The HIV positive dentist in the United Kingdom – a legal perspective

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VERIFIABLE CPD PAPER

IN BRIEF

- Considers the position of HIV-infected dentists in the UK from a legal and philosophical viewpoint.
- Highlights the potential exposure to litigation of HIV-infected dentists if allowed to continue to work.
- Considers public awareness of HIV infection and the implications for consent to treatment by HIV-infected dentists.
- Confirms the professional difficulties of HIV-infected dentists in the UK.

GENERAL

In 1991, the United Kingdom Advisory Panel (UKAP) was set up under the aegis of the Expert Advisory Group on AIDS (EAGA) to consider individual cases of HIV infected healthcare workers.¹ Policy and guidance relating to HIV infected healthcare workers is set out in a Department of Health report.² Although more recently the EAGA has advised that an HIV positive dentist may under certain conditions provide clinical treatment for patients who are also HIV positive,³ the advice from UKAP relating to exposure-prone procedures means, in effect, that dentists who become HIV positive must cease contemporary clinical dentistry. The plight of dentists who become HIV positive and face this situation has been poignantly described as '...the dental practice equivalent of clearing your desk and being escorted off the premises.'⁴

Contextually the UKAP guidelines are bound to the case of Dr Acer, the eponymous 'Florida Dentist' who infected six patients in his care with HIV,^{5,6} through what remains an unproven mode of transmission.^{5,7} There have been three other cases of transmission of HIV from an infected healthcare worker to a patient. These have involved a French orthopaedic surgeon,⁸ a Spanish obstetrician⁹ and a somewhat unusual case involving a French nurse.¹⁰

Since the time of Dr Acer, the introduction of highly active antiretroviral therapy (HAART) has led to a dramatic decline in morbidity and mortality among patients infected with HIV,¹¹ to the extent that in Britain and the North Western World, at least, HIV/AIDS has been transformed from being a fatal disease to a chronic illness.¹²

In the United Kingdom, anti-discrimination law is governed by the Sex Discrimination Act 1975 (SDA), the Race Relations Act 1976 (RRA), the Disability Discrimination Act 1995, the Employment

Equality Regulations 2006, and the Equality Act 2006. These prohibit direct discrimination, indirect discrimination, and victimisation. However, it would appear that people living with HIV/AIDS in Britain do not litigate, and as a result legislation that might assist them has remained underused.¹³ There are very few examples in the case law,¹⁴ and it is argued that the central weakness of HIV/AIDS law in the UK stems from the fact that litigants and their advisers readily settle out of court; and thus the law remains underdeveloped.¹³

In the United States there is a comparable system of anti-discrimination law,^{15,16} and a more extensive collective experience of HIV and AIDS litigation.¹⁷ Despite this, HIV infected healthcare workers (HCWs) in the United States have been lawfully removed from clinical duties^{18,19} because they pose a 'direct threat', defined as a 'significant risk to the health and safety of others that cannot be eliminated by reasonable accommodation'.

Notwithstanding the known cases, the risk of transmission of HIV from an infected healthcare worker to a patient is generally accepted to be remote.²⁰⁻²² Lookback procedures have consistently failed to demonstrate the transmission of HIV from an infected healthcare worker to a patient.²³⁻²⁵ Recent studies support the non-transmissibility of the disease from individuals effectively treated with

anti-retrovirals,^{26,27} and the 2009 Beijing Declaration supports the view that oral healthcare professionals with HIV do not pose a risk of transmission to patients in the dental setting.²⁸ There have been forceful arguments that condemn the treatment of HIV infected dental HCWs in the United Kingdom as unacceptable²⁹ and illogical.³⁰ Some European countries now allow HIV positive dentists to work,³¹ and the current UKAP guidelines are under review.³² However, a positive change in the UKAP guidelines may not be an end to the professional problems of the HIV infected dentist.

An area of HIV/AIDS litigation that is not underdeveloped in the United Kingdom is that of reckless transmission of HIV infection. These cases relate to the transmission of HIV from an infected individual, through unprotected, consensual intercourse to an unsuspecting partner. Very particularly, the unknowing partner, while consenting to intercourse, does not consent to the risk of HIV infection.³³ There have been numerous convictions that have led to significant custodial sentences.

A parallel may be drawn with HIV infected dental surgeons treating patients. In the event of actual transmission of HIV from an infected dentist to a patient during dental treatment, without taking appropriate precautions and perhaps even with precautions, the dentist may be liable for

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inflicting grievous bodily harm contrary to s 20 of the Offences Against the Person Act 1861 (OAPA), unless the patient was fully informed of the risks, and consented to them. This would inevitably require the disclosure of the dentist's HIV status.

A conviction in 2003³⁴ made it clear that prosecution for the transmission of HIV under the recklessness provisions of the OAPA was not only feasible, but had become a priority for the Crown Prosecution Service (CPS).³⁵ If the CPS evidential test was met, it is hard to believe that they would regard prosecution as not 'in the public interest.'

An alternative remedy in the event of actual transmission of HIV might be provided by the Control of Substances Hazardous to Health Regulations 2002 (COSHH Regulations). The virus would be a 'biological agent' within the definition of 'substances hazardous to health'.³⁶ Although these regulations focus primarily on the protection of employees, reg. 3(1) purports to impose a duty on employers to protect 'any other person, whether at work or not, who may be affected by the work carried out by the employer.'

COSHH regulations have advantages for the claimant over negligence actions in that the regulations impose strict liability, and require a different test for causation.³⁷

The defendant may argue that they have taken all reasonably practical steps to reduce the risk of infection, but the burden of establishing this defence lies on the defendants.³⁷

The possible use of these regulations has been argued in relation to failure to protect against MRSA infections,³⁷⁻⁴⁰ and is being tested in a yet undecided case in Scotland.⁴¹

In the United States, there have been a number of claims asserted by individuals claiming injury based on their fear of acquiring AIDS by a potential exposure to an HIV infected person, even though those individuals have not in fact acquired AIDS or HIV infection.⁴² Those that have been successful have usually followed the case of Brown,⁴³ and precluded recovery of injuries suffered more than six months after exposure.⁴⁴⁻⁴⁷ This is based on the facts that HIV tests are 99% accurate, and that 95% of HIV positive individuals test positive within six months of exposure. However, in a very recent case,⁴⁸ a nurse

exposed to HIV while working at hospital following a needlestick injury with a hypodermic used on an HIV patient, defeated on appeal, the defendant's motion to limit damages to the six-month period.

Cases involving fear of contracting HIV or AIDS from infected healthcare workers have met with mixed success. In *Faya v Almaraz*⁴⁹ the court held that in view of the seriousness of potential harm, the plaintiff's fear of acquiring AIDS was not unreasonable. In *Kerins v Hartley*,⁵⁰ however, 'the minuscule risk' of transmission from an HIV-infected surgeon to a patient was insufficient to support a claim for emotional distress. The *Kerins* decision has been followed in a number of other cases,⁵¹⁻⁵⁴ but some courts continue to allow plaintiffs to recover emotional distress if it can be proven that their fears are legitimate.⁵⁵⁻⁵⁸

In some dental cases,^{59,60} it was held that while the claimants' fears of being exposed to HIV were reasonable, they were not severe enough to warrant tort. In one of these⁶⁰ the plaintiffs also sought a claim of fraudulent misrepresentation, based on the allegations that some patients had asked the dentist about his HIV status, and he had lied in his response.

An automatic legal duty of care arises when a health care professional accepts a patient for treatment,⁶¹ and if the dentist is employed by a NHS trust, then the trust will be vicariously liable for the dentist's negligence.⁶¹

As a general rule, medical treatment should only proceed when the clinician has first obtained a patient's consent.⁶² Consent may be expressed or implied, and the principle applies in the overwhelming majority of cases.

Of concern here is the undisclosed risk and the patient's autonomy. The aggrieved patient claims they were not informed of a risk (the dentist's HIV seropositivity) and something happened (reckless transmission of HIV), or something might have happened, or may happen in the future (fear of AIDS litigation).

In the United Kingdom the case law has demonstrated a robust affirmation of patients' right to self determination,^{63,64} and it is likely that the Human Rights Act will also protect the individual's right to make medical decisions (Articles 2, 3, 5, 8 and 9). Following the seminal case of

Sidaway,⁶⁵ the material risks of a procedure must be disclosed.

'A risk can be defined as material if a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it.'

'...it is material if the medical practitioner is, or should reasonably be, aware that the particular patient if warned of the risk would be likely to attach significance to it.'

Significance is a function not only of incidence, but of the severity of the risk. In *Sidaway*, the 10% risk established in *Reid v Hughes*,⁶⁶ was one where the clinician could hardly fail to appreciate the need to warn the patient, while non-disclosure of the risk of less than 1% of damage to Mrs Sidaway's spinal cord was deemed proper.

Nearly 25 years later a 1 in 100 risk of spinal cord damage as immaterial might raise eyebrows, but it gives a perspective to the risk of transmission of HIV through dental procedures. In *Rogers v Whittaker*,⁶⁷ however, it was negligent to not disclose a risk of 1 in 14,000, and significantly:

*'...it would be illogical to hold that the amount of information to be provided by the medical practitioner can be determined from the perspective of the practitioner alone...'*⁶⁷

Numerous cases have now shown a move away from the Bolam standard in disputes over information.⁶⁸⁻⁷⁰ Patient choice is crucial and a choice can only be real and valid if it is based on adequate information.⁷¹ A considerable hurdle in these matters can be the credibility of the plaintiff's assertion that, had they known the risk they would not have consented to the process.^{72,73} However, clearly in the case of the HIV positive dentist, it is not that the patient would not proceed with the treatment, simply that they would not proceed with the treatment provided by this particular dentist.

Consent then is premised not on the basis of what the dentist thinks the patient should know, but on what the patient thinks s/he ought to know. In short it is the patient who decides if the HIV status of the dentist is relevant to their treatment.

Arthur Schaffer describes the situation in strident tones, '...The AIDS epidemic fits most of the usual plague stereotypes and well deserves the title "God's gift to bigots"...' ⁷²

AIDS is certainly a personal issue and an issue for the individual. But it is also a public and social issue.⁷⁵

Bickenbach is more measured and pragmatic:

*'As a general matter, the social perception of a contagious disease – and the metaphors that shape our public discourse about it – will profoundly affect the debate over the kinds of social measures required to alter its course. In a society such as ours, committed by law and liberal political tradition to the protection of both individual rights and general welfare, this important debate must resolve tensions between equally important but conflicting interests. In particular, our social response to an epidemic must weigh the rights of those already infected against the rights of those who are not, and must balance the effectiveness of public health measures in checking the epidemic against the sacrifices those measures demand of individual citizens'*⁷⁶

Everyone agrees on two objective factors:

1. The risk of transmission during surgery from HCW to patient is extremely low
2. Actual transmission will almost always result in catastrophe.⁷⁶

The sufficient risk/reasonable accommodation analysis places the onus of proof on those who would limit the rights of people with HIV. This is important as those who are HIV positive constitute a minority whose voice could be drowned out by the demands of an apprehensive majority. The analysis also requires a realistic and scientifically accurate determination of risk of infection, an important safeguard against the distorting effects of misinformation and misconception, and do not needlessly violate the core political values that underwrite a free and democratic community.⁷⁶

Currently it would seem that the standard for sufficient risk is set as low as possible, so that the merest possibility of a risk is sufficient to justify what may otherwise be regarded as unequal and right infringing treatment.⁷⁶

The risk of the healthcare worker being infected by a patient is greater than the risk of the healthcare worker infecting the patient.⁷⁷ Patients may refuse to consent to treatment by an HIV infected healthcare

worker, but the healthcare worker may not refuse a person treatment solely because of their HIV status. The distinction is premised on the notion that the HCW has a fiduciary duty to the patient, whereas the patient does not have a corresponding ethical duty to the clinician,⁷⁸ nor is the patient burdened by any requirement of confidentiality in their relationship with the clinician.

The general clinical view seems to favour, a pragmatic approach that accepts there is a risk of transmission of the HIV virus from an infected dentist to a patient; but that the risk is sufficiently small to be insignificant. They would point to the fact that clinical decisions are constantly made on the basis of finely balanced judgements about the relative risks to which a patient is exposed. They would make a plea for a well informed public that held a broad understanding and agreement based on cogent arguments about the true relative risks of transmission of the HIV virus from an infected dentist to patients.

Unfortunately while public knowledge about HIV transmission increased dramatically from the mid 1980s through 1990, levels of knowledge have since remained relatively stable.⁷⁹ A 2007 survey reported that people were '...still alarmingly ignorant about HIV';⁸⁰ and the National AIDS Trust claims there has even been a significant decline in public knowledge over the last decade.⁸¹ Indeed, it is reported that in general, most public risk perceptions are at odds with scientific estimates, are inconsistent with the rules of formal logic, and vary considerably in populations over time.⁸²

An illuminating *BMJ* report⁸³ outlines the public and media response to the knowledge of three doctors diagnosed as HIV positive. In one case the media and public responded positively, and accepted reassurances given. In the second case, the press pursued the deceased doctor's relatives, forcing them to move. Of the patients responding to the helpline organised by the health board, only 41% were patients that had been treated by the HIV positive doctor. Sixty-two patients requested counselling, including 18 who were not patients of the doctor. Fifteen patients treated by the doctor requested HIV tests, two of whom had not undergone exposure-prone procedures. All tests were negative. In the third

case, newspapers incorrectly identified the doctor. In response the doctor allowed himself to be identified to avoid speculation regarding colleagues, and to reassure patients. The media reacted positively to the disclosure.

In *H (A Healthcare Worker) v Associated Newspapers Ltd*,⁸⁴ the court recognised:

'There is a higher risk of public alarm and of inaccurate public perception of risk if communication of the risk is through sensationalised news stories in the national media.'

Moreover in a commentary on the case:⁸⁵

'A wider and more worrying aspect of the decision (in the above case) relates to the enduring stigma and moral blame attached to HIV infection and AIDS and those who are victims of it. The attitude of the newspaper in the case is a clear indication of this.'

'In reaching its decision the court is undoubtedly aware of the controversial status of HIV infection and AIDS, and the stigma resulting from adverse media attention and public anxiety associated with it. It is highly regrettable that years after HIV/AIDS came to public attention it is still perceived in this way.'

Nor is the anxiety, misunderstanding, confusion or prejudice confined to the general public. Dentists are well informed about risks of transmission of HIV.⁸⁶ Even so it is reported that some avoid treating or have reservations about treating HIV positive patients.⁸⁷⁻⁸⁹

In a 2006 report two healthcare workers developed disabling post traumatic stress disorder after needlestick exposure, even though both continue to test negative.⁹⁰

English Law does not recognise a general right of privacy.⁹¹ Courts have been willing to protect the identity of HIV positive individuals,⁹² but sometimes confine their decision to very narrow grounds.⁹³ The United Nations' HIV/AIDS and Human Rights International Guidelines⁹⁴ discuss the right to privacy provided under article 17 of the International Covenant on Civil and Political Rights (ICCPR). The point is made that States have a duty to protect the right of privacy that includes the obligation:

'...that confidentiality is protected particularly in health and social welfare settings, and that information on HIV status

is not disclosed to third parties without the consent of the individual.'⁹⁴

However, surveys have shown that patients do want to know if their doctor or dentist is infected with HIV,^{95,96} and as seen earlier, this is a key factor in determining valid consent.

Medical knowledge about the HIV disease process *has* increased over time. Infectivity is not constant.⁹⁷ Viral load is the chief predictor of risk of heterosexual transmission of HIV-1, with transmission rare among persons with levels of less than 1,500 copies of HIV-1 RNA per millilitre.⁹⁸

Antiretroviral therapy can reduce HIV type 1 viraemia to below the detection limit of ultra sensitive clinical assays (50 copies of HIV-1 RNA/ml).^{99,100}

Universal and standard infection control procedures are designed to protect healthcare workers and patients,¹⁰¹ although compliance in dental practice is sometimes lacking.¹⁰¹ Glove perforation is not uncommon,¹⁰² but most,^{103,104} though not all¹⁰⁵ reports support the practice of double gloving as effective.

The General Dental Council (GDC) requires dental professionals to be familiar with and understand: current standards that affect their work; the evidence base that supports those standards; and relevant guidelines issued by organisations other than the GDC.¹⁰⁶

UKAP would point to the fact that their current precautionary but restrictive policy reflects a risk that is low, but nevertheless real.¹⁰⁷ Standards of cross infection control may not be universally implemented, and discontinuation of antiretroviral therapy results in a rapid rebound of plasma viral load to pre-treatment levels.¹⁰⁸

Their policy, they would argue, is proportionate. Nevertheless, current policies on the management of healthcare workers infected with HIV in the UK are under review.^{32,107} Perhaps HIV infected dentists will be allowed to continue to practise provided they have undetectable viral loads, have regular testing to confirm this, and follow universal, standard cross infection control measures.

However, in the worst case scenario they may be vulnerable to a charge of reckless transmission, or the untested failure to protect against infection. In the absence of actual transmission, the dentist may be

exposed to fear of AIDS litigation that has yet to be tested in the UK courts.

The public outcry and repercussions to the profession in general should such transmission occur, can only be imagined. A utilitarian view would argue for the HIV positive clinician to remove him or herself from clinical practice, not only to eliminate risks to patients, but for the benefit of the profession. In which case, it has been suggested, some form of compensatory payment might be applicable.^{32,109}

Prior consent by an informed patient would remove the legal risk (assuming it is possible in these circumstances to consent to potential harm). Informing patients of HIV status undoubtedly leaves the dentist open to prejudice and discrimination by not only the patients who are informed, but by others who have nothing to do with the dentist's practice, but who will inevitably come to know of the dentist's condition.

Clearly the choice faced by the dentist between disclosure and informing patients, or enforced retirement is not a happy one.

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