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Voluntary, named testing for HIV in a community based antenatal clinic: a pilot study

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Despite the increasing advantages of identifying HIV infection in pregnant women, only some 12% of HIV positive women attending antenatal clinics in London have been identified by named testing. As virtually all antenatal care will be community based within the next two to three years, we assessed the problems of introducing named HIV testing during pregnancy into the primary care setting. Planning the service took a considerable time and required the production of educational material for both staff and pregnant women and some reorganisation of procedures. Over a one year period an uptake of 44% was noted. Several problems were encountered including an average of 21 minutes needed to give information on AIDS and HIV, an adverse effect on the midwife-mother relationship, and anxiety (affecting both women and midwives). Possible solutions to this difficult problem are discussed.

The need for a change in screening policy

Anonymous testing for HIV infection among pregnant women has shown that the prevalence of the infection among women attending community antenatal clinics and hospital based antenatal clinics at St Thomas's Hospital rose from 0.05% to 0.44% between 1988 and 1990¹ and that in London it has risen steadily from 0.18% in 1990 to 0.26% in 1993 (range 0.0-5%).^{2,3} Such studies have also shown the association of HIV infection in pregnancy with such recognised risk factors as African ethnicity and injected drug use.^{4,5} Relatively few pregnant women, however, are tested on a named basis, and throughout London only 12% of those found to be positive by anonymised testing were identified by named testing in antenatal clinics.^{3,6} The Department of Health considers this lack of named testing and identification to be a matter of "considerable public concern."⁷

However, some pregnant women do not understand

the concept of anonymous testing, think that they have had a named test, and assume that they are HIV negative when they are not informed otherwise.⁷ A recent survey of 374 women attending antenatal clinics based at St Thomas's Hospital showed that only 131 (35%) pregnant women knew about the anonymous screening programme, and only 38 (29%) of these women were aware that they had been screened as part of this programme. Only 19 (5%) women who were questioned fully understood what anonymous unlinked screening meant, and 138 (37%) believed that they would be told if the result was positive. Older and more educated women were more likely to understand (JK, unpublished results).

In view of the increasing benefits to both mother and child of identifying HIV infection in pregnancy,⁸⁻¹² the Department of Health issued guidelines recommending that named testing be made available to all pregnant women in areas of relatively high prevalence.^{13,14} Although named HIV testing is available on request in most antenatal clinics in the United Kingdom, only four clinics offered the test to all women in 1993,⁸ and those clinics were apparently hospital based. Most antenatal care, however, is now undertaken in the community by midwives and general practitioners, and virtually all antenatal care for women at low risk of complications is expected to be community based within the next two or three years.¹⁵ Consequently, if the Department of Health's guidelines are to be implemented named testing for HIV will have to be provided in primary care.

Implementing Department of Health's guidelines—pilot project

Testing for HIV in primary care may pose different problems from those encountered in hospitals. We therefore initiated a pilot project to assess the introduction of routine HIV testing in pregnancy into the practice attached to the department of general practice

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Voluntary, named testing for HIV may become accepted as routine

in a London teaching hospital with a high prevalence of HIV infection in pregnant women.¹

This inner London group practice has one antenatal clinic a week at which pregnant women are "booked in" for the first time, and it sees about 120 pregnant women a year from mixed ethnic and social backgrounds. The antenatal clinic is run by three community midwives in rotation. Before the pilot study, women attended the booking clinic after confirmation of pregnancy and were seen by a community midwife, who took routine antenatal blood samples. On average two to three women were seen at each clinic. The women returned four to six weeks later to see their general practitioner or midwife, from whom they received their results. The few women (1%) requesting a test for HIV infection were referred to the midwife specialising in HIV (JK) at the hospital based antenatal clinic.

Changing this system to one in which all pregnant women would be offered a named HIV test required extensive discussions and planning with the practice. The practice had to be convinced of the benefits of implementing a named testing programme which, based on prevalences determined by anonymous testing¹ and practice size, was likely to reveal only one HIV positive woman every two or three years.

To answer the women's questions and to provide appropriate information before obtaining informed consent, general practitioners and practice midwives asked for up to date information about the epidemiology of HIV (worldwide and local), heterosexual transmission, rates of transmission from mother to unborn child, and the benefits of early detection and for training in basic counselling skills. An aide-mémoire was produced for general practitioners, and a day course for community midwives was organised. The course cost about £2000 to run, with a major component being the cover by agency staff for the midwives attending the course. The course is now run six times a year, is open to all the midwives in the district, and is approved by the English National Board for Nursing, Midwifery, and Health Visiting for five years.

Some important alterations to existing practice in the booking clinics were necessary. General practitioners and midwives thought that HIV testing needed to be seen to be part of routine antenatal screening and that the test should be offered by the midwife at the booking visit rather than by the general practitioner. They thought that the information given should not place undue emphasis on HIV testing at the expense of other, and for many women, more relevant,

screening procedures. In addition, they thought that the opportunity to give some basic information, especially about recent advances in mother to baby transmission, should not be lost.

Basic information leaflets on screening and HIV/AIDS were included in a literature pack given to all women by their general practitioner when their pregnancy was confirmed. The screening leaflet covered routine urine and blood tests; ultrasound, sickle cell, and thalassaemia tests; amniocentesis; and chorionic villus sampling. HIV testing was included in the section on blood tests and the reader was also directed to the separate leaflet on HIV and AIDS. This leaflet defined AIDS, explained how infection with HIV occurred and about the HIV test, and discussed reasons for testing—emphasising that testing would not be done without explicit consent. The leaflets were produced after several drafts (some of which were piloted on pregnant women attending the surgery) to ensure that both contained enough information and would be suitable and comprehensive for all women. The Flesch scores for readability¹⁶ for the final draft were easy (screening leaflet) and standard (HIV/AIDS leaflet). The leaflets were initially produced only in English but are being translated into the 10 commonest languages spoken in the district, which include those spoken by groups with increased prevalence of HIV infection.

Surgery staff estimated (on the basis of a few pilot interviews) that the additional consultation time necessary to obtain informed consent would be 20 minutes and to give HIV test results 5 minutes but considered that the extra time would probably be absorbed without the need for additional staff or undue lengthening of clinics. The staff recognised the desirability for a counsellor specialising in HIV to be available at each booking clinic—for the first few months of the study at least—and the necessity for such a counsellor to be present lest a woman had a positive result. The staff also thought that it would be unreasonable to expect women to wait six weeks for the result of an HIV test and that they should be given the result in person. Arrangements were therefore made for them to return for their HIV result the following week. Arrangements for transporting specimens and for laboratory procedures had to be amended to ensure that the results of the HIV test and of other tests were available at that time. Whenever possible these results were to be given by the midwife who had initially seen the woman.

Problems in implementing guidelines

The pilot programme, which started in November 1993, ran for 12 months. Of 126 women seen, 56 (44%) accepted the offer of a named HIV test; the results of all these tests were negative. This relatively low uptake was, however, typical of antenatal clinics in inner London in which HIV testing is offered to all women, in which uptake has varied from 17% to 74%.^{17 18} It also equated well with the 51% of 134 women who stated that they would accept an HIV test in a survey conducted during late 1993 and early 1994 at the community based antenatal clinic reported here and hospital based antenatal clinics at St Thomas's Hospital (I Chau, personal communication).

For part of the time midwives were asked to trial a questionnaire that asked about problems during booking, including time taken. Analysis of 42 completed questionnaires showed that booking visits lengthened on average by 21 minutes to a mean of 66 minutes (range 40-90 minutes), with most of the additional time being associated with discussions on HIV. Although this extra time had little effect on the clinic in this practice—with small numbers of women attending—

in antenatal clinics that are currently fully committed, additional staff, and possibly even additional accommodation, would probably be needed.¹⁹

About half of the women attended with their partners, a few of whom asked for an HIV test. While it may not be practical or appropriate for a midwife to offer counselling and testing to partners, midwives did not consider it ideal to direct partners wanting a test to a local department of genitourinary medicine—the only option available during this study. An HIV testing service for partners, concurrent with the booking clinic, may need to be developed if additional resources are available.²

The major problem associated with offering HIV testing was a perceived change in the dynamics of the booking visit and in the midwife-mother relationship. Although some women did not mind having an HIV test, many thought that HIV and AIDS issues had “taken over” the booking visit and they became disturbed or anxious as a result. Most of the midwives also thought this; they also felt responsible for the anxiety generated, became concerned about the detrimental effect this might have on their relationship with the mothers, and began questioning their role in offering HIV testing.

The way forward

The diagnosis of HIV infection in pregnant women is without doubt becoming increasingly important as more ways of reducing the risk of vertical transmission are identified (zidovudine during pregnancy, caesarean section, avoidance of breast feeding⁹⁻¹²) or developed (for example, combination chemotherapy, therapeutic vaccines, vaginal lavage during delivery). Furthermore, prophylactic treatment may be offered to both mother and baby and social support provided for the family. Such matters, together with issues such as whether to continue the pregnancy and disclosure to other health professionals, partners, and family members, are naturally discussed during counselling sessions after the test with the specialist midwife.

Although relatively high uptake of the HIV test has been noted among women attending antenatal clinics in parts of Scotland (for example, over 90% in Dundee (R Smith, personal communication)), over 85% of pregnant women positive for HIV in London remain unidentified. Current arrangements would therefore seem to be unsatisfactory and inconsistent with good medical practice.

The detection of all HIV positive women would, of course, be achieved if all women agreed to be tested. Although it is unrealistic to expect this in the short term, in time, as some of the deterrents to testing—such as adverse and uninformed publicity, the attitudes of insurance companies, and the stigma attached to HIV and AIDS—are gradually eroded and as management is improved, HIV testing may become accepted as “routine” alongside testing for rubella, syphilis, and hepatitis B virus. Until such time, other strategies will need to be used. However, to follow the Department of Health’s guidelines,^{13,14} which require women to give explicit consent after appropriate counselling, is extremely costly (£150 000–200 000 for a population of 4000 women a year¹⁹), and implementing the guidelines requires considerable planning and modifications to current procedures. Although a recent survey of HIV testing in a hospital based antenatal clinic in inner London (with a 36% uptake) concluded that HIV testing did not seem to cause anxiety,²⁰ our experience is that it does—affecting the nature of the communication at this important first antenatal visit and the close relationship between a pregnant woman and her midwife. This, coupled with the potential difficulty of maintaining interest in a screening procedure that

will detect only one positive woman every two to three years, may jeopardise the Department of Health’s initiative, especially once antenatal care is almost entirely community based.

As most maternal HIV infection in Britain is still concentrated in recognised risk groups, selective screening has sometimes been advocated.⁶ Such a programme, however, has been shown to be ineffective for hepatitis B screening, with 50% of women positive for hepatitis B surface antigen remaining undetected.²¹ Furthermore, the perceived stigmatisation of the selection process has been reported as resulting in an increased number of women refusing to be tested.²²

Perhaps a procedure whereby those at little or no risk of infection are given a leaflet with relevant information and minimal counselling (similar to that given to blood donors), possibly supplemented by videotape,²³ while those perceived or who perceive themselves to be at higher risk are counselled at greater depth, would provide a compromise. This, coupled with an “opt out” rather than “opt in” philosophy, would be cheaper, would generate less anxiety among women and midwives, and should identify more pregnant women who are HIV positive. This would require, however, an accurate assessment of risk of infection either by the midwife or by the woman herself, and such accuracy might not always be possible. In addition, should those who consider themselves to have been at risk refuse to accept the offer of a test, they would, if HIV positive, remain unidentified.

Whichever protocol is adopted, surveillance throughout Britain must continue so that any significant spread outside recognised risk groups is identified. In addition, evaluation studies must determine the number of HIV positive or “at risk” women who do not wish to be tested and who are slipping through the net; examine reasons for decisions on testing; determine factors influencing midwives’ attitudes to testing; and assess cost effectiveness. After the recent report on anonymous HIV testing in England and Wales³ Dr Angus Nicholl stated, “the challenge now is for purchasers to combine national and local data to provide an idea of local needs for services.”²⁴ With regional and local purchaser support we intend to continue our progressive introduction of the offer of named HIV testing to hospital and other community based antenatal clinics in our inner London area and will continue our detailed monitoring and evaluation. It is only in this way that this essential service will be developed in the most sensitive and cost effective way.

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Improving oral examinations: selecting, training, and monitoring examiners for the MRCGP

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Unless examiners are carefully selected, trained, and monitored, examinations may become hazardous. This is perhaps most true of oral or viva voce ("viva") examinations, which can generate marks unrelated to competence. To help other bodies to short circuit some years of experiment in connection with the oral component of the Royal College of General Practitioners' membership examination (MRCGP), this paper describes the selection, training, guidance, and monitoring arrangements that have been developed.

The oral or viva voce examination ("viva")—a general non-patient based encounter between a candidate and one or more examiners—has held an important place in medicine for centuries.¹ Tradition aside, it is used for its flexibility, its apparent fidelity (much medicine concerns oral encounters over issues of diagnosis and management), and its potential for testing higher order cognitive skills.

Unfortunately oral examinations are prone to many errors.² These include errors relating to halo effects (a judgment of one attribute influences judgments of others); errors of central tendency (judgments cluster in the middle); so called errors of logic (mistakes); a general tendency towards leniency; and errors of contrast (judgments of a candidate are influenced by impressions of preceding candidates). Oral examinations tend to test at a low taxonomic level—for example, factual knowledge rather than problem solving.³ Scores are related to irrelevant attributes of candidates such as appearance or confidence.⁴ Agreement between examiners is often poor.⁴ It is, moreover, difficult to establish in any formal way how valid an oral examination is.⁵

Largely abandoned in North America, oral examinations are still widely used in undergraduate and postgraduate examinations in the United Kingdom. In 1990, 19 out of 27 medical schools used vivas in their final qualifying examinations, 11 as a major assessment method.⁶

The membership examination of the Royal College of General Practitioners (MRCGP) also uses oral examinations. Hitherto, a practical clinical component has not been thought feasible as there are some 2000 candidates each year. Given the centrality of the consultation in general practice, an oral examination component has been regarded as appropriate, often being referred to informally as a "clinical by proxy."

Evidence suggests that oral examinations can be improved by the careful selection⁷ and training⁸ of

examiners. Much effort has been expended towards enhancing the reliability and validity of the MRCGP, especially by addressing the selection, training, and monitoring of examiners. We describe our approaches and make general recommendations from our experience.

MRCGP examination

The MRCGP examination currently comprises three written components—a multiple choice test, a modified essay question paper, and a critical reading question paper—and two half hour oral vivas, each conducted by two examiners. Major changes to the examination, planned for 1996, will not affect the vivas.

Poor performance on the aggregate of the written papers excludes some candidates from the oral examinations. A pass is achieved on the aggregate of the five marks. Statistical monitoring ensures that each component contributes equally to the total. The examination and its impact on candidates' learning behaviour have been described.^{9 10}

Selection of examiners

Examiners need knowledge and skills relating to their subject and towards participation in the design and conduct of the examination. The ability to conduct oral examinations effectively (and to participate in the planning of the written components) requires three further attributes: an approach to the practice of medicine and the delivery of health care that is within the limits of that acceptable to the examiners as a whole; effective interpersonal skills; and the ability to act as a productive member of a small team.

Examiners have consistent and contrasting marketing behaviours—for example, hawk or dove and restrained or theatrical.¹¹ Unless extreme (for instance, an examiner who gives the same mark to all candidates), such behaviours are containable, as they can be changed either statistically or by training.^{12 13} Behaviour that cannot readily be changed, however, is disagreeing with fellow examiners about what is a better answer and what is a worse answer—in other words, a low rank order correlation with colleagues' marks.

To ensure that examiners are of high quality the college requires that potential examiners must be members of the college and in active general practice. If they took the examination more than 10 years ago, they must retake it. They are required to undertake

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