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LEADING ARTICLES

CLINICAL RESEARCH • PAPERS AND SHORT REPORTS • PRACTICE OBSERVED

MEDICAL PRACTICE

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- *All letters must be typed with double spacing and signed by all authors.*
- *No letter should be more than 400 words.*
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- *Because we receive many more letters than we can publish we may shorten those we do print, particularly when we receive several on the same subject.*

Testing for HIV: the non-medicolegal view

SIR,—I note with more than casual interest the dilemma in which Dr A J Keidan and colleagues find themselves in the case of their patient positive for human immunodeficiency virus (23 January, p 288).

Firstly, their letter raises the problem of confidentiality, for when numbers of HIV positive women are so small there is a genuine danger of the patient's identity being discovered. Secondly, I am impressed by the authors' honesty in admitting their clumsiness in not only failing to provide adequate precounselling but also not informing the patient that the test was being performed. It is now two years since the incident, and I hope that we have all come a considerable distance in experience and sensitivity.

There is no doubt that the clinicians in this case were placed in a cleft stick, and whichever course of action they embarked on would have been hazardous. If the woman had received counselling consent for the test would probably never have been granted and she would probably have left the hospital as hostile as she did on receiving the positive result.

Outside London HIV positivity is still rare among women, and the odds are more than good that the result in any case of this nature will be negative, but clearly informed precounselling covering all eventualities is essential. Perhaps it is time that as a profession we were more honest about all tests that we perform on our patients; should we not explain why we want to test for syphilis and hepatitis B?

Unfortunately, this patient reacted dramatically to the seropositivity and sought help from three further medical experts, desperately clutching at straws in the hope that someone would give her the answer she wanted to hear—sadly to no avail. She has subsequently become embittered towards all doctors and feels no trust is possible; we represent a personal conspiracy that has to be beaten. To this end she is resolved to show that the result is wrong and constantly displays her good health as witness.

Recently, a further complication has developed with the inevitable final evidence of her testimony; she is now pregnant and determined to proceed even after extensive counselling about the possible outcome.

There is no doubt that this case is not the first nor will it be the last case of an HIV positive pregnant woman but it does highlight numerous dilemmas which the medical profession has to recognise and debate honestly before our patients can receive genuine well informed advice. I thank Dr Keidan and colleagues for their letter even if it is only to serve as a lesson for us all.

THE PATIENT'S GP

Surgeons and others and HIV

SIR,—I would like to comment on the leading article by Mr A J W Sim and Professor H A F Dudley in the light of our experience (9 January, p 80).

In our operating rooms we provide anaesthesia for about 50 patients positive for the human immunodeficiency virus (HIV) each year, and for the past two months we have been implementing a set of precautions to prevent transmission of HIV.

The basic rule is that our health care workers must take precautions to prevent exposure to skin and mucous membranes when contact with blood or other body fluids of any patient may occur. Gloves must be worn for touching blood and body fluids, mucous membranes, or non-intact skin of all patients; for handling items or cleaning surfaces soiled with blood or body fluid; and for performing venepuncture and other vascular procedures. Gloves should be available in all rooms and be carried in the pockets of health care workers, and they must be changed and hands washed after contact with each patient. Secondly, masks and protective eye wear or face shields must be worn during procedures likely to generate droplets of blood or other body fluids to prevent exposure of mucous membrane of the mouth, nose, and eyes. Gowns or aprons must be worn during procedures likely to generate splashes of blood and other body fluids. Thirdly, needles must not be recapped, bent, or broken by hand, removed from disposable syringes, or otherwise manipulated by hand. After use all needles, syringes, and sharps must be placed in puncture resistant containers for disposal. Fourthly, to minimise the need to use resuscitation mouthpieces resuscitation bags or other ventilation devices must be available wherever resuscitation is predictable. Finally, health care workers with exudative lesions or weeping dermatitis must refrain from all direct patient care and from handling patient care equipment.

In practice this means that we now wear gloves at all times. The type of glove does not appear to matter. There is no scientific evidence that intact latex and intact vinyl have any difference in barrier effectiveness. The thinner latex of condoms protects against transmission of HIV, and the Federal Drug Administration allows a failure rate of 4 in 1000 condoms. Sterile surgical gloves must conform to a Federal Drug Administration failure rate of 15 in 1000 (American Society for Testing and Materials), and non-sterile gloves must have a failure rate of 25 or less in 1000. We remove gloves and wash hands between patients and any time we leave the operating room.

The obvious disadvantages of this are, firstly, expense and inconvenience; secondly, the discomfort of wearing "plastic" gloves; and, thirdly, the loss of feel in performing delicate tactile procedures such as venepuncture. However, after an initial relearning period the success rate for procedures has returned to normal. To some of us