



HIV testing

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public health experts. General practitioners and other clinicians need to be aware that anyone who has been scratched or bitten by a bat or whose eyes, broken skin, or mucous membrane have come in contact with bat saliva or neural tissue from a bat should be offered post-exposure rabies vaccination as soon as possible. Immunoglobulin may also be given if the bat is known or strongly suspected to be rabid. Detailed advice on post exposure prophylaxis is now available for clinicians in the revised *Green Book's* chapter on rabies and also advice on the public health management of a case of human rabies.⁹⁻¹⁰ The Department for Environment Food and Rural Affairs has also published a draft rabies contingency plan for consultation.¹¹

The risk to public health needs to be put in context. Only licensed or volunteer bat handlers will routinely come into contact with bats. Current advice from the Department of Health says that all bat handlers should be vaccinated before exposure and should wear bite proof gloves when handling bats. Daubenton's bats are one of 16 species of bats in the United Kingdom and, unlike pipistrelles (*Pipistrellus* species) and long eared bats (*Plecotis auritus*), rarely roost in houses or come in contact with people. In the United Kingdom, pipistrelles and long eared bats have to date not been found to harbour European bat lyssaviruses. Therefore the likelihood of a member of the public coming into contact with an infected bat is small. Bats excreting European bat lyssaviruses in saliva are more than likely to show abnormal behaviour such as flying during daylight or being grounded or paralysed. A sick or injured bat should therefore never be handled by a member of the public but rather reported to either the Bat Conservation Trust (tel 0845 1300228), the Scottish Society for the Protection of Cruelty to Animals (tel 0870 7377722), or the relevant animal health divisional office.

We need to raise awareness in the general public of this small risk to human health without creating a fear

of bats, which are a protected species under the Wildlife and Countryside Act 1981. Similarly, awareness among health professionals of current post exposure regimens also needs to be raised as rabies due to European bat lyssaviruses seems to be similar to classical rabies in being incurable but completely preventable.¹²

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HIV testing

Should no longer be accorded any special status

Before highly active antiretroviral therapy (HAART) was introduced, the advantages to infected individuals of knowing their HIV status were minimal, and counselling before HIV testing was the recommended practice.¹ This usually limited testing, by relying on people who were obviously at risk presenting themselves for testing. Such groups included injecting drug users and men who have sex with men and their sexual contacts. Targeting of these groups will become an increasingly less useful concept as HIV continues to spread into the population that is conventionally not at risk. Do we need to reconsider if routine voluntary counselling and testing is appropriate today?

Since 1991 heterosexual transmission of HIV has been the most common mode of transmission in the United Kingdom.² Currently, nearly half of those infected heterosexually and a quarter of infected men who have sex with men in the United Kingdom are undiagnosed.³ A quarter of newly diagnosed patients in

the United Kingdom in 2002 were diagnosed late with serious immunosuppression.³ Unless further initiatives are undertaken the epidemic will worsen. Possible initiatives would be to lower thresholds for HIV testing by reducing the emphasis on pre-test counselling.

Reasons for low HIV testing rates and thus low detection rates include concerns about confidentiality, legal and insurance issues, self perceptions of low risk in those who would test positive, denial, dislike of counselling, and wishing to avoid anxiety when waiting for results.⁴⁻⁵ Fear and denial are the commonest obstacles to HIV testing among those acknowledging that they have been at risk.⁶

Additionally doctors' awareness of the effectiveness of early interventions is low and they may not encourage HIV testing.⁷⁻⁸ The most common reason, however, is lack of time for pre-test counselling, even in genitourinary medicine clinics.⁹ Average times for counselling are not less than 21 minutes with 18% of people requiring two sessions.¹

Low detection rates imply longer duration of infections, which imply increased risk of HIV transmission. In an unpublished study, 70 randomly selected, HIV positive patients attending our centres were estimated to have been infected for a mean of 8.5 years. In that study, for only 56% had doctors broached HIV testing, only 6% of patients had ever declined HIV testing, and 46% of those who were HIV positive reported that their explicit consent to testing should not have been needed. Such results need to be replicated, but implications are clear.

Lowering the threshold for HIV testing will lead to early diagnosis and treatment of infected individuals, which may prevent the development of AIDS and the transmission of infection.^{10 11}

What is the role of voluntary counselling and testing? Voluntary counselling and testing has been accepted practice for more than 10 years. Uptake of voluntary counselling and testing, however, has been poor, even in those with high risk sexual activities.² Sizeable proportions of infected people never attend genitourinary medicine clinics for voluntary counselling and testing even if referred. In addition, it seems that pre-test counselling is, on balance, not dramatically effective in reducing high risk sexual activity.¹²

Many HIV infected individuals receive medical attention before they are diagnosed and opportunities for testing may have been discouraged by the "need" to perform or organise voluntary counselling and testing. Such patients would include, for example, those with persisting lymphopenia, neutropenia, or thrombocytopenia. A routine approach to testing would almost certainly increase the number of early HIV diagnoses, which would then allow concentration on subsequent informed counselling and education of patients and their partners and possible reduction in spread of infection.

Highly active antiretroviral therapy has rendered HIV similar to other serious diseases. We believe that HIV testing should be widely accepted, without conventional voluntary counselling and testing, as patients at risk of cancer do not receive voluntary counselling and testing before chest x rays, or patients with chest infections do not routinely receive voluntary counselling and testing before stains for acid fast bacilli on sputum are requested.

The current combination of reluctance of busy doctors to initiate pre-test counselling and denial by patients has resulted in late diagnosis and ongoing spread of infection. We propose that if a patient freely consents to be investigated, a doctor can initiate tests aimed at excluding serious diseases without an in depth discussion of all possible results, provided that the test result, positive or negative, should benefit the patient.

Routine voluntary counselling and testing was appropriate to the 1980s. Times have changed. The benefits of early diagnosis of HIV are multiple. HIV testing should now not be accorded any special status. Doctors should now undertake the test by using the same approach as used in any other test with serious implications.

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Simulation based training

Is being extended from training individuals to teams

Simulation has been used for many years to train aviation and military personnel for work in hazardous environments. Effective and safe performance in these settings requires both highly skilled individuals and a high degree of team coordination. In addition to individual competence, communication between team members and decision making become particularly important during the management of crisis scenarios. Over the past few years several articles have described the use of simulations, simple and computer based, for the acquisition of technical skills in surgery, endoscopy, and anaesthesia.¹⁻³ The focus

has largely been on the acquisition and assessment of individual technical skills, but now the role of simulations in training teams to work with a greater degree of coordination is being acknowledged.

Simulations are beginning to play an important part in the training of personnel in the operating theatre, emergency department, and the obstetric suite.^{3 w1 w2} For example, courses in anaesthesia crisis resource management address the technical skills and

 References w1-w5 are on bmj.com