by:
British Medical Association
Tavistock Square
London
WC1H 9JP

Cover photo: Scanning electron micrograph of a T4 lymphocyte, infected with HIV. (mag. × 10,000)

(By courtesy of The National Institute for Biological Standards and Control)

Printed by The Chameleon Press Limited, London

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1 Introduction

1.1 HIV and AIDS

1.1.1 The agent which can cause AIDS is a virus called the human immunodeficiency virus (HIV). People catch HIV through sexual contact or infected blood by sharing needles or syringes, from infected mother to unborn child, or treatment with contaminated blood or blood products.

1.1.2 Infection with HIV can have several effects on the human body. The two most important effects are on the immune system and the brain. The immune system is responsible for maintaining the body's natural defences against infectious and malignant illnesses. After a person's immune system has been damaged he or she becomes susceptible to a variety of other diseases. In uninfected individuals these other diseases are usually mild and treatable, but they are difficult to treat or fatal in people with damaged immune systems. These diseases are known as opportunistic infections. The range of symptoms due to severe impairment of the immune system caused by HIV is called the acquired immune deficiency syndrome (AIDS). It is called a syndrome because AIDS can only be diagnosed on the basis of a range of symptoms, not all of which need be present in any one patient. HIV can also attack brain cells, causing progressive loss of mental function. The result of this is dementia, similar to the dementia suffered by some elderly people.

1.2 Natural history of HIV infection

1.2.1 A person should be regarded as infectious to others from the time of exposure to HIV. After a period, which varies between different individuals from about four weeks to six months, detectable antibodies to HIV develop. About 10% of people suffer a brief, acute illness similar to flu about the time they develop antibodies. The further progress of the illness is not at present accurately known but the best estimates are that 60-70% of infected people will develop some clinical symptoms and signs over the next 3-5 years. The first to appear are enlarged lymph nodes (persistent generalised lymphadenopathy) sometimes with symptoms such as fever or night sweats. 30% of the total people who are infected will progress to the full blown AIDS syndrome. If full AIDS develops, the person is likely to suffer a number of acute episodes of severe illness due to opportunistic illnesses, before becoming gradually more weak and debilitated, and ultimately dying.

1.2.2 As well as causing damage to the immune system HIV can attack brain cells, causing dementia. In one study, a quarter of patients presented with symptoms of neurological impairment before AIDS was diagnosed from signs of immune system damage [1]. About 60% of people who develop AIDS show signs of neurological damage, though some of this may be secondary, due to diseases resulting from impaired immunity rather than directly to HIV. It is possible that some individuals may remain in good physical health for long periods, while suffering progressive loss of mental function as a result of attack of HIV on brain cells.

1.3 Some historical comparisons

1.3.1 This is by no means the first time that people have been faced with a pandemic of an apparently incurable disease. Since the Black Death ravaged Europe in the fourteenth century nearly every generation has had its experience of plague or pestilence. However, there are few historical parallels that can usefully be drawn with AIDS. The modes of transmission of HIV differ fundamentally from those of most epidemic diseases: tuberculosis, smallpox, diphtheria and influenza are transmitted through the air; cholera and typhoid through food or water; bubonic plague and malaria through animal vectors. In contrast, HIV is only spread through sexual or blood contact, including from mother to unborn baby. This means that the useful historical comparisons are likely to be with other sexually transmitted diseases, especially syphilis and hepatitis B. AIDS resembles syphilis in that both are characterised by long periods of latency, the possibility of severe neurological damage, a variety of different ways of presenting, and, before the advent of effective treatment, high fatality. Methods of controlling the spread of infection that are effective for syphilis are likely also to be effective for HIV. AIDS differs from syphilis in that it is not a single disease but a syndrome, the primary feature of which is susceptibility to other diseases.

1.3.2 Like HIV, hepatitis B virus is transmitted sexually and through infected blood, including from mother to unborn child. People can carry hepatitis B virus and infect others for many years while remaining in good health. Hepatitis B virus causes acute illness soon after infection in some people, but can also lead to the development of liver cancer after a period of years. Hepatitis B only became preventable through vaccination within the last few years.

1.4 Cases in the United Kingdom

1.4.1 AIDS was first identified in New York and California in 1981, and thereafter quickly became more common. The syndrome certainly existed before it was first identified, although we cannot be certain for how long. In the UK, the earliest cases known are two people who presented in 1979 with symptoms that were retrospectively identified as AIDS [2]. The agent which causes AIDS, HIV, was not identified until 1983.

1.4.2 It is likely that 30-50,000 people in the UK may have been infected with HIV. By the end of November 1986, 599 cases of AIDS had been reported through the Public Health Laboratory Service, of whom 296 had died. The number of cases is currently doubling every nine or ten months. 1,300 new patients are expected in 1987 and 3,000 in 1988.

1.5 Dealing with AIDS

1.5.1 Even if further transmission of the virus were to stop today, because of the latent period there will still be thousands of new cases within the next few years. The problem should thus be approached in three ways: **preventing** the spread of infection; **caring** for those who develop AIDS or AIDS-related symptoms; and finding a **vaccine or cure** to eradicate the disease.

2 Public Health Promotion

2.1 Transmission of HIV

2.1.1 HIV is spread through sexual intercourse and transfer of contaminated blood on shared syringes and needles, from infected mother to unborn child, or through contaminated blood or blood products. Despite extensive study of the epidemiology of HIV infection, in several countries, there is no evidence to support other modes of transmission.

2.2 Casual contact

2.2.1 HIV is not spread through coughs and sneezes, non-intimate touching or a greeting kiss. There is evidence that HIV is not spread through ordinary social contact. For example, among pupils at a boarding school for haemophiliac and non-haemophiliac children half of the haemophiliacs developed antibodies to HIV through infected blood products. Despite close daily contact, over a period of years in some cases, none of the non-haemophiliac children developed antibodies [3]. During the first two years of the AIDS epidemic in San Francisco it was believed that the syndrome was caused by drug abuse, not an infective agent. No especial precautions were taken by health care workers treating or nursing AIDS patients, but no health care worker who themself was not in a high risk group contracted HIV infection.

2.2.2 HIV is easily destroyed by heating above 71 degrees centigrade for at least three minutes (eg the hot cycle of a domestic washing machine) or by household bleach (one part in ten parts water). It is safe to eat food prepared by infected individuals, to share washing, eating and drinking utensils or toilet facilities, since cream cleanser or soap and hot water will kill HIV unless there is a lot of blood or dirt present as well. It is safe to live with infected individuals, provided sexual contact is avoided. Sharing of tooth-brushes, razors or other items likely to become contaminated with blood **may** be a source of risk, although no-one is known to have become infected by this route. Exposure to blood should always be avoided, especially on mucous membranes or damaged skin; blood spills should be cleaned away promptly with bleach solution. Heavy gloves should be worn while clearing away blood; this is only because where blood is spilt there is often a sharp edge to cut the person cleaning it up.

2.2.3 There is no evidence that animals can carry HIV infection. Thus contact with animals, including being bitten severely, carries no risk of transmitting the virus.

2.2.4 Hepatitis B virus is considered to be transmitted in the same ways as HIV, but is more infectious. Many years of study have shown that hepatitis B is not transmitted through non-intimate contact.

2.3 Health education

2.3.1 At present, education on the routes of transmission of HIV is the only weapon we have to combat its spread. Because it is impossible to identify all carriers of HIV (section 3.6) every person needs to avoid practices that can lead to the spread of the infection. It takes two people to spread HIV, so both those who are already infected and those who are not should be involved in prevention. The aims of health education should be: to reduce the number of partners with whom people engage in penetrative sexual acts or at least ensure that condoms are used; to discourage use of drugs by injection or at least ensure that clean equipment is used; to discourage people at high risk of infection from blood donation. Health education also needs to dispel harmful myths as well as to provide factual information. Currently, ignorance leads to anxiety and irrationality in public attitudes and behaviour towards AIDS sufferers and HIV carriers.

2.3.2 To date, the spread of HIV infection in the UK has largely occurred among drug users and within the homosexual community. However, prevention means acting **before** the problem spreads. Although there is concern that some heterosexuals may be excessively worried that they may have contracted HIV infection, public education should avoid being so reassuring as to swing the pendulum the other way. A clear distinction should be made in health education for heterosexuals between past and future risks of infection.

2.3.3 Heterosexuals should be reassured that they are in most cases unlikely to have been infected with HIV so far. At the moment the risk to heterosexuals is not great, but this is only because they are unlikely to have had sex with an infected person. If a person does have sex with an infected individual the risk of acquiring HIV infection may be similar for anal and vaginal intercourse.

2.3.4 Health education demands particular skills; for instance, it is well established that the sections of the population most at risk of cervical cancer are least easily reached by conventional health education on the value of smear testing. In order to reach the people at risk of HIV infection and AIDS it will be necessary to make use of the best available expertise in the health education field. Continuing evaluation of education and advertising campaigns is essential to improve effectiveness in reaching the target groups. Several different statutory and voluntary agencies will be involved in the production of informational material for various sectors of the community. In general this diversity is to be welcomed, as different styles of presentation are appropriate to different target groups. However, to avoid confusion, all material presented to the public should be based upon consistent factual information regarding the nature of HIV infection and AIDS. This may require coordination and consultation between the various agencies involved.

2.4 Target groups

Key target groups for education are:

2.4.1 Young people: They should be told in a straightforward way the dangers of AIDS before they start to participate in activities which could lead to HIV infection. This must be done at school as part of routine health and sex education. Youth groups, radio, television, cinema and magazines aimed at this age group provide other useful avenues for health education.

2.4.2 Sexually active people (heterosexual, homosexual and bisexual): They need to know what AIDS is and how it is transmitted; information on whether it would be wise to be tested, and where tests are available; the use of condoms to cut down the risk should also be explained. Clear information describing sexual practices that are likely to transmit infection is needed, using language that is widely understood. Those who are likely to be at high risk of infection must be encouraged to refrain from blood donation.

2.4.3 Drug users: Information must be given on the dangers of sharing needles and the extremely dangerous habit of mixing blood in the syringe before it passing on for another person to use. Community information programmes will be necessary for those who are homeless with no access to Government information on television, in newspapers or through letter boxes. Drug users need information on the sexual transmission of HIV and the need to refrain from blood donation as well.

2.5 Everyone

2.5.1 AIDS is not confined to the homosexual community or to drug users. Everybody must be given straightforward facts if we are to combat the spread of HIV and to prevent people in risk groups, infected individuals and AIDS sufferers from being stigmatised.

2.6 Language used in health education

2.6.1 The language used in health education needs to be carefully researched. It must be clear and simple enough to be widely understood among the intended target groups. This will require explicit language in some circumstances.

2.7 Education of occupational groups

2.7.1 Members of several professions are especially likely at times to come in contact with HIV carriers or AIDS patients. These include all health service professions, teachers, clergy, environmental health officers, social workers, home helps and other local authority social services workers, the police, prison officers, personal attendants such as hairdressers. Each of these groups needs basic information about AIDS that will enable them to carry out their jobs properly and confidently, in a manner reassuring to the public. A consistent approach to dealing with HIV carriers and AIDS sufferers is essential to avoid misunderstanding.

2.7.2 As well as basic information about the nature of HIV and AIDS, people in many occupations require guidelines on how to conduct specific procedures hygienically. Such guidelines should be drawn up in consultation between representatives of the occupation concerned and experts in the transmission of HIV and other infections. In many cases, the provision of clear guidance will reassure people who currently over-estimate the ease of transmission of HIV.

2.7.3 Within the health service it is important to recognise that although staff in some areas, particularly London, have developed considerable expertise in dealing with AIDS and HIV infection, this may not be reflected throughout the country. General practitioners need information to enable them to advise patients and staff; insufficient guidance has been available, particularly on practical hygienic procedures. This has led to undue concern about the risks of transmission of HIV in some occupational contexts.

3 Control of Spread of Infection

3.1 Risk groups

3.1.1 The groups who are most frequently infected with HIV are promiscuous heterosexuals, people who use drugs by injection, some haemophiliacs, homosexuals and bisexuals, heterosexuals from certain areas of sub-Saharan Africa or the Caribbean, newborn babies of infected mothers, and people who had blood transfusions before safe blood became available. However, as the virus can be spread through heterosexual intercourse, from men to women and vice versa, increasing numbers of cases of infection must be expected outside these risk groups.

3.2 Condoms

3.2.1 Condoms provide a valuable protection against HIV and other infections. Public education should emphasise the value of condoms, without suggesting that they guarantee complete safety.

3.2.2 Condoms should be widely available, free or at extremely low cost, from a variety of outlets, including out-of-hours sources. Access to condoms should be as easy for women as for men; possible sources include family planning and sexually transmitted disease clinics, health centres, chemist shops, hair-dressers, supermarkets, public toilets, pubs, bars and clubs, petrol stations, colleges and other places where young people meet. There is no need for the supply of condoms to be restricted by the necessity to obtain a prescription, as no clinical advice is required.

3.2.3 Although increasing evidence is emerging of the value of condoms, further research is needed into their effectiveness, and ways in which it could be improved. We are concerned that widely available types of condom, designed for contraceptive use, may not be strong enough to withstand anal intercourse, especially if people use non-water based lubricants.

3.2.4 Patterns of contraception over the last fifteen years or so have meant that many young people do not know how to use condoms effectively. The provision of condoms should be backed up by education in their correct use in each packet and in other health promotion.

3.3 Other barrier methods

3.3.1 Barrier methods of contraception other than condoms, such as the cap, diaphragm or spermicide sponge appear to provide a degree of protection against HIV transmission. These methods may not be as effective as condoms.

3.4 People who use drugs by injection

3.4.1 Evidence suggests that many intravenous drug users are amenable to health education on the risks of sharing needles and syringes. Although they may not cease using drugs, some will go to considerable lengths to ensure their equipment is clean.

3.4.2 There have been proposals that health education for drug users should be reinforced by the supply of clean needles and syringes, primarily on a new for old exchange basis. The effects of such a policy would be likely to depend on local patterns of drug use and on health education and counselling accompanying the issue of equipment. It is therefore difficult to predict to what extent supplying syringes and needles would be effective in reducing the spread of HIV infection without leading to a serious increase in illegal drug use. This makes it imperative that if equipment is supplied, there should be ongoing monitoring and review of the policy. We feel it is a matter for urgent decision at Departmental level whether drug users should be issued with injecting equipment and we recommend that facilities be immediately set up in some locations and monitored as pilot studies.

3.4.3 There are a number of possible outlets for the supply of injecting equipment to drug users. Drug dependence units are likely to be appropriate only for registered users; other users are less willing to attend such units, many of which operate waiting lists. Other possible sources include general practitioners, pharmacies, sexually transmitted disease or other clinics, street agencies and reputable counsellors. We are, however, concerned that single-handed general practitioners could be in danger of attack if they were to hold stocks of injecting equipment.

3.4.4 Extensive health education is needed for drug users, on the risks of transmission of HIV both through infected blood and through sexual intercourse. Health education and counselling must be available at any source of supply of syringes or needles.

3.4.5 An active campaign to discourage the use of drugs by injection is needed. However, it is important that people do not switch from injection to more harmful forms of drug use, such as 'crack', a rapidly absorbed form of cocaine. The McClelland Report on HIV in Scotland [4] recommends the use of substitution prescribing where this is likely to be effective in discouraging users from injecting, and as a means of maintaining contact with injecting drug users.

3.5 Acupuncture, earpiercing, tattooing, electrolysis and other needles

3.5.1 There are a number of circumstances in which people who are not medically qualified undertake procedures involving skin puncture. This could lead to transmission of HIV infection if strict hygiene is not observed. Under the Local Government (Miscellaneous Provisions) Act 1982, Part VIII, local authorities are permitted to enact bye-laws requiring practitioners of acupuncture, earpiercing, tattooing and electrolysis to be registered, and subject to inspection. Although we recognise that it will never be possible to register all practitioners, we believe the legal provision for registration and control of practice should be extended throughout the country. Codes of practice should be drawn up for non-medical skin piercing based upon guidance from the Advisory Committee on Dangerous Pathogens on both HIV [5] and hepatitis B virus. Useful guidance to practitioners, based upon the risks of hepatitis B transmission, is already available [6]. The public should be informed of the possible risks attaching to skin puncture, and advised to use only reputable practitioners using hygienic practices.

3.6 Antibody testing

3.6.1 After a person becomes infected with HIV they usually produce antibodies to the virus between four weeks and six months later. This production of antibodies is called seroconversion. There is no test for AIDS — it can only be diagnosed on the basis of a range of clinical and laboratory features. There is no simple laboratory test for HIV. Available tests detect only antibodies, when these are produced in response to HIV infection. Thus a person may carry the virus for several months before the infection becomes detectable. This means that **it is impossible** to identify every person carrying the HIV infection, even if the whole population were to be screened. **At any one time up to 5% of people** infected with HIV do not show antibodies. There have been a few cases where people have not shown antibodies for more than a year after they are known to have infected others. Recently there have been reports of other types of HIV, and that antibodies to these may not be detected with some of the existing tests.

3.6.2 There have been reports that tests are being developed which will detect the HIV antigen itself in blood. This would enable infected individuals who have not developed antibodies to be detected. We do not know when such a test will be routinely available.

3.7 Donor blood and tissues

3.7.1 All donors of blood, bone marrow, milk or semen, organs for transplantation or other transferred bodily materials should be tested for HIV antibodies. There is no ethical objection to this so long as donors understand in advance that they will be tested, and can refrain from donation if they do not wish this. Methods of testing used in this country are generally highly effective in detecting antibodies, when these are present, and rarely give false positive results when combined with confirmatory tests.

3.7.2 It should be clearly understood that antibody testing alone will not guarantee a wholly safe supply of blood. HIV itself cannot yet be detected, and not all HIV carriers show antibodies which can be detected. Therefore, in addition to antibody testing, people who may have been at risk of infection must be persuaded not to give blood. This requires resources for health education, and may lead to problems in maintaining the supply of blood. Current evidence suggests that people in high risk categories have responded well to instructions not to donate blood, but difficulties could arise if infection became prevalent outside identifiable risk groups.

3.7.3 Adequate, convenient and well publicised provision of alternative test sites is essential to prevent people donating blood in order to be tested for antibodies.

3.7.4 Britain continues to import large quantities of plasma from commercial suppliers. A stringent watch must be kept on all imported blood products. The country of origin of all imports must be known, not just the country of processing. Blood products originating in countries with a high prevalence of HIV infection, or where the prevalence is uncertain, must not be used. The situation whereby the British health services pay large sums to multinational companies for suspect blood products is highly unsatisfactory. This dependence on imported blood products should be reduced by increasing the home-produced supply. People in Britain who are not at high risk of HIV infection must be encouraged to donate blood more regularly. The use of blood and blood products should be re-examined in the education of the medical profession, and restricted to circumstances in which it can be clearly justified.

3.7.5 There is no risk of HIV infection to a person donating blood or giving a blood sample. Sterile needles are used and destroyed after each person.

3.8 Testing sites

3.8.1 Antibody testing facilities should be available at all STD clinics and through at least one separate designated doctor in every district, since many people concerned about AIDS may not wish to use the STD clinic. The provision of testing sites suitable for drug users demands particular consideration. Each District Health Authority should make appropriate arrangements for testing. In some districts it may be sensible to use the medical pathology laboratory as a testing site; transport of samples will not then be needed, and the doctor in charge will be able to arrange counselling and if necessary medical advice for the person coming for testing. Counselling is always necessary before testing and when the person is told the result.

3.8.2 General practitioners should understand the testing arrangements in their area, and be able to refer patients and samples for testing. However, patients need to be able to self-refer for testing without the knowledge of their general practitioner.

3.9 Antenatal clinics

3.9.1 Information should be provided through leaflets at antenatal clinics, advising women on the risks of continuing with a pregnancy when carrying HIV, and making it clear how a test may be obtained if they consider themselves at risk. Individual doctors at antenatal clinics should exercise their clinical judgement in deciding whether certain women likely to be in high risk groups, eg drug users, should be advised to undergo testing. HIV infection in pregnancy is an indication for considering therapeutic abortion, as proceeding with the pregnancy endangers the mother's health and is very likely to lead to the birth of an infected baby.

3.10 Seropositive individuals

3.10.1 Discrimination against HIV carriers in employment or non-sexual social contact is unnecessary and unjustified. The established modes of transmission of HIV make it clear that there is no risk of transmitting the infection in virtually all work and social contexts.

3.10.2 People who are known to have antibodies to HIV have to come to terms with the knowledge that they may develop the full disease, and that they could infect others if they participate in sexual acts or needle sharing. Discrimination does occur at work, in family and social contacts, and in insurance, if their antibody status is made known. Thus even when a person remains healthy there are considerable personal disadvantages in being identified as having antibodies to HIV.

3.11 Screening

3.11.1 There is no particular advantage to an individual in being found to carry HIV infection, since no effective treatment is available. Pregnant women are an exception to this, as if they are found to be infected the pregnancy can be terminated. Indeed, there are considerable disadvantages, such as the psychological burden of the threat of serious disease, discrimination in insurance and employment, stigma, and social rejection. However, seronegative individuals may derive considerable reassurance from being tested, and testing may reinforce the need for behavioural change in both infected and non-infected individuals. Furthermore, identification of infected individuals, with their consent, provides doctors with valuable opportunities to study HIV and AIDS. It is therefore desirable to encourage people in risk groups to be voluntarily tested for infection, on the understanding that confidentiality will be maintained.

3.11.2 We strongly oppose screening for the population as a whole for the purpose of detecting individuals with antibodies (as opposed to anonymous screening to estimate prevalence of infection, section 6.2). This would not detect HIV carriers who have not yet developed antibodies, and would be an illogical response to the dangers of the situation leading to a wholly false sense of security. There is no acceptable public health measure that could be taken on the basis of screening results. Screening would involve a distraction of effort from other actions that would be more likely to control the spread of infection (eg public health promotion, section 2). Population screening could not be introduced without compulsion, especially as some of those at most risk of AIDS (eg drug users) would be most unlikely to come forward voluntarily. Such compulsion would be ethically unacceptable and a gross interference with civil liberties, not least because there is little benefit and significant disadvantage to the individual in being found to carry HIV antibodies.

3.11.3 Compulsory screening of population groups at particular risk of HIV infection would be even more pointless and objectionable than screening everybody. Members of groups such as bisexuals, promiscuous heterosexuals, injecting drug users and homosexuals cannot be identified with any reliability, unless they willingly identify themselves. The threat of compulsory screening, with the risk of psychological damage, insurance refusal and discrimination in employment, would surely deter such candour. Haemophiliacs form the only risk group that can be reliably identified.

3.11.4 There may be a case for screening not of population groups at particular risk of infection, but of all people involved in certain activities where there is a particular risk of infection being transmitted. In each such case, a clear justification for screening must be provided.

3.12 Routine surgery and other invasive procedures

3.12.1 Patients undergoing invasive investigation or treatment who carry HIV, or who are at high risk of infection but have chosen not to be tested, should always be encouraged to inform the medical or dental practitioner of this. This enables suitable additional measures to prevent cross-infection to be instituted, eg use of special instruments or putting the infected person last on the operating list to allow time for full sterilisation of equipment before the next patient is treated. In general however, routine procedures ought to be of sufficient standard to avoid the transmission of infection.

3.12.2 There are no circumstances in which a person should be refused necessary medical or dental treatment because they carry HIV infection. In certain forms of surgery, where the risk of cross-infection is particularly high, it may be justified to test prospective patients for HIV infection. Full consent is essential before such testing, and facilities for treatment of those found to carry antibodies must be made available.

3.12.3 If a patient comes from or is suspected of coming from a group at high risk of HIV infection, or there is clinical evidence of infection eg enlarged lymph nodes, but that patient refuses to be tested for HIV antibodies, then the surgeon is justified in placing that patient at the end of the operating list, informing theatre staff, and taking the precautions advised by the DHSS for dealing with infected individuals.

3.13 Foreign Countries

3.13.1 The prevalence of HIV is higher among heterosexuals and the population generally in several other countries, including the United States of America, parts of sub-Saharan Africa, the Caribbean and Europe, than it is in the UK. In certain African cities a very high proportion of prostitutes are infected.

3.13.2 We oppose the screening of overseas visitors to the UK as a means of controlling the spread of AIDS. Since HIV infection is already endemic in the UK its spread cannot be controlled by restricting admission to the country. If screening were to be introduced, it would be necessary to apply it to all visitors, and not just those from countries where the prevalence of infection is known to be high. This is because some countries have been less than candid in revealing the scope of their AIDS problem. Discrimination against certain countries would be likely to have adverse effects on cooperative research programmes (section 6.1.3). To avoid discrimination all visitors would have to be screened, which would be ineffective as a means of controlling HIV and a distraction of resources away from measures likely to be effective. Returning British nationals who have had sexual intercourse, tattooing, acupuncture, other skin puncture or treatment with blood or blood products abroad may be as likely to be infected as foreign visitors. All travellers should be provided with information on the risks of HIV and how transmission of infection can be avoided. Travellers should be informed as to which countries are not screening blood supplies for HIV antibodies.

3.14 Consent

3.14.1 People should only be tested for HIV antibodies if they have freely consented to this, and fully understand the possible implications, because of the considerable disadvantages to the individual in being found to have antibodies. Consent means the ability to choose, free of duress and with the benefit of relevant information, what course of action to take. Moves to test people against their will or without their knowledge might encourage them to conceal behaviour that could place them at risk eg to deny they inject drugs or are homosexual, and to avoid seeking medical attention for problems that may be wholly unrelated to AIDS. It is essential that the medical profession commands the confidence of patients and prospective patients; if patients perceive the actions of doctors as contrary to their interests this will deter them from seeking necessary advice or treatment to the detriment of their health, and will undermine the effectiveness of measures aimed at controlling the spread of infection.

3.15 Confidentiality

3.15.1 The traditional confidentiality of the doctor-patient relationship must be upheld in the case of patients suffering from AIDS and HIV seropositive individuals. According to DHSS guidelines, unless the patient has given consent personal health data should not be disclosed to anyone for any purpose other than the health care of that patient, except where disclosure is necessary to prevent the spread of infection. As HIV is not spread through casual non-sexual contact there could be very few circumstances in which disclosure would be justified. Under the NHS (Venereal Diseases) Regulations 1974, people who attend sexually transmitted diseases clinics must be treated in confidence. There is a serious danger that if breaches of confidentiality occur this will deter others at risk of HIV infection from coming forward for testing or treatment.

3.15.2 With counselling, the majority of infected individuals can be persuaded voluntarily to inform their general practitioner, dentist and sexual partner(s) of their infected status. Women of child-bearing age have a particular need to be informed if they are placed at risk of HIV infection, in view of the dangers to both mother and child of pregnancy while carrying the virus.

3.15.3 It is the duty of the general practitioner to ensure that information is kept strictly confidential, unless the patient consents to disclosure. Patients should be strongly encouraged to permit disclosure when there are firm medical reasons for this, such as when undergoing surgery. In general however, the fewer people know of a person's antibody status the more people in high risk groups will come forward voluntarily for testing or treatment. Much of the pressure for disclosure of patients' antibody status has resulted from misconceptions about the levels of risk, which still remain common among doctors and other health service professionals. This indicates the importance of clear education for these groups.

3.15.4 Insurance companies sometimes ask general practitioners to provide information about patients who are seeking insurance. General practitioners should complete insurance company forms truthfully to the best to their knowledge, but should make it clear to the patient what information is being disclosed, and what the possible implications may be. It is then up to the patient to decide whether the form should be sent. Attempts by insurance companies to obtain unsubstantiated information from doctors may well lead patients to conceal worries about the risk of HIV infection, and enlarge the pool of undetected HIV carriers. The insurance companies' desire for information set against the public health needs of the community as a whole represents a tension which should be resolved by Government. General practitioners should not make statements about their patients' lifestyles unless they are absolutely certain of the facts. For example, a patient should never be described as a homosexual or possibly homosexual unless he has himself told his doctor of this. Otherwise, the general practitioner should say that he does not know any relevant lifestyle details.

3.16 Notification

3.16.1 We oppose the introduction of compulsory notification of AIDS sufferers or of HIV seropositive individuals. There are two reasons why diseases may be made legally notifiable: to provide immediate information so that prompt measures may be taken to control the spread of communicable diseases; and to provide statistical information to help to plan health care facilities and longer-term preventive measures over a wide range of environmental activities. In the case of AIDS the first reason is not applicable because the disease is not transmitted through ordinary forms of contact. Moreover, as it would be impossible to identify and notify all those infected (section 3.6.1) notifying those **known** to be infected might promote a false sense of security among the public. Compulsory notification might also deter people from coming forward to be tested for antibodies.

3.16.2 Statistical information for planning health care and prevention is already available at a national level, through voluntary and anonymous reporting of cases and infected individuals. However, greater statistical information should be made available to District Medical Officers and Medical Officers of Environmental Health, to facilitate local planning.

3.16.3 The DHSS recognises that in countries where compulsory notification has been introduced the numbers of people coming forward for testing have declined. Historical experience has shown that notification is an effective means of dealing with infections that are transmitted through the air or through food or water. For cholera, typhoid and diphtheria, notification and isolation of sufferers can arrest the spread of outbreaks. However, for sexually transmitted diseases, control measures based upon identification of infected individuals have consistently failed. The nineteenth century Contagious Diseases Acts empowered the police in specified areas to compel suspected prostitutes to undergo medical examination and treatment. Not only were these Acts ineffective in controlling the spread of syphilis, but they also angered feminists for stigmatising women. Doctors were concerned at being made into agents of law enforcement, distorting their professional integrity and responsibility to the sick. The failure of the Contagious Diseases Acts led to their repeal, and indirectly to the development of the network of voluntary clinics that survives today. The Royal Commission of 1913 argued that control of sexually transmitted diseases would be far more easily achieved with the willing cooperation of sufferers than through legal sanctions. This has proved to be the case, as the voluntary and confidential services of the clinics have kept the spread of sexually transmitted diseases within reasonable bounds throughout most of this century.

3.17 Isolation of infected individuals

3.17.1 We oppose the compulsory isolation of HIV carriers or AIDS patients to control the spread of HIV as an illogical and inhumane response to the problem. Such isolation must be distinguished from reverse barrier nursing, which is often necessary to protect AIDS patients from secondary infections (section 5.3.2).

3.17.2 Isolation is a traditional means to control the spread of diseases with modes of transmission, eg airborne transmission, that cannot be prevented. In contrast, all the modes of transmission of HIV (sexual, blood contact) are preventable. Isolation is therefore not an appropriate means of control. Isolation would also not be effective as HIV carriers who have not seroconverted cannot be identified, even if the whole population were screened, which is unacceptable (section 3.11). The numbers of people carrying HIV are substantial and the majority of these people will remain in good health for a long period. It would a waste of resources to isolate these people from their normal work, and there is no scientific justification for this isolation and the consequent infringement of civil liberties. Isolation could not be brought into effect without the introduction of compulsory notification. As we have stated, such a measure would be ineffective and potentially counter-productive (section 3.16.1).

3.17.3 In very rare and exceptional circumstances some AIDS patients may need to be isolated to prevent the spread of HIV. This could occur, for example, if an AIDS patient was bleeding profusely and refusing treatment. The Public Health (Infectious Diseases) Regulations 1985 permit AIDS sufferers to be detained in hospital in such circumstances, and no further provision is necessary or desirable. The Regulations should be invoked only in cases of dire necessity; to our knowledge no appropriate case has so far arisen. The excessive use of such powers will assuredly deter people from coming forward voluntarily for treatment of AIDS related conditions. Proper individual counselling of HIV carriers and AIDS patients will avoid the need for compulsory measures.

4 Occupational Health

4.1 Risks to health workers

4.1.1 Workers within the health and emergency services are a low risk group for HIV infection. Routine hygiene procedures such as disinfection by heat treatment or bleach will destroy the virus. However there may be isolated circumstances when special problems will arise. In the health service the main source of risk is accidental skin piercing with contaminated needles or scalpels. Worldwide, hundreds of accidents of this sort have been documented, but only four health workers have developed antibodies to HIV as a result. Ancillary workers such as cleaners and porters do not normally need to know when patients have antibodies to HIV. The type of contact such staff have with patients does not place them at risk of infection. Many patients with AIDS-related illnesses are likely to receive hospital treatment before their condition is diagnosed. Because of this, staff should be taught to maintain careful hygiene in dealing with all patients, and not just those with known AIDS. Staff should also be educated to understand the positive reasons for maintaining confidentiality with regard to HIV and AIDS and that this does not place them at risk.

4.1.2 In emergencies, where large amounts of blood are spilt, special precautions may be needed. Appropriate protective clothing should be worn in circumstances where the rescuer(s) could be at risk of cuts or grazes leading to blood contact. Emergency workers must be made aware that the majority of people carrying HIV infection have not been identified, so that all blood and body fluids must be regarded as potentially infectious.

4.1.3 Laboratory staff and others handling samples of body fluids or tissues must be made aware that the majority of people carrying HIV have not been identified, so all samples must be regarded as potentially infected. Staff should be reminded that vaccination against hepatitis B gives no protection whatsoever against HIV. No relaxation of hygienic procedures should be permitted among staff immunised against hepatitis B.

4.2 Health workers who are seropositive

4.2.1 There are limited circumstances in which a health care worker infected with HIV could transfer the virus to patients. People who have antibodies to HIV should not participate in procedures where there is a risk that if they inadvertently cut themselves, they could infect a patient. Re-training, re-placement and if necessary compensation should be provided for NHS staff who are unable to continue with their usual work because of HIV infection.

4.3 Other occupational groups

4.3.1 We are opposed to the suggestion that people entering certain occupational fields, such as catering, should undergo pre-employment screening for antibodies to HIV. The argument usually put forward to support such screening, that it would prevent occupational transmission of HIV, is invalid as there is no risk of occupational transmission to justify such screening. Basic standards of hygiene, designed to prevent the spread of other infections, will also prevent transmission of HIV.

4.3.2 We are concerned at the possible implications if employers seek to screen prospective employees for HIV antibodies in order to avoid the costs of training staff who subsequently to become too ill to work. In view of the low prevalence of HIV within the population as a whole, it is likely that the social disadvantages of pre-employment screening, in terms of stigma and psychological distress, would outweigh the benefits to employers in excluding the few individuals found to carry antibodies. Employers should certainly be advised that selective screening of individuals believed to be members of groups at high risk of infection, such as promiscuous heterosexuals or homosexuals, will be ineffective, as members of such groups cannot reliably be identified.

4.3.3 Because there is no risk of occupational transmission of HIV, discrimination against workers who contract the infection is unjustified. We welcome the Department of Employment's statement that this could constitute unfair dismissal [7].

4.4 Prisons

4.4.1 We oppose the introduction of compulsory screening for people entering prison, to protect staff and other prisoners. Prisoners should enjoy the same medical rights regarding confidentiality and consent to treatment or testing as the general population. 'The loss of autonomy implicit in imprisonment (ie the restriction by confinement, compliance with an imposed routine, and constraints on an individual's work and leisure activities) should not extend to any part of an individual's medical treatment' [8]. As with other occupations, there is almost no risk of occupational transmission of HIV to prison staff. We are, however, concerned at the risk of transmission of HIV between prisoners, in view of the probable level of homosexual activity in prisons [9]. It is essential that all prisoners receive health education regarding the risks attaching to homosexual activity and injecting drugs.

4.5 Assault

4.5.1 A particular hazard that may very occasionally arise is assault by a person infected with HIV. This is only a problem if body fluids are transferred into the body of the person attacked. Members of some occupational groups, eg the police, are sometimes bitten in the course of their duties. However, although HIV can sometimes be found in saliva, it is present in low concentrations and infection by this route is highly unlikely. It has been reported that saliva contains two substances that inactivate the virus [10].

5 Care of AIDS Sufferers

5.1 Numbers

5.1.1 It is estimated that there may be 30-50,000 people in the UK infected with HIV, of whom 30% (9-15,000) will develop AIDS (section 1.2.1). This estimate has changed from 10% a year ago, and may increase further as there is no known maximum possible incubation period before the syndrome develops.

5.1.2 As described in section 1.2.2, brain damage can result from HIV infection. Clearly if significant numbers of people survive for long periods while infective and suffering from dementia this would have serious implications for the provision of care. Certainly, the effects of neurological impairment mean that some AIDS sufferers need nursing care and assistance throughout the course of their disease, even when their physical health is relatively good.

5.1.3 There has been a serious lack of strategic planning for the care of AIDS patients. As we describe below (section 5.5, 5.6), AIDS has enormous resource implications which have not yet been met. There have been problems in distribution of limited resources at the sub-regional level. Much of the burden has fallen on clinical academic staff whose funding arrangements have enabled them to respond flexibly to the demands of caring for AIDS sufferers. However, this flexibility cannot be infinite. We applaud the dedication of the small group of people who have provided the bulk of care, but these people now feel they are overwhelmed by the scale of the problem. The involvement of clinical academic staff has reflected the research emphasis of much of the work on AIDS to date. We are now moving out of the main learning phase, as regards care of sufferers, and research should be giving way to routine administration and management of care for AIDS patients. This will require appropriate expansion of NHS staff in all grades, subject to manpower planning approval.

5.1.4 Although AIDS is incorrectly perceived as a problem almost confined to London, and to a few hospitals within London, the prevalence in other areas is growing. Every district and area of the United Kingdom should be developing its strategy for dealing with AIDS now. All District Health Authorities and Health Boards should establish a task force to face the challenges posed by the spread of AIDS. Planning should extend throughout the whole range of services including acute, community and hospice care of sufferers, staff training, health education, counselling and testing provision, sterilisation of operating suites and other facilities, blood supply and liaison with outside bodies. Those districts that have not yet encountered any AIDS patients are under no less obligation to be prepared for the future than those that have become experienced in care of AIDS victims. Their role in prevention is even more critical.

5.2 Seropositive individuals

5.2.1 Once a person has been found to have antibodies to HIV (ie to be seropositive) he or she needs ongoing counselling to avoid transmitting the virus through sexual practices or needle sharing, and to provide support in dealing with the fear of developing AIDS itself, and with social stigma or difficulties with family, friends, employment, insurance etc. Women who have been infected with HIV should be counselled against pregnancy because of the risk of transmitting the infection to the baby, and because pregnancy appears to increase the likelihood of the woman herself developing symptoms of AIDS.

5.3 Acute illnesses following compromised immunity

5.3.1 AIDS patients suffer from a variety of secondary infections and malignant illnesses because the natural defences against infection and certain tumours are damaged. Although many AIDS patients can be cared for in the community through most of the course of the disease, during episodes of acute illness they require the full facilities of a well-equipped district general hospital or equivalent. As we have stated (section 3.12.2) people should never be refused necessary treatment because of HIV infection. The mean length of each admission to hospital is around 17-18 days, and patients will typically be in hospital for 2-5 periods before death. AIDS patients commonly require intensive investigation using the full range of modern laboratory and clinical facilities. Thus their care is more expensive than that of the average hospital patient.

5.3.2 Because AIDS sufferers are highly susceptible to secondary infections, they need to be protected from exposure to the ordinary organisms that healthy people carry. Thus they often require reverse barrier nursing (ie to protect the patient from infections carried by the nurse) with separation from other patients. Many AIDS patients also suffer from symptoms leading to high dependence on nursing care eg. incontinence, nutritional and psychological problems [11]. Thus AIDS patients are particularly demanding of nursing resources.

5.4 Later stages of AIDS

5.4.1 In the later stages of AIDS sufferers may become severely weak and debilitated. The most appropriate form of care at this stage is specialist nursing within a hospice or in the community. Although there is no medical reason why patients in the terminal stages of AIDS should not be nursed in hospices alongside other terminally ill people, in the absence of a wholesale change in public attitudes and prejudices it will be necessary to provide special hospices for AIDS patients.

5.4.2 A number of different groups have initiated projects to provide hospice care for AIDS patients, but these groups lack sufficient funding, especially for long-term revenue costs. It would be appropriate for the DHSS to help to coordinate the efforts of these voluntary groups, and provide at least partial funding. There could be no danger of overprovision since, even in the unlikely event that the expected AIDS epidemic does not materialise, there is considerable unmet demand for hospice places among sufferers from cancer and non-malignant diseases.

5.5 Costs of care

5.5.1 It is possible to derive an estimate of the likely future costs of caring for AIDS patients from the Communicable Disease Surveillance Centre projections of the number of cases. If it is assumed that 72% of people presenting with AIDS during a given year are still alive at the start of the following year, and 45% of that 72% survive to the start of the year after [12], a crude estimate of the numbers of people requiring care at any one time can be reached. This may be an underestimate, if, as seems likely, there are improvements in the survival of patients with AIDS.

5.5.2 As we have indicated (section 5.3), AIDS sufferers require both intensive clinical investigation and treatment, and specialist nursing. A proportion of AIDS patients have additional nursing needs because of neurological impairment (section 5.1.2). Appropriate care is needed in the terminal phase of AIDS (section 5.4). We therefore consider it reasonable to estimate that the cost of care of an AIDS patient is of the order of £20,000 per year, until death.

5.5.3 Based on these assumptions, the following costs can be estimated:

Year	Number of patients alive at start of year	Accounting year	Costs of care
1987	474	1986/7	£9,480,000
1988	1114	1987/8	£22,280,000
1989	2581	1988/9	£51,620,000

5.6 Other costs

5.6.1 There are many additional costs involved in the prevention and treatment of AIDS, besides those relating directly to patient care (section 5.5.3). Areas with resource implications include: health education; supply of condoms and injecting equipment; research; training and employment of counsellors; blood supply, screening and treatment; operating theatre procedures and duplication of equipment for treatment or investigation of HIV infected individuals; laboratory procedure; staff training at all levels; antibody test facilities; protective clothing and equipment for emergency services workers; disposal or sterilisation of contaminated materials; disposal of cadavers.

6 Research

6.1 Areas for research

6.1.1 All that is currently being done to treat AIDS patients and prevent the spread of HIV infection is largely palliative. Fundamental research is needed towards the development of a vaccine against HIV and treatment for sufferers. So far, little more than £1 million of government funding has been directed towards research on AIDS, and this is grossly inadequate.

6.1.2 The aims of research should include the development of a vaccine against HIV, and antiviral treatments. A wide range of disciplines can contribute to the prevention and treatment of AIDS and other conditions related to HIV. Clinical studies, immunology, virology and molecular biology provide the framework for our understanding of how HIV affects the human body. This research is vitally important if we are to develop effective ways of intervening in the disease process by which AIDS develops. Improved preventive and therapeutic measures are needed against diseases which commmonly occur in AIDS sufferers, such as pneumocystis pneumonia, Kaposi's sarcoma and herpes. Further study of the epidemiology and natural history of HIV infection would facilitate planning decisions and possibly identify ways of arresting or slowing the progression to full-scale AIDS. Behavioural research has an important role to play in devising and monitoring measures to control the spread of infection through behavioural change.

6.1.3 A great deal of valuable research into HIV and AIDS has been conducted overseas; in some cases British scientists have been involved in collaborative ventures, especially in Africa. In Britain we may well derive greater benefit from this research than our collaborators abroad. This is because here there is still time to arrest the spread of HIV infection, while a well-developed network of health services is available within which to introduce innovations in the care of AIDS sufferers. It is therefore important that international cooperation in AIDS and HIV research is not threatened in any way (section 3.13.2).

6.2 Epidemiological research

6.2.1 In order to increase understanding of the prevalence of HIV and its patterns of spread, it is desirable to screen blood sampled for other reasons from a variety of sources eg antenatal clinics, STD clinics, hospital patients. This method is well-established and has been widely used in other circumstances, for example to assess the effectiveness of immunisation programmes. Further study of the HIV infection by this means could give valuable early warning of the spread of the virus to new groups within the population, and facilitate the prompt initiation of prospective studies of these groups. There can be no ethical or practical objections to studies of this sort provided they are **strictly** anonymous, so that there is no way of tracing back positive samples. This sort of **prevalence** screening must be clearly distinguished from screening to identify infected **individuals** which is unacceptable (section 3.11.2). Protocols for prevalence studies should be drawn up with this in mind, and prevalence screening should be encouraged and facilitated.

7 Summary of recommendations

7.1 Health education

7.1.1 Widespread health education is essential to prevent the spread of HIV infection (section 2.3, 2.4). This should be undertaken using the best available expertise and with continuing evaluation (2.3.4). The objectives of health education should be to reduce the numbers of partners with whom people engage in penetrative sexual acts, or at least ensure that condoms are used; to discourage use of drugs by injection, or at least ensure that clean equipment is used; to discourage people at high risk of infection from blood donation (2.3.1). Some coordination of the agencies involved may be necessary (2.3.4). Target groups include young people, sexually active heterosexuals and homosexuals, drug users, and the population as a whole (2.4, 2.5). The use of language in health education needs to be carefully researched (2.6). Certain occupational groups, including health service staff, have particular educational needs (2.7, 4.1). The public should be advised that condoms provide a valuable, but not complete, protection against infection (3.2.1). Health education is needed in the correct use of condoms (3.2.4). The public should be advised of the possible hazards of non-medical procedures involving skin puncture (3.5). People who are not at high risk of HIV infection must be encouraged to donate blood more regularly (3.7.4). All travellers should be advised of the risks of HIV infection, and how it can be avoided (3.13.2). Prisoners should be particularly advised of the dangers of homosexual activity and injecting drugs (4.4).

7.2 Prevention of the spread of infection

7.2.1 Condoms should be widely available, from a wide variety of sources, free or at extremely low cost (3.2.2). Prescription of condoms is inappropriate. Other barrier methods are likely to be less effective but are useful to women who are not able fully to trust their partners (3.3). It is a matter for urgent decision at Departmental level whether drug users should be issued with injecting equipment. We recommend that facilities be immediately set up in some locations and monitored as pilot studies (3.4.2). Any policy for issue of equipment must be subject to monitoring and review. Active measures are needed to discourage the use of drugs by injection, without people switching to more harmful forms of drug use (3.4.5). Legal provision for registration of practitioners involved in acupuncture, tattooing, earpiercing and electrolysis should be extended to the country as a whole (3.5). Exposure to blood should always be avoided, and spilt blood should be cleaned away with bleach while wearing gloves (2.2.3). Stringent control of imported blood products is necessary (3.7.4). Dependence on imports should be reduced by measures to increase the home-produced supply and restrict blood and blood product use to circumstances in which it can be clearly justified.

7.3 Research

7.3.1 More resources are needed for research aimed at development of a vaccine against HIV, antiviral treatments, treatment and prevention of diseases that occur in AIDS patients, and the epidemiology and natural history of HIV infection (6.1.1, 6.1.2). Clinical research and basic research in immunology, virology and molecular biology is fundamental to the study of HIV and AIDS and should be supported (6.1.2). International collaborative research should be promoted (6.1.3). Strictly anonymous screening of blood samples to estimate the prevalence of HIV infection should be encouraged (6.2). Applied study is needed to evaluate and improve the effectiveness of condoms and other methods of prophylaxis (3.2.3). Behavioural research is needed to facilitate and monitor methods of control of HIV infection based on behavioural change (6.1.2). The language used in health education requires careful study (2.6).

7.4 Antibody testing

7.4.1 All donor blood, bone marrow, milk or semen, organs for transplantation or other transferred bodily materials should be tested for HIV antibodies (3.7.1). Alternative antibody test facilities should be publicised to prevent people donating blood in order to be tested (3.7.3). Antibody testing facilities should be available through all STD clinics, and through a separate designated doctor in each district (3.8.1), by self-referral or general practitioner referral (3.8.2). Testing should always be accompanied by counselling (3.8.1). Information should be provided through antenatal clinics on the risks of HIV infection in pregnancy and the availability of testing (3.9). Individual doctors should exercise clinical judgement in advising individual patients attending for antenatal care to be tested. People at risk of HIV infection should be encouraged to undergo voluntary testing (3.11.1).

7.5 Screening for HIV infection

7.5.1 The population as a whole should not be screened for HIV infection (3.11.2). Members of population groups at particular risk of HIV infection should not be screened, but should be encouraged to undergo voluntary testing (3.11.3, 3.11.1). There may be a case for screening people involved in certain activities liable to transmit infection, but this should always be justified in each circumstance. Overseas visitors to the UK should not be screened for HIV antibodies (3.13.2). People entering prisons should not be compulsorily screened for HIV antibodies (4.4).

7.6 Compulsory measures

7.6.1 AIDS and HIV infection should not be made notifiable diseases (3.16.1). HIV carriers and AIDS sufferers should not be subject to compulsory isolation (3.17.1), except in extremely unusual circumstances as provided for by the Public Health (Infectious Diseases) Regulations 1985 (3.17.3). Such circumstances can be avoided through proper individual counselling.

7.7 Medical and dental treatment

7.7.1 HIV carriers, and those at high risk of infection who have chosen not to be tested, should be encouraged to tell their dentist, general practitioner and any surgeon operating on them of their infection (3.12.1 and 3.15.2). In certain forms of surgery, with a high risk of cross-infection, it may be justified to test prospective patients for antibodies, with their full consent (3.12.2). Where there are grounds for suspecting that a patient may be at high risk of infection, but that person declines to undergo testing the same precautions may be taken as for a person known to be infected (3.12.3). There are no circumstances in which a person should be refused necessary treatment because of HIV infection (3.12.2). Facilities for treatment of infected individuals must be made available. HIV infection in pregnancy is an indication for considering therapeutic abortion (3.9).

7.7.2 Strategic planning is urgently needed in all districts for the care of people who develop AIDS or HIV related conditions (5.1.3). Greater statistical information should be made available for local planning from the voluntary anonymous reporting of AIDS and HIV infection (3.16.2). Each District Health Authority or Health Board should establish a task force to deal with the problems posed by HIV and AIDS (5.1.4). Increased resources will be needed in many areas (5.5, 5.6). Full acute care facilities, community or hospice nursing care, and counselling services are all needed (5.2, 5.3, 5.4, 5.1.2). Additional provisions such as health education, supply of condoms and injecting equipment, research, training and employment of counsellors and other staff, blood supply, screening and treatment, procedures and equipment for dealing with HIV infected individuals, laboratory procedure, test facilities, protective clothing and equipment, disposal and sterilisation also demand planning (5.6). Hospice care is particularly appropriate during the later stages of AIDS, and the DHSS should coordinate hospice initiatives and provide at least partial funding (5.4).

7.8 Medical ethics

7.8.1 There are no circumstances in which a person should be refused necessary treatment because of HIV infection (3.12.2). People should only be tested for HIV antibodies with their consent (3.14). Consent means the ability to choose, free from duress and with the benefit of relevant information. Prisoners should enjoy the same medical rights regarding confidentiality and consent to treatment or testing as the general population (4.4).

7.8.2 The traditional confidentiality of the doctor-patient relationship should be upheld in respect of patients with AIDS or HIV infection (3.15.1). Infected individuals should be encouraged to disclose their infection to their general practitioner, dentist, surgeon, and sexual partner(s), especially women of child-bearing age (3.15.2). General practitioners should complete insurance company forms to the best of their knowledge, but ensure the patient understands the possible implications of information being disclosed (3.15.4). General practitioners should not speculate about their patients' lifestyles, in the absence of certain knowledge.

7.9 Conflict of interest

7.9.1 The Government should seek to resolve the conflict between insurance companies' desire for information and the public health needs of the community as a whole (3.15.4).

7.9.2 There is a potential for conflict between employers wishing to screen prospective employees for health problems and the interests of the community at large (4.3.2).

7.10 Employment

7.10.1 Health service workers are at low risk of HIV infection, except in the special case of accidents involving skin puncture (4.1.1). Special protective measures may be needed in emergencies, particularly if there is any risk of injury to the rescuer (4.1.2). Health service workers who are themselves infected with HIV should not participate in procedures where there is a risk that if they cut themselves they could infect a patient (4.2). Re-training, re-placement and if necessary compensation should be provided for affected staff.

7.10.2 Discrimination against HIV carriers in employment or non-sexual social contact is unnecessary and unjustified (3.10.1, 4.3.3). Pre-employment screening to prevent the spread of HIV infection is unjustified, as there is no risk of transmission of the virus in this context (4.3.1). Being bitten by a person infected with HIV is highly unlikely to transmit the virus (4.5).

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