halc
HIV/AIDS Legal Centre Incorporated (NSW) ABN 39 045 530 926

**Submission**

# Willing to Work: National Inquiry into Employment Discrimination Against Older Australians and Australians with Disability

## Discussion and Recommendations on the

## "Australian National Guidelines for the Management of Health Care Workers Known to be Infected with Blood-Borne Viruses"

**Author**

**HIV/AIDS Legal Centre**

**Endorsed by**

**NAPWHA and AFAO**

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414 Elizabeth Street Surry Hills NSW 2010
email: halc@halc.org.au
www.halc.org.au
Tel: (02) 9206 2060
Fax: (02) 9206 2053
Freecall: 1800 063 060

# ABOUT HALC

We are a not-for-profit, specialist Community Legal Centre that deals with HIV-related legal issues, and are the only one of its kind in Australia. While we are mandated to provide services in NSW, we have over the last 5 years expanded service delivery interstate, and have run matters in all Australian States and Territories.

We are a high caseload service, allowing us to identify systemic issues through their reoccurrence in casework. In addition, we work closely with a number of allied HIV sector organisations on a variety of matters including direct service delivery, community education and law reform.

Despite significant advances in medical treatments available for HIV, with corresponding reductions in HIV-related mortality, morbidity and infectivity, stigma and discrimination against people with HIV remains a fact of life. HIV is now considered a chronic, manageable medical condition. Life expectancy for a person with HIV (PHIV) newly diagnosed, and with access to appropriate treatments, is close to that of median life expectancy in Australia. Treatment also has significant impacts on the infectivity of HIV resulting in the removal in overseas jurisdictions of traditional barriers on work for people with HIV, such as for instance, restrictions on surgeons performing certain procedures in the United Kingdom.

However there remain a number of discrete systemic barriers to work in Australia for people with HIV. It is strongly arguable that the evidence base for these restrictions no longer exists. These submissions deal with the policy entitled “Australian National Guidelines for the Management of Health Care Workers Known to be Infected with Blood-Borne Viruses” that imposes:

- A non-discretionary ban on health care workers who are known to be HIV positive from performing exposure prone procedures; and
- A ban in some instances upon health care workers who are known to be hepatitis C or B positive from performing exposure prone procedures.

# ENDORSEMENTS

These submissions are endorsed by the following organisations:

- Australian Federation of AIDS Organisations (AFAO)
- National Association of People Living with HIV Australia (NAPWHA)

## AFAO

AFAO is the national federation for the HIV community response. AFAO provides leadership, coordination and support to Australia's policy, advocacy and health promotion response to HIV/AIDS. Internationally AFAO contributes to the development of effective policy and programmatic responses to HIV/AIDS at the global level, particularly in Asia and the Pacific.

## NAPWHA

The National Association of People with HIV, Australia (NAPWHA) is the peak organisation representing people with HIV at the national level. Our membership includes all of the State and Territory organisations of people living with HIV. NAPWHA promotes the meaningful involvement, visibility and centrality of PLHIV in all aspects of Australia's response.

# HIV – A MODERN PERSPECTIVE

- The Human Immunodeficiency Virus (HIV) attacks the immune system, and gradually causes damage. Without treatment and care, a person with HIV is at risk of developing serious infections and cancers that a healthy immune system would fight off. In general terms, in the absence of treatment, a person with HIV would generally progress to AIDS approximately 10 years after infection.

- Current treatment for HIV works by reducing the amount of HIV in the body so the immune system can work normally.

- Treatment cannot completely eradicate the virus, but it can reduce the levels of the virus in a person's blood to the point where it cannot be detected through laboratory testing. This is the general aim of treatment and is a marker for treatment response, as well as directly related to infectivity and long term prognosis.

- The first case of AIDS in Australia was diagnosed in around 1982, though HIV as the cause of AIDS was not identified till around 1984. From this time until around 1996, HIV was associated with extremely high mortality rates.

- Various drugs were developed between 1987 and 1996 which were able to slow the progression of HIV to AIDS; however, in 1996 *triple combination therapy* (which is using three anti-retroviral medications from two drug classes in combination) was trialled and has since become the standard for HIV care.

- Since the introduction of triple combination therapy (or *combination antiretroviral therapy* ('cART')), HIV has transformed from a near universally fatal condition to a chronic manageable condition.

- In addition, significant advances in drug therapy since 1996 mean that newer treatments are better tolerated, easier to administer, and are significantly less toxic.

- These significant medical advances in the treatment of HIV, particularly over the last decade have resulted in near normal life expectancy for those patients who have access to the appropriate healthcare and services.

- The life expectancy of recently diagnosed asymptomatic HIV-infected patients now approaches that of uninfected individuals[1].

- People with HIV who have been diagnosed sufficiently early, on treatment, and with an undetectable viral load, are able to maintain a full and productive working life.

[1] See for instance Lewden et al., *All cause Mortality in Treated HIV infected adults with CD>4>500mm3 compared with the general population: evidence from a large European Observational Cohort Collaboration* IJE 2012 41: 433-445; McManus et al., Australian HIV Observational Database *Long-term Survival in HIV positive patients with up to 15 years Antiretroviral Therapy* PloS One 2012 7(1): e48839; *Mortality in well-controlled HIV in the continuous antiretroviral therapy arms of the SMART and ESPIRIT trials compared with the general population AIDS* 2013 27:973-979

# COMMONWEALTH POLICY: 'AUSTRALIAN NATIONAL GUIDELINES FOR THE MANAGEMENT OF HEALTH CARE WORKERS KNOWN TO BE INFECTED WITH BLOOD-BORNE VIRUSES'

The 'Australian National Guidelines for the Management of Health Care Workers Known to be Infected with Blood-Borne Viruses' ("the policy") asserts that the aim is to ensure the safety of patients and health care workers ("HCW") in a health environment. The policy is premised on the assumption that there is a very low, but still a risk of transmission of blood borne viruses ("BBV") including HIV, hepatitis B ("HBV") and hepatitis C ("HCV") from an BBV positive HCW in some circumstances to a patient in an Australian health care environment[2].

To effect the policy HCW with BBV are restricted from performing certain duties. Similar policies in the states and territories also exist and provide further direction on how HCW with BBV should be managed.

HCW who perform exposure prone procedures ("EPP") must know of their status. The policy requires medical practitioners who perform EPP or reasonably anticipates that they will perform EPP 'must know their infectious status;'[3] however this is not enforced and rather this element of the policy relies upon self-reporting. The policy also aims to promote and encourage the confidentiality of testing arrangements for HCW to encourage them to know their BBV status. The implementation of confidentiality encourages HCW to seek appropriate testing, counselling and treatment and to disclose their status to their employees.[4]

The policy observes that there is evidence for a significantly low rate of HIV transmission risk[5], the Policy acknowledges that there have been no cases of a HCW transmitting HIV to a patient in Australia.[6] Despite this, the policy, in summary imposes restrictions on certain health professionals who are living with HIV.

Unlike with other BBV such as HBV and HCV, the policy does not distinguish between the particulars of an HIV positive HCW, such as whether they are on treatment and have an

[2] Australian Government Department of Health and Ageing, 'Australian National Guidelines For The Management Of Health Care Workers Known To Be Infected With Blood-Borne Viruses' (2012) 5.
[3] Ibid 6.
[4] Ibid 7.
[5] Ibid.
[6] Ibid.

undetectable viral load. Where a HCW tests positive for HIV they are required to cease performing EPP.

We believe that the policy subjects HIV positive HCW with greater burdens and further obligations, which are not imposed on other uninfected HCW, despite scientific evidence which demonstrates that the risk of transmission in certain circumstances is nil.

We also believe that the policy can have *negative* public health implications.

The policy also entirely fails to consider the amendments to the *Disability Discrimination Act 1992* which now places a positive obligation upon employers to make *'reasonable adjustments'*[7] so that the person can continue their duties.

The policy imposes a blanket prohibition on various medical duties of HIV positive HCW who perform EPP with important examples listed below:

| **Profession** | **Duties Prohibited** |
|---|---|
| Anaesthetists | Anaesthetics: although not all medical duties are not exposure prone, there are certain procedures that infected anaesthetists cannot undertake including the placement of portacaths and the insertion of chest drains in trauma cases.[8] |
| Dentists (including hygienists) | Procedures in dentistry which do not involve the possibility of injury to the dentist's hands are not considered as EPPs, including oral examination and radiology. However, procedures falling under category 3 may be prohibited, including: oral surgical procedures, including the extraction of teeth and other surgical procedures (e.g. implants).[9] |
| Emergency Departments | Staff who are designated in emergency departments are restricted from performing EPPs must not provide trauma care. They should not conduct physical examination, handle acute trauma patients or open tissues because of the 'unpredictable risk of injury from sharp tissues such as fractured bones'.[10] |
| Gynaecology | Open surgical procedures towards the female genitalia are considered exposure prone. Minor gynaecological procedures |

[7] Ss.5 and 6 *Disability Discrimination Act 1992* (Cth)
[8] Ibid 12.
[9] Ibid 13.
[10] Ibid 14.

| | |
|---|---|
| | are not considered EPP. The Commonwealth Policy has stressed that if 'fingers remain visible at all times when sharp instruments are in use' – this is not considered EPP.[11] |
| Ophthalmology | Generally, the greatest majority of procedures are not EPP, but orbital surgery are considered EPP. |
| Orthodontics | See Dentistry |
| Orthopaedics | A number of EPPs including open surgical procedures, tasks involving the cutting or fixing of bones and procedures that require the transfer of tissue from a second site.[12] |
| Surgery | Open surgical procedures are exposure prone. |

[11] Ibid.
[12] Ibid 16.

The policy can cause significant financial, professional and personal detriment to HIV positive HCW. There are various cases studies where HIV positive HCW have been unable to perform their job as the policy restricts them from performing EPP; this inevitably resulted in substantial professional and pecuniary damages. The policy leads to an unfounded change in professional duties, loss of opportunities to work, potential inadvertent disclosure of their HIV status to others, and damage to reputation. The shortage and low rate of medical practitioner participation and the high income salary warrants the conclusion that an HIV positive HCW who is barred from their main professional duties of EPP may likely suffer substantial loss and damage.

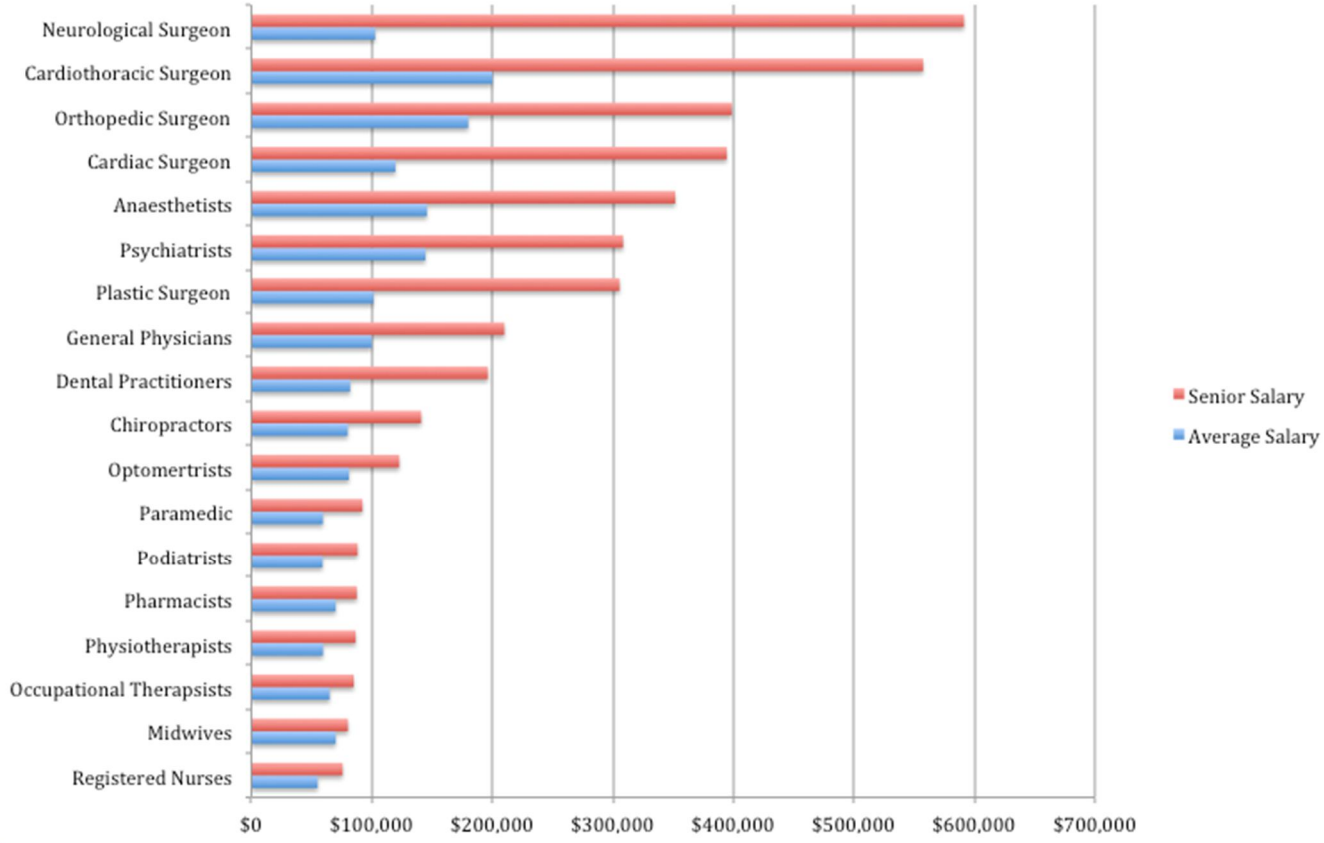
*a) Financial Damage*

Generally speaking, the salary of medical practitioners who fall under the distinct bracket of upper and specialist medical practitioners earn a substantial sum as compared to the average salary per annum across Australia. Although difficult to quantify, given the lack of transparency surrounding the precise figures earnt by specialist medical practitioners, Wade reports that surgeons top the list for Australia's top earnt jobs after tax with an annual income of approximately $350,000.[13] It is also important to observe that under the same list, a number of other HCW also landed on the list, including anaesthetists who also conduct EPP. Similarly, Business Insider Australia in using data collated by Open Universities and PayScale, Australian medical professionals earn a substantial sum.[14]

[13] Matt Wade, 'http://www.smh.com.au/National/Surgeons-Make-The-Cut-As-Our-Highestpaid-20130503-2Iyma.Html' *The Sydney Morning Herald*, 2015 <http://www.smh.com.au/national/surgeons-make-the-cut-as-our-highestpaid-20130503-2iyma.html>.

[14] Sarah Kimmorley, 'Here's How Much Money Australian Doctors Actually Earn' *Business Insider Australia*, 2015 <http://www.businessinsider.com.au/heres-how-much-money-australian-doctors-actually-earn-2014-5>.

**Diagram 1: Graph of salary per annum amongst Australian medical professionals**[15]




The diagram above suggests the extraordinary financial incentives of these respective medical professions, in which a number of the abovementioned occupations involve EPPs. In other words, under the current policy, for HCW under these professions who have HIV are set to suffer tremendous financial detriment if the policy is set to continue.

*Case Study: Johnathon and his surgical profession*

In a case study involving a medical practitioner in [redacted] whom, as part of his professional duties conducts EPP, the compelled withdrawal from performing these type of procedures have resulted in significant financial loss. Johnathon comments that because of the policy, he is unable to continue to progress in his career, barring him from further specialisation in his desired medical field of surgery. In financial terms Johnathon would have expected to earn about $500,000 per year, coupled with a potential salary increase of $100,000 per year rising up to $1 million in his position.

[15] *Business Insider Australia*

Johnathon has been forced to withdraw from performing EPP. Because of the nature of his work if he is unable to perform EPP then he will not be able to meet the inherent requirements of his job and therefore he has had to cease employment and retrain to obtain a new speciality.

Johnathon has spent close to a decade training, from the commencement of university, to reach this point in his career and he will now have to retrain in a new speciality; resulting in further time, expense and loss of income.

*b) Professional Damage*

It is well settled that the dentistry community is small and the orthodontists community is even smaller within Australia[16]. Disclosure of HIV and/or the forced demotion or termination of employment will presumably travel quickly around social circles within the dentistry and orthodontist community.

*Case Study: Sarah and her orthodontist profession*

In the context of Sarah, who is professionally committed to her occupation and who has recently been diagnosed with HIV, the professional damage in her field of dentistry and orthodontics are purportedly immense. Sarah has said that the forced withdrawal from her profession without explanation to the wider orthodontic community has caused substantial damage, given the fear of disclosure. It is well known that the dentistry community, particularly in areas of specialisation runs in small and well connected circles. Any pathway that Sarah takes will lead to irreparable damages in relation to her professional reputation. For instance, her abrupt withdrawal will lead to potential slander of her character and reputation behind closed doors and also, inevitable isolation from her peers within the community. Additionally, disclosure of her HIV status will involve the potential removal of her EPP duties.

*c) Personal Damage*

Cases such as Sarah and Johnathon have led to a plethora of personal implications. Johnathon felt that after the disclosure of his status, he was unsupported and uninformed by his employer. Both Johnathon and Sarah reported that the loss of employment, finances and the damage to reputation led to compounded distress and personal anxiety about the diagnosis and professional future. It is well settled amongst the medical community and the literature that stress can be highly

[16] See Australian Society of Orthodontists official webpage <http://www.aso.org.au>

detrimental to a person living with HIV[17]. The lack of support from his employer and his own community has arguably damaged his sense of identity, given that Johnathon has spent more than 10 years dedicating himself to achieving this dream of being an esteemed member of the surgical community. These set of circumstances of forced withdrawal from employment and subsequent financial loss compelled Johnathon to disclose his status to his family and to peers. Although his family was supportive of his status and circumstances, he initially did not want to reveal anything that would unnecessarily worry them. His family is now concerned and anxious. Unfortunately, because of this personal anxiety and distress, Johnathon has now sought psychological advice to accommodate to his needs.

[17] Elaine Schmidt, 'UCLA Scientists Discover Stress Accelerates AIDS Progression, Undermines Anti-HIV Drugs' Effect' <http://newsroom.ucla.edu/releases/UCLA-Scientists-Discover-Stress-2811>.

## COLLECTIVE AND COMMUNAL IMPACT

The ongoing operation of the policy will adversely impact the community. From a logistical viewpoint, the blanket prohibition of infected HCW from EPP translates into a lower number of HCW being available for the carrying out the medical functions of EPP.

*a) Skilled Migrants*

Of relevance here is the immigration to Australia of highly skilled individuals from countries with a high HIV prevalence. Current policy preventing healthcare workers with HIV from engaging in EPP denies Australia a meaningful proportion portion of a highly skilled and motivated workforce.

The Australian healthcare system is highly dependent on foreign born doctors and nurses. While this dependence was traditionally on doctors from the United Kingdom, recent years have seen a shift to migrating professionals from India, China and Malaysia.

*HALC sees a statistically significant number of healthcare workers from countries such as Zimbabwe, Philippines and India seeking permanent migration to Australia. This is in line with global migration patterns, and present significant opportunities for Australia in terms of attracting highly skilled medical professionals.*

The most recent (April 2013) *Australian Social Trends* report on *Doctors and Nurses* by the Australian Bureau of Statistics notes that[18]:

- The number of overseas born doctors and nurses in Australia has increased in recent years. In 2011, more than half of GPs (56%) and just under half of specialists (47%) were born overseas, up from 46% and 37% respectively in 2001. One third (33%) of nurses in Australia were born overseas in 2011, compared with one quarter (25%) in 2001.
- The proportion of medical practitioners born overseas who were recent arrivals (that is, those who arrived to live in Australia in the preceding five years) has also increased. In 2001,12% of overseas born GPs and 15% of overseas born specialists were recent arrivals. By 2011 this had increased to around one fifth of GPs and specialists (both 19%). The proportion of nurses born overseas who were recent arrivals also increased, from 9% in 2001 to 19% in 2011.

[18] http://www.abs.gov.au/AUSSTATS/abs@ nsf/Lookup/4102.0Main+Features20April+2013

- The increase in overseas born doctors is consistent with recent investments by Commonwealth, State and Territory governments into initiatives aimed at increasing the numbers of medical practitioners in Australia.
- The country of origin profile (being previously largely the United Kingdom) is changing. In 2001, one in five (20%) GPs and over a quarter (29%) of specialists who were born overseas were from the UK. By 2011 however, a smaller proportion of GPs (13%) and specialists (22%) were from the UK, while the proportion from India had increased. In 2011, 12% of GPs and specialists were from India, increasing from 9% and 7% respectively, in 2001.
- Similarly, the proportion of overseas born nurses from the UK decreased from around one third (36%) to about one quarter (26%) between 2001 and 2011. The proportion of overseas born nurses from India increased from 2% in 2001 to 8% in 2011, one of the largest proportional increases over this period.

The Migration Policy Institute comments on the issue as follows[19]:

> *In recent years […] migration of health workers — from highly skilled physicians to those in lesser skilled positions, from the developing world to wealthier destinations — has increased. Moreover, the countries with the most alarming outflows include those sub-Saharan African nations suffering acutely from the HIV/AIDS epidemic and dwindling numbers of health workers.*
>
> *Notable source regions for health care-related migration are Africa, the Caribbean, South Asia, and Southeast Asia. According to the Organization for Economic Cooperation and Development (OECD), the primary destinations are the Anglophone countries of Canada, the U.S., the UK, Australia, and New Zealand. Across these countries, an average of 23 to 24 percent of physicians are trained abroad.*

While the focus of the article is on the ethical concerns such migration causes for resource poor countries, it clearly highlights the significance to Australia of the potential of skilled migrants from countries that have high HIV prevalence. Finally, such restrictions also place individual applicants at risk of human rights violations.

[19] http://www.migrationpolicy.org/article/global-tug-war-health-care-workers

*HALC has assisted two dentists from India who were not eligible for to obtain employment in their field. Both dentists have had to retrain at significant cost, and remain waiting for a visa 6 and 8 years respectively after arrival. Both applicants face similar restrictions if they have to return, as well as real risks in terms of harm from stigma, discrimination and access to treatment.*

The policy impacts on various medical fields, including surgeons, gynaecologists and dentists who fall under category 3 of procedures.[20] Migrants with HIV are thereby barred from working in these fields.

*b) Economic Investment*

For professionals qualified in Australia who have to retrain following diagnosis, the policy represents a significant loss of investment. The funding that the Australian Government and universities must subsidise for Bachelor of Medicine/Surgery for Australian students electing to pay their tuition fees on HECs is substantial.

**Table 1: University tuition fees of certain medical/health related qualifications**

| Institution | Medicine | Dentistry |
|---|---|---|
| UMelb | $57,760[21] | $48,480[22] |
| USYD | $41,760[23] | Undergraduate: $62,419[24]<br>Postgraduate: $41,760[25] |
| UNSW | Undergraduate: $62,419[26]<br>Postgraduate: $41,760[27] | NA |
| Monash | Undergraduate: $52200[28]<br>Postgraduate: $56,000[29] | NA |

[20] Australian Government Department of Health and Ageing, 'Australian National Guidelines For The Management Of Health Care Workers Known To Be Infected With Blood-Borne Viruses' (2012) 13.
[21] https://futurestudents.unimelb.edu.au/__data/assets/pdf_file/0009/1539324/2016-tuition-fees_Australian-fee-paying-students_TuitionFeeTables_November2015.pdf
[22] Ibid.
[23] Sydney.edu.au, *Doctor Of Medicine- Courses - The University Of Sydney* (2015) <http://sydney.edu.au/courses/Doctor-of-Medicine>.
[24] Sydney.edu.au, *Bachelor Of Science (Advanced) And Doctor Of Dental Medicine- Courses - The University Of Sydney* (2015) <http://sydney.edu.au/courses/bachelor-of-science-advanced-and-doctor-of-dental-medicine>.
[25] Above n 21. <http://sydney.edu.au/courses/Doctor-of-Medicine>.
[26] Above n 22.
[27] Above n 21.
[28] Monash University, *Medicine - 3896 - Study Monash* (2015) <http://www.study monash/courses/find-a-course/2016/medicine-3896?domestic=true#fees>.
[29] Ibid.

Australian citizens who are on Commonwealth Supported Places (CSP) place their university tuition fees on HECS-HELP and thus, receive a student loan.[30] As a result, the government expends a tremendous amount of tax to fund for students who enrol in health related courses that engage in EPP, including medicine and dentistry. The above diagram demonstrates the fee for CSP students studying medicine and dentistry over a designated period. In other words, if the Commonwealth Policy remains in place, it potentially costs the Australian Government and the public institutions a substantial amount of public money in educating and training students.

In a similar vein, organisation and societies that facilitate the development and education of HCWs will suffer comparable disadvantage. The Royal Australasian College of Surgeons (herein, RACS) expends a substantial amount of money in funding and supervising the professional training and development of its medical practitioners. In one of their mission statements, the RACs characterises the rationale of their professional development programs in the following.

> *The Professional Development Program for Fellows aims to support surgeons in aspects of their professional life, encouraging professional growth and workplace performance. Life long learning through professional development can improve our capabilities and help us to realise our full potential as surgeons as well as individuals.*

Moreover, the RACs has developed a comprehensive system of endowments, supplementary funding and loans for the purposes of maximising the professional development surgeons in Australia and the future landscape of medicine and surgery.[31] There is an argument to be made that the operation of Commonwealth Policy may undermine the purpose of these financial grants and scholarships if registrars and trainees are prohibited from EPPs.

*c) Loss of trained staff*

Obviously the policy results in trained and experienced professionals being forced to leave their chosen profession. A number of the fields restricted to HCWs with HIV require – even among the high standards generally for medical professionals – significant personal commitment and training.

[30] studyassist.gov.au, *HECS-HELP - Study Assist* (2015) <http://studyassist.gov.au/sites/studyassist/helppayingmyfees/hecs-help/pages/hecs-help-welcome#WhatIsHECS-HELP>.
[31] Surgeons.org, *Scholarships, Awards, Lectures And Prizes | Royal Australasian College Of Surgeons* (2015) <http://www.surgeons.org/member-services/scholarships-awards-lectures-prizes/>.

Successfully admitted and practising professionals represent a tiny fraction of overall applicants. The loss of such highly trained and technically capable professionals translates to a significant loss to the community.

*d) Adverse Public Health Outcomes*

As detailed above, the policy relies on an "honour system" among HCW undertaking EPP to know their BBV status. Diagnosis with HIV results in loss not only of employment but occupation for these healthcare workers, creating a significant disincentive to test. The evidence base shows clearly that treatment reduces risk of transmission to that effectively of zero. An effective public health policy therefore would aim at having HCW diagnosed as close in time to infection as possible, and directing them onto treatment.

*HALC is aware of a HCW who did perform EPP daily who had been engaging in high risk sexual activity and was aware of having had unprotected sex with sexual partners with HIV, because of the existence of this policy and the impact that an HIV positive diagnosis would have upon his career despite having concern that he had contracted HIV he elected to not get tested for HIV for some years; he was subsequently diagnosed with HIV.*

Late diagnosis can also have other impacts. There is growing evidence of correlation between the onset of cognitive impacts and untreated HIV. It is critical that HCW involved in high stress care situations, or involved in complex procedures are encouraged to test and treat early, to ensure both optimal individual health outcomes as well as ensuring their effectiveness as HCW.

We believe that the policy ought to align itself with international counterparts whom have introduced reforms as to HIV positive HCWs conducting EPPs. Given the socio-historical similarities to the United Kingdom, we believe that the current United Kingdom framework serves as an effective model in introducing gradual reforms to the policy.

In 2007, the Expert Advisory Group on AIDS (EAGA) suggested a change and review in the UK's policy restricting the practice of HIV-infected primary care dentists.[32] In a similar vein, the UK Advisory Panel for Healthcare Workers Infected with Blood-borne Viruses (UKAP) also suggested that such reforms should be undertaken in the context of a wider review of restrictions on BBV infected HCWs.

Shortly after, a Tripartite Working Group, consisting of UKAP, EAGA and the Advisory Group was established in order to review the UK's previous policy on BBV in relation to HCWs. After considering a plethora of updated literature and expert opinions, the panel concluded

that a relaxation of the policy on HIV positive HCW could be justified and recommended that HCW with HIV be permitted to perform any EPP, provided that the level of viral load is 'non detectable'.

[32] AGH. EAGA, UKAP, 'Management Of HIV-Infected Healthcare Workers The Report Of The Tripartite Working Group April 2011' (2011) <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216126/dh_131574.pdf>

## RECOMMENDATIONS

The following recommendation is made in contemplation of the findings of the UK working group, and the available medical evidence that supports these changes. The following recommendation would also ensure employers compliance with *Disability Discrimination Act 1992* to make *'reasonable adjustments.'*

1. HCW with HIV are permitted to perform any EPP if they are on combination a antiretroviral therapy (cART) and have a plasma viral load suppressed consistently below 200 copies/ml. The HCW will need to demonstrate a sustained response to cART. (i.e viral load <200 copies/ml on two consecutive plasma samples) prior to starting or resuming EPP and will be subject to testing, treatment and follow-up in accordance with the recommendations of their treating physician, an expert in the treatment of BBV.