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Hepatitis B and admission to medical school

New policy unclear and unreasonable

EDITOR,—We agree with A M L Lever's editorial on hepatitis B and medical students.¹ While some of our views on this subject have already been described,² we should like to make several additional points.

We strongly support existing practices whereby medical students are screened for hepatitis B virus and vaccinated early after admission to medical school. The medical school and each student share responsibility to complete the vaccination protocol. After this students should be investigated for seroconversion, told of their antibody titre, and advised about boosters. Students who fail to seroconvert but are shown to be uninfected should repeat the vaccination. Students who are found to be infectious carriers of hepatitis B virus (e antigen positive) should be counselled and receive interferon treatment. While they are infectious their courses and preregistration house officer year should be modified to exclude "exposure prone procedures," as described by the Department of Health's guidelines.³ All students should have access to occupational health and careers advice.

The new policy being adopted by the Council of Deans of UK Medical Schools, the Committee of Vice-Chancellors and College Principals, and the Universities and Colleges Admission Service is both unclear and unreasonable. It is unclear in not specifically addressing the issue of students who fail to seroconvert but are shown to be uninfected. We see no justification for such students being denied entry to medical school or having their admission delayed. With regular testing of their antigen status these students do not pose any risk to patients.

The policy is unreasonable in being an alarmist overreaction to a problem with a manageable solution, where risk of infection can be reduced to bizarre theoretical levels. With regard to the future careers of affected students, there are already adequate guidelines on pre-employment screening for specialties in which "exposure prone procedures" are performed. In addition, we would not be opposed to restrictions on registration for people who are infectious chronic carriers, limiting the areas of practice open to them. The necessary statutory amendments could be included during the present review of General Medical Council health procedures.

In view of our objections and those described elsewhere, we recommend that the new policy on hepatitis B and medical students should be withdrawn and attention switched to promoting current practices, which, when efficiently implemented, protect both students and patients from this infection.

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Test medical students while preclinical

EDITOR,—A M L Lever may be right in declaring that routine testing for hepatitis B e antigen before students enter medical school sets a dangerous precedent but is wrong to imply that infected students present no risk to patients.¹ Medical students are likely to help in theatre during their clinical years and during the preregistration year as house surgeons. Unless universities alter the curriculums to abolish such clinical experience or the General Medical Council changes the mandatory requirements for registration, all students who are positive for hepatitis B e antigen will at some stage be an infective risk in theatre. When students have graduated and start surgical house jobs their employing hospital will, as a matter of course, ensure that they have been immunised against hepatitis B and, if they have not responded to the vaccine, screen them for markers of infection. So why not do this at medical school before they start their clinical years?

It is misleading to suggest that this is the thin end of the wedge with regard to multiple serological testing. In any assessment of the risk of transmission of bloodborne infection from doctor to patient hepatitis B virus is by far the most important pathogen; there have been numerous examples of carriers of hepatitis B e antigen causing outbreaks through surgical procedures. HIV and hepatitis C virus do not have such an established track record. Unfortunately, even since an effective vaccine was introduced the number of outbreaks of hepatitis B associated with surgery or dentistry has not fallen—hence the need of guidelines from the Advisory Group on Hepatitis.²

Personally, I would not want anyone who might be positive for hepatitis B e antigen to have his or her hands in my abdominal cavity near sharp instruments. All students should be immunised in their preclinical years and should know their response to the vaccine. It is then simple to test the 7% or so who are non-responders for the presence of hepatitis B surface and e antigens. They should be referred for clinical management, have career counselling, and have their clinical studies and preregistration house jobs adapted to cater for their infective status.

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- 1 Lever AML. Hepatitis B and medical student admission. *BMJ* 1994;308:870-1. (2 April.)
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Patients must come first

EDITOR,—One body of evidence and two different conclusions is nothing new in medicine. One reason is the difference between, on the one hand, the luxury of opinion without responsibility and, on the other, the necessity of making publicly accountable decisions. The Council of Deans of UK Medical Schools and Faculties repeatedly debated the potential risk to patients from students infected with hepatitis B virus and the responsible policy to adopt. We took impeccable expert advice. After two years of deliberation we arrived at the recommended policy challenged by A M L Lever,¹ a policy that vice chancellors were free to accept or reject and chose to accept.

The situation was changing, and the matter had

to be addressed: concerns included new awareness of potential risks, which were small but real enough to worry our consciences and interest lawyers; growing public concern, acknowledged by the General Medical Council, that doctors may be a health risk to their patients; the widespread development of medical curriculums that no longer separate preclinical from clinical work and bring students into contact with patients from their earliest days at medical school; and greater emphasis on competence in practical skills before qualification and the continued requirement for hands on medical and surgical responsibility as a house officer before full registration with the General Medical Council. Applicants to medical school want to become doctors, which almost invariably means that they wish to look after patients. If for reasons of their health, as it concerns either themselves or others, they are absolutely or relatively unsuited to the task (in a highly competitive field) they need to know this at the outset. Further, it is important that they are told about the many non-medical alternative pathways to major contributions to health care through, for example, laboratory science, epidemiology, economics, or management. They may also, of course, need advice about their own treatment.

Deans are familiar with the occasional but unenviable task of balancing the interests of needs be patients against the aspirations of would be doctors with problems of health or habits. The task falls morally to the dean, while legally it seems to be nobody's responsibility. The public can reasonably expect the balance of doubt to fall in its favour. If hepatitis B is only the tip of an iceberg of ensuring as far as possible the safety of students from their patients and patients from their students, so be it: that is the cost and responsibility of our calling. That patients should come first is not "totalitarian" but uncompromisingly our professional duty. In these circumstances, for the *BMJ* to put the weight of its authority behind the subtitle "No reason to exclude applicants who are e antigen positive from medical school" is unfortunate if not irresponsible.

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- 1 Lever AML. Hepatitis B and medical student admission. *BMJ* 1994;308:870-1. (2 April.)

Safer use of traditional remedies

Don't generalise about traditional remedies

EDITOR,—David J Atherton's article on traditional remedies makes repeated generalisations about these remedies, their practitioners, and patients.¹ He states that "when people from less developed countries emigrate they continue to seek medical advice from traditional practitioners" and that "large amounts of traditional medicine are imported into Britain," but he offers no references to substantiate these claims. It would be interesting to know if there is indeed any evidence to support his statements.

Atherton also credits Indian practitioners of traditional medicine with training, understanding, and beneficial effects. It then almost seems a disservice to speculate about the hazards of their treatments, particularly when orthodox or Western medicine has a long history of progress through empiricism. Perhaps some traditional therapies have a rather better holistic approach, which compensates for their lack of "science."

Many of David Atherton's points strike us as sensible, and there does seem to be little published