Knowledge of HIV infection and AIDS, and attitudes to testing and counselling among general practitioners in Northern Ireland

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SUMMARY. All 922 general practitioners in Northern Ireland were sent a questionnaire on human immunodeficiency virus (HIV) infection and the acquired immune deficiency syndrome (AIDS). Five hundred and ninety four general practitioners (64.4%) returned the questionnaire. Thirty eight respondents (6.4%) knew of an HIV positive patient in their practice and 93.3% felt they should be informed if one of their patients was found to be HIV positive at a genitourinary medicine clinic, even without the patient's consent. Of the respondents, 76.8% were willing to be involved in the management of AIDS patients in their practice in cooperation with hospital colleagues but only 37.5% felt confident to provide AIDS counselling and advice. Of the 368 general practitioners who did not feel confident to provide AIDS counselling and advice, 41.3% felt that they had insufficient knowledge and 79.6% felt uncertain of their counselling skills. The information gathered on the administration of injections, taking blood samples and disposal of needles indicated that further education for general practitioners is required to ensure safety at work.

Introduction

THE advent of human immunodeficiency virus (HIV) infection has provided new challenges in all fields of medical practice and has caused a re-examination of many professional roles. General practitioners have been encouraged to care for patients with HIV disease and the acquired immune deficiency syndrome (AIDS) in the community,[1-3] and they are also expected to provide counselling for patients who are worried about HIV infection and those who wish to take preventive measures against acquiring it. HIV infection has also led doctors to scrutinize their own practical procedures with regard to health and safety at work. In addition, general practitioners need to communicate with other health care workers and educate members of their own staff on these important matters.

Northern Ireland has so far been the region in the United Kingdom with the smallest number of identified HIV positive persons per 100 000 population (Ellam A, Public Health Authority Communicable Disease Surveillance Centre, London, personal communication). To date the majority of the HIV positive patients in Northern Ireland with the exclusion of haemophiliacs, have attended the department of genitourinary medicine at the Royal Victoria Hospital, Belfast. Against this background it is possible that general practitioners in Northern Ireland could be less aware of the potential impact of HIV infection on their practice than doctors in other parts of the UK.

A questionnaire survey was carried out to assess Northern Ireland general practitioners' attitude to HIV testing and to counselling and caring for AIDS patients; their technique with regard to taking blood samples, giving injections and disposal of needles; and the communication that they have had with other health care workers and staff about HIV disease and AIDS.

From the results obtained, it was hoped to make recommendations for measures that the health and social services boards might institute, both to satisfy the needs of general practitioners in counselling and managing patients with HIV disease and to ensure health and safety at work during day-to-day practical procedures such as venepuncture and giving injections.

Method

In May 1988 the questionnaire, based on closed format questions, and accompanied by a covering letter was posted to all 922 general practice principals on the Central Services Agency list for the four health and social services boards in Northern Ireland. The general practitioners were asked to complete the questionnaire anonymously. Stamped, addressed envelopes were provided to facilitate the return of the questionnaires. The results were entered on to a computer data base allowing appropriate cross tabulation of responses.

Results

By mid-October 1988 594 completed questionnaires had been returned — a response rate of 64.4%. The ratio of men to women respondents was 4:1 which was slightly higher than the ratio of 3.5:1 on the Central Services Agency list. The age–sex distribution of the respondents showed that men practitioners in the 25–39 years age group had the highest response rate (75.8%) and women practitioners over 50 years old the lowest (38.7%).

Only 38 respondents (6.4%) were aware of an HIV positive patient in their practice.

Attitudes to HIV testing

Of the 594 respondents 224 (37.7%) would refer all cases of possible HIV infection to a genitourinary medicine clinic before testing. This figure rose to 349 (58.8%) if the patient was considered to be at 'high risk' of infection.

If a patient refused referral, the overwhelming majority of respondents (528/573, 92.1%) would explain the HIV test, the implications for the patient's life if the result was positive and the need for safer sex even if the result was negative. Four hundred and ninety nine respondents (84.0%) would explain the consequences for future insurance policies whether the result was positive or negative.

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Five hundred and fifty four respondents (93.3%) felt they should be informed if one of their patients attended a genitourinary medicine clinic and was found to be HIV positive, even if the patient had asked for the general practitioner not to be informed.

Attitudes to care of AIDS patients

Only 221 out of 589 respondents (37.5%) felt confident to provide counselling and advice about AIDS; 260 (44.1%) did not feel confident and 108 (18.3%) answered 'do not know'. The 368 respondents in the 'not confident' to counsel and 'do not know' subgroups were asked to offer reasons for their lack of confidence or uncertainty: 293 (79.6%) felt uncertain about the appropriate counselling skills and 152 (41.3%) felt they had insufficient knowledge to provide AIDS counselling and advice. Other reasons given were lack of time (1.4%), difficulty in keeping up to date (3.0%) and lack of experience (6.0%).

The 368 respondents were also asked how they felt they could best acquire expertise in AIDS counselling: 44.2% favoured an AIDS facilitator to visit their health centre or surgery, 30.9% preferred courses organized by the Northern Ireland Council for Postgraduate Medical Education, 15.0% courses organized by health and social services boards and 9.9% postal information.

Four hundred and fifty six respondents (76.8%) said they would be willing to look after a patient with AIDS in cooperation with hospital colleagues, 342 respondents (57.6%) said they would be willing to look after the terminal care of an AIDS patient at home and 97 (16.3%) felt that they would prefer that hospital services looked after all AIDS patient care.

Practical procedures

Of 592 respondents 342 (57.8%) never wore gloves when using needles and 232 (39.2%) wore gloves only sometimes. Among the latter group the commonest reason why the general practitioner chose to wear gloves was that the patient was suspected of exhibiting 'high risk' behaviour for HIV infection (208 respondents (89.7%)). Other possible reasons why gloves were only sometimes used included: not always remembering, no time and lack of availability. Only 18 general practitioners (3.0%) always wore gloves when using needles.

A detailed analysis of the practice of re-sheathing needles is shown in Table 1. It can be seen that re-sheathing was commoner among the younger age group. Of the 559 respondents who described the type of container used for needle disposal 69.1% used a plastic container, 27.4% used a cardboard container and 3.6% used other undefined containers. The method of disposal of these containers was described by 581 respondents (Table 2). The majority of general practitioners (83.0%) used hospital or health centre based systems of disposal but 11.6% used the domestic rubbish collection or an unknown method.

Table 1. Practice of re-sheathing needles among 592 general practitioners.

Frequency of re-sheathing needles	Number (%) of respondents by age		
	25–39 years (n=286)	40–49 years (n=144)	50+ years (n=152)
Always	178 (*62.2*)	73 (*50.7*)	64 (*42.1*)
Sometimes	81 (*28.3*)	46 (*31.9*)	54 (*35.5*)
Never	16 (*5.6*)	21 (*14.6*)	22 (*14.5*)
Do not know	11 (*3.8*)	4 (*2.8*)	12 (*7.9*)

n = total number of respondents in age group.

Table 2. Method used for disposal of sharps containers by 581 general practitioners.

Method of disposal	Number (%) of respondents
Hospital health centre system	482 (*83.0*)
Do not know	37 (*6.4*)
Domestic rubbish collection	30 (*5.2*)
Commercial collection	20 (*3.4*)
Incinerated by general practitioner	8 (*1.4*)
Other	4 (*0.7*)

Table 3. Communication with other health care workers about AIDS by 582 general practitioners with and without an HIV positive patient in their practice.

Communication with:	Number (%) of respondents	
	With HIV +ve patient (n=37)	Without HIV +ve patient (n=545)
Practice nurses	29 (*78.3*)	325 (*59.6*)
Receptionists	14 (*37.8*)	141 (*25.9*)
Health visitors	13 (*35.1*)	161 (*29.5*)
District nurses	12 (*32.4*)	194 (*35.6*)
Midwives	8 (*21.6*)	91 (*16.7*)
Social workers	5 (*13.5*)	21 (*3.9*)
None of above	4 (*10.8*)	167 (*30.6*)

n = total number of respondents in group.

Of the respondents 38.8% felt that the advent of AIDS had resulted in a change in their procedures of venepuncture and giving injections and 41.7% said that their method of disposal of needles had changed. When treating HIV positive patients 59.6% of general practitioners said that they alone would give injections and 67.1% said that they alone would take blood samples.

Communication with other health care workers about AIDS

The communication with other health care workers about AIDS among general practitioners with and without an HIV positive patient were compared (Table 3). It is interesting to note that there was a statistically significant difference in communication with practice nurses (78.3% versus 59.6%, chi square = 4.404, df=1 $P<0.05$). There were no other statistically significant differences.

Discussion

The response rate of 64.4% to the questionnaire among general practitioners in Northern Ireland was similar to the response rates obtained in surveys carried out in Oxford and London[4,5] although this study had a larger sample size. It was encouraging to note that most general practitioners (76.8%) would be willing to cooperate with the hospital services in the care of AIDS patients. Models of such cooperative care already exist in London, for example, at St Stephen's Hospital. In areas where there are only a small number of HIV positive patients close contact can be maintained between the genitourinary medicine clinic and the general practitioner.

Almost all of the general practitioners in this study (93.3%) felt they had the right to be informed that their patient was HIV positive, even if the patient did not wish them to be told. Similar findings have been reported previously.[5] However, the local medical committee conference in 1987 concluded that 'the only right involved was that of a patient to confide in his or her doc-

tor', and that general practitioners had no right to know anything about a patient.[6] Problems can arise though if a patient withholds personal information from the attending doctor.[7] In practical terms it is to be hoped that through counselling, patients will accept that it is to their advantage that their general practitioner is aware of their exact diagnosis. The ethical problems encountered in the management of HIV disease and AIDS are the subject of guidelines from the General Medical Council.[8]

With regard to HIV testing there seemed to be a high level of awareness of the issues which need to be discussed with patients seeking an HIV test but refusing referral. Over 90% of respondents said that they would discuss the meaning of the test, the implications of a positive test and the need for safer sex whether the result was positive or negative. In addition, 84.0% of respondents would discuss the implications for future insurance policies whether the test result was positive or negative. This is an important part of pre-test counselling as there have been unfortunate instances of HIV tests being performed unnecessarily and having an adverse effect on subsequent insurance policies.

In the light of the high proportion of doctors who would explain the HIV test it was striking to note that only 37.5% felt confident to provide AIDS counselling and advice. The remainder were uncertain about the appropriate counselling skills and felt they had insufficient knowledge in vital areas. These areas need to be addressed in future general practitioner education and the educational method preferred by the doctors in this study was the provision of an AIDS facilitator to visit health centres and surgeries. This system provides a private forum for practitioners to voice doubts or concerns that they may not wish to discuss more publicly. An AIDS facilitator will soon be appointed to one of the health boards in Northern Ireland. The second most popular option for AIDS education was further courses through the Northern Ireland Council for Postgraduate Medical Education; the Council should be aware of this continuing demand for seminars on HIV infection.

Although the Department of Health has written to general practitioners suggesting that needles should not be re-sheathed and puncture-proof boxes should be used, this is by no means standard practice. In addition, present boxes are not in fact puncture proof. The diverse responses from general practitioners with regard to the use of gloves and the handling and disposal of sharp items in this survey illustrates a certain amount of confusion. Of those wearing gloves only sometimes, 89.7% said they would wear gloves if they suspected the patient of exhibiting 'high risk' behaviour for HIV infection, but how is this determined? It is worth pointing out that gloves do not prevent needlestick injuries but they do offer protection from blood spills. The disposal of sharps containers was mainly via health centre or hospital based systems but it was disturbing to note that 11.6% of containers were disposed of in the domestic rubbish or via unknown methods. All aspects of the safe use and disposal of needles have been covered by the Department of Health in circulars but the information gathered in this survey indicates that other methods of informing general practitioners about HIV infection and AIDS are needed.

General practitioners were more likely to have discussed AIDS with practice nurses than any other group of health care workers and this proportion was significantly higher if respondents had an HIV positive patient than if they had not. The overall figure was similar to that found in the Oxford study.[4] Discussion with other health care workers was less frequent and the level of communication with social workers was very low indeed. This is unfortunate as social workers have much to offer in supporting patients with HIV infection and AIDS and in helping with problems relating to employment, housing and social security.

It is important that all health care workers should be aware of the issues surrounding HIV infection and AIDS. In Northern Ireland one of the health and social services boards is organizing a large scale AIDS awareness training programme which aims to educate all staff and help them to explore their personal attitudes to HIV infection and AIDS. There is a need to build on this initiative to ensure a consistency of approach in individual practices.

The results of this survey suggest that general practitioners in Northern Ireland have similar levels of awareness of HIV infection and AIDS to general practitioners in other parts of the United Kingdom despite practising in an area of low seroprevalence. However, topics have been highlighted on which education is still needed and these should be addressed by the health and social services boards and the Northern Ireland Council for Postgraduate Medical Education.

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