3.1.2 Professional Competence: The HIV Infected Physician

B. Lynn Johnston, MD, FRCPC

Educational Objectives

1. To appreciate the basis, in ethics and guidelines, of the physician’s responsibility to minimize the infectious risk that he/she may pose to his/her patients.
2. To understand the responsibility that physicians who care for other physicians infected with a blood borne pathogen have in advising and reporting these individuals.
3. To appreciate the privacy rights of the infected health-care worker.

Case

Dr. Leblanc is a 38-year-old surgeon in Halltown, a city west of Toronto (population 150,000). He has a successful practice and is active in the community, coaching a bantam hockey team that has reached the provincial finals for two years in a row. He is in a long-term relationship (8 years) with Jason, a teacher. They were both tested for HIV 10 years ago when each of them got life insurance. Jason was tested again after an episode of multidermatomal zoster; his test came back positive. They have an open relationship and acknowledge that each of them has had casual partners, but they have been careful to have protected sex with those other partners. Dr. Leblanc feels perfectly well and cannot believe that he might be HIV-infected.

After considerable deliberation and soul-searching, Dr. Leblanc goes to an anonymous HIV testing clinic in Toronto. Much to his distress, the test does come back positive. He realizes that this might have a major impact on his practice, let alone his health. However, he currently feels well and knows that it may be several years before his HIV status impacts on his well-being. He is glad that he was afforded the anonymity of the Toronto clinic and wonders if he might just let things ride until he feels that the HIV is affecting his health. After all, no one aside from him and Jason knows their test results.

After some consideration, Dr. Leblanc realizes that he has a responsibility to be checked out medically and to determine whether he might pose a risk to his patients. He makes an appointment to see the family physician that he had when he was a resident in Toronto. Dr. MacDonald confirms that Dr. Leblanc is asymptomatic with respect to the HIV and has no abnormal physical examination findings. Laboratory testing reveals that his T cells are fine (750/cc), but that his viral load is moderately elevated at 150,000 copies/mL. He is immune to the hepatitis B virus (HBV) (from a prior vaccination) and negative for hepatitis C virus (HCV). Dr. MacDonald confers with one of her colleagues to see what she should do about Dr. Leblanc’s work situation. Her colleague tells her that nothing needs to be done, but she is not convinced that is correct.

Dr. Leblanc decides to take a 6-week leave of absence and starts antiretroviral treatment to lower his viral load. He tolerates the medications well, and within 4 weeks his viral load is undetectable. He generally feels well, but is consumed by the thought that if the administrators at his hospital find out about his HIV status they will retract his privileges and make a public notification of his status. He also wonders if, when he goes back to work, he’ll have to divulge his HIV status to his patients.

Questions

1. Did Dr. Leblanc have any professional obligation to undergo HIV testing?
2. Does Dr. Leblanc have a professional obligation to notify anyone that he is infected with HIV?
3. Are there any reporting requirements that Dr. MacDonald has to comply with?
4. Are there guidelines regarding the workplace management of the HIV-infected physician that Drs. Leblanc and MacDonald could refer to?
5. Are there any situations where the public needs to be notified of a physician’s HIV status?
6. Does informed consent require Dr. Leblanc to tell his patients that he has HIV?

Discussion
There are probably few infections that present as much fear and concern for contagion to patients and physicians alike as HIV,\(^1,2\) despite evidence that it is rarely transmitted from patient to health care worker (HCW) and extraordinarily rarely transmitted from HCW to patient. To date, there are only four instances where HIV has been attributed to care provided to patients by an HIV-infected HCW. One of these is the famous case in the early 1990s of the Florida dental surgeon.\(^3\) In that instance, the mechanism of transmission was not determined and may have been related to poor infection-control practices. The other instances include one patient who acquired HIV from an infected orthopaedic surgeon during a prolonged surgical procedure\(^4\) and one patient who acquired HIV during a Caesarean section during which the obstetrician suffered a needle-stick injury.\(^5\) The fourth transmission was attributed to an HIV-infected nurse who was not involved in an invasive procedure, leaving the transmission route unclear.\(^6\) In addition to these reports, there have been a number of look-backs that have tested tens of thousands of patients cared for by HIV-infected HCWs, including a number of surgeons.\(^7-9\) In none of these studies was transmission identified.

We can therefore say with some confidence that the transmission of HIV from HCW to patient is extremely low. However, it is recognized that there is a risk for transmission of blood-borne pathogens from HCWs to patients.\(^10\) To maintain the public confidence in the safety of health-care environments, it is important that we identify where risks for transmission do exist and take appropriate measures to reduce those risks.

**Q1. Did Dr. Leblanc have any professional obligation to undergo HIV testing?**

The Canadian Medical Association (CMA) has prepared a Code of Ethics that is subscribed to by the Royal College of Physicians and Surgeons of Canada.\(^11\) In the preface to the Code, it is noted that together with CMA policies on specific topics, the Code constitutes a compilation of guidelines that can provide a common ethical framework for Canadian physicians.

Among the fundamental responsibilities are first considering the well-being of the patient, practicing the art and science of medicine competently and without impairment, and promoting and maintaining your own health and well-being. One of the specific responsibilities to patients is to take all reasonable steps to prevent harm. Finally, physicians have a responsibility to seek help from colleagues and appropriately qualified professionals for personal problems that might adversely affect their service to patients, society or the profession. More specifically, CMA policy encourages HCWs who perceive themselves to be at risk of HIV infection to seek voluntary counselling and HIV antibody testing.\(^12\)

In 1996, Health Canada convened a consensus meeting to formulate recommendations regarding the management of HCWs infected with blood-borne pathogens to minimize the risk of transmission of these pathogens from HCW to patient. The proceedings of the consensus conference were published in 1998.\(^13\) One of the recommendations is that HCWs who perform exposure-prone procedures have an ethical obligation to know their serologic status with reference to the blood-borne pathogens of HBV, HCV and HIV.

In 2004 the Public Health Agency of Canada (PHAC) was established to respond to, among other things, issues related to chronic and infectious diseases. PHAC has taken responsibility for many issues previously managed under the Health Canada mandate. Thus, both PHAC guidelines and the CMA Code of Ethics indicate that Dr. Leblanc has an obligation to undergo HIV testing.

**Q2. Does Dr. Leblanc have a professional obligation to notify anyone that he is infected with HIV?**

CMA policy and PHAC guidelines are clear on this issue as well. The CMA recommends that infected HCWs consult their family physician for a medical evaluation.\(^12\) Although Dr. Leblanc may feel well, a full medical assessment by a qualified infectious diseases physician or a family physician experienced in managing HIV is important to identify any health effects that he might be experiencing that could impair his ability to properly and safely care for his patients. Additionally, he may be at a stage where he would benefit from antiretroviral therapy.

From a public health perspective, it is important to counsel people who have HIV about preventing transmission of the virus to others through personal behaviour or accidental exposure.\(^14\) Although not a specific goal of therapy, successful antiretroviral therapy would reduce Dr. Leblanc’s HIV viral load to undetectable, further reducing an already exceedingly remote risk of transmission to patients.

PHAC guidelines state that HCWs who perform exposure-prone procedures and who learn that they are infected with a blood-borne pathogen are ethically obligated to report that fact to their profession’s regulatory body.\(^13\) It is recommended that an expert panel is established by the regulatory body to review the physician’s practice and determine whether practice modifications should be imposed. Most provincial colleges have established expert panels/committees to advise on the work practices of physicians infected with a blood-borne pathogen who are
Q3. Are there any reporting requirements that Dr. MacDonald has to comply with?

Since May 1, 2003, HIV infection has been reportable by law to the public health authorities in all provinces and territories. Dr. MacDonald is therefore required to report Dr. Leblanc’s positive HIV status to the local medical officer of health. Public health authorities may be able to provide Dr. MacDonald with information on referral of Dr. Leblanc to the College’s advisory panel and on available infection prevention and control resources and recommendations.

CMA policy recommends that, when appropriate and taking care to ensure confidentiality, the family physician should seek advice from medical or public health experts regarding the current knowledge of risks of transmission to patients. Dr. MacDonald would be advised to take advantage of those resources.

Q4. Are there guidelines regarding the workplace management of the HIV-infected physician that Drs. Leblanc and MacDonald could refer to?

As noted, the PHAC has published guidance on the management of HCWs infected with a blood-borne pathogen. A consultation mechanism that includes referral to an expert panel is recommended. Referrals may be received from the HCW, his/her personal physician, the regulatory body or a public health official. The panel’s mandate would be to assess the transmission risk to patients posed by the infected HCW during exposure-prone procedures and make recommendations on the HCW’s practice. It is probably outside of Dr. MacDonald’s expertise to make that assessment. Additionally, as Dr. Leblanc’s physician and advocate, she may not be able to make impartial decisions regarding work restrictions that could negatively affect his livelihood.

There has been much debate about what constitutes exposure-prone procedures. This term was first coined by the Centers for Disease Control and Prevention (CDC) in its 1991 publication on the prevention the transmission of HIV and HBV in the health-care setting. Characteristics of exposure-prone procedures include digital palpation of a needle tip in a body cavity or the simultaneous presence of the HCW’s fingers and a needle or other sharp instrument or object in a poorly visualized or highly confined anatomic site. Performance of exposure-prone procedures presents a recognized risk of percutaneous injury to the HCW, and—if such an injury occurs—the HCW’s blood is likely to come into contact with the patient’s body cavity, subcutaneous tissues and/or mucous membranes. The CDC did not specify what exactly constituted an exposure-prone procedure, and professional medical and dental associations have declined to contribute suggestions. Thus, expert panels looking to guidance from Canadian and US health authorities are left to use their best judgment to specify what procedures pose a risk of transmission of a blood-borne pathogen. Fortunately, there is more definitive guidance from the UK on what procedures (and specialties) should be considered as exposure-prone.

Q5. Are there any situations where the public needs to be notified of a physician’s HIV status?

The stand taken by the PHAC is that patients do not need to be notified of the health status of an HIV-infected HCW. If a significant exposure has taken place that could put a patient at risk for infection, the patient must be notified that he/she was exposed to the blood of a member of the HCW team, but does not need to know who that HCW is. Patient notification (to seek testing for HIV) may be necessary if a HCW’s practice is modified because of safety concerns. In this situation, it is not recommended that the HCW’s identity be divulged. It should be noted that not all countries or individuals subscribe to this approach and, even within a country, practice may between areas.

In fact, a survey of public attitudes in 2000 found that only 38% of respondents thought that HIV-infected doctors and dentists should be allowed to provide patient care.

Q6. Does informed consent require Dr. Leblanc to tell his patients that he has HIV?

In its 1991 publication, the CDC recommended that HCWs infected with HIV or HBV (and HBeAg positive) should inform patients of their serologic status before engaging in exposure-prone procedures. Despite the CDC’s claims over the years to be in the process of revising the 1991 guidelines, none have yet been published. Even with this recommendation from the CDC, many US states do not require disclosure to patients.
PHAC recommendations state that provided the infected HCW has been assessed by the expert panel and that all of the panel’s recommendations are followed, disclosure of a HCW’s infected status to patients before an exposure-prone procedure is carried out is not required as a way of protecting patients from blood-borne pathogens. As noted in the discussion related to Question 3, should there be reason to believe that Dr. Leblanc is behaving wilfully in a manner that could put colleagues or patients at risk for transmission of HIV, the CMA Code of Ethics notes the physician’s responsibility to report this to the local licensing body or public health services. In this situation, Dr. Leblanc’s HIV status may become known to others, including the general public.

Gostin has argued that the doctrine of informed consent should not require HIV-infected HCWs to disclose their HIV status to patients. The risk of HIV transmission is too low to meet the legal standard for disclosure of a material risk and, if the risk is significant, the logical strategy is to restrict the HCW’s practice, not notify the patient. Cook and Dickens have noted that when health-impaired practitioners practice within such approved conditions, modern courts hold that they have no legal duty to voluntarily disclose their status to their patients. Furthermore, it is duly noted that the HIV-infected HCW is a patient with privacy and confidentiality rights of his/her own.

It should also be noted that the law protects the physician, as it does any other person, from discrimination based on HIV status or sexual orientation. Dr. Leblanc cannot be discriminated against in the workplace and, provided that he works within the guidelines set forward by the expert panel reviewing his case, is not obligated to inform his patients of his HIV status.

References


