Appendix A.

CMO(81)11

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
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Your reference
Our reference

To: Regional Medical Officers
Area Medical Officers

Copies to: Medical Officers for Environmental Health
Port and Airport Medical Officers
Secretaries of Boards of Governors
of Specialist Postgraduate Teaching
Hospitals

31 December 1981

Dear Doctor

HEPATITIS B AND NHS STAFF

Advice on hepatitis and the treatment of chronic renal failure was issued in 1972 (CMO 25/72). Further advice on staff in Blood Transfusion Services was issued in 1972 and 1975 and on Hepatitis in Dentistry in 1979. All this advice still stands.

Knowledge about hepatitis B has been increasing, and the subject has now been reviewed by an Advisory Group on Hepatitis established recently under the Chairmanship of Sir Robert Williams. In particular the Group considered the question of the employment in certain posts of National Health Service staff who had been found to be carriers of hepatitis B surface antigen (HBsAg). The Group has advised that such a finding need not affect the position of the great majority of staff but that there are a few situations in which particular care is needed. Their recommendations are contained in an appendix to this letter.

Yours sincerely

GRO-C

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Chief Medical Officer

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Further copies of this letter may be obtained from DHSS Store, Health Publications Unit, No. 2 Site, Manchester Road, Heywood, Lancs, OL10 2I quoting code and serial number appearing at top right-hand corner.

GUIDANCE ON HEPATITIS B SURFACE ANTIGEN CARRIERS AMONG NHS STAFF

The advice from the Rosenheim Committee that members of staff who are found to be carriers of the hepatitis B surface antigen (HBsAg) should not work in renal dialysis units is confirmed; the reasons for this are the particular susceptibility of patients with renal fialure to hepatitis B infection and the ease with which the virus has spread in haemodialysis units. Staff who work in other departments, and who are found to be carriers of HBsAg should not be barred from work except in the very rare situation where an individual has been shown to be responsible for spreading infection with hepatitis B virus.

There are no other reasons for limitation on employment of HBsAg carriers within the National Health Service except that, when a member of staff is found to be a carrier of HBsAg, he should receive expert advice on how to avoid transmitting the infection to others, particularly if his blood has the markers of high infectivity.

In the very rare instances where a member of staff who is a carrier appears to have been the source of hepatitis B infection in patients, that individual should perform only those activities in which the possibility of further transfer is remote; surgeons should not carry out operations but may continue non-operative work with patients, including taking blood or giving injections, using suitable precautions.

It has been estimated that among clinical National Health Service staff in the United Kingdom there are several hundred HBsAg carriers, most of whom will be unaware that they have ever been infected. Having considered the advantages and disadvantages, the Group advised that routine screening for HBsAg could not be recommended for either patients or staff.

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These views are similar to those expressed by the World Health Organisation Scientific Group on Viral Hepatitis. In a report published in November 1981 on its work, which was completed in 1979, it was stated that there was no evidence at the present time that HBsAg carriers among the health professions and in close contact with the general population presented a hazard provided that they took adequate general hygienic precautions.

The Advisory Group recommended that no restriction should be placed on HBsAg carriers so far as employment outside the National Health Services was concerned, although they should be counselled about appropriate hygiene.

Healthy volunteer blood donors who are HBsAg carriers are identified as a result of the hepatitis B screening of all blood donations. They and other known carriers should be able to receive the same medical and dental treatment as they would have received if they had not been carriers, precautions being taken by staff to prevent the spread of infection.

December 1981

ANNEX B.

IHCW(1) 2

OCCUPATIONAL ADVICE FOR HIV INFECTED HEALTH CARE WORKERS

1. Recommendations on working practices of HIV infected health care workers were made by the Expert Advisory Group on AIDS in "AIDS/HIV Infected Health Care Workers" published in March 1988.

2. The Report considered the risk of transmission of HIV from infected health care workers to patients. It concluded that such risks could only arise during an invasive procedure where an injury to the operator allowed blood to enter the open tissues of the patient. Invasive procedures were defined as "surgical entry into tissues, cavities or organs or repair of major traumatic injuries, cardiac catheterisation and angiography, vaginal or caesarean deliveries or other obstetric procedures during which bleeding may occur; the manipulation, cutting or removal of any oral or perioral tissues including tooth structure, during which bleeding may occur".

3. This updated guidance gives further advice to HIV infected health care workers, their physicians and employers and indicates where specialist occupational advice on individuals' working practices can be obtained at a national level. Whilst some of the work-associated problems of HIV infected health care workers may be able to be resolved locally, EAGA has recommended that in order to achieve consistency of advice between health regions and districts problem cases could be referred in confidence to a central (UK) specialist panel of experts.

RISK OF TRANSMISSION OF HIV TO PATIENTS FROM HIV INFECTED HEALTH CARE WORKERS

4. Only one case of possible HIV transmission from a health care worker to a patient has been reported in the medical literature. The report from the Centers for Disease Control, Atlanta, claimed that a woman became infected with HIV following a tooth extraction carried out by a dentist with AIDS.

   A follow up study of patients operated on by a surgeon in the UK within three months of his death from AIDS, did not identify any who had seroconverted[2]. In another study, 616 patients operated on by a surgeon who was diagnosed with AIDS were investigated. Only one, an injecting drug misuser, was HIV antibody positive[3,3a].

   In the absence of any estimate of risk to patients, the risk of transmission of HIV from infected patients to health care workers may be regarded as a surrogate measure of risk. Evidence from a number of surveillance studies indicates that the risk of HIV transmission from a single sharps injury from a known HIV infected patient is about 0.5%[4]. By April 1990, 19 documented cases of

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occupational transmission of HIV worldwide had been reported of which four occurred from non-parenteral exposure. A further 15 cases worldwide of presumptive occupational transmission have been reported in health care workers (Source: CDSC, London).

GENERAL PRINCIPLES ON WHICH TO BASE SPECIALIST OCCUPATIONAL ADVICE

5. Provided routine infection control measures are taken, the circumstances in which HIV could be transmitted from a health care worker to a patient are restricted to invasive surgical procedures in which injury to the health care worker could result in bleeding into a patient's open tissues.

Examples of such procedures are those in which hands may be in contact with sharp instruments or sharp tissues (spicules of bone or teeth) inside a patient's body cavity and when the hands are not completely visible.

A UK Advisory Panel (see para 9) has been established to provide advice to the occupational physician, or other physician responsible for an infected health care worker on the activities that such a person may safely pursue.

SCREENING OF HEALTH CARE WORKERS FOR HIV ANTIBODIES

6. Routine screening of health care workers undertaking invasive procedures as a measure to protect patients from infection is not considered justified. The risk of HIV transmission to patients in the health care setting is extremely small, depending as it does on an unlikely sequence of events. With the possible exception of the case involving a dentist, no cases of transmission to patient from health care worker have been confirmed. As well as practical and legal difficulties, such a policy would have other consequences including the screening of patients. Any policy of compulsory screening of defined groups of individuals would be [? is regarded as] detrimental to the public health.

RESPONSIBILITIES OF HEALTH CARE WORKERS

7. The General Medical Council, General Dental Council and UK Central Council for Nursing, Midwifery and Health Visiting have issued statement to their professional members on HIV and AIDS which refer to the ethical responsibilities of health care workers towards their patients (Annexes C, D and E).

Health care workers who believe they may have been exposed to infection with HIV have an obligation to seek professional medical advice and if appropriate, after suitable counselling, a diagnostic test for HIV antibodies.

Health care workers infected or potentially infected with HIV must obtain occupational advice on their work practices which may need to be modified or restricted in order to protect their patients. Such

occupational advice should be sought from their attending physician or occupational health physician, who may wish to seek guidance from the UK Advisory Panel on the particular work practices involved in a health care worker's specialty.

Physicians of infected health care workers who have not followed advice to modify their practice have a duty to inform the Disciplinary Committee of the appropriate Professional Body.

Infected health care workers need to remain under close medical supervision and receive appropriate medical and occupational advice as their circumstances change.

RESPONSIBILITIES OF EMPLOYERS AND RIGHTS OF HEALTH CARE WORKERS

8. Patient safety is dependent on the voluntary self declaration of the health care worker and employers must promote a climate which encourages such disclosure.

It is extremely important that HIV infected health care workers receive the same rights of confidentiality as any patient seeking or receiving medical care. Occupational health physicians have a key role in this process, acting as they can as advocates for both the health care worker and the employing authority. The close involvement of occupational health departments in developing local procedures for managing HIV infected health care workers is strongly recommended.

HIV status may need to be disclosed to the employer but this should only be done with the consent of the health care worker.

Health care workers must be assured that their contractual rights as employees are safeguarded and that their employers will make every attempt to arrange suitable alternative work should this be necessary.

SOURCE OF SPECIALIST ADVICE TO HEALTH CARE WORKERS AND THEIR PHYSICIANS

9. A UK Advisory Panel has been set up under the aegis of the Expert Advisory Group on AIDS. It is available to provide specific occupational advice to personal physicians of health care workers, occupational health physicians and Professional Bodies.

The Panel is available to be consulted when the general guidelines provided in this document cannot be applied to particular cases, when a health care worker disputes the advice given or where special circumstances exist. Physicians seeking the Panel's advice should ensure the anonymity of the referred health care worker.

Health care workers who wish to contact the Panel directly may do so and the approach will be treated in confidence.

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