

The “contagious” clinician

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ABSTRACT

The many new airborne viral pathogens such as coronavirus (Covid-19), the novel variant (SARS-CoV-2), acute respiratory distress syndrome (ARDS), severe acute respiratory syndrome (SARS), and Middle East respiratory distress syndrome (MERS), have brought about a whole new avalanche of problems.

These airborne pathogens are all highly contagious and transmissible, especially in the dental setting where the procedures and machinery used may generate enormous amounts of aerosol spray. This is an ideal vector for air/droplet spread.

Most dentists have implemented screening procedures to determine if their patients are well enough to be treated, and have begun wearing a full gamut of personal protective clothing (PPE). Nonetheless, a concern that has received limited attention in the literature is the “contagious clinician” who continues to work and who may pose a risk of infecting their patients.

This paper explores both the patient’s rights to quality care in a safe and healthy environment, as well as the clinician’s rights to determine for themselves if they are mentally and physically competent to practice. It also poses questions about whether health care practitioners can be mandated to be inoculated against potentially life-threatening and highly infectious agents.

INTRODUCTION

In the early eighties when the world first heard about HIV/AIDS, there was a frenzy that occurred throughout the medical and dental professions. Some of the concerns related to fear of patient-to-patient, and patient-to-dentist transmission.



This brought about new surgical disinfection and sterilization protocols that needed to be adhered to, to prevent cross-contamination. The reported incidences of dentist to patient infection were rare and usually occurred as a result of poor adherence to disinfection and sterilization protocols.

At this time, it became the norm for dentists to start wearing surgical gloves - something that had rarely been done for general dental work, except during surgical procedures. Many also started to wear facemasks and protective goggles to protect themselves from the aerosol back spray.

Fear of infection from the HIV virus also led to several position papers and publications on both practical and ethical principles related to HIV. The Health Professions Council of South Africa (HPCSA) published guidelines to clinicians on the management of patients with HIV infection or AIDS.¹

These regulations explored issues such as whether dentists could insist on patients being tested and declaring their status before being treated; if they could refuse to treat HIV positive patients; if and when confidentiality about a patient’s HIV status could/or should be breached; and whether they were obliged to inform other health care practitioners or family members of a patient’s status.

Due to the sensitivities and stigmas associated with HIV infection at that time, it was regulated that clinicians could not insist on patients being tested or declaring their positive status before treatment.

As such, it became the practice to consider “all patients as possibly positive” and to adhere to the strictest disinfection and sterilization protocols recommended for the various categories of dental instruments and surgery areas, as well as the necessary personal protective protocols to adopt for themselves, their staff and their patients.¹

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Booklet 6 also documents comprehensive guidelines on the necessary steps that all practitioners are expected to take to prevent or minimise the risks of transmission of any infectious agents from one person to another, including disposal of biohazardous and biological waste.¹

The “new enemies”

Acute respiratory distress syndrome (ARDS), severe acute respiratory syndrome (SARS), Middle-East respiratory syndrome (MERS), Coronavirus (Covid-19), the novel variant (SARS-CoV-2), and other airborne viral pathogens have brought about a whole new avalanche of problems.²

These viral pathogens are all highly contagious and transmissible, especially in the dental setting where the procedures and machinery used in the surgeries and laboratories generate enormous amounts of aerosol spray which is an ideal vector for air/droplet spread.

Dentists who are concerned about their health and safety have implemented basic screening procedures for their patients and have begun wearing a full gamut of personal protective clothing (PPE). They are also at liberty to refuse to treat a visibly ill, or Covid infected patient unless the condition is life-threatening (which is rare in dentistry).

They can usually provide temporary relief for a patient with antibiotics, analgesics or anti-inflammatory drugs until they are well enough to be treated. Also, presumably, a sick patient would cancel or postpone treatment until they feel better. The greater risks are the contagious, but asymptomatic patients.

A “concerned clinician” ought to take every possible precaution to protect themselves, their patients, and their staff. But what about the “contagious clinician” who continues to work? They may not be that ill as to warrant staying away from their surgery; may not want to risk the loss of income or inconvenience of cancelling patients and having to fit them in later; not want to pay staff to come to work and do nothing, and have high overhead costs to worry about.

These individuals may insist on working despite being ill and potentially contagious. They may wear full PPE, or generally at least will don gloves and masks when operating. However, in between patients they should dispose of these garments and put on a new clean set.

During this time, they may walk from room to room without either any of the PPE apparel and can potentially be spreading viruses particles throughout their surgeries. If they have air conditioners this will allow atmospheric spread as well, which is even faster and more dispersed.

Another concern is that when Covid-19 first surfaced, people were advised to cough into a handkerchief or their sleeve. Imagine then, a sick dentist coughing into their sleeve, or using their arms to wipe their nose or brow, and then leaning over an open-mouthed patient while working. This will result in a direct avenue for the virus to be inhaled through the nose or mouth of the unsuspecting patient, and a very high risk of them becoming infected.

Ethical issues

1. Patient-related issues

The Department of Health is committed to providing all patients with “caring and effective services”.³ To this end, they have drawn up a set of guidelines known as The Patients’ Rights Charter.³ The very first one states, “Every patient has a right to a healthy and safe environment”.

At the same time, patients have a responsibility to “provide health care workers with relevant and accurate information for diagnostic, treatment, rehabilitation or counselling services”. If this is the case, then surely, patients also have a right to expect the provision of, and compliance with, the same from their treating clinicians.

Patients have confidence and trust that their doctors will act professionally and in their best interest at all times. The clinician may feel that despite being ill themselves, they pose no risk of harming their patients. In their minds, the treatment will thus be both beneficial (doing good), to the patient and non-maleficent (not harmful). However, they need to also consider the other ethical principles outlined by Beauchamp and Childress,⁴ especially that of patient autonomy.

This encompasses the patient’s right to choose for themselves what they wish to have done to their bodies and depends on the clinician’s duty to truth-telling and communication.⁵ An honest clinician would inform their patients they are ill and could be contagious and allow the patient to autonomously decide if they wish to proceed with the scheduled treatment. Ideally, this should be conveyed to them before they spent time and money getting to the surgery.

The fourth principle relates to justice (fairness and fair treatment), and includes legal justice (the respect for morally acceptable laws), distributive justice (fair distribution of limited resources) and rights-based justice (respect for people’s rights).⁵ These issues will not be discussed further in this paper as they are not directly related to the topic being explored.

2. Clinician-related issues

The clinician may feel and argue that they have the right to work and earn a living, and to judge for themselves if they are mentally and physically competent enough to do so. However, could they be considered negligent or even found guilty of malpractice if they knowingly work when they are ill and inadvertently infect a patient?.

Based on the four principles of biomedical ethics, such clinicians may be acting with beneficence with regards to alleviating patient pain and addressing their dental needs. However if they have not disclosed their impediments to their patients they have denied the patients their right to autonomy.

At the same time if the person being treated suffers in any way as a direct consequence of the dental treatment, the clinician would also be guilty of acting with maleficence.

A further and future issue relates to vaccination. There are people who for various personal reasons object to taking vaccinations. If and when a vaccine becomes available for Covid-19, every person (and clinician) will have the right to choose whether they wish to be vaccinated and if they are prepared to accept any possible side effects that may be associated with the immunization. They may not fully trust the research or elect to wait and see how well the inoculation works before being vaccinated themselves.

This is a personal choice and needs to be respected. However, if they have not yet had Covid-19, they will be potential carriers and spreaders of the infection if they catch it at a later stage. Once again this poses a threat of them infecting their patients, especially if they are asymptomatic and continue to work. Would they still be considered negligently in this situation? Their intention was never to cause harm, and they were fully justified to choose whether or not to be vaccinated. In this case patients were not denied autonomy and the clinician did not intentionally act with maleficence.

The same practitioners may feel they are doing more good (being beneficent) by treating patients who may be in pain, than staying home if they are not ill. If they intended to provide a service, and were truly unaware of their impairments, they cannot be held accountable if they inadvertently infect their patients. They may feel that their actions were fully justified and would argue this point if it went to a court of law. At the same time, it would be very difficult for the patient to prove conclusively that their dentist infected them.

CONCLUSION

Given the many factors and concerns raised in the above scenarios, there are no simple or fully “right or wrong” answers to most of the questions posed. In the authors’ opinion, it all depends on “intent” and whether their actions were motivated to benefit the patient or their pocket.⁶ As such, it remains the duty of the dentist to act responsibly and professionally, and at all times to adhere to the core ethical principles.

This will include their behaviour within their practice, as well as regarding their personal mental and physical health and well-being. They must ensure strict adherence to correct disinfection and sterilization protocols, wearing of the requisite PPE by themselves and their staff in all surgical areas, never placing patients or staff members at risk of being infected with a contagious agent or harmed in any way due to their negligence, and acting professionally at all times.

This encompasses far more than merely following the adage of “First do no harm”. It includes weighing up risks versus benefits in every situation, making it more subjective and less straightforward.⁷

A far better guide is another affirmation from the Hippocratic Oath that states, “I will follow that system of regimen which, according to my ability and judgment, consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous”.⁸

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