

# Healthcare Workers Infected with Blood-Borne Illnesses in Canada

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**H**ealthcare workers (HCWs) infected with blood-borne illnesses present profound ethical and legal problems. While we seek to protect patients from threats and respect their right to bodily integrity and informed consent, we also recognize the right to privacy and the human rights interests of the infected worker to be free from discrimination. In the context of blood-borne illnesses, this balancing is profoundly influenced by the severity of the consequences of infection – there is no cure for illnesses such as hepatitis B, acquired immunodeficiency syndrome (AIDS) or the human immunodeficiency virus (HIV, known to cause AIDS), and these diseases can be fatal. Under these conditions, a clear and reasoned approach to the issue of infected HCWs is needed.

At present, Health Canada has reported three known cases of HCWs occupationally infected with HIV (Canadian Centre for Occupational Health and Safety 2005). Out of concern for repercussions from their employers, HCWs may hide their HIV status; it has recently been reported that the true number of HIV-infected HCWs may be much higher (McCarthy et al. 2006). Infection rates for hepatitis B are thought to be similar in HCWs as in the general population; this has been estimated at 4.9% (McQuillan et al. 1999).

When it is revealed that a worker is infected, there is immediate concern for transmission to patients – former patients are contacted and screening programs are undertaken. This mobilization of resources was seen recently when a surgeon in Prince Edward Island was diagnosed with hepatitis C (CBC News 2007, February 28, March 8). In the case of HIV, this concern is even more acute. In the wake of the AIDS-related death of a Montreal surgeon (CBC News 2004, January 23), widespread screening of the surgeon's former patients was undertaken. While this screening revealed no instances of HIV transmission, this is sadly not always the case. The 1991 high-profile case of Dr. David Acer, a Florida dentist infected with HIV who is thought to have infected six of his patients, confirms patients' fears regarding the transmission of blood-borne infections (Centers for Disease Control [CDC] 1991b; CDC 1993; Ciesielski et al. 1992). In addition to Dr. Acer, there have been two other reported cases of transmission from an HCW to a patient. These involved a French orthopedic surgeon in 1995 (Lot et al. 1999) and a Spanish gynecologist in 2003 (Bosch 2003). Transmission of other blood-borne illnesses between HCWs and patients has also been observed. This includes transmission of hepatitis B from a Canadian orthopedic surgeon to

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four of his patients (Health Canada, Laboratory Centre for Disease Control [LCDC] 1992b).

The frequency of transmission following exposure to a blood-borne illness varies. While the risk of transmission after exposure is low in the case of HIV, it is much higher with hepatitis B. While dependent on the particular status of the infected person, the transmission of hepatitis B in the healthcare context has been observed in cases where there has been no injury or breach of infection control practice (Harpaz et al. 1996). Additionally, the risk of transmission of illnesses such as HIV increases with the amount of virus present in the infected person's blood (the viral load).

All things considered, the risk to patients of contracting a blood-borne illness when undergoing an invasive procedure is low – the Public Health Agency of Canada (PHAC) quotes mathematical models that put the chance of transmission of hepatitis B at 240–2,400 transmissions per million procedures, of hepatitis C at 50–500 transmissions per million procedures and of HIV at 2.4–24 transmissions per million procedures (Bell et al. 1992). While the chance of transmission appears to be small, the fact that such transmission is both theoretically possible and seems to have in fact occurred means it cannot be ignored. Beyond the threat to patients' safety, the impact on an infected HCW's career is uncertain in jurisdictions without policy or regulation on this issue (CBC News 2007, March 8).

After a brief overview of legal liability issues, this article focuses on the current state of policy in Canada governing the scope of practice of infected physicians.

### Liability of Physicians in Civil Context

A physician with a blood-borne illness who does not disclose the infection to patients and puts them at risk could face legal liability by failing to obtain voluntary and informed consent from the patient. It is a long-standing rule at common law that medical treatment can only be provided when the patient has given his or her consent. A Supreme Court of Canada ruling emphasizes that “everyone has the right to decide what is to be done with one's own body” (*Ciarlariello v. Schacter* 1993). To be legally valid, consent must be informed and given voluntarily. To give informed consent, a patient must be provided with all information material to the proposed treatment plan and the physician must disclose all “material, and special or unusual risks” (*Hopp v. Lepp* 1980;

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*Reibl v. Hughes* 1980). When the consequences of a very rare risk are quite grave (such as death), this risk should be treated as material and disclosed to the patient (*Videto v. Kennedy* 1981). As some blood-borne illnesses carry serious and life-threatening consequences, this suggests that the possibility of transmission from an infected physician to a patient (however remote) is considered a material risk.

However, the vanishingly small risk of this danger actually materializing injects an element of social policy into the legal analysis. While there are no Canadian cases on this issue exactly, the 1992 New Jersey case of *Behringer Estate v. Princeton Medical Center* (1991) held that a plastic surgeon with AIDS must tell his patients of his illness, and that failure to do so does vitiate their consent. The only Canadian case to consider the issue of a physician's duty to disclose his or her own personal medical conditions and the legal issues of informed consent and negligence is the 2001 Alberta ruling in *Halkyard v. Mathew* (2001). Here, it was held that a doctor need not disclose his or her own medical condition where there is no causal link between the condition and harm suffered by the patient (Johnson 2001).

In *Halkyard*, a woman died following a total hysterectomy. The plaintiff alleged that the doctor's failure to disclose his controlled epilepsy vitiated consent to the surgery. The doctor did not suffer a seizure during the operation, nor did the doctor's condition have any effect on the outcome of the surgery. The Court of Appeal focused on the issue of causation and held that the causal link between the physician's epilepsy and the loss was not made. Taking an oddly narrow and retrospective view, it stated that "there is no liability unless the loss is caused by the failure to disclose or inform" (p. 3). If a causal connection between a physician's condition and the injury suffered by the patient were found, the physician *may* be liable in negligence (Heinz 2003).

While *Halkyard* does state that physicians are not required to disclose their health conditions where these conditions do not cause injury to the patient, exactly how this informs the elements of informed consent and negligence is unclear. As this case was decided on the issue of causation, it is still open as to whether a physician's infection status amounts to a "material risk" and must therefore be disclosed. As this ruling fosters neither a more protective medical environment for patients nor a more certain legal environment for physicians, some other form of guidance or policy in this area is required.



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## Law and Policy

While neither the federal nor provincial governments have taken binding steps to address the specific risk of transmission of blood-borne illness from infected HCWs to patients in the clinical context, the LCDC has released recommendations that have prompted the professional regulatory bodies to produce policy on the issue. This response by the colleges is the only direct and binding regulation on the issue of infected HCWs in Canada.

## The Evolution of Policy Development

The Acer situation in Florida sparked the early policy response to the issue of HCWs with blood-borne illnesses. Since then, health agencies in several countries (including Canada, the United States and the United Kingdom) have acted to address the issue. The LCDC organized a national consensus conference and a series of meetings in 1992. The result was a set of national recommendations on the transmission of blood-borne pathogens including hepatitis B and HIV from HCWs to patients (Health Canada, LCDC 1992a). Its recommendations were extended to include hepatitis C in 1995.

This initial report provided recommendations on many aspects of the issue of infected HCWs. It recommended against mandatory testing and against mandatory disclosure to patients. It put the primary evaluation of the HCWs in the hands of their primary care physicians and recommended the establishment of a confidential and anonymous consultation mechanism.

In response to the difficulty of the colleges in limiting or regulating the practice of infected physicians and in developing effective consultation mechanisms, the LCDC organized a second consensus conference. This second conference led to the publication of a revised set of guidelines for infected HCWs in 1998 (Health Canada, LCDC 1998). This second set departed from the 1992 recommendations in several key ways. The 1998 guidelines recommend mandatory immunization and screening of HCWs for hepatitis B and detailed a new system of management for infected HCWs. The language of "exposure prone procedures" was also adopted. The definition of exposure prone procedure focused on the potential for the patient's open tissue to be exposed to the blood of an injured HCW.

The changes in policy appearing in the 1998 LCDC guidelines prompted objections by the Canadian Medical Association (CMA) and the Canadian Dental Association (CDA). Both were concerned about mandatory testing and felt voluntary programs represented a more effective and efficient approach. These objections were published as responses in appendices following the report of the proceedings.

The 1992 LCDC guidelines were a call to action in face of the theoretical threat of HCW-to-patient transmission, made real in Florida. These guidelines prompted the formation of expert advisory panels in several provinces and shone a spotlight

**Table 1. Selected aspects of provincial Colleges of Physicians and Surgeons' policies on HCWs infected with blood-borne illnesses, compared with 1998 LCDC recommendations\***

	<b>Hepatitis B – Mandatory Immunization for Those Doing EPPs</b>	<b>Hepatitis B – Follow-Up Testing for Hepatitis B and Screening (HBsAg) Annually</b>	<b>Expert Panel Should Be Established to Advise HCWs Infected with Blood-Borne Illness†</b>	<b>If HBsAg+, Test for HBeAg. If HBeAg+, Refer to Expert Panel and Cease Practice Pending Expert Recommendations</b>	<b>If HBsAg+, Test for HBeAg. If HBeAg–, Refer to Expert Panel but Need Not Cease Practice Pending Expert Recommendations</b>	<b>Definition of EPP</b>
LCDC 1998	Yes	Yes	Yes	Yes	Yes	Yes
Alberta 1992/1994	“Should be immunized”	Post-vaccination testing “may be considered”	Yes	Can restrict practice but only if HCW performs invasive procedures	Refer to panel only if HBeAg+	Undefined; uses the term invasive procedure
British Columbia 2004/2006			Yes	Both EPPs and non-EPPs are prohibited	Depends on viral load	Uses UK definition and model
Manitoba 2002	“Should be”	“Should be assessed” after immunization	Registrar will consult experts, may convene an advisory panel	If HBV positive, must cease practicing EPPs pending expert review		Uses LCDC definition
Nova Scotia 2004/2006			Yes			
Ontario 2004/2005	“All should be”		“College will consult ... experts”			Uses LCDC definition
Quebec 2004	Recommends immunization as part of universal precautions	Recommends verification of immunity; rejects systematic screening	Yes			Uses LCDC definition
Saskatchewan 2006			Yes			
CMA 2000/2001	No. HCWs “have a moral duty and are strongly encouraged to be vaccinated”	Follow-up testing should be offered to those vaccinated	Yes	If HBsAg+, should cease risky procedures until assessed by expert committee		

CMA = Canadian Medical Association; EPP = exposure prone procedure; HBsAg = hepatitis B surface antigen; HBeAg = hepatitis B e antigen; HCW = healthcare worker; HIV = human immunodeficiency virus; LCDC = Laboratory Centre for Disease Control; + = positive; – = negative.

\*Notes: “Yes” indicates that an item forms part of a body's policy. “No” indicates the item was explicitly considered and rejected in the body's policy. A blank box indicates that the item is not addressed by a body's policy.

New Brunswick originally adopted a policy “similar to Alberta” but does not follow it. New Brunswick evaluates instances of infected HCWs on a “case-by-case basis.”

Like the United Kingdom, British Columbia prohibits HIV-positive and hepatitis C-positive physicians from performing any EPPs. The BC policy may even prevent non-EPPs if the physician has broken skin.

The Alberta College is the only one that has not reviewed its policies since the publication of the 1998 LCDC recommendations. Its guidelines, however, are largely consistent with the prevailing position of Canadian colleges and with the CMA.

†HIV and hepatitis.

Table 1. Continued.

	Disclosure to Patient of HCW's HIV Serostatus Not Required	Obligation on HCWs to Know Their Serostatus	When Patient Exposed to HCW, Patient Told of Exposure but Not Told Identity of Infected HCW	If Patient Exposed to HCW, HCW Must Be Tested. If +, Patient Has the Right to Know to Which Pathogen He or She Was Exposed
LCDC 1998	Yes	Ethical	Yes	Yes
Alberta 1992/1994	Yes	"Encouraged" to know, if practice involves invasive contact		
British Columbia 2004/2006		Ethical		
Manitoba 2002		If at risk of infection, "should know" status		
Nova Scotia 2004/2006		Cites LCDC's "ethical obligation"	Refers to 1998 LCDC recommendations	Refers to 1998 LCDC recommendations
Ontario 2004/2005		"Ethically obliged" if doing EPP		
Quebec 2004	Yes	"Must know" serostatus if performing EPP		
Saskatchewan 2006		"Responsibility to know"		
CMA 2000/2001	Yes	"Should determine status" if to perform procedures with risk of transmission	Yes	

on the issue of infected HCWs. The 1998 guidelines, with their thorough consideration of the issues and contentious position supporting mandatory testing for HCWs, serve as a challenge to the colleges to institute clear provincial policies.

### Response by the Provincial Colleges

The degree to which the provincial colleges have taken up the challenge of establishing policy in this area varies (Table 1). Of

the provincial colleges, only the colleges of Prince Edward Island and Newfoundland and Labrador do not have a policy in place. None of the three territories has a policy on physicians infected with blood-borne illnesses. Some provinces have addressed nearly all the key aspects identified by the 1998 LCDC guidelines, while some have chosen to write a barebones consultation framework, creating a mechanism to provide direction to infected physicians but not taking a stand on any issues or compelling any action from its members. New Brunswick, for instance, has adopted a policy similar to that of Alberta but does not follow it (E. Schollenberg, personal communication, November 2, 2006). New Brunswick found that instances of HIV-infected physicians requiring guidance were so rare that they simply "consider each case based on the science of the day." It should also be noted that certain features of the LCDC recommendations can be seen as implied by a college's code of ethics, particularly the duties to always act in the best interest of patients and to refrain from practising in a compromised physical or emotional state. While these codes may imply certain duties, a clear and well-defined policy that includes formal guidelines for behaviour of infected physicians is far more valuable than nebulous and open-ended statements regarding ideal conduct.

### Expert Advisory Panels

The essential requirement of college policy in this area is the recognition of the risk presented by infected physicians and the proposal of a mechanism to contain this risk. A first step toward this goal is the establishment of an expert advisory panel or committee to provide advice and guidance to infected physicians. This was a feature of the 1992 LCDC guidelines

(see part VIII, recommendation 4), which recommended the establishment of a “consultation mechanism” for the infected worker’s primary care physician. The nature of the consultation mechanism was formalized in the 1998 guidelines, which recommend the establishment of expert advisory panels by each provincial and territorial regulatory body. To date, all provinces with policies on infected physicians make reference to the use of experts. Most state that such an expert panel shall be convened. Ontario does not explicitly require the convening of an expert panel but notes that “the College will consult and receive advice from experts in the field” when reviewing the medical practice of infected physicians.

While the physician’s code of ethics may generally suggest an ethical obligation for physicians to know their serological status with respect to blood-borne illnesses and to report themselves to their regulatory body when they know themselves to be infected, its broad nature, noted above, provides ample room for argument. While the CMA *Code of Ethics* is the source of the ethical framework adopted by the provincial colleges, CMA policy on HCWs infected with blood-borne illnesses simply states that “health care providers have a moral duty not to subject their patients to unacceptable risk” (CMA 2001: 2). Most colleges have included a statement in their policy on blood-borne illnesses referencing the physician’s duties in this regard. Some claim that the physician is under an “ethical duty” to know their serostatus and report to an expert advisory panel, while others simply state that the physician “must” or “should” know their status and report to an expert advisory panel.

The function of the expert panel is to evaluate an infected physician’s practice and recommend restriction, where necessary, to control the risk to patients. These recommendations are binding in all cases; all published policies have mechanisms to ensure compliance with recommended practice restrictions. Non-compliance appears to be rare – in the electronically available archives of physician disciplinary actions (Ontario and British Columbia), there are no reported cases of non-compliant physicians being disciplined, and the College of Physicians and Surgeons of BC (CPSBC) confirms that no physician in British Columbia to date has refused to comply with the expert advisory panel’s recommendations (E. Phillips, personal communication, October 31, 2006).

While the use of expert advisory panels has advantages such as specialized knowledge and familiarity with current scientific information, it has drawbacks as well. There are concerns that such a mechanism puts too much discretion in the hands of a small group of “elusive experts” and presents the opportunity for a conflict of interest between these panel members and the infected physicians (Barrigar 2001).

### Privacy, Confidentiality and Disclosure

Any policy in this area represents a balancing of the rights of patients and infected physicians, and all published policies mention the need for privacy and confidentiality for physicians. The significance of confidentiality was explicitly recognized in the 1992 LCDC guidelines. Some colleges provide for a degree of anonymity in the referral process; these include Alberta, Manitoba and Saskatchewan. In Saskatchewan, the medical director of the expert advisory committee serves as an intermediary for the purposes of information exchange and written recommendations to ensure the anonymity of the infected physician. If the infected physician is found not to comply with the recommendations, the medical director is to notify the college. The other provincial colleges do not explicitly provide any measure of anonymity in the process but simply ensure confidentiality in their dealings with personal information.



**While these college codes of ethics may imply certain duties, a clear and well-defined policy that includes formal guidelines for behaviour of infected physicians is far more valuable than nebulous and open-ended statements regarding ideal conduct.**

The 1998 LCDC guidelines continue to recommend that disclosure to patients of an infected HCW’s serostatus is not required, unless the patient has been exposed to the blood of the infected worker. In the international debate regarding infected HCWs, the issue of disclosure to patients has been controversial. It is recognized that the impact on a physician’s career would be significant. Though the US CDC advocates the notification of patients prior to an infected HCW performing an exposure-prone procedure (CDC 1991a), few states have implemented this recommendation. While most provincial policies are silent on the issue, Alberta and Quebec explicitly state that disclosure to patients is not justified. CMA policy on HIV infection in the workplace also advocates that HCWs should not be required to inform patients of their HIV status (CMA 2000). In the context of hepatitis B, some commentators have advocated for disclosure by infected physicians to patients before performing any invasive procedures, combined with mandatory hepatitis B screening in order to pair infected physicians with infected patients (Barrigar 2001). On the other hand, utilitarian arguments exist recommending against mandatory disclosure based on predictions that infection is better prevented by emphasizing infection control protocols than by identifying and isolating infected HCWs (Daniels 1995).

### Specific Infections and Practice Restriction Imposed on Infected Physicians

When an expert advisory panel assesses a physician's practice, it is empowered to make recommendations regarding practice restrictions. As noted earlier, these recommendations are binding. While the use of expert advisory panels is nearly universal across jurisdictions nationally and internationally, the ultimate guidelines applied and the recommendations made by these panels can differ greatly.

In addition to describing the obligation on physicians to be tested and to report to their regulatory body in the event of infection, the 1998 LCDC guidelines pay particular attention to hepatitis B infection. Depending on the characteristics of a particular physician's hepatitis B infection, different courses of action are recommended. If physicians test positive for the hepatitis B surface antigen (HBsAg), their hepatitis B e antigen (HBeAg) status must be determined. If the infected physicians are found to be HBeAg positive, they are to cease all practice pending assessment by the expert panel. If the infected physicians test HBeAg negative, they are permitted to continue practising but are still required to submit to an assessment by the expert advisory panel.

Most provincial colleges have chosen not to delve into the specifics of hepatitis B infections. The simpler provincial policies make reference to an expectation to contact an advisory board in the event of an infection but do not describe specific steps for different types of infection. It appears that physicians are generally permitted to continue to practise during their expert assessment and, afterward, are subject only to the restriction recommended by the expert panel. Three colleges with more detailed policies do, however, outline infection-specific courses of action.

Beyond requiring an expert review, the policy of the Manitoba College of Physicians and Surgeons notes that an infected physician who is positive for hepatitis B, hepatitis C or HIV must cease practising pending receipt of an expert review. This appears to apply to all physicians, regardless of whether their practice includes exposure prone procedures or not. This seems overly broad; it is well documented that the risk of transmission of blood-borne illnesses is very low in certain clinical contexts. The PHAC notes that there is "no risk to ... patients during consultation visits" (PHAC 1998).

The approach taken by the Alberta College of Physicians and Surgeons can be seen as a further step-up in policy detail. Their policy on hepatitis B infection in HCWs draws distinctions between three different states of hepatitis infection. When "acute infection" is detected in HCWs, they are to refrain from "invasive patient contact" until no longer HBsAg positive. Alberta defines the expression *invasive patient contact* in a way similar to the 1998 LCDC definition of *exposure prone procedure* (College of Physicians and Surgeons of Alberta 1994).

Additionally, HBsAg-positive workers who perform invasive procedures are to be tested for HBeAg. If HBeAg negative, practice restrictions are not justified. Restrictions are only justified when HCWs are HBeAg positive and perform invasive procedures. If workers are not engaged in invasive procedures, no restrictions on practice are justified, even if the workers are HBeAg positive.

The most detailed policy appears in British Columbia. While taking its cues from the 1998 LCDC guidelines, the CPSBC has chosen to model their policy after that of the UK Department of Health. The BC guidelines are much more detailed than those anywhere else in Canada and arguably are more restrictive than even the 1998 LCDC guidelines. The guidelines created by the BC College of Physicians and Surgeons Advisory Committee on Blood-Borne Communicable Diseases in Physicians describe "exposure prone procedures" and "non-exposure prone procedures" and go on to give detailed examples from various medical specialties for each. While ultimately the identification of an exposure prone procedure is to be done on a case-by-case basis, the listing of previously assessed procedures significantly undermines the spirit of contextualized assessment. Providing such a list of examples adds certainty and guidance but reduces the significance of contextual factors such as physician skill and experience, and operating environment. By publishing a list of exposure prone procedures, the CPSBC takes a step no other North American jurisdiction has chosen to take. In addition, it departs from the rest of Canada in that it explicitly prohibits infected physicians from performing both exposure prone and non-exposure prone procedures in some cases of infection. While the practice restrictions imposed by colleges in other provinces could essentially amount to a prohibition on exposure prone procedures, British Columbia is the only jurisdiction to explicitly prohibit non-exposure prone procedures in some cases.

In addition, the CPSBC further differentiates states of infection on the basis of viral load in the blood or detectability of the virus. If found HIV positive, physicians are prohibited from performing exposure prone procedures, but non-exposure prone procedures are not restricted provided the HIV is below a detectable limit. If physicians are found to be hepatitis C positive and the virus is ribonucleic acid positive, performing exposure prone procedures is prohibited but non-exposure prone procedures are not restricted. For physicians infected with hepatitis B (i.e., HBsAg positive), there are different classes of restriction depending on the details of the infection. If HBeAg positive, the infected physicians are prohibited from doing both exposure prone and non-exposure prone procedures. If HBeAg negative, the degree of restriction depends on the detectable level of hepatitis B deoxyribonucleic acid (DNA) in the blood. At low concentrations, infected physicians are not subject to any restrictions. At mid-level concentrations, only non-exposure prone procedures are permitted. And at higher levels,

neither exposure prone nor non-exposure prone procedures are permitted. Barring both exposure prone and non-exposure prone procedures, especially in cases of HBeAg-negative physicians with high levels of detectable hepatitis B DNA in their blood, represents the most restrictive policy position in Canada.

### Challenges for Provincial College Policy Making

Regardless of approach, any policy in this area faces significant challenges. The exact nature and extent of expert advisory committee authority have proven difficult to define. Once practice restrictions have been recommended, there has been a lack of mechanisms to follow up on these recommendations and to ensure that infected physicians are compliant with the restrictions. While several guidelines identify the need to periodically reassess a physician's health and practice, clearly defined mechanisms to accomplish this are absent. These challenges are explicitly recognized in the position statement of the Collège des médecins du Québec, but even this does not clearly identify solutions. For example, on the issue of follow-up and compliance, the Quebec position simply states that "the College ... will see to it that the recommendations of the committee ... are followed, and, in healthcare settings, will do so jointly with the medical authorities" (Collège des médecins du Québec 2004: 9). While a position statement may not be the place to articulate detailed features of such an enforcement mechanism, to express such goals without details of how this is to be accomplished does not clearly address the problem. While they have clearly identified some of the challenges to policy in this area, the Collège des médecins du Québec appears to be relying on the same good intentions as the other Canadian jurisdictions. One consideration here is that the issue of infected HCWs arises rarely – for some jurisdictions, maybe once a year or less. Though confronting the issue may be rare, it is still important to ensure that functioning mechanisms are in place to address these significant inadequacies.

### International Responses

To round out a survey of typical levels of restriction on the practice of infected HCWs, it is worth considering some international positions. *The World Medical Association Statement on HIV/AIDS and the Medical Profession* advocates that physicians infected with HIV should not engage in any activity that creates the risk of transmission of the disease to others (World Medical Association General Assembly 2006). It goes on to support the assessment of activity risk level by an expert panel. This position either places caution above efficiency or has a flexible notion of "risk of transmission."

The US CDC recommendations from 1991 permit HCWs to continue to perform exposure prone procedures provided their practice has been evaluated by an expert panel. Following a 1991 law passed by the US Congress directing states to adopt

some form of standards on the issue of infected HCWs, the New York state's Department of Health drafted policy that notes "HIV or HBV infection alone is not sufficient justification to limit a healthcare worker's professional duties" (New York Department of Health 1992).

Of the major international responses, the United Kingdom has been the most cautious in its approach to infected HCWs and has passed extensive and detailed guidelines on the issue of workers infected with HIV. These guidelines, particularly their definition and list of exposure prone procedures, served as a blueprint for the CPSBC. According to the most recent version of the UK guidelines (2005), HCWs infected with HIV are prohibited from performing exposure prone procedures. Depending on the recommendations of an expert panel, HCWs may be prohibited from performing non-exposure prone procedures as well.

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### Conclusions

Infected HCWs present a pressing problem for both the patients under their care and for society as a whole. The situation requires striking a difficult balance between the rights of patients to be free from the danger of infection and the rights of the infected worker to privacy and freedom from discrimination. Making policy in this area is a challenge – while the risks appear low, the consequences are serious and the social stigma associated with blood-borne illnesses (especially HIV) is high. In addition, there are open questions about legal liability. College regulation of infected physicians is uneven across Canada; some provinces operate without regulation at all, while others disallow infected physicians from performing any invasive procedures whatsoever. While the United Kingdom has chosen to prohibit infected workers from performing risky procedures, North America has generally taken a softer approach. With the exception of British Columbia, most regions have taken a cautious approach, recognizing the rights of infected workers to privacy and protection. Clearly, the transmission of illnesses such as HIV causes greater concern than the transmission of the rarely fatal hepatitis B. Were there to be a Canadian case of transmission of HIV from a surgeon to a patient, policy in that jurisdiction would come under extreme scrutiny.

When the risk is so small and the damage so great, everyone hopes that the situation will never materialize. As a society, we must explicitly weigh the interests at stake and strike the necessary balance. If a national policy were implemented, programs could be developed to deal with possible negative outcomes.

While the issues presented are difficult, a comprehensive policy on the matter is required – for the protection of HCWs and patients alike. **HQ**

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**About the Author**

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## Healthcare Quarterly



### Top 10 Reasons for Not Washing Hands

1. I'm a doctor
2. Germs? What germs? I don't see any germs!
3. There was no sink or soap or paper towel in a two step radius
4. No one was watching me
5. I only washed a little old lady
6. I used gloves, that's enough right?
7. I washed them 10 minutes ago
8. My boss didn't wash his/her hands
9. But I am sure I did, I always wash them
10. I had my flu shot.

– Sara Holland, Infection Control Practitioner  
Capital Health, Edmonton



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