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The doctor with hepatitis B — some legal issues

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The purpose of this brief article is to discuss certain legal issues in respect of a doctor who contracts hepatitis B in the course of his practice or in the performance of his duties as an employee. Firstly, there is the question of whether the doctor is entitled to compensation for having fallen prey to an ever-present occupational risk of health-care workers. Secondly, there is the question of whether an infected doctor, who is now a risk to his patients in that he may infect them in the course of his professional activities, would expose himself to a claim for damages should a patient be infected by him. Thirdly, there is the question of whether a doctor who is infected with the disease may continue to practise.

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Although this article deals specifically with hepatitis B, the issues examined here are not necessarily confined to that condition. The same issues arise in respect of any serious communicable disease, particularly AIDS. The questions addressed have given rise to a good deal of debate in recent years. A major point of distinction, however, is that the contracting of hepatitis B is preventable by means of immunisation, while there is no vaccine against HIV as yet. Another difference is that AIDS is an incurable condition whereas hepatitis B may resolve spontaneously, although a favourable prognosis is less certain than in cases of virus A infection, especially in the elderly and post-transfusion cases, where the mortality rate may reach 10 - 15%.

Is the infected doctor entitled to claim compensation?

It is almost inconceivable that a doctor who is infected by a patient whom he knows (or ought to know) is suffering from a particular disease would be entitled to claim damages from the patient under common ("uncodified") law on the basis of a delict (civil wrong). The essentials of delictual liability will be elaborated below. Suffice to say that the prudent doctor, who treats a patient who to his (the doctor's) knowledge is or may be suffering from a communicable disease, is expected to take reasonable steps to prevent himself from being infected. Failure to do so may result in the defence of contributory negligence being raised; this may partially defeat a claim for damages. To the extent that there is a known risk of infection, the doctor may be said to have voluntarily assumed that risk — a defence which, if upheld, would defeat a claim for damages. The job of a doctor, like that of a fireman, policeman or soldier, entails certain inherent risks.

In any event, the act of a patient who is ill and consults a doctor with a view to receiving treatment, can by no stretch of the imagination be said to be wrongful. Nor can fault in the legal sense of the word attach to the patient's conduct. In theory, it would seem, the question of liability on the part of the patient can only arise if there was an act of fraud on his part, e.g. fraudulent concealment of his symptoms. But the question would of course arise as to whether the prudent doctor would allow himself to be fooled in that way!

In the situation where a doctor or other health-care worker contracts the virus in the work situation in consequence of the negligence of an employer, the employee-doctor will be entitled under common law to sue the employer for damages, unless the employer-employee relationship falls within the ambit of the Compensation for Occupational Injuries and Diseases Act 130 of 1993 (COIDA) (the successor to the Workmen's Compensation Act 1941).

Private-sector employees and state employees generally fall under the COIDA, although there are major categories of employee who do not. Certain categories of employer are individually liable. The requirement (in terms of the older legislation) that employees earn salaries or wages lower than a prescribed limit in order to be entitled to claim compensation under the COIDA no longer applies. Claims

for compensation under the COIDA are not dependent on proof of negligence on the part of the employer, be it his own negligence or that of a fellow employee. An employee is entitled to claim compensation in terms of the COIDA for an occupational injury or an occupational disease. (Where the accident or the contracting of a disease was due to the negligence of the employer, the employee would be entitled to apply to the Compensation Commissioner for increased compensation.)

An 'occupational injury' is a personal injury sustained as a result of an accident, and 'accident' is defined in the COIDA as an accident arising out of and in the course of the employee's employment and resulting in a personal injury. 'Occupational disease' is defined as any disease mentioned in the first column of Schedule 3 to the Act, arising out of and contracted in the course of an employee's employment.

Hepatitis B is not listed as an occupational disease. The Compensation Commissioner has ruled, however, that an anaesthetist who contracted hepatitis B while employed at a hospital where about 5% of the patients were infected with the disease, was entitled to compensation under the Act. It was successfully contended on behalf of the claimant that it was sufficient to prove that the infection had been the result of contact at some particular time, and that that particular time was during the course of employment. On the basis of English precedents it was argued that injury or disease may be an accident in terms of the Act. In line with English precedents it was also contended that it was not necessary to fix the exact date on which infection took place; each occasion on which there was an incident of possible infection amounted to an "assault . . . which constituted an accident".

To the extent that the employer's alleged negligence may be relevant to a health-care worker's claim for damages under common law or the amount of compensation under the COIDA, the question arises as to whether failure on the part of the employer to offer hepatitis B immunisation to health-care workers might be regarded as negligence. By common law a duty rests on employers to take steps to ensure reasonable safety in the workplace. Because immunisation is a relatively cheap and harmless precaution, and given the prevalence of hepatitis B in our society (to which reference is made below), it is submitted that a court of law might conceivably find that failure to arrange for free or semi-free hepatitis B immunisation of health-care workers constitutes negligence. An adverse finding on this issue would depend on factors such as: (i) the availability and cost of the vaccine; (ii) the financial position of the employer; (iii) the magnitude of the risk to health-care workers and patients; and (iv) the feasibility of avoiding the risk by other means, e.g. education and training, protective equipment, safe procedures). In South Africa several major hospital groups are offering immunisation on a voluntary basis to all their health-care employees; this is a sensible policy. Failure or refusal on the part of a health-care worker to avail himself or herself of such an offer might well defeat an eventual claim in the event of accidental infection in the work situation.

Can a doctor be sued by a patient infected by him?

Liability for damages on the basis of a delict requires proof of the following: an act or omission which was wrongful, in respect of which there was fault (in the form of either intent or negligence), and which was the cause of the harm suffered by the plaintiff.

In cases where the element of wrongfulness has not yet been established unambiguously, the final assessment will depend on a value judgement based on considerations of morality and public policy. The decision of a court to protect one kind of interest and not another reflects our society's prevailing norms of what is reasonable or proper — the so-called *boni mores*.

The conscious exposure of a patient to the virus, by a doctor with hepatitis in circumstances where communication of the virus was reasonably preventable, would in my view probably be regarded as wrongful, and the eventual liability of the doctor would then depend on proof by the patient of fault on the part of the practitioner. In essence, the question would then be: (i) whether a reasonable doctor in the position of the defendant would have foreseen the possibility of communication of the virus to the patient, and taken reasonable steps to guard against such an occurrence; and (ii) whether the defendant failed to take such steps.

In matters of alleged professional negligence our courts are guided largely by expert evidence. Our courts do not recognise 'negligence in the air', and judges will refrain from pontificating on how a professional man should or should not have conducted himself.

If convincing expert evidence is provided that a doctor with hepatitis B could have avoided transmitting the virus to his patient by taking certain recognised and reasonable precautions, there can be little doubt that the defendant may incur liability. Because of the seriousness of the disease, the liability thus incurred may be quite substantial.

I am not aware that any case of this kind has come before a South African court, however; neither, within the time available to me, have I managed to find a reference to such a case in overseas jurisdictions. Cases that did occur in American jurisdictions revolved around issues such as the following: (i) hospital liability for hepatitis contracted in consequence of blood transfusion; (ii) doctor's and hospital's liability for the death of a patient on account of acute toxic hepatitis which probably resulted from an overdose of drugs; (iii) a doctor's liability for negligent failure to advise a woman that having sexual relations within 6 months of accidental exposure to the blood of a patient who was a carrier of hepatitis would pose a risk of infection; and (iv) the liability of a blood bank for serum hepatitis contracted by a patient who had received blood.

The question should be asked whether failure of a doctor, who later contracted hepatitis, to have himself vaccinated against it, can *per se* be relied upon by a patient as negligence constituting a basis for an action for damages. I can only say that it is doubtful that a South African court would find negligence solely on that ground. In fact, a court will probably be loath to find against the doctor on the logically antecedent question, namely whether there was

legally a causal connection between the doctor's omission and the patient being infected with the virus. An omission would ordinarily result in liability only if there were a legal duty for the defendant to act positively. The right to personal privacy is rated so highly in modern legal systems, such as ours, that it is unlikely that a court would rule that there is a legal duty for individual health-care workers to have themselves immunised against a particular disease merely because there is a slight statistical possibility that the worker may be infected at some stage and yet another slight possibility that the infected worker might in turn infect a patient some time in the future. It is a fact that despite the prevalence of hepatitis B and the global threat of AIDS, relatively few cases of health-care workers who have contracted hepatitis B or AIDS have been reported world-wide.

It must be mentioned, however, that it was reported about 4 or 5 years ago that 5 - 10% of the black population of South Africa were hepatitis B carriers. (In the white community the figure was reported to be less than 1%.) This underlines the wisdom of a hospital's offering immunisation to all its health-care personnel and of staff's availing themselves thereof.

From the point of view of employment law, there is little doubt that a hospital, when recruiting personnel, is entitled to impose immunisation as a condition of appointment.

May a doctor with hepatitis B continue to practise?

This question raises difficult ethical and legal issues and also involves considerations of fairness. The very same issues have come to the fore in recent years in respect of AIDS.

It must be stated that the mere fact that a doctor or other health-care worker suffers from a particular disease or disability does not provide sufficient justification for denying him his livelihood. You don't become a non-person because you are physically disabled, blind, epileptic, have AIDS or hepatitis B.

True, there is a possibility of the hepatitis B virus or HIV being communicated to a patient by an infected doctor in the course of treatment but, from available case reports, the possibility is very slight and can almost certainly be avoided by taking effective preventive measures. In the clinical context virtually the only instance in which the virus can be transmitted to the patient is when the infected person's blood comes into contact with an open wound on the patient's body.

In coming to a decision on how the doctor with hepatitis B should conduct himself, guidance may be obtained from ethical guidelines on doctors with AIDS. A very useful source of guidance is the policy of the South African Medical and Dental Council (SAMDC).

In its 1993 guidelines on AIDS, the SAMDC formulated its policy on doctors with AIDS as follows: 'Any doctor who finds himself to be HIV positive must seek counselling from an appropriate professional source, preferably one designated for this purpose by a medical academic institution. Counsellors must of course be familiar with

recommendations such as those of the Centers for Disease Control, so that unnecessary, onerous and scientifically unjustifiable restrictions are not placed on the professional activities of an HIV-positive doctor. Infected doctors may continue to practise. They must, however, seek and implement the counsellor's advice on the extent to which they should limit or adjust their professional practice in order to protect their patients.'

In my opinion this solution to the problem of the doctor with AIDS is eminently sensible, i.e. that the infected doctor should place himself/herself in the care of an appropriate professional source. There is no reason why the same approach should not be followed in the case of doctors with hepatitis B (or, for that matter, any other serious infectious disease). Such an action on the part of the infected doctor, and compliance with the advice of his counsellor, will have another advantage: if ever an allegation of negligence were made against the infected doctor, he would be able to defend himself by contending that he acted reasonably in order not harm his patients.

The SAMDC in its earlier AIDS guidelines (1989) went somewhat further than the statement quoted in the preceding paragraph, and stated that if the doctor who has counselled an HIV-infected colleague becomes aware that his advice is not being followed, he 'has a duty to inform an appropriate body . . . If the circumstances so warrant, the Council is empowered to take action to limit practice of such doctors or to suspend their registration.' Even though there was no express reference to a reporting duty in the 1993 guidelines, I submit that morally there is clearly such a duty. In extreme cases, where patients' safety would be compromised, a legal 'rescue duty' — taking the form of reporting the offending doctor to the SAMDC — may even arise.

One or two additional questions arise in the present context. Would the infected practitioner who continues practising, be obliged to inform his patients that he has hepatitis B? The answer to that, in my opinion, is 'no'. There is no reason why a doctor who takes all reasonable precautions not to infect his patients should tell them of his condition. To do so would mean professional *hara-kiri*, because patients will probably desert him at once. In the case of a doctor who is employed, the question arises whether he should inform his employer. As in the case of the HIV-infected doctor, this question must be answered in the negative. It is only when an employee becomes dysfunctional or unable adequately to perform the work he was hired for that a commonlaw duty arises to inform his employer of that fact. Of course employees may, in terms of their conditions of employment, be required to submit to periodic medical examinations.

It goes almost without saying that if an employer is informed of, or happens to find out about, an employee's condition at a stage when the employee is perfectly capable of doing his work, and in such a manner as not to endanger others in any way, he (the employer) may be anxious either to terminate the contract or move the employee to some other area of occupational activity. Without going into detail, I must mention that comprehensive labour relations legislation in South Africa today protects the rights of employees against actions by employers that may constitute an unfair labour practice.