ABC of AIDS

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NURSING CARE

Physical care

Physical care= basic nursing care

Knowledge

Clinical skill

Interpersonal skills

To cope with any possible multisystem failure:

Respiratory infections

Nutritional problems

Gastrointestinal disturbance

Oral infections

Malignancies

Neurological disease

At present we can offer neither an effective vaccine nor a cure to those suffering from the acquired immune deficiency syndrome (AIDS); therefore excellent nursing is of paramount importance. True nursing is concerned with "care" rather than "cure," beginning with education and following through to terminal care and the support of those left behind. It can take place in the community, in hospitals and clinics, in hospices, or at home. Clearly, several people may be concerned in the care of any one patient, and a multidisciplinary approach is required within an integrated inpatient and outpatient service.

Nursing a patient with AIDS or HIV related illness is no different from nursing any other ill patient. Sound knowledge, clinical skill, and good interpersonal skills are essential for safe, effective care and treatment. Clinically the disease ranges from respiratory infections, nutritional problems, gastrointestinal disturbance, and recurrent painful mouth infections to malignancies, cerebral changes, blindness, deafness, paralysis, and early dementia. The basic physical care is nothing extraordinary. The patient will need frequent mouth care to ease his painful mouth, cleansing and fresh linen to make him comfortable after a night sweat, and constant kindness and reassurance when faced by the fear of being unable to breathe.

The needs of individual patients vary: some may need intensive nursing and support while others may be able to care for themselves but require a sensitive ear to help them cope with an uncertain future. Lovers, families, and friends will experience a variety of problems too—they need both answers and support. None of these needs are new to nurses. The condition requires us to review our own feelings about sexuality, homosexuality, and the disability and death of predominantly young people. Prejudice and fear are not conducive to good nursing practice.

Safety

Transmission of AIDS

AIDS is transmitted:
through sexual intercourse
via blood to blood contact
vertically

Specific questions arise over safety, confidentiality, and support. Information about the infectivity of the human immunodeficiency virus has been inconsistent, often resulting in panic and inappropriate preventive measures being taken by those asked to care. Earlier articles have shown that HIV is spread through sexual intercourse, blood to blood contact, and vertically. There is no evidence to suggest that it is transmitted through social contact.

All hospitals should already have a policy for dealing with blood, body fluids, and other materials infected with the hepatitis B virus. Since hepatitis B is much more readily transmitted than HIV, these measures are more than adequate. Special clothing need not be worn routinely. Gowns, gloves, and masks are necessary only when carrying out invasive procedures or when the patient himself requires protection because of severe immunosuppression. The advice to wear gloves when handling blood and body fluids is sensible nursing practice and will ensure the safety of both patient and nurse.

Safety

Apply common sense
 Wear gloves when dealing with blood and body fluids
 Clean up spillages promptly
 Wear additional protective clothing for:
 invasive procedures
 where splash injuries may occur
 to protect the patient
 Never resheath needles
 Always dispose of sharps correctly—promptly

Basic physical care does not require special precautions, but it is sensible to cover any cuts and abrasions, just as it is not advisable to work knowingly with an infection that might compromise the patients. A microtransfusion of infected blood by a needlestick injury is required to cause seroconversion to HIV: hepatitis B is much more easily contracted. Clinical waste should be double bagged and incinerated. Only soiled linen should be considered infected, and even then a hot wash at 71°C for three minutes—as in the hot cycle of a domestic washing machine—will destroy the virus. It is safe to share washing equipment, eating and drinking utensils and toilet facilities with an infected individual. Soap and hot water will kill HIV. Blood spillages should be cleaned up with bleach solution, but, again, this is sensible action for all blood spills regardless of the patient's antibody status or diagnosis.

Isolation

Patients with infectious conditions—eg salmonellosis, tuberculosis
 Patients with diarrhoea
 Patients who are dying
 Patients with neutropenia

There is no case for routinely isolating a patient with AIDS. Patients need to be cared for in side rooms only if they have an additional infection that would routinely warrant such measures, such as salmonella or tuberculosis. A dying patient or someone suffering from diarrhoea may prefer the privacy of a single room, but patients with pulmonary complications are more easily observed and reassured on an open ward. A patient with severe neutropenia may need protective isolation, and this poses specific problems: the claustrophobia of a single room, the sheer boredom of confinement for 24 hours a day, and the overwhelming knowledge of being isolated. The nurse must reassure the patient of the reasons for his separation, explain all treatments and procedures in language that the patient understands, and instil a sense of hope and motivation to recover. Books, games, and a television may alleviate the monotony, but a nurse who listens and cares will be far more therapeutic.

Confidentiality and support

All patients are entitled to confidentiality whether they are HIV antibody positive, have AIDS, or are about to have their hernia repaired. In the case of sexually transmitted diseases staff have a legal as well as a moral obligation to ensure such confidentiality. Access to medical records should be restricted to relevant staff and should be monitored. The nurse must ensure that the patient's identity is not disclosed without his or her permission. Nursing and medical staff must be aware of exactly how much partners and families know about the patient's condition and lifestyle before entering into conversation with them about such matters. This is an emotive issue, and the social implications for the patient are immense. Who should know the diagnosis? The wife, the lover, the general practitioner, the dentist, or the school? Nurses must use their counselling skills to discuss such issues with the patient, but how much and whom to tell must remain the patient's decision. This may seem unfair to those being asked to care for the patients in the community, but none of us knows how many of our other patients are infected with the virus. It is much more sensible to "sharpen up" our routine practice for all patients. Patient compliance is born out of trust between patients and staff. We must earn that trust by maintaining confidentiality.

Nurses play an important part in providing support to the patients because they are with them most of the time. Nevertheless, nurses must recognise their limitations and bring in other members of the team when necessary: counsellors, psychologists, outside agencies providing a "buddy" service, or self help groups may be appropriate. These must not, however, be forced on the patient. The patient has a right to accept, a right to change his mind, and the right to refuse. He must at all times be considered part of the "team" and be allowed to be concerned in his own care.

A patient who has lost his job, has reduced mobility, and is malnourished needs more practical help. Support from social workers and health advisors

Support

Support must be subtle, consistent, and confidential

Possible members of support network:

- Attending nursing and medical staff
- Families and friends
- Counsellors and psychologists
- Social services
- Support groups, such as Terrence Higgins Trust, Body Positive, etc

may need to be arranged. The provision of alternative accommodation and of practical and financial help varies throughout Britain, and often the burden is placed on the partners and families. In small communities the burden may weigh heavy, particularly if confidentiality is to be ensured. Loved ones can also suffer the stigma of the disease and may be ostracised by neighbours and colleagues. Partners may harbour the fear of developing the illness themselves. They all need support and an outlet for their fears and frustrations. Support groups will provide an opportunity to discuss problems, express feelings, and share experiences.

Caring for people with HIV infection or AIDS is not difficult if common sense is applied. No special training is required—simply first class clinical competence, a willingness to learn and to understand, and a desire to care with compassion.

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What is a Good Consultant?

A worm's eye view

D F NEWTON

When I was a child I lived in a house where doctors came for dinner, walked the dog with us, and built trains with my Lego. No one ever explained their rank to me and I never thought of them as anything other than benevolent uncles and aunts. When, at the age of 12, I had to go to see a consultant paediatrician I considered him as a more distant member of the same species. He was disturbing only in so far as he might take me into hospital for tests. "When I was a child . . . I thought like a child," but now I am a woman I know that Lego is a thing of the past.

Despite my careers mistress's obvious delight in my medical background none of it prepared me for my experience in medical training. Consultants, who presumably played with other children's Lego, suddenly turned into menacing paragons of wisdom and oracles of criticism—what a colleague of mine aptly terms "terrortomas": something of which one is extremely cautious until one has established whether it is benign or malignant.

Medical students may have some high ideals when they arrive on the steps of clinical medicine. I know that I did. I was repeatedly told by well meaning doctors and by my peers that my standards were too high, my ideals unrealistic, and my attitude naive. Unfortunately, no one had the insight or the humility to point out that it was not my ideals that were unrealistic but my expectations. It took me a good year to absorb the obvious facts that doctors, even hospital consultants, are human beings and human beings make mistakes. They are exposed to the same environmental forces as all of us and their characters inevitably influence the way they practise medicine. It was not that some of them were bad doctors—though some of them were—but merely that I didn't happen to like them.

It is easy to criticise, and in many ways it would be easier to write about what a good consultant is not. He is not, for instance,

someone who arrives drunk to his outpatient clinic or who makes sexist comments or who fails to warn the patient before doing a rectal examination. I have witnessed consultants who do all these, and I know that my peers could add to the list. I was given many examples, some serious, some less so. For example, a considerate ear, nose, and throat surgeon is someone who does not have curry for lunch. Several of the students whom I asked to define a good consultant said that they had never met one. Many of the definitions I was given centred on a consultant's ability to shed superiority.

Is he a good teacher?

We all assess the worth of others, however subconsciously or superficially. One of the problems in forming an opinion about any particular consultant is that you are assessing him or her on several different and often conflicting parameters. As a student your initial impression is often created by the consultant's teaching abilities and attitudes. The lack of any formalised teacher training in most teaching hospitals means that the former depends largely on the latter. Those who are interested in teaching generally teach better than those who are not. They are more likely to put thought and effort into the way in which they present information. Unfortunately, the ability to impart information does not always correlate positively with the ability to provide helpful feedback. Most medical students are taught by a system of negative reinforcement, in the form of sarcastic remarks, and derogatory comments. Many of us must have heard tardy colleagues greeted thus: "You're just like an undescended testicle: you're late arriving, you make a hell of a fuss getting here, and when you do you're useless." In many instances this is effective, but it is discouraging and can become self defeating. The time honoured excuse that this is the traditional way of things is no justification.

The good consultant, then, is a good teacher. He is also a good clinician and an inspiration to his students. He must be skilled in all aspects of history taking, examination, and diagnosis. He must instigate appropriate investigations and treatment and