HIV test counselling at a tertiary hospital

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A questionnaire was distributed to 64 of the 78 interns working at a teaching hospital in Cape Town in August 1992 to examine their attitudes and practice in respect of HIV test counselling. The questionnaire was completed by 61 interns. Thirteen per cent of those who responded counselled all patients, 49% counselled some patients and 38% counselled no patients. Thirty-four per cent stated that they felt that pre-test counselling was always necessary and 57% that post-test counselling was always necessary. The most frequently stated reasons for not counselling patients were language barriers, time constraints, feelings of incompetence on the part of the intern and the fact that the patient was too ill.

It is recommended that standard counselling procedures be established in each ward and formal under- and postgraduate counselling training for medical students and interns be instituted.

S Afr Med J 1994; **84:** 512-514.

As early as 1988, Schoub[1] pointed out the uniqueness of the HIV antibody test. The serious psychological, financial and social implications of a positive result make counselling a necessity.[2,3] Interns at a teaching hospital in Cape Town are regularly expected to draw blood for and request HIV antibody tests, and yet little is known about their practice of, attitudes towards and problems with pre- and post-test counselling. The aim of this study was to determine these attitudes and practices and decide on the necessity and proposed content of an intervention programme.

Subjects and methods

All 78 interns working at the teaching hospital during the time period 25 - 27 August 1992 were identified. Fourteen interns were unavailable during the study period. The remaining 64 were approached and a pre-tested, self-administered questionnaire was completed by 61 of them.

Permission for the study was granted by hospital administration. Interns were free to complete the questionnaire at their own discretion and no identifying data were captured. Results were analysed with an Epi Info package.

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Results

The population's mean age was 25 years.

During their 8 months of internship, 23 (38%) of the respondents had requested fewer than 10 HIV antibody tests, 29 (48%) between 10 and 30 tests and 9 (14%) more than 30 tests.

Twenty-one (34%) of the respondents obtained informed consent for each test and 5 (8%) informed consent for none. The mean percentage of tests requested by the respondents with informed consent was 63%.

Twenty-three (38%) of the respondents stated that they did not practise pre-test HIV counselling, while 38 (62%) of the respondents did. Of those who did practise pre-test counselling, 8 (13%) practised it in all cases.

Twenty-one (34%) of the respondents felt that pre-test counselling was always necessary and 40 (66%) that it was sometimes necessary (Fig. 1).

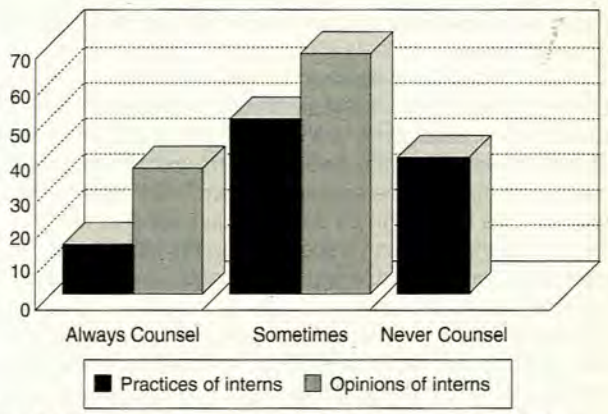

Fig. 1. Practices and opinions of interns concerning pre-test counselling.

Thirty-five (57%) of the respondents felt that post-test counselling was always necessary and 26 (43%) that it was sometimes necessary.

Only 8 (13%) of the respondents had been exposed to comprehensive information pertaining to HIV test counselling. Of these, 6 received information at university and 2 from the AIDS Training, Information and Counselling Centre (ATICC).

Fifty-nine (97%) of the respondents had never received formal training in HIV test counselling techniques. Of the 2 respondents who had received training, 1 had attended an ATICC counselling course and the other had viewed a training video.

Thirty-eight (62%) of the respondents had never received formal training in general counselling. Of the 38% with formal training, 19 (83%) had received it at university and 4 (17%) at a Lifeline course.

Twenty-four (39%) of the respondents felt competent to counsel patients about HIV tests.

The reasons for not counselling a patient are given in Fig. 2. The most frequent reasons were (with percentage of interns citing this reason in brackets): time constraints (23%), a language barrier (21%), feelings of incompetence experienced by the intern (11%), a patient who was too ill (11%), a patient with no knowledge of HIV infection (10%), a patient unaware that the test was being performed (10%) and a negative HIV test (6%).

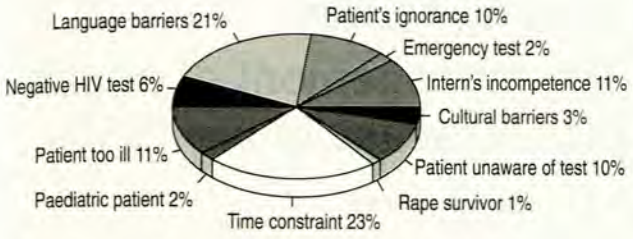

Fig. 2. Reasons for not practising HIV test counselling.

Forty-nine (80%) of the respondents felt that health care workers other than interns should be responsible for HIV test counselling. Of these, 41% suggested a team approach, 12% suggested social workers, 4% suggested nurses, 7% suggested specialist counsellors and 36% did not specify.

A limitation of this study was that pre- and post-test counselling were not defined on the questionnaire, which led to a certain amount of confusion among respondents. This was particularly evident when interns were questioned about their post-test counselling practices, as some had interpreted the question as applying only to HIV-positive individuals. The results of this question have therefore been omitted. In addition, few demographic data were obtained from the respondents. In particular, their university or teaching hospital of origin could have provided useful information about differences in undergraduate training.

Discussion

By the year 2005, between 18% and 24% of the adult South African population will be infected with HIV.[4] This alarming figure serves to warn us that medical students need to be well trained now to deal with all aspects of the infection — including the initial HIV antibody test.

Informed consent before testing for HIV antibody has been accepted as a necessity by the SAMDC[5] and MASA.[6] However, interns at the teaching hospital who are requesting a considerable number of HIV antibody tests are not routinely obtaining informed consent. Only 34% of the respondents obtained consent from all their patients, and 8% had not obtained consent at all. This mirrors attitudes described by other authors.[5,7]

Counselling, however, involves a lot more than the obtaining of informed consent (although it has been stated that informed consent should include counselling in order to be comprehensive).[2] The current view is that pre-test counselling should cover such concepts as knowledge about HIV and the HIV test, risk assessment, risk reduction techniques, contact and employer notification, possible reactions to the test result, treatment options and follow-up. Post-test counselling involves working through feelings evoked by the test result (positive or negative) and reinforcement of issues covered in pre-test counselling.[8-10] This method of counselling is known as frontloading and has arisen from the experience that the client hears little apart from the test result in the post-test session.[10]

That 38% of the respondents never practised pre-test counselling, while 34% felt that it was always necessary and 66% that it was sometimes necessary (Fig. 1), indicates a marked disparity between attitude and practice, which is a cause for concern.

The patient's ignorance of HIV or lack of awareness that the test is being performed (Fig. 2) are clearly not acceptable reasons for lack of counselling. A negative test is also not a good reason for lack of counselling, as most of the information-giving should occur in the pre-test session, prior to knowledge of the patient's HIV status.[10]

Lack of time is a problem often quoted by interns and other health care workers,[5,7] and is a very real one that needs to be addressed. Language and cultural barriers are also very real at the teaching hospital concerned, where the patient profile is, at present, considerably different from that of the attending doctors.

It is surprising that feelings of incompetence in respect of counselling took such a low profile in the list of reasons for not counselling, when one considers that 61% of the respondents did not feel competent to counsel (Fig. 2). In addition, their lack of exposure to comprehensive information on (87%) and formal training in (97%) HIV test counselling or general counselling (62%) would surely be enough to explain the discrepancy between attitude and practice.

Recommendations

Counselling, when inclusive of the topics outlined above, is not only important in the management of the HIV-positive or concerned individual, but is also a very important method of prevention, and means of reaching high-risk individuals and educating the general public about HIV infection.[7] Counselling of individuals is probably the most effective way of motivating reliable changes in sexual behaviour.[8,9]

It is therefore incumbent upon all medical schools and teaching hospitals to train students and interns in HIV test counselling. Not only is the intern frequently the only person available for the task, but he/she will not necessarily always have the benefit of a good referral system once having left the teaching hospital. In addition, it is important that teaching hospitals teach by example and ensure an effective counselling system for each ward.

Information pertaining to HIV test counselling should be presented to student and postgraduate interns in the form of seminars and workshops, as well as lectures and handouts.

Interns and medical students should undergo a formal AIDS training course presented either by the medical school or an AIDS training centre. In view of the perceived lack of training in general counselling, this would perhaps be most effective as part of a formal general counselling programme for all undergraduates.

In a tertiary hospital one has the added benefit of a large number of health care worker subgroups. Among the respondents, 80% felt that health care workers other than the intern should be responsible for HIV test counselling, and 41% of these suggested a team approach. This is indeed feasible, but heads of firms need to be encouraged to establish a standard procedure for their firm, to avoid a haphazard approach to counselling. For example, Baragwanath Hospital has established a nurse counsellor system that has made available counsellors who are able to reach the patients in their own language and idiom.[11]

Conclusion

HIV tests are frequently requested by interns at the teaching hospital, but informed consent and pre- and post-test counselling are inadequate. The most important reasons appear to be time constraints, feelings of incompetence and language barriers between interns and patients. Very few interns have received formal training in HIV test counselling and most feel that other health care workers should be at least partially responsible for HIV test counselling.

Subsequent to the writing of this paper, the issue of HIV test counselling was discussed at an AIDS Advisory Committee meeting and the following made known in a hospital newsletter. Staff were advised that social workers and many nursing personnel at the hospital had attended either ATICC HIV counselling courses or ones held by the Human Resources Development Unit of the hospital. Means of contacting these people were made known.

In addition, it was stated that, from 1993, all student interns were to receive AIDS counselling courses. Staff members were asked to encourage interns and student interns to attend counselling sessions for patients under their care in order to gain hands-on experience of counselling. Other means of staff training available to those interested were also advertised. It was suggested that some departments devote one of their departmental meetings to the issue of HIV counselling. This would indeed facilitate the drawing up of standard protocols for HIV test counselling.

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Accepted 3 Aug 1993.