Preamble

P.1 The impact of potentially serious blood borne and sexually transmitted viral infections such as HIV/AIDS, Hepatitis B and Hepatitis C, (hereafter these infections) continues to be an issue of public health significance.

Many aspects of Australia’s response have contributed positively to the control of these infections in this country, as well as gaining international recognition. In relation to HIV/AIDS, for example, Australia has been recognised for:

(a) the high quality of testing and screening services available;
(b) the quality of care and other services provided to those infected;
(c) the quality and depth of the research being undertaken;
(d) the relative lack of discrimination against those who are infected;
(e) the bipartisan approach taken by the major political parties;
(f) the partnership which has developed between the medical profession, the communities at greatest risk of infection and governments; and
(g) the comprehensive national approach taken towards health promotion and health education to enable people to reduce their risk of becoming infected.

P.2 Since the mid 1980s, the ongoing debate over HIV/AIDS has brought into focus many difficult issues that are of long-term concern in relation to these disease epidemics. Since its discovery, HIV/AIDS has had major social, political and ethical implications for all sectors of Australian society.

HIV/AIDS, like Hepatitis B and Hepatitis C, is a viral infection spread mainly by infected blood and bodily secretions. After a long and variable period, however, HIV/AIDS proves fatal for many of those who acquire it.

The usual principles of control of communicable disease apply to HIV/AIDS. It is differentiated from other infections, however, as a result of its modes of transmission and by its long period of asymptomatic infection, as well as the social stigma and discrimination those who contract it can experience.

P.3 Australian society entrusts medical, scientific, and other health care professionals, along with government, with the responsibility for the prevention and control of these infections and for caring for those who are infected. The medical profession has a central role in the prevention and management of these infections. In carrying out this role, each doctor has a responsibility to both the individual patient and the Australian community.

Care

1 Duty of Care

1.1 People who contract these infections have the same rights to dignity, respect, and appropriate treatment and care as all other patients. Medical services and public hospitals should provide suitable facilities with appropriate equipment and trained staff or arrange for such services to be made available for the continuing treatment and care of people with these infections.

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2 The Medical Profession

2.1 The medical profession is recognised for its tradition of caring for patients with communicable infections. Doctors have a professional responsibility to be aware of all their patients’ medical conditions. They should at all times behave in a responsible manner, ensuring that they do not discriminate against individual patients on the basis of any personal risk or difference of moral opinion.

2.2 A doctor who suspects that he/she has become infected has an ethical responsibility to seek testing and counselling. If testing reveals that he/she is indeed infected, he/she should seek appropriate medical care from a doctor qualified to manage these infections.

2.3 If the doctor’s clinical practice requires that he/she perform invasive procedures, he/she should also seek and follow advice from either the Chief Health Officer or the Medical Board in their State/Territory about modifications to their professional practice that may be necessary to protect their patients.

2.4 A doctor, who, after counselling an infected colleague, becomes aware that he/she has failed to modify their practice as recommended, has an ethical duty to inform the appropriate authority.

2.5 Persons known to be suffering from these diseases cannot under current legislation be denied entry to medical school if they qualify as students. If they become infected during their studentship, they should be allowed to continue their studies, complete their medical training and to graduate, subject to complying with the requirements of the course and provided patient safety is not compromised. They should otherwise be subject to the same provisions that apply to other infected health care professionals (see also paragraph 6). Medical students with no prior history of vaccination or infection should be encouraged to be vaccinated against Hepatitis B prior to the commencement of their course.

3 Patient Care

3.1 The treatment of infected patients is optimal when undertaken by the doctor responsible for the continuing medical care of the patient in consultation with others expert in these infections. Counselling is an integral part of that ongoing medical care. The responsibility for counselling concerning the emotional and health-related aspects of these infections rests with those who undertake the continuing care of the patient. The extent and degree of patient counselling should be tailored to the individual requirements of each patient and should include information about the available community supports.

3.2 In the absence of any definitive cure, drugs which may benefit patients with these infections, should be made available in accordance with the usual procedures for introducing new drugs.

4 Testing and Informed Consent

4.1 Universal compulsory testing for these infections cannot be justified on epidemiological or other public health grounds. The AMA considers, however, that everyone in the community should have ready access to testing. Discussion of a positive test result will include the importance of responsible action towards partner/s and health care providers. Responsible

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2 An invasive procedure is any procedure that pierces skin or mucous membrane or enters a body cavity or organ. This includes surgical entry into tissues, cavities or organs or repair of traumatic injuries. Exposure prone procedures form a subset of invasive procedures and is a term characterised by the potential for direct contact between the skin (usually finger or thumb) of the health care worker and sharp surgical instruments, needles, or sharp tissues (spicules of bone or teeth) in body cavities or in poorly visualised or confined body sites (including the mouth). In the broader sense an exposure prone procedure is considered to be any situation where there is a potentially, high risk of transmission of blood borne disease from a health care worker to patient during medical or dental procedures (National Health and Medical Research Council – Infection Control in the Health Care Setting – Guidelines for the Prevention of Transmission of Infectious Diseases, 1996).

3 See also AMA position statement on Medical Students: Immunisation and Blood Borne Viral Infections
action with partner/s includes, for example safe sex practices, disclosure of their disease status to their partner/s or non-sharing of injecting equipment.

4.2 Testing for these infections should be on a voluntary basis and with the informed consent of the patient. Informed consent should be obtained within the context of pre-test counselling. Test results should be given during post-test counselling to minimise the trauma of positive results.

4.3 The discussion of the test should include an explanation of the implications of both positive and negative results. The patient should be informed if the infection concerned is notifiable. The primary obligation to inform sexual or needle-sharing contacts of a positive result rests with the infected individual and is voluntary. The doctor’s duty in counselling is to explain the high risk behaviours that may cause harm to partners and other members of the community, to make the patient aware of their obligation to third parties and to provide whatever assistance the patient may require in notifying partners.

4.4 In exceptional circumstances, where repeated attempts at counselling fail, a doctor may need to take action which will ensure notification of a patient’s partner/s. However, this should be undertaken only in close consultation with the relevant State or Territory health department (see also paragraph 14.2).

4.5 Some patients will derive greater benefit from testing than the general population, for example, if they are from a higher prevalence group, undertake high risk sexual or drug taking behaviours, or if their treatment involves, for example, immunosuppression. These potential benefits should be outlined when seeking informed consent from such patients to testing.

4.6 The doctor-patient relationship works best when there is full and trusting communication between doctor and patient about the patient’s medical conditions. Patients who are aware that they have one or more of these infections should disclose this to the doctors treating them to optimise medical care.

4.7 Prior to surgery, patients should only be tested for antibodies to HIV and Hepatitis B and C if clinically indicated. Testing should be done with the patient’s full knowledge and consent and with appropriate counselling. (see paragraphs 4.3, 4.4 and 4.5 above).

4.8 If there is no emergency, patients who are unable, or who refuse to consent to testing, should be managed as if they are infected, and in accordance with the infection control guidelines jointly promulgated by the NHMRC and ANCA.4

4.9 If there is an emergency, where the patient or their guardian is unable to provide informed consent, the treating doctor may consider it prudent to perform any test that is clinically relevant to the management of the patient.

4.10 Irrespective of whether there is an emergency, high standards of infection control should be maintained at all times regardless of whether or not a patient is known to be infected. The implementation of ‘standard and additional’ precautions, where and when indicated, should enable procedures to be performed on all patients with minimal risk of transmission of infection to other patients, doctors and other health professionals.

4.11 When such tests become available, large or regional public hospitals should aim to provide a 7-day per week rapid and reliable diagnostic testing service for antibodies and antigens.

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4.12 Mandatory testing for HIV, Hepatitis B and Hepatitis C is required for donors of blood and blood fractions, organs and other tissues intended for transplantation, and for donors of semen and ova collected for artificial insemination or in-vitro fertilisation.

4.13 The AMA acknowledges that mandatory testing of prison inmates will not, on its own, prevent the transmission of these infections in prisons. Effective prevention among prison populations requires the establishment of preventive education programs, needle exchange for intravenous drug users and safe sex programs for those who engage in high-risk sexual behaviour. Prisoners and detainees have the same right to access, equity and quality of health care as the general population. The AMA considers that appropriate arrangements for proper care for prisoners found to have these infections should be made and that prior to release, effective community follow-up should be organised.

4.14 National policy provides for routine testing of would-be immigrants to Australia prior to their acceptance for immigration. The AMA supports this, provided that human rights are respected in the process.

4.15 HIV transmission can now be prevented from mother to child but only if appropriate drug treatment is given to the mother during pregnancy and to the infant at birth. The AMA strongly recommends that voluntary HIV testing become part of routine ante-natal care. This should be accompanied by HIV test counselling following informed consent. If consent is not given, this should not affect the provision of ante-natal care.

4.16 The AMA recommends that, in Australia, mothers who are HIV positive should not breast feed because of the risk of transmission.

Epidemiology

5 Surveillance

5.1 Data on the prevalence and incidence of these infections are essential information for governments wishing to plan an effective public health response.

5.2 Although surveillance depends upon data derived from individuals who have been tested voluntarily, the AMA also acknowledges the value of incidence and prevalence data derived from testing samples of blood given for purposes other than diagnosis or exclusion of these infections. Such blood samples, especially if derived from large numbers of people, are less susceptible to participation bias than samples obtained only from individuals seeking testing. Voluntary testing data are nevertheless particularly useful when questions are asked about the relation between behaviour and incidence. Epidemiological research and surveillance can thus make good use of serological data derived from the results of voluntary tests and from the screening of blood samples obtained from anonymous subjects for other reasons.

6 Incidental and Occupational Infection in Doctors and Other Health Care Professionals

6.1 Risk of infection

Doctors and other health care professionals are potentially exposed to blood borne viruses by the same routes as members of the general population. In addition, some doctors and other health care professionals have become infected in the course of their work. Based on available reports, 6 doctors and nurses in Australia had been infected with HIV through occupational exposure by February 2003. There has been less systematic reporting of Hepatitis B and Hepatitis C transmission to health care workers, but such cases are known to have occurred.

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5 See also AMA position statement on Health Care of Prisoners and Detainees
6 See also the Royal Australian and New Zealand College of Obstetricians and Gynaecologists – Screening in Pregnancy statement
7 See World Health Organisation Statement “Effect of Breastfeeding on Mortality among HIV-Infected Women” 7 June 2001 (endorsed by the AMA in 2001)
6.2 Surveillance for occupational exposure to blood borne viruses through a national tertiary hospital network found that there were around 22-29 incidents of skin penetration or mucous membrane splash per 100 daily occupied beds per year in the period 1995 to 1998. In participating hospitals, the proportion of patients tested following such incidents, who were found to be chronically infected, was around 1% for HIV and 7% for Hepatitis C in 1998. Around 3% were positive for Hepatitis B surface antigen.

6.3 Because such infections are so serious, doctors and other health workers are deeply concerned about the risk to themselves. The AMA acknowledges the depth of this concern.

6.4 **Prevention of Occupational Infection**

The key to prevention of incidental and occupational transmission of these infections is strict adherence to ‘standard and additional’ infection control methods regardless of whether or not any individual patient is known to be infected. The AMA considers that those in charge of all health care facilities have a responsibility to their staff, including contracted and sub-contracted staff, to provide the necessary facilities for such precautions and that health care professionals have a responsibility to comply with such precautions.

6.5 The medical profession has a responsibility to encourage adherence to standard and accepted methods of infection control by all health professionals and to support the dissemination of relevant information to ensure the maintenance of effective control measures.

6.6 All blood, bodily secretions and tissue should be treated as potentially infective, regardless of the diagnosis of the patient. Gloves and, if necessary, plastic aprons and protective eyewear should be worn if contact with these substances is anticipated.

6.7 There must be adequate input from the medical profession in the development of work practices, the implementation of infection control guidelines, testing policies and decisions about how and where infected individuals will be treated.

6.8 The AMA calls for additional research and development in relation to protective devices which are used as part of the **Standard and Additional** infection control methods. It is essential that such protective devices are effective, comfortable and available to all doctors who need them.

6.9 **Rights and Obligations**

The AMA considers it essential that medical practitioners carrying out invasive procedures ensure they seek routine, regular testing for HIV, Hepatitis B and C. For other health professionals, routine or mandatory testing is not considered to be an effective strategy for controlling transmission in the health care setting and is not recommended. However, confidential testing should be available to all health care professionals.

6.10 There are mutual obligations by both doctors and patients concerning the risk of transmission of blood borne viral infections during treatment. The AMA considers that it is reasonable to expect that patients will voluntarily agree to testing in the event of a needle stick injury to a health care worker.

The AMA considers there is an obligation on infected doctors to ensure that they only perform invasive procedures where:

- the relevant health authority believes the risks of disease transmission are minimal; and
- they inform their patients of their infection status and have their informed written consent prior to proceeding.

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8 National Centre in HIV Epidemiology and Clinical Research *HIV/AIDS, Hepatitis C and Sexually Transmissible Infections in Australia. Annual Surveillance Report 1999*
In some cases infected doctors may find themselves in an emergency situation where an invasive procedure is required to preserve life and an alternative medical practitioner is not available. In this circumstance the doctor must assess the risk of acting in relation to disease transmission against the risk of not acting.

6.11 Having timely access to test results may alter the optimal management of the health care worker who has had a needle stick injury as well as of the patient. In the case of the health care worker, for example, it may mean that drugs are not given unnecessarily. Having the information may also be valuable for health care workers following occupational exposure in lessening anxiety and enabling them to have greater confidence that they will be able to continue their work.

6.12 The AMA considers that some situations may arise where information on the patient’s infection status is not available and there needs to be some legal recourse to enable the testing of blood, including that already collected prior to surgery.

6.13 If a patient is tested following a needlestick injury or other occupational exposure, the health organisation has an obligation to the patient to ensure that the test results are followed up with counselling and treatment, if appropriate, and in a way that is in the best interests of the patient.

6.14 Appropriate insurance cover must be available to all health care professionals, in both the public and private sectors, who are at risk of exposure to these infections. Adequate compensation and counselling must be provided for those who may contract such infections in the course of their work.

6.15 **Management of infected health care professionals**

A health care professional who becomes infected should be counselled to seek medical supervision from a doctor qualified to manage the infection. Advice should also be sought and followed from the Chief Health Officer or Medical Officer in the State or Territory.

6.16 A health care professional who becomes infected has the same right to confidentiality and to quality treatment as has any other infected person. The physician providing care should monitor the physical, emotional and cognitive status of the infected individual. Questions or decisions regarding the individual's continuing ability to carry out their professional functions must be dealt with sensitively, and additional expert opinion sought as necessary.

6.17 If a medical practitioner receives a needle stick injury or other occupational exposure, he/she should follow the recommended workplace procedures to minimise the risk of acquiring infection, including post exposure prophylaxis. A medical practitioner should not attempt to manage the injury him or herself.

6.18 In the absence of any demonstrated risk, there is no reason why an infected health care professional should not continue to practise. Expert advice suggests however, that infected health care professionals should not engage in exposure-prone investigations or invasive procedures where there is a possible risk to the patient. Such health care professionals should seek expert advice as to what procedures they may or may not perform. (see paragraph 2)

7 **Blood Transfusion**

7.1 Because of the potential risk of transmission of infection despite current testing procedures, every effort should be made to minimise the use of homologous blood transfusion. Blood conservation techniques such as haemodilution, pre-donation and intra-operative autologous transfusion should be considered for operative procedures.

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9 See also AMA position statement on Health of Medical Practitioners
Government Strategies

8.1 In 1999 it was estimated that there were 12,000 people living with HIV infection in Australia. Hepatitis C is now the most commonly notified communicable disease with over 200,000 people affected. There is good evidence however, that these infections are not evenly spread throughout the population but are more prevalent in population groups whose sexual and drug taking behaviours place them at increased risk.

8.2 Because of the particular modes of transmission of these infections, there is a strong argument for health education and promotion, seeking to prevent high-risk behaviours amongst those most at risk. To maximise the chance of success, government strategies should be developed by consultation with all stakeholders, including affected communities, and based on appropriate research.

8.3 The AMA supports the incorporation of advances in the management of these infections into mainstream health and community care, mindful that some identified programs will still be necessary. Current government strategies in this area are appropriately situated within a broader communicable disease framework and take into account the need to link with other national population health strategies.

Prevention

9 Education of Health Care Professionals

9.1 Members of the medical profession have an obligation to be well informed about these infections and their physical, emotional and social impact on patients and to provide factual, scientific information. If doctors are to play an effective role in educating patients, they may require additional training especially in communication skills and in human sexuality. Training in these areas should include exploration of attitudes and values as well as the acquisition of knowledge.

9.2 In cooperation with experts in the field, the AMA has a role to play in the provision and dissemination of factual information about these infections to its members and to the community.

9.3 Information about these infections and exploration of attitudes and values in relation to them should also feature in the education of medical undergraduates and in postgraduate medical studies. Education should also be provided for other health care professionals in their training programs. Adequate resources should be directed towards education for all sections of the health care professions.

Public Education

10 Appropriately directed education of the community at all levels has been shown, in the case of HIV/AIDS, to be critically important in achieving a reduction in transmission and spread of this infection in Australia. General information and education programs on these infections should continue to be provided to the public. In addition, special measures should be used to reach individuals and groups with less access to prevention information and education. These individuals and groups include people from non-English speaking backgrounds, Aboriginal and Torres Strait Islander people, the mentally ill and people with an intellectual disability, the alcohol dependent population, adolescents, the homeless, immigrants and refugees.

10.2 Public education, especially of young people, should include information about how to avoid the risks of contracting these infections, especially by avoiding unsafe sex and intravenous drug use. Such programs should seek to provide communication and decision making skills to assist people, particularly young people, to be able to take responsibility for avoiding infection and, if they become infected, for preventing the transmission of these infections to others. Education should also address issues of sexual diversity.
10.3 Public comments about these infections should be accurate and not cause confusion, stigma, or undue concern. Public statements on research and public health issues, as they relate to these infections, should be made only by people with appropriate training and expertise.

10.4 The AMA supports programs that provide measures of protection, such as the ready availability and proper use of condoms and needle exchange programs.

10.5 To limit further the spread of these infections, the AMA supports the development and maintenance of effective education programs for travellers entering and leaving Australia.

11 Infection Control
11.1 For HIV and Hepatitis C, vaccines, once developed, offer the best prospects for control of transmission. In the interim, however, emphasis should be placed on education since behavioural change is the only available means to prevent transmission of infection.

11.2 There is an effective vaccine for Hepatitis B. All health professionals likely to have any contact with blood or bodily secretions should be vaccinated for Hepatitis B. The NH&MRC recommends universal childhood vaccination for Hepatitis B. If an individual is identified as not being vaccinated, he/she should be encouraged to be vaccinated. If a patient has Hepatitis B a medical practitioner should encourage the identification and the vaccination of those individuals who are at risk.

11.3 While the methods of treatment of HIV are advancing, there is, as yet, no cure. Nor is a cure imminent for most cases of Hepatitis B and C. Until vaccines are developed for HIV/AIDS and Hepatitis C, strong support for other public health measures of infection control must continue. All health care facilities should have in place appropriate infection control protocols that treat all blood and bodily fluids as potentially infectious, and should modify work practices to lessen the prevalence of accidents.

11.4 In the face of these infections, there has already been a substantial upgrading of infection control procedures in Australia. However, with the identification of Hepatitis C and several other viruses such as HTLV-1 and transfusion-transmitted virus, these measures should be reassessed to ensure their contemporary adequacy.

12 Research
12.1 In general, research into these infections should be designed to ensure that communities participating in the research would benefit from the results as soon as possible.

12.2 Australian-based research plays an important role in the understanding of the spread, control and treatment of these infections.

12.3 The increasing prevalence and potential risk of Hepatitis C infection make it imperative for governments to recognise the long-term nature of research programs into such infections and to provide continuity through long-term support.

12.4 If public and professional confidence in such programs is to be maintained, potential research projects must be peer reviewed by independent, experienced assessors. Achievements of all funded projects must be assessed against set objectives, and funding sustained or increased where programs are shown to be effective.

13 Ethical Issues
13.1 Undue concern about the infectivity of blood borne viruses has resulted in discriminatory attitudes towards certain groups in the community. All health care professionals must seek to avoid and discourage discrimination occurring on an individual or group basis.
14 Confidentiality
14.1 Confidentiality regarding an individual's communicable disease status should be maintained at all times, unless disclosure is required by law to protect other people. In the normal course of providing optimal patient care, it will be necessary, with patient consent, for a doctor to disclose, from time to time, information about their communicable disease status to health care personnel who are also managing the patient. Those to whom the information is disclosed should observe the same confidentiality as the primary physician.

14.2 The usual principles of professional secrecy and patient confidentiality should apply to positive test results. The doctor's duty in counselling includes the need to explain how certain behaviours on the part of the patient may cause harm to others. Doctors should help to increase the patient’s awareness of his/her obligations to partners and the community. In exceptional circumstances, where repeated attempts at counselling fail, a doctor may need to take action which will ensure notification of a patient's partner/s. However, this should only be undertaken in close consultation with the relevant State or Territory health department.

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