

Editorial

Informed consent, AIDS, and the practicing dentist

The primary obligation of health care workers is to do no harm. Thus, dentists or dental health team members involved in patient care and infected with communicable diseases have the responsibility to prevent the transmission of any such diseases from themselves to their patients. In the event that the disease in question is fatal, this obligation looms enormous.

The recent announcement that not one, as previously believed, but three patients of the late Dr David J. Acer were infected by him, probably during dental treatment, warrants great concern. Dr Acer continued practicing despite the fact that he knew he had acquired immunodeficiency syndrome (AIDS). He was wrong in continuing to practice without informing his patients of the small, but apparently viable, risk of transmission of his fatal disease. Now three of his patients must face a long and painful journey to their untimely deaths.

Some argue that there is no need to inform patients about the operator's or health worker's infection with the human immunodeficiency virus (HIV) since the risk of disease transmission is so small. Agreeably, the risk is small — it is calculated by the Centers for Disease Control (CDC) to be from 1 in 263,158 to 1 in 2,631,579.¹ However, no matter how small the risk, we are not discussing a herpetic lesion of the oral tissues. We are talking about a *fatal* infection. Even if the risk is very small, it should be the *patient's* choice to take that risk or not. Who are we to make potential life and death decisions for our patients?

The disclosure of a dentist's seropositive status for AIDS or even hepatitis falls, in my opinion, under the guidelines of informed consent. The patient's desire and unquestionable right to make an informed decision is paramount. Thus, all material risks should be disclosed to a patient prior to any treatment.

What is a material risk? *Materiality* is the traditional legal test for measuring the significance in decision making. A risk is material when "a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach signifi-

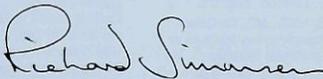
cance to the risk or cluster of risks in deciding whether or not to undergo the proposed therapy."²

Surely most reasonable people, if faced with an invasive dental treatment that will cause bleeding, would choose not to be treated by an HIV-positive dentist, even if the risk is as minute as that estimated by the CDC. Is not this fear of losing patients the real reason that some argue against disclosure of AIDS infection and for the privacy of the individual? This choice smacks of self-protection without regard for the protection of the patient.

I do not mean to seem unsympathetic to AIDS-positive colleagues or anyone inflicted with this dreaded disease. Intolerance and bigotry have no more place in health care than they do in life in general. But, the right to practice dentistry is necessarily subordinate to the patient's right to choose whether or not to be subjected to the risk of a fatal infection.

Will all seropositive dentists voluntarily disclose their status? Probably not, since, astonishingly, neither American Dental Association nor CDC guidelines mandate such disclosure. And even if they did, many seropositive dentists would rationalize that the risk to the patient is so small that it is acceptable for the dentist to make the decision for the patient. Forcing disclosure would naturally involve mandatory testing, a highly charged, emotional issue.

Informed consent of seropositive status is not the triumph of emotion over rationality. The guiding principle of health care is to do no harm. If we are to err, it should be on the side of protecting the patient.



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1. Altman LK: U.S. experts try to estimate AIDS infections by doctors. *New York Times* February 7, 1991, page A10.
2. Waltz JR, Scheuneman TW: Informed consent to therapy. *Northwestern Univ Law Rev* 1970; 64:628-650.