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Confidentiality concerning HIV/AIDS status — the implications of the Appeal Court decision

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The Appellate Division recently overturned a Supreme Court judgement concerning the disclosure of a patient's HIV status by his general practitioner to another general practitioner and a dentist. This article examines the content of both judgements with particular reference to its implication for the medical profession, and considers the arguments that may be raised for and against disclosure of a patient's HIV seropositivity.

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If your patient tests HIV positive: (*i*) to whom if anybody do you have a right or duty to disclose the information; and (*ii*) if such a right or duty exists, is there a correct procedure that must be followed in the disclosure of this information?

These questions were the subject for consideration in the Supreme Court[1] and Appellate Division decisions.[2]

Facts of the case

The nature of the action

The plaintiff (McGeary) was informed by his general medical practitioner (Kruger) that he was HIV-positive on 10 March 1990. The day after informing McGeary of his HIV-positive status, Kruger disclosed the information to two medical colleagues while on the golf course. McGeary later sued Kruger for breach of confidentiality that led to invasion of his privacy. His claim was based on Kruger's personal disclosure to Van Heerden, a general medical practitioner, and Vos, a dentist, and his liability as employer for the action of an employee, viz. his secretary, who had allegedly disclosed the information to a third party with no interest in the matter.

Kruger's justification for disclosure

To the dentist (Vos). Kruger himself was a patient of Vos and was aware that Vos had treated McGeary in the past. His evidence justifying his disclosure was that he was concerned about Vos's precautionary measures. He felt that Vos needed to be informed of McGeary's status and wanted to warn him of the danger of treating McGeary without taking the special care necessary for the handling of an HIV-positive patient. Kruger also wanted to warn Vos against any possible 'retrospective exposure' to the virus. ('Retrospective exposure' was Kruger's description of the possibility that McGeary had infected Vos before he was diagnosed HIV-positive).

To the doctor (Van Heerden). Kruger was aware that Van Heerden was one of a group of doctors in Brakpan who were on call from time to time for all off-duty practitioners in town. Kruger was unaware that Van Heerden had previously seen McGeary as a patient. Kruger also knew that Van Heerden's wife was a business partner of McGeary, and Van Heerden claimed that this was why Kruger disclosed McGeary's status to him.

Although there is no mention of patient consent in the Supreme Court judgement, the Appeal judgement notes that not only did Kruger not seek to obtain McGeary's consent to disclosure; on the contrary, he promised not to divulge the information.

The decision of the Supreme Court

Judge Levy found that Kruger had not erred in making the disclosure to Van Heerden and Vos.

Because Vos was still McGeary's dentist and would presumably be approached by him in the future, the judge felt that it was in fact Kruger's *duty* to inform Vos of McGeary's HIV status and not rely upon Vos's own preventive practices. Judge Levy was under the impression that McGeary would not have disclosed his HIV status to Vos.

In Van Heerden's case, the judge believed that his position as an emergency on-call doctor required him to be informed of McGeary's HIV status for his own safety's sake as well as for the better treatment of McGeary, should the occasion arise.

Rules laid down by the South African Medical and Dental Council and the College of Medicine of South Africa were considered by the judge to carry substantial weight in determining the reasonableness of Kruger's conduct.

The decision of the Appellate Division

The findings of the Appellate Division overruled the Supreme Court decision on the following grounds: (*i*) Kruger had not attempted to obtain McGeary's consent to a disclosure. On the contrary, he had promised not to divulge the information; (*ii*) By the time of the disclosure McGeary had moved to Nylstroom and the likelihood of his requiring the services of either Vos or Van Heerden was remote; (*iii*) Justice Harms felt that Vos and Van Heerden had not, objectively speaking, been at risk and that there was no reason to assume that they had to fear a 'prospective' exposure; (*iv*) there was no factual basis for the opinion that McGeary would have failed

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to inform his future attendants of his illness; and (*v*) there was no evidence for 'retrospective' exposure in either instance.

Discussion

There are reasons for and against the disclosure of a patient's HIV status to other health care workers.

Advantages of disclosure

Three major factors of importance apropos a practitioner's disclosure of a patient's HIV status to his colleagues are: (*i*) the better treatment of the patient; (*ii*) more stringent infection control procedures on the part of health care workers; and (*iii*) post-exposure prophylaxis with zidovudine following needlestick injuries involving HIV-positive patients.

The better treatment of the patient

The prolongation and improvement of the life of the HIV-positive patient involve current medical knowledge that is changing rapidly. In order to demonstrate the medical benefits an HIV-positive patient will gain from disclosure of his HIV status to a caregiver directly involved in diagnosing and treating the patient, a few aspects of the disease will be discussed in detail.

In 1986 the Centers for Disease Control[3] established a classification system that outlined the clinical progression of HIV disease. No laboratory parameters were included. The median survival times, according to this classification, were estimated to be 10,3 years for stage 1, 10,1 years for stage 2, 5,8 years for stage 3 and 1,4 years for stage 4.[4]

The survival time of all adults with AIDS in San Francisco has increased from a median of 10,1 months in 1981 to 15,6 months in 1987.[5] Reasons for this improvement included earlier detection of HIV infection, improved management of infection and neoplasia, prophylaxis against opportunistic infection and therapy with zidovudine.[6]

In the past few years the understanding of HIV immunopathogenesis has progressed and the monitoring of CD4+ T lymphocytes has become procedure in the standard care of HIV-infected patients, including the timing of antiretroviral therapy.[7]

For this reason the Centers for Disease Control revised the 1986 classification of HIV infection early in 1993 to emphasise the clinical importance of the CD4+ T-lymphocyte count in HIV-related clinical conditions.[8]

Physicians use immunological measures to assess the stage of infection and guide therapy. Antimicrobial prophylaxis and antiretroviral therapies have been shown to be more effective within certain levels of immune dysfunction.

As far as dentists are concerned numerous articles have been written on the oral care of the HIV-infected patient.[9-12] In one study of 160 HIV-infected patients, one or more oral findings were recorded in 90,6% of the patients while a total of 33 different lesions was observed.[13] In 16 of the patients the suspicion of HIV infection was based exclusively on the presence of oral lesions.

Opportunistic fungal infections are common and major causes of morbidity in patients with AIDS. The incidence and severity of serious fungal infection increase with progression of HIV infection and reduction in CD4+ counts.[14] McGeary was diagnosed as having had oral candidiasis when he was seen by off-duty doctor Van Heerden in Brakpan.

Mucocutaneous candidiasis occurs in up to 90% of patients at some time in the progression of HIV disease. Treatment is complex and based on some of the following criteria: (*i*) the CD4+ cell count; (*ii*) the frequency of recurrence of the infection; (*iii*) whether or not the patient has oesophagitis; and (*iv*) the cost of the drugs.[14]

Given the complex nature of HIV infection and its treatment, it is prudent to work in close collaboration with medical colleagues at all times.

In order to gain a patient's consent to divulge his information to individuals who, according to the American Academy of Family Physicians, have the compelling right to know, good counselling is essential.[15]

The Centers for Disease Control identify the following as the major functions of HIV counselling services which may be publicly funded or handled by private doctors:[16] (*i*) to provide a convenient opportunity for patients to learn their current HIV serostatus; (*ii*) to allow such patients to receive preventive counselling to help initiate behaviour change to avoid infection or, if already infected, to prevent transmission to others; (*iii*) to help patients obtain referrals to receive additional preventive counselling, medical care and other needed services; (*iv*) to provide preventive services and referrals for sex and needle-sharing partners of HIV-infected patients.

Adoption of universal precautions

Health care workers who do not practise universal precautions can implement more stringent infection control procedures. Prospective surveys show the risk of HIV seroconversion after a single needlestick or sharps injury involving known HIV-infected blood to be approximately 0,34%.[17]

Intact skin and mucous membranes are an important defence against HIV. In 1987 three health care workers who had eczema or dermatitis and who did not observe barrier precautions were exposed to HIV-infected blood and acquired HIV without a sharps injury.[18]

HIV is less transmissible than hepatitis B virus, and usually requires hollow needles and larger volumes of blood. An estimated 40% of American surgeons are infected with hepatitis B virus during surgery at some point in their careers; 4% become carriers.[19]

In Natal/KwaZulu, which has a 4,77% rate of HIV seropositivity, the highest in South Africa,[20] there have been five recorded HIV seroconversions in health care workers (2 doctors, 3 nurses) (D. Pudifin — personal communication).

It has been estimated that 40% of needlestick injuries and two-thirds of non-parenteral exposures that result in HIV infection could have been prevented if infection control guidelines had been followed.[21]

Double gloving decreases the chance of hand contamination. Gerberding *et al.*[22] maintain that double gloving not only reduced the perforation of the inner glove by more than 60% but also prevented hand exposure to blood. They estimated that at least 50% of cutaneous hand exposures caused by glove tears in health care workers wearing single gloves would have been prevented by double

gloving. Perhaps a better glove type may be used. Burke[23] demonstrated that Biogel D gloves lasted three times longer than the next best gloves.

Lewis *et al.*[24] demonstrated that during the treatment of HIV- and HBV-infected patients HIV proviral DNA and HBV DNA were taken up or expelled from both high-speed and slow dental handpieces. For these reasons the Centers for Disease Control and Food and Drug Administration have recently recommended that high-speed and prophylaxis angles be cleaned and heat-treated before use on a new patient.

There has only been one report of an HIV-positive health care worker (dentist) transmitting HIV to his patients. In the most recent Centers for Disease Control update the sixth infected patient to be discovered had not had extensive treatment.[25] An examination, radiography prophylaxis and two restorative fillings under local anaesthesia were all that were done.

Excluding the Florida dental practice mentioned above, as of March 1993 the CDC was aware of investigations in which HIV testing of 19 036 patients treated by 53 HIV-infected health care workers had been completed. No additional cases of HIV transmission to patients have been documented.[25]

Available data indicate that the risk of HIV transmission from an infected HIV health care worker to a patient during an invasive procedure is very small, certainly much smaller than the occupational risk of HIV infection faced by health care workers.[26,27]

Post-exposure prophylaxis with zidovudine following needlstick injuries involving HIV-positive patients

Zidovudine is the only drug considered to offer the possibility of modifying the risk of HIV infection after an inoculation incident.[28] Some physicians believe that zidovudine should be offered as prophylaxis after certain occupational exposures[29,30] whereas others believe that zidovudine should not be recommended for uninfected persons after occupational exposure because of the lack of data demonstrating efficacy in postexposure prophylaxis,[28] reports of alleged failure of zidovudine prophylaxis in humans,[31] the limited data on toxicity in uninfected individuals, and the fact that zidovudine has been shown to be carcinogenic in rats and mice.[28]

Disadvantages of disclosure

Evidence suggests that neither knowledge of diagnosed HIV infection nor awareness of a patient's high-risk status for such infection influenced the rate of exposure. This was one of the most significant findings to emerge from the San Francisco study of Gerberding *et al.*[22]

Exposures occurred during 27 of 375 (7,2%) of the procedures involving patients at high HIV risk and during 57 of 932 (6,1%) of those involving patients at low HIV risk.[22]

A major concern of HIV-infected patients is that medical care may be inaccessible to them if they are found to be HIV-infected.

A study of South African dentists and dental specialists found 43% unwilling to treat HIV positive patients.[32] Two-thirds of them said they would rather refer these patients to somebody else. The same dentists showed more willingness to treat hepatitis B carriers.

Professional associations including the MASA,[33] SAMDC[34] and the College of Medicine[35] stipulate that no health care worker may ethically refuse to treat a patient solely on the grounds that the patient is, or may be, HIV-seropositive.

However, the College of Medicine guidelines also note that a health care worker is not legally obliged to accept a particular patient at his or her private practice except in an emergency or where no other treatment facility is available.

Accidental exposure to the blood of hepatitis B-infected patients has been shown to produce less fear than accidental exposure to HIV, even though both have an approximately equal overall risk of death (~1%)[36] Schneiderman and Kaplan[36] feel that the apparently excessive fear of HIV exposure is not an irrational manifestation but rather the rational reaction to the prospect of living with the certainty of imminent death.

Fear, ignorance and uncertainty have produced illogical and judgemental behaviour that has undermined respect and discriminated against those who are infected, engage in high-risk behaviour or belong to populations in which the prevalence of HIV infection is high.[37] Often this has deprived HIV-infected people of social support, employment, housing, education, travel and health care.[38,39]

Conclusion

There is a potentially insurmountable conflict between a patient's right to confidential information and the caregiver's knowledge that disclosure of a patient's HIV status will benefit diagnosis and treatment planning and enable extra precautions to be instituted.

The dilemma for the medical profession is particularly acute because there is no certainty as to who must be warned and under what circumstances. It is left to the physician's discretion and if he/she makes the wrong decision it could result in liability.

Given so much uncertainty, what advice can be given to caregivers in the light of present guidelines?

1. Doctors should always try to obtain consent. This should be concluded subsequent to the doctor's counselling the patient as to the benefits disclosure of his/her HIV status to other caregivers would have for the patient. In Pennsylvania, USA, confidentiality laws require a patient's written consent.[40] A general consent form is not sufficient. It must state specifically who is to get the information, for what purpose, and for what period of time the consent remains valid. SAMDC, MASA and College of Medicine guidelines on confidentiality concerning the HIV patient do not indicate that consent needs to be in writing. According to Navia *et al.*[41] AIDS dementia complex occurs in more than 60% of AIDS patients. Early symptoms of AIDS dementia include memory and concentration impairment and mental slowing.[42] Doctors are advised to obtain the consent in writing in case an issue arises over whether consent was given at all.

2. The referring practitioner and HIV-positive patient have an obligation to inform specific caregivers of HIV seropositivity. The American Academy of Family Physicians believes that there are categories of individuals who need access to information about HIV positivity.[15] The first includes caregivers who require accurate information in

order to make meaningful decisions for the patient's own benefit. Among these are the attending physicians, consultants and other providers who make medical judgements concerning diagnosis or treatment. The second group deserves information for the benefit of persons other than the patient, who are at imminent risk of infection. Among these are: (*i*) sexual contacts; (*ii*) other individuals who have sustained or who are at risk of clinically significant exposures; (*iii*) blood, organ tissue and body fluid banks; and (*iv*) public health agencies directly involved in contact identification.

With regard to the McGeary v. Kruger case, Bruce Leech[43] wrote the following after the Supreme Court judgement but before the Appellate Division decision:

> 'The two doctors were for all practical purposes not involved at all in the provision of care for the plaintiff, and there was no sound, or non-speculative, reason to suspect they would do so in the foreseeable future. Thus the information was not disclosed in the context of a professional relationship between the defendant and the doctors. There was therefore no justification for the disclosure in terms of the test formulated above, and the breach of confidentiality was therefore, with respect, wrongful.'

The McGeary v. Kruger case emphasised a number of fundamental principles regarding confidentiality and the HIV patient. It is important for both the legal profession and the patient to understand the benefit of referral given the highly specialised form of treatment the HIV patient requires; just as importantly, caregivers need to view good law as essential for the regulation of the medical encounter in the interests of patients, physicians and society.

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