

Confidentiality for doctors with AIDS

EDITOR,—A recent article in the *Independent* gave not only the name of a doctor dying of AIDS but what amounts to a precis of his entire curriculum vitae.¹

Under the new set of guidelines issued last month by the Department of Health the employer has a duty of confidentiality to the HIV positive employee in such cases. The employer has no legal right to release the employee's name without consent unless it is deemed to be in the public interest. If the doctor concerned was so sick that he was not able to assist the investigation was he really in a fit state to give such consent? Perhaps public interest amounts to what is likely to sell a tabloid.

How can Greater Glasgow Health Board justify its action in releasing the man's name? This action can hardly be expected to encourage doctors who suspect that they might be HIV positive to come forward, especially as it comes so soon after the release of the guidelines.

The newspaper quotes a BMA spokesperson as trying to allay public anxiety. Quite rightly. But isn't it time that the profession did something to allay the anxiety of sick doctors? Insisting that confidentiality is respected as it would be for any other patient would be a positive start: we would deplore it if any other patient was treated in such a way. Sadly, it seems that a medical degree takes away such rights and the need for compassion.

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1 Cusick J. Hospital doctor dying of AIDS. *Independent* 1993; May 27:10.

Doctors' HIV risk difficult to quantify

EDITOR,—In their editorial on the revised guidelines for health care workers infected with HIV A Graham Bird and Sheila M Gore recommend that studies should be carried out in which trained observers record hazardous exposures in operating theatres and these records are then compared with self reporting by staff.¹

To quantify risks of exposure to blood and body fluids for operating theatre staff we undertook a detailed survey in 1991, which highlighted the difficulties in estimating risk that such studies may pose. Theatre staff self reported incidents involving likely exposure to blood or body fluids during 2341 consecutive procedures over two months. Sixty five procedures were observed directly by an occupational health nurse or doctor. Surgeons also completed an anonymous questionnaire recalling the number of exposures during the second month of the survey, and 1737 used surgical gloves were collected after 293 consecutive routine procedures and tested for perforations. The variation in rates of apparent exposure produced by surveying the same population over the same period by different methods (table) made it impossible to quantify the risk to staff and raises questions about the value of these methods of assessing risk.

During our survey it became apparent that staff modified work practices while being observed, and it was difficult to observe effectively surgery performed in abdominal or pelvic cavities or done by several operators. In addition, the response rate

Rate of incident or injury involving likely exposure to blood or body fluids according to method of survey

	Method of survey		
	Self reporting	Observation	Retrospective questionnaire
No of procedures	2341	65	1142
Type of incident (no/100 procedures):			
Contamination of intact skin	2.5	8	23
Contamination of mucous membrane	1	1	4
Sharps injury	0.4	0	8
All exposures	4	9	35

to the questionnaire was low (55%)—a recurring problem found in questionnaire surveys of health care workers. Perforation of a glove occurred more commonly than other types of incident (29 perforations/100 procedures), but it was not possible to assess how many perforations resulted in the wearer being exposed to the patient's blood.

It has been difficult to compare our results with those of other surveys^{2,3} as there are differences in the specialties surveyed, the types of procedure undertaken, operating techniques, and protective clothing worn.

We recommend that surgeons should be encouraged to report to their occupational health departments, confidentially if necessary, those procedures that regularly place them at risk of exposure to blood. Occupational health professionals should work closely with theatre staff to devise and encourage use of appropriate preventive measures in reducing risks of cross infection despite the limitations of currently available methods of evaluation.

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- 1 Bird AG, Gore S. Revised guidelines for HIV infected health care workers. *BMJ* 1993;306:1013-4. (17 April.)
- 2 Gerberding JL, Littell C, Tarkington A, Brown A, Schechter WP. Risk of exposure of surgical personnel to patients' blood during surgery at San Francisco General Hospital. *N Engl J Med* 1990;322:1788-93.
- 3 Panilio AL, Foy DR, Edwards JR, Bell DM, Welch BA, Parrish CM, et al. Blood contacts during surgical procedures. *JAMA* 1991;265:1533-7.

Do we need more hospices?

EDITOR,—Claud F B Regnard criticises the continuing proliferation of inpatient hospices, arguing that they are an inefficient use of resources and that the present number of hospice beds—for patients with cancer at least—probably exceeds demand.¹ Most terminally ill patients with cancer wish to die at home, with only 15% wishing to die in a hospice.² The reality, however, is that almost half spend their last days in hospital, often in a busy acute ward.² As hospital doctors we often see terminally ill patients brought in by distressed relatives who are no longer able to care for them at home. Unfortunately, all too often there are neither hospice beds available nor the facilities in the community to provide the extra support required.

Regnard argues for a limited number of regional hospice centres, which could educate carers both in the community and in hospitals and direct resources effectively into the community. We agree with this in principle. Though the public will donate money to hospices in their local area, however, they may be reluctant to do so for a large

regional unit with little direct link with them. Also, can it be guaranteed that all the local government funding that would have gone to local hospices would find its way to these larger units? Finally, who would provide the extra funding required to buffer this transfer of resources from existing small hospices to larger units?

The expectations of the public for good quality palliative care will, rightly, continue to increase. We in the caring professions must endeavour to meet these demands. The trend for a continuing proliferation of hospices is not the ideal solution but will be difficult to reverse.

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- 1 Regnard CFB. Do we need more hospices? *BMJ* 1993;306:1754. (26 June.)
- 2 Townsend J, Frank AO, Fermont D, Dyer S, Karran O, Walgrove A, et al. Terminal cancer care and patients' preference for place of death: a prospective study. *BMJ* 1990;301:415-7.

Working part time is rewarding and fun

EDITOR,—I am one of the fortunate 200 people who have had a part time career registrar post created for me under the EL(91)5 scheme. This was indeed a simple (albeit long winded) process, as Trish Groves suggests.¹ I was fortunate in the support and encouragement I received from both the personnel department of my regional health authority and my supervising consultant.

I have never enjoyed a job so much, perhaps because I am not too tired to reap the benefits fully. Learning is fun, and life as a junior doctor in training should be a rewarding educational experience. But there is a service commitment to fulfil, and this should be integrated into, and not in direct competition with, the education of a junior doctor. When I was in full time training I, like all my colleagues, relied on precious evenings off and weekends to study for postgraduate examinations, to read the medical press, and, if I felt really enthusiastic, to write some papers. This "overtime" is an essential element in any doctor's continuing education, but it does not mix well with family life.

I am contracted to work seven sessions a week. I "work" from 9 am to 6 pm five days a week and am on call about once a fortnight. Within this framework I use the spare time to do what most full time doctors do in their overtime. My overtime is spent with my partner and children. As a result my life, like that of Trish Greenhalgh, is "happy, fulfilling, and mostly stress free."² It is said that one has to work part time to achieve this enviable goal of satisfaction in one's professional and personal lives. It is also regrettable that three quarters of my salary is used to pay a full time nanny.

Once we can eliminate the stigma of part time work and persuade the royal colleges that seven sessions with ample time to educate oneself and keep up to date are worth well over half the training gained in a full time post, we will be in a strong position to reverse the current attrition of women from 50% at medical school to 16% at consultant grade.¹ To achieve equal numbers of men and women consultants, however, we must await the unlikely scenario of government sponsored creche facilities at work.

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- 1 Groves T. Part time doctors' training expands. *BMJ* 1993;306:1565. (12 June.)
- 2 Greenhalgh T. Working part time. *BMJ* 1993;306:1619. (12 June.)