A DECADE OF HIV TESTING IN AUSTRALIA

PART 2: A REVIEW OF SOME CURRENT DEBATES

ROGER S MAGNUSSON*

I. INTRODUCTION

Part 1 of this article reviewed the growing body of legislation which regulates the HIV testing process in Australia. Despite its scope and detail, this legislation has done little to resolve a number of ongoing controversies which have arisen within the context of medical practice particularly over HIV testing and the use and disclosure of HIV test results. This is not only because these debates raise novel issues of law which courts and legislatures have not directly considered, but also because they involve conflicts between opposing models of public health regulation as well as conflicts between the perceived interests and claimed rights of health care workers, and those with HIV/AIDS.

This part of the paper will review, from a legal perspective, several of the most important current debates which regularly feature in the media and in medical literature, focusing in particular upon the legal issues surrounding:

* BA LLB (Hons) (ANU), PhD (Melb). Barrister & Solicitor of the Supreme Court of Victoria; Postdoctoral Research Fellow, Faculty of Law, University of Melbourne. This research is supported by a Commonwealth AIDS Postdoctoral Research Fellowship from the Commonwealth Department of Human Services and Health. I am very grateful to Professor Harold Luntz, Faculty of Law, University of Melbourne, for some extremely helpful comments on an earlier draft of Part 2 of this article. Any errors are mine.

(i) the mandatory HIV testing of all hospital or surgical patients in order to reduce the risk of occupational transmission to hospital or surgical staff;
(ii) the HIV testing and exclusion from regular duties of surgeons and health care workers performing exposure prone procedures;
(iii) the disclosure of HIV test results to the sexual partners of patients whose irresponsible behaviour poses a risk of HIV transmission;
(iv) the disclosure of HIV test results to the employers of health care professionals and other workers who continue to work in the face of a perceived risk of HIV transmission.

Providing a legal perspective on these emotionally charged issues is, it is submitted, a useful exercise, by indicating the legality of current practices and stated positions and by suggesting how the law would interact with any proposed resolution of the issues.

II. FEAR OF NEW DISEASES, AND MANDATORY TESTING

The human tendency to respond to new diseases by attributing blame to visible minority groups,[1] combined with the introduction of a reliable HIV test, has encouraged calls for widespread testing to identify or 'flush out' those capable of transmitting the disease. Calls for widespread coercive testing in order to 'protect the innocent' received additional 'legitimacy' and impetus from community disapproval of homosexuality and IV drug use, both of which have been implicated in HIV transmission. In one particularly ludicrous example, in 1990 the Queensland Association of Catholic Parents was reported to have advocated the branding of all homosexuals to stop AIDS.[2] Even where prejudice is not a factor, HIV testing and the identification of those capable of transmitting the virus have still been seen by some as a high priority in a public health policy designed to minimise HIV transmission.

It is possible that public opinion in Australia, as in America, would show strong support for widespread compulsory HIV testing.[3] Even so, broad screening programs have been criticised in Australia[4] where it appears the 'human rights' model of infection control has prevailed over a coercive 'contain and control' model. As noted in Part 1, this is appropriate for an infection transmitted by voluntary, and essentially un-policeable behaviour. Indeed, the imposition of mandatory HIV testing requirements upon individuals in the absence of

---

1 See W R Albury, "Historical Reaction to 'New' Diseases" (1985) 18 *Australian Journal of Forensic Sciences* 5.

2 "Brand Homosexuals to Stop AIDS, Say Catholic Parents" *The Evening Post* (NZ), 20 July 1990.

3 In America, polls suggest high levels of public support for mandatory testing: arrestees (87 per cent), prostitutes (87 per cent), marriage applicants (79 per cent), health care workers (70 per cent), food handlers (66 per cent), and patients (60 per cent): J Gerberding, Associate Professor of Medicine (Infectious Diseases), University of California, San Francisco, "The HIV Infected Health Care Worker", presented at the 6th Annual Australasian Society for HIV Medicine (ASHM) Conference, 6 November 1994.

4 For example, The Honourable Justice Michael Kirby, "AIDS Legislation - Turning Up the Heat?" (1986) 60 *Australian Law Journal* 324.

authorising legislation may be illegal. Mandatory testing requirements imposed in the absence of legislative authority may contravene relevant provisions of the *Disability Discrimination Act* 1992 (Cth) by making the provision of goods, services and facilities, accommodation and so on subject to a condition (that condition being mandatory testing to determine HIV status) when HIV status cannot lawfully be used as a basis for exclusion.[5] Similarly, it would be unlawful to discriminate on the basis of a person's refusal to undergo HIV testing because this would amount to discrimination on the basis of imputed HIV status. The medical context, however, is one where the legality of mandatory testing, imposed in the absence of legislation, is still a matter of debate because of the argument that mandatory testing, and any resulting delay in, or re-evaluation of, treatment would not be discriminatory in view of the patient's own health interests and the public health exception in anti-discrimination statutes.[6]

III. OCCUPATIONAL TRANSMISSION OF HIV/HBV/HCV IN HEALTH CARE SETTINGS

It is useful to contrast the occupational transmission of HIV with Hepatitis B (HBV) and Hepatitis C (HCV), where data are available. While the medical and social consequences of hepatitis infection are less severe when compared to HIV, HBV and HCV are also transmissible through needlestick injury, and HBV is considerably more infectious than HIV. This paper will adopt the definitions of 'invasive procedures' and 'exposure prone procedures' used in the NSW Health Department guidelines on occupational transmission of HIV/HBV/HCV, discussed below.

A. Transmission from Patient to Health Care Worker ('HCW')

Occupational exposure to blood and body fluids, mostly through needlestick injuries, is disturbingly frequent.[7] One Sydney hospital reported 144 occupational exposures over one 12 month period, mostly from needlestick injuries, although no case of HIV seroconversion was detected.[8] Forty-five percent of the percutaneous exposures were due to inadequate disposal of used needles. There was prior

---

5 For the same reason, it may also contravene anti-discrimination legislation (in all jurisdictions except Tasmania) and certain provisions of the *HIV/AIDS Preventive Measures Act* 1993 (Tas), although State and Territory legislation will not be considered here.

6 *Disability Discrimination Act* 1992 (Cth), s 48; *Anti-Discrimination Act* 1977 (NSW), s 49P; *Equal Opportunity Act* 1984 (Vic), s 39(da); *Anti-Discrimination Act* 1991 (Qld), ss 107-108; *Equal Opportunity Act* 1984 (WA), s 66U; *Anti-Discrimination Act* 1992 (NT), s 55; *Discrimination Act* 1991 (ACT), s 56; *Equal Opportunity Act* 1984 (SA), s 71(2).

7 This article deals only with accidental injuries, although in 1990 a prison warder at Sydney's Long Bay jail was stabbed with a blood-filled syringe by an HIV infected prisoner: "AIDS Prisoner Stabs Officer" *Sydney Morning Herald*, 23 July 1990; "Inmate Yelled 'AIDS' after Attack: Officer" *Sydney Morning Herald*, 24 July 1990; "HIV Transmission by Stabbing Despite Zidovudine Prophylaxis" (1991) 338 *Lancet* 884. The warder contracted HIV and has since died from AIDS.

8 D Marriott, A McDonald, G Dolan et al, "Characteristics of Occupational Exposures to Blood and Body Fluids at St Vincent's Hospital, Sydney" (October 1991) 7(Supp 4) *Australian HIV Surveillance Report* 1.

knowledge of the HIV positive status of the blood for only 20 per cent of the exposures, while for 31 per cent the HIV status was unknown. The high frequency of 'sharps' injuries has been confirmed in subsequent Australian studies,[9] and under-reporting may misrepresent the full nature of the problem.[10] Worldwide, 100 cases of HIV seroconversion following accidents have been reported,[11] while in Australia, there are at least 7 cases, involving nurses, medical practitioners, and ambulance officers.[12] Predictably, new cases of occupational transmission and new studies indicating frequent needlestick injuries, re-open the debate over mandatory pre-operative testing.[13]

The above figures, while disturbing, suggest that as a percentage of total HCW/patient contacts, the risk of occupational HIV transmission is exceedingly low. Calculating the risk involves considerable speculation, although a trend is emerging. In 1989, Gostin summarised the research as follows:

> There is a range of 0.03 to 0.9 percent probability that an HCP [health care professional] will contract HIV following a documented case of percutaneous (eg, a needle-stick or cut) or mucous membrane (eg, a splash to the eye or mouth) exposure of HIV-infected blood. This rate of seroconversion compares favourably with the risk of twelve to seventeen percent after accidental percutaneous injection from patients with hepatitis B virus (HBV), even after passive immunisation of recipients by immune serum globulin.[14]

More recently, Gerberding summarised the risk of seroconversion following *needlestick* exposure to contaminated blood as 5-40 per cent for Hepatitis B, 2.7 per cent for Hepatitis C and 0.2-0.4 per cent for HIV.[15] The risk is significantly less for *mucous membrane* exposure.[16]

In the United States, the Centre for Disease Control (CDC) has estimated that 12 000 HCWs are infected with HBV each year by exposure to patients' blood,

---

9 D Mallon, W Shearwood, S Mallal et al, "Exposure to Blood Borne Infections in Health Care Workers" (1992) 157 *Medical Journal of Australia* 592; F Bowden, B Pollett, F Birrell et al, "Occupational Exposure to the Human Immunodeficiency Virus and other Blood-borne Pathogens" (1993) 158 *Medical Journal of Australia* 810; B de Vries, Y Cossart, "Needlestick Injury in Medical Students" (1994) 160 *Medical Journal of Australia* 398.

10 D Cato, B Mulhall, "Needlestick Injuries in Health Care Workers: Continuing Risk and Under-reporting" (1994) 161 *Medical Journal of Australia* 285.

11 Although only 35 have been documented: Royal Australasian College of Surgeons (RACS), *Infection Control in Surgery and Management of AIDS (HIV) and Hepatitis B*, 1994 at 14.

12 *Ibid.* The most recent reported case involved a Victorian doctor whose finger was pricked with a butterfly needle after withdrawing blood: "Needlestick Injury in Practice" (1994) 161 *Medical Journal of Australia* 339; "Doctor Infected with HIV Virus" *Australian*, 5 September 1994, p 4.

13 For example, "Doctors Seek Powers to Test for HIV" *Sydney Morning Herald*, 5 April 1994, p 3; "HIV Test Laws not Needed: Surgeons" *Australian*, 7 April 1994, p 3; "Virus Hits 6: Doctors Act on Risk" *Sunday Age* (Melbourne), 17 April 1994, pp 1, 17.

14 L Gostin, "Hospitals, Health Care Professionals, and AIDS: The 'Right to Know' the Health Status of Professionals and Patients" (1989) 48 *Maryland Law Review* 12 at 17.

15 J Gerberding, Associate Professor of Medicine (Infectious Diseases), University of California, San Francisco, "Occupational Issues for HIV Care Providers", presented at the 6th Annual Australasian Society for HIV Medicine (ASHM) Conference, Manly, 5 November 1994; see more recently, J Gerberding, "Management of Occupational Exposures to Blood-Borne Viruses" (1995) 332 *New England Journal of Medicine* 444.

16 More than 0 per cent for HBV; between 0 per cent and 0.2 per cent for HIV and unknown for Hepatitis C.

resulting in 250 deaths annually.[17] Hepatitis B, rather than HIV, is thus the major occupational disease for health care workers. Assuming, however, that "a busy general surgeon might suffer two or three needle stick injuries per year and a busy orthopaedic surgeon could suffer this many stick injuries per month",[18] the risk of HIV (and HBV) transmission must be acknowledged, particularly among surgeons and HCWs working in hospitals specialising in AIDS care. One study has estimated the risk of HIV transmission from an HIV positive patient to a surgeon during an operation at between 1/4 500 and 1/130 000.[19]

Ironically, it is HIV rather than HBV which has led to calls for the mandatory screening of all hospital or surgery patients and re-awakened interest in infection control. Indeed, the risk of HIV transmission may well have contributed to a recognition that the risk of HBV transmission is no longer tolerable.[20] Health Departments and professional medical bodies have developed protocols utilising universal precautions[21] which, when followed, have been shown to significantly reduce the number of occupational exposures among health care workers.[22] However, a high level of non-compliance with universal precautions was found in a recent study of a large Sydney teaching hospital.[23]

The policy factors for and against the introduction of mandatory HIV/HBV testing of hospital, and more specifically, surgical patients, have been considered elsewhere.[24] Advocates of pre-operative screening point out that universal blood and fluid precautions are inconvenient and time consuming to implement and, as a result, are often ignored by HCWs.[25] The current Australian Medical Association (AMA) Position Statement on AIDS states that while "effective infection control

---

17 N Daniels, "HIV-Infected Health Care Professionals: Public Threat or Public Sacrifice?" (1992) 70 *The Milbank Quarterly* 3 at 14.

18 TW O'Connor, "Do Patients have the Right to Infect their Doctor?" (1990) 60 *Australian and New Zealand Journal of Surgery* 157 at 160. Another study has estimated that for surgeons, a significant skin puncture occurs once every 40 cases, or nine times a year for an average surgeon performing 360 operations per year: MD Hagen, KB Meyer, SG Pauker, "Routine Preoperative Screening for HIV" (1988) 259 *Journal of the American Medical Association (JAMA)* 1357.

19 MD Hagen et al, *ibid* at 1358.

20 See M Barnes, N Rango, G Burke et al, "The HIV-Infected Health Care Professional: Employment Policies and Public Health" (1990) 18 *Law, Medicine & Health Care* 311 at 319-20, 322.

21 For example, Royal Australasian College of Surgeons, note 11 *supra*; Department of Community Services and Health, *Infection Control Guidelines: AIDS and Related Conditions*, June 1990; National Health and Medical Research Council, *Guidelines for the Prevention of Transmission of Viral Infection in Dentistry*, 1992. 'Universal precautions', as the term is used in this paper, are infection control procedures which require HCWs to assume that the blood and body substances of all patients are potentially infectious regardless of diagnosis or perceived risk.

22 E Wong, J Stotka, V Chinchilli et al, "Are Universal Precautions Effective in Reducing the Number of Occupational Exposures Among Health Care Workers?" (1991) 265 *JAMA* 1123; R Gershon, C Karkashian, S Felknor, "Universal Precautions: An Update" (1994) 23 *Heart & Lung* 352.

23 E Herdman, "Health Care Workers, Universal Precautions and HIV: A Cases Study in Institutional Discrimination" (1994) 8(7) *National AIDS Bulletin* 26. For a 'lack of compliance' literature review, see R Gershon et al, *ibid.*

24 For example, GD Wright, "HIV Testing of Hospital Patients" (1990) 153 *Medical Journal of Australia* 50; RS Magnusson, "Specific Consent, Fiduciary Standards and the Use of Human Tissue for Sensitive Diagnostic Tests and in Research" (1995) 2 *Journal of Law & Medicine* 206 at 211.

25 TW O'Connor, note 18 *supra* at 160; "Doctors Seek Powers to Test for HIV" *Sydney Morning Herald*, 5 April 1994, p 3; "Sticking Point" *Weekend Australian*, 9-10 April 1994, p 20.

measures" should be adopted, "[t]hese measures are not, however, alternatives to appropriate testing".[26] The Position Statement states that "[t]he adoption of barrier nursing procedures for all patients, regardless of their HIV status, is impractical, costly and impedes patient management", although it recommends the adoption of the infection control protocols developed by the RACS by hospitals and government departments.[27] On the other hand, HIV testing will not prevent accidents, nor encourage compliance with the procedures which do prevent accidents; it may, in fact, have an opposite effect and generate a sense of complacency.[28] Broad HIV screening of surgical or hospital patients would be difficult to justify on economic grounds, in view of the geographically pocketed nature of HIV in Australia, and the low prevalence of undiagnosed HIV among patients reporting no other risk factors.[29] Nevertheless, the Royal Australasian College of Surgeons[30] and the Australian Medical Association[31] advocate the HIV testing of patients prior to surgery with consent, HIV testing without knowledge in emergencies, and deferral of surgery and the right to refuse to provide elective treatment to patients who refuse testing. These policies seem somewhat inconsistent with the CDC recommendations, which emphasise voluntary testing and provide that persons who decline HIV testing must not be denied medical care or given sub-optimal medical care.[32]

B. HIV-Infected Health Care Workers

The occupational transmission of HIV can have a disastrous effect upon the personal and working life of HCWs, and it is important to recognise the human dimension behind the statistics. The human impact was brought to the attention of the medical community in 1989 when the *New England Journal of Medicine* published a first-person account of a resident who acquired HIV early on in the epidemic, when a capillary tube shattered and lacerated his finger. Later, when his HIV status was confirmed, his career and social network disintegrated.[33] This article attracted considerable comment.[34] In Australia, there are reported cases of surgical and nursing careers coming to an abrupt end as a result of disclosure of HIV status in breach of confidence.[35]

---

26 Australian Medical Association, *AIDS Position Statement 1992* at [5.6]. The writer has been informed that this policy will be reviewed over the coming year.

27 *Ibid* at [5.4], [13.2].

28 R Penny, "Dealing with the Thorny Issue of HIV Testing" *Canberra Times*, 27 April 1994, p 15.

29 C Reid, J Kaldor, R Lord et al, "HIV Risk Factors and Seroprevalence in Surgical Patients" (1993) 158 *Medical Journal of Australia* 21.

30 Note 11 *supra* at 3-4.

31 AMA, note 26 *supra* at [3.2]-[3.8].

32 Centre for Disease Control (CDC), "Recommendations for HIV Testing Services for Inpatients and Outpatients in Acute-Care Hospital Settings" (1993) 269 *JAMA* 2071 at 2072.

33 H Aoun, "When a House Officer gets AIDS" (1989) 321 *New England Journal of Medicine* 693.

34 (1990) 322 *New England Journal of Medicine* 1154-7 (letters); J Dwyer, "Compassion, Compensation and HIV" (1990) 153 *Medical Journal of Australia* 1.

35 "HIV Doctor Says Ignorance and Prejudice Forced him to Quit his Job" *Age* (Melbourne), 17 August 1992, p 18; No author listed, "HIV Infection, Confidentiality and Discrimination" (1992) 157 *Medical Journal of Australia* 282; and see the case of 'Leon', discussed in RS Magnusson, note 24 *supra* at 225-6.

In most cases, HCWs with HIV will not have been infected through needlestick injuries or other accidents. Despite the low risk of transmitting HIV from HCW to patient (see below), guidelines issued by the New South Wales Health Department and the Royal Australasian College of Surgeons (RACS) would preclude health care workers with HIV (or HBV) from performing 'exposure prone procedures'.[36] The AMA Position Statement on AIDS advises that HIV infected HCWs should not perform "'invasive procedures or operations', except upon other infected HIV patients".[37] These policies conflict with the Australian Nurses Federation Policy on HIV/AIDS, which supports the right of HIV infected nurses to continue their work if universal precautions are followed.[38]

The exclusion which would operate under the NSW Health Department guidelines calls for a definition of 'exposure prone procedures'. Exposure prone procedures are defined in the guidelines as a subset of invasive procedures. Invasive procedures are any surgical entry into tissues, body cavities or organs, or repair of traumatic injuries. It would therefore include administering an injection or dressing a bloody wound. Exposure prone procedures are:

> characterised by the potential for direct contact between the skin (usually finger or thumb) of the HCW and sharp surgical instruments, needles, or sharp tissues (spicules of bone or teeth) in body cavities or in poorly visualised or confined body sites (including the mouth).

The NSW guidelines state that "[p]rocedures which lack these characteristics are unlikely to pose a risk of transmission of HIV or HBV from infected HCW to patient".[39] The NSW Health Department has established an Advisory Panel for Health Care Workers infected with Blood Borne Viruses which, among other things, can advise on whether certain procedures are to be regarded as 'exposure prone' under the guidelines.

In addition to precluding HIV infected HCWs from performing invasive procedures, the NSW Health Department and Royal Australasian College of Surgeons (RACS) guidelines encourage HCWs who may be exposed to HBV to undergo a course of immunisation, and regular serological testing for HIV/HBV based on individual exposure risk is also encouraged. Testing is also required after significant occupational exposure to blood or body fluids, or otherwise every 12 months. The RACS guidelines emphasise the importance of universal precautions which require all body fluids to be treated as potentially infectious, and the NSW Health Department guidelines require health care organisations to ensure that HCWs are informed about, and comply with, recommended infection control procedures. Recent legislation in NSW enables regulations embodying infection control procedures to be legally imposed upon medical practitioners and dentists,[40] and draft regulations embodying the above features are being prepared. This has

---

36 NSW Health Department, *HIV and Hepatitis B Infected Health Care Workers (draft policy)*, 1994; Royal Australasian College of Surgeons, note 11 *supra* at 7. A similar ban is being considered in Victoria: (1995) 9(1) *National AIDS Bulletin* 2.

37 AMA, note 26 *supra* at [5.7].

38 Australian Nursing Federation, Policy Statement, *HIV/AIDS and the Nursing Profession*, 1991.

39 NSW Health Department, note 36 *supra* at 3.

40 *Health Legislation (Miscellaneous Amendments) Act* 1994 (NSW), Schedule 4.

led to a concern that regular HIV screening of HCWs may be enforced as a legal requirement, with incidents of 'misconduct' being investigated by the NSW Medical Board or Health Care Commission.[41]

In the United States, CDC guidelines issued in 1991 rejected mandatory testing, advocated universal precautions, yet provided that HCWs who perform exposure prone procedures should know their HIV/HBV status, and that those infected with HIV/HBV should not perform exposure prone procedures except under the guidance and in accordance with any restrictions laid down by an expert review panel.[42] These guidelines were opposed by a number of professional medical organisations on the basis that the low risk of transmission did not justify restricting the practices of HIV infected HCWs.[43] No professional body agreed to draw up a list of 'exposure prone invasive procedures', and the CDC revised its guidelines, recommending that HCWs performing 'invasive surgical, dental or obstetric procedures' should know their HIV status. The new guidelines recommend that expert review panels should decide on an individual basis which invasive procedures an HIV infected HCW may perform.[44] US federal legislation requires each State to adopt the CDC guidelines or their 'equivalent', as a condition of receiving federal Medicaid and Medicare funds.[45]

The NSW Health Department and the CDC therefore advocate alternative models of risk control. The former seeks to control the risk of transmission by banning all infected HCWs from performing a certain category of procedures defined as 'exposure prone'. The latter seeks to control transmission risk by focusing on the lack of skill of individual HCWs performing a (wider) category of procedures defined as 'invasive'.

C. Transmission from HCW to Patient

The risk of occupational transmission of blood borne viruses flows in both directions. In the United States, the CDC has reported 20 clusters of documented transmission of HBV infection from infected HCWs to over 300 patients since 1970.[46] More recently, it was reported that one Florida dermatologist infected 213 of 2 331 former patients with HBV.[47] Despite continuing surveillance through 'look-back' studies, however, the only documented instance of occupational HIV

41 P Blair, "Compulsory Testing of Health Workers" (1994) 5(4) *HIV/AIDS Legal Link* 22.

42 CDC, "Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients during Exposure-Prone Invasive Procedures" (1991) 40 *Morality and Morbidity Weekly Review* (No RR-8) 1 at 5.

43 B Lo, R Steinbrook, "Health Care Workers Infected with the Human Immunodeficiency Virus" (1992) 267 *JAMA* 1100 at 1101-02; L Glantz, W Mariner, G Annas, "Risky Business: Setting Public Health Policy for HIV-infected Health Care Professionals" (1992) 70 *The Milbank Quarterly* 43 at 48-53. The American Medical Association was a notable exception, having issued guidelines in 1988 requiring doctors not to engage in practices involving *an identifiable risk* of transmission.

44 B Lo et al, *ibid*; L Glantz et al, *ibid*.

45 *Treasury, Postal Service and General Government Appropriations Act* 1992 (US), s 633 (Public Law 102-141; 105 STAT 876).

46 N Daniels, note 17 *supra* at 11.

47 D Beane, "AIDS Crisis and the Health Care Community: Public Concerns Triggering Questionable Private Rights of Action for Emotional Harms and Legislative Response" (1994) 45 *Mercer Law Review* 633 at 645 (n 64).

transmission from HCW to patient remains the six Florida patients reported to have acquired their infection from a bisexual dentist, Dr Acer.[48] Dr Acer never disclosed his condition to his patients and continued practising until shortly before his death in 1990. One of his patients, Kimberly Bergalis, attracted widespread publicity and sympathy and advocated mandatory HIV testing of health care providers before a US Congressional Committee. However, the exact means of transmission to Bergalis remains unknown; there are several theories, and intentional transmission has not been ruled out.[49] In Australia, similar concerns of occupational HIV transmission arose following the leaking of a letter from the South Australian Health Commission to a newspaper revealing that an Adelaide dentist with AIDS had continued to practise until shortly before his death, without revealing his condition.[50]

The CDC has estimated the risk of HIV transmission from surgeon to patient as in the range of 1/400 000 and 1/40 000, and in the range of 1 in 260 000 to 2.6 million from dentist to patient.[51] HCWs thus run a relatively greater risk of acquiring HIV from a patient, rather than the other way around. Another estimate puts the risk of HIV transmission from surgeon to patient as one chance in 21 million per hour of surgery, and the risk of HIV transmission from a known HIV positive surgeon to a patient as one chance in 83 000 per hour of surgery.[52] To put the CDC numbers in perspective, the risk of death during a coronary bypass is 7000 times greater than the risk of contracting HIV during surgery from a *known* HIV-positive surgeon.[53]

However, while the individual risk to any one patient is small, the risk that *a patient* will be infected by an HIV positive HCW rises over time. If one assumes the CDC estimates given above (an estimated risk of acquiring HIV from an infected physician after a seriously invasive procedure ranging from 1/400 000 to 1/40 000), then the risk that at least one patient will be infected rises with the number of operations performed. If 100 operations are performed, the risk ranges from 1/4000 to 1/400 that a patient will be infected. If 1000 operations are performed, the risk becomes 1/400 to 1/40.[54]

Despite the low risk to any one patient, public perception of risk clearly goes beyond statistical probability, and reports of HIV positive HCWs have met with public panic. In England, the public disclosure of the HIV positive status of a

---

48 J Witte, "Update: Investigations of Persons Treated by HIV-Infected Health-Care Workers - United States" (1993) 42 *Morality and Morbidity Weekly Review* 329; "Dentist Kept Infection Secret, Five Infected" *Canberra Times*, 24 July 1991, p 12; "I Blame Every One of you Bastards" *Bulletin*, 2 July 1991, p 68.

49 "Experts Exhume Victim's Memory" *Sunday Herald-Sun* (Melbourne), 3 July 1994, p 18; D Breo, "The Dental AIDS Cases - Murder or an Unsolvable Mystery?" (1993) 270 *JAMA* 2732.

50 For references, see *Advertiser* (Adelaide), 22-28 January 1992.

51 N Daniels, note 17 *supra* at 13.

52 A Lowenfels, G Wormser, "Risk of Transmission of HIV from Surgeon to Patient" (1991) 325 *The New England Journal of Medicine* 888.

53 D Rogers, "The Influence of Attitudes on the Response to AIDS in the United States" (1994) 169 *Journal of Infectious Diseases* 1201 at 1203. Similarly, the risk of a New Yorker being murdered in New York City is 10 times the risk of acquiring HIV during surgery from an HIV positive surgeon, although equal to the risk of death from receiving penicillin.

54 See L Gostin, "CDC Guidelines on HIV or HBV-Positive Health Care Professionals Performing Exposure-Prone Invasive Procedures" (1991) 19 *Law, Medicine and Health Care* 140 at 141.

gynaecologist[55] and the alleged HIV status of an eye surgeon,[56] respectively, led to a flurry of publicity and 'AIDS help-lines' to cope with thousands of inquiries from former patients. Similarly, the non-disclosure of a junior doctor's death from AIDS led to charges of a cover-up.[57]

It has been estimated that there would be 20 general practitioners infected with HIV practising in Sydney's eastern suburbs.[58] In 1994, the NSW Health Department undertook a 'look-back' study involving 149 former patients of a Sydney-based trainee obstetrician who tested HIV positive following a needlestick injury involving blood from a patient who turned out to be HIV negative.[59] The impetus for the investigation came from the fact that the HCW involved had performed invasive procedures upon pregnant women. No evidence of occupational transmission was found,[60] although the doctor's privacy became a casualty of the investigation, and the wisdom of the 'look-back' was debated in medical circles in view of the cost and the anxiety caused to patients.[61] Worldwide, a number of look-back studies have been carried out involving thousands of patients treated by HIV infected HCWs, and with the exception of the 6 Florida dental patients, no cases of occupational transmission have been identified.[62]

The absence of evidence from look-back studies has led to criticism of the NSW Health Department guidelines (see above) which require HIV infected HCWs to refrain from performing exposure prone procedures.[63] It seems clear that whatever the exact risk of transmission from HCW to patient is, it is extremely low: "of all the factors that patients die from as a direct result of medical care, AIDS is at the bottom of a very long list".[64] On the other hand, the absence of evidence from look-back studies proves very little. The HBV model shows that transmission occurs in clusters: while most HCWs will not transmit any infection, a very few

---

55 "Women in Panic over HIV Doctor" *Age* (Melbourne), 3 March 1993, p 7 (reporting on the announcement of the HIV positive status of an English gynaecologist who over a period of a decade had treated 17 000 women and operated on 6 000 women); "HIV Doctor Alarms Women" *Guardian* (UK), 8 March 1993, p 1; "Doctor with HIV Operated Days Before Illness Known" *Guardian*, 9 March 1993, p 20.

56 "Surgeon in HIV Scare Stays Silent Despite Hospital Plea" *Guardian*, 7 July 1992, p 4; "Check-up for Eye Surgeon in HIV Scare" *Guardian*, 9 July 1992, p 5.

57 "Doctor's Death from AIDS Kept Secret for Five Months" *Guardian*, 11 March 1993, p 2; cf "Hospital Defends HIV Nurse" *Herald-Sun* (Melbourne) 28 November 1994, p 6 (hospital defending male nurse with AIDS who continued to work with immune-suppressed patients in an intensive care unit for several years following HIV diagnosis).

58 "The Cutting Edge" *Australian*, 26 January 1993, p 9.

59 "HIV Doctor Treated 149 Mums" *Australian*, 2 August 1994, p 3; "Health Experts May Tighten Doctors' HIV-Risk Guidelines" *Age* (Melbourne), 3 August 1994, p 3.

60 M Bek, J Gold, M Levy et al, "Investigation of Patients Potentially Exposed to an HIV-Infected Health Care Worker" (1994) 8(5) *New South Wales Public Health Bulletin* 83. The study revealed one HIV positive woman who was positive at the time of exposure.

61 D Baxter, "Lessons From a 'Lookback'" (1994) 8(7) *National AIDS Bulletin* 6.

62 J Witte, note 48 *supra*; A Rogers, J Froggatt III, T Townsend et al, "Investigation of Potential HIV Transmission to the Patients of an HIV-Infected Surgeon" (1993) 269 *JAMA* 1795; C Fordham von Reyn, T Gilbert, F Shaw, Jr et al, "Absence of HIV Transmission from an Infected Orthopedic Surgeon" (1993) 269 *JAMA* 1807.

63 For example, E Vlahakis, G Brieger, A MacGibbon, "Restrictions on HIV-infected Health Care Workers" (1995) 162 *Medical Journal of Australia* 109.

64 L Glantz et al, note 43 *supra* at 64.

will transmit it to several people.[65] This suggests that infection control record, rather than HIV status, may be a better indication of transmission risk. Barnes and others have argued that individualised inquiry into the transmission risk arising from the lack of skill of HCWs, with recommendations for improvement of infection control techniques and occupational restrictions if necessary (regardless of HIV/HBV status), is a fairer and more efficient means of controlling transmission risk than excluding all infected workers from performing exposure prone procedures.[66] The debate continues.

In Australia, shortly after the Sydney obstetrician incident became public, the Royal Australasian College of Surgeons called for compulsory HIV testing of surgeons and relevant health care workers, as well as HIV testing for patients undergoing surgery to be conducted at the doctors' discretion.[67] Concern at the prospect of HIV infected HCWs has also resulted in statements issued by the medical faculties of the University of Sydney[68] and the University of Tasmania[69] that students with HIV/HBV may not be able to complete course requirements which would involve participation in exposure prone procedures. However, mandatory HIV testing of HCWs, or the compulsory HIV testing of medical students, share the same disadvantages as the HIV testing of all surgical or hospital patients. In view of the low prevalence of undiagnosed infection likely to exist among HCWs and the sensitivity and specificity of existing HIV tests, false-positive diagnoses are likely to outnumber true positives.[70]

D. Transmission from Patient to Patient

In November 1989, the first documented examples of occupational HIV transmission from patient to patient occurred in a Sydney surgery.[71] Four women contracted HIV from a male patient with AIDS who had been treated in the surgery earlier the same day, presumably as a result of contaminated surgical instruments following a breakdown in infection control procedures. The cases became public in December 1993,[72] and sparked renewed debate over the HIV testing of patients.[73] One of the patients involved, a 31 year-old woman, commenced

---

65 L Gostin, "The HIV-Infected Health Care Professional: Public Policy, Discrimination, and Patient Safety" (1990) 18 *Law, Medicine & Health Care* 303 at 306; B Mishu, "HIV-Infected Surgeons and Dentists: Looking Back and Looking Forward" (1993) 269 *JAMA* 1843.

66 M Barnes, N Rango, G Burke et al, note 20 *supra* at 322-3.

67 "Nurses Reject HIV Tests Call" *The Australian*, 4 August 1994. These calls post-date the RACS protocol released in February 1994, note 11 *supra*; also see notes 36-41 *supra* and accompanying text.

68 Public Interest Advocacy Centre, Sydney, *Students Take Legal Action against University for HIV & Hepatitis Discrimination* (notes for media).

69 "HIV Students Told to Own Up" *Australian*, 23 March 1994, p 2; "HIV Backdown" *Age* (Melbourne), 24 March 1994, p 5.

70 See M Roizen, "Potential Cost of Screening Surgeons for HIV" (1994) 272 *JAMA* 434 (letter).

71 "HIV Spread in Surgery" *Age* (Melbourne), 16 December 1993, p 1.

72 K Chant, D Lowe, G Rubin et al, "Patient-to-Patient Transmission of HIV in Private Surgical Consulting Rooms" (1993) 342 *Lancet* 1548; P Collignon, "Patient-to-Patient Transmission of HIV" (1994) 343 *Lancet* 415.

73 "New Push for HIV Disclosure" *Age* (Melbourne), 17 December 1993, p 1. The Victorian Premier foreshadowed legislation requiring patients to disclose their HIV status to their doctors, although these comments have been criticised as hasty and ill-informed.

proceedings against the doctor concerned for negligence.[74] The doctor's identity has since been released,[75] and following a hearing by the NSW Medical Tribunal, the doctor was found guilty of unsatisfactory professional conduct.[76] Despite the absence of conclusive evidence explaining the infections, contaminated anaesthetic equipment has been suggested as a likely cause.[77]

Since the introduction of HIV screening for blood donations since April 1985, there have been no cases of transfusion acquired HIV, despite the occasional donation of infected blood in defiance of legislation.[78] Current diagnostic tests for identifying HCV in blood supplies are not entirely accurate, however, and there were several reports of transfusion-acquired HCV infections in 1994.[79] HCV transmission between patients in hospital has also been reported.[80]

IV. A REVIEW OF SELECTED LEGAL ISSUES SURROUNDING OCCUPATIONAL TRANSMISSION FROM PATIENT TO HCW

There has been some litigation of these issues in the United States, although almost none in British Commonwealth jurisdictions. The discussion below, therefore, can only adapt general principles to the special circumstances of occupational transmission, noting relevant American decisions. The discussion below will focus on HIV, although the same issues are also relevant to HBV/HCV, bearing in mind their different levels of infectivity.

A. Consent to HIV Testing

Some doctors have responded to the perceived risk of acquiring HIV from their patients by screening them for HIV without their knowledge. This is not difficult to do when blood has been provided for other purposes. A rapid HIV test exists which would make test results available within hours, and its licensing within Australia has been advocated to enable the screening of hospital patients.[81] However, where (i) testing is carried out without specific consent; and (ii) the patient tests positive, the doctor will be placed in the difficult position of having to inform the patient of a distressing result obtained surreptitiously. HIV testing

74 "AIDS Surgery Victim to Sue Doctor" *Australian*, 17 December 1993, p 1.

75 "Doctor in AIDS-infection Case Can be Named, Says Judge" *Australian*, 24 May 1994.

76 "AIDS Transfer Surgeon Guilty" *Weekend Australian*, 10-11 December 1994, p 3.

77 "Surgery Gear May have Passed Virus" *Age* (Melbourne), 21 May 1994, p 8; "Tribunal Told of HIV Cross-Infection" *Age* (Melbourne), 30 August 1994, p 1; "Doctor Denies Breach Led to HIV" *Age* (Melbourne), 3 September 1994, p 3; W Jamrozik, "Surgical Nightmares" *Independent Monthly*, September 1994, p 46; "Research Links HIV Risk to Multi-Dose Anaesthetic Vials" *Age* (Melbourne), 15 May 1995, p 3.

78 "Court Told of HIV Blood Bank Risk" *Age* (Melbourne), 8 December 1993, p 1.

79 For example, "Transfusion Gives Boys Hep C" *Age* (Melbourne), 11 June 1994, p 1; "Hepatitis Victims Sue Blood Bank" *Australian*, 22 June 1994, p 3; "Review Reveals Grim Figures on Hepatitis C" *Age* (Melbourne), 29 June 1994, p 5 (reporting 41 cases in NSW).

80 T Allander, A Gruber, M Naghavi et al, "Frequent Patient-to-Patient Transmission of Hepatitis C in a Haematology Ward" (1995) 345 *Lancet* 603.

81 "A HIV Test Due for All Hospital Admissions" *Age* (Melbourne), 18 March 1995, p 20; cf "Universal Precautions Safer than Tests" *Age* (Melbourne), 22 March 1995, p 16.

without specific knowledge and consent is inconsistent with the national HIV/AIDS strategy, and it ignores the importance of pre- and post- test counselling.[82] Commentators have argued that such testing may amount to an assault, breach of a duty of care, a breach of fiduciary duty, or even conversion, although the position is uncertain.[83]

A patient asked to undergo HIV testing may, of course, refuse. In the absence of legislation a doctor or hospital has no authority to require a patient to undergo a blood test when he or she does not wish to undergo.[84] Withdrawing blood without consent would be a battery.[85] Courts have never considered whether the common law recognises a 'public interest' defence to medical battery in view of the public interest in preventing transmission of disease (by non-consensual screening), although it is highly unlikely.[86] The argument is further weakened in view of the modest risk of exposure and the opportunity for HCWs to protect themselves by following universal precautions. It follows, however, that in all States except Victoria and Tasmania,[87] there would be no legal basis for requiring a patient of unknown HIV status to undergo testing to exclude the possibility of HIV transmission to an HCW following a needlestick injury. The HIV testing of blood obtained previously for other purposes involves the uncertainties noted above.

B. HIV Infected Patients and Discrimination

As noted above and in Part 1 of this article, the *Disability Discrimination Act* 1992 (Cth) prohibits several distinct forms of HIV related discrimination in the provision of health care services:

(i) Clearly, the refusal of medical treatment to a person known or suspected of having HIV/AIDS would be unlawful. For example, it would be unlawful for a hospital to routinely deny treatment to persons with HIV on the basis that it did not have appropriate facilities for treating HIV positive patients, in view of the fact that universal precautions, properly implemented, will prevent blood to blood contact between surgeon and patient;

(ii) The provision of treatment subject to unreasonable and medically unnecessary conditions, would also be unlawful. Thus, the wearing of, say, gloves and facemasks by staff whenever they entered the room of the HIV positive patient could not be justified;

---

82 In some jurisdictions, legislation requires pre- and post- test counselling: see Part 1, Section IV.

83 See RS Magnusson, note 24 *supra*; RS Magnusson "Confidentiality and Consent in Medical Research: Some Recurrent, Unresolved Legal Issues Faced by IECs" *Sydney Law Review* (forthcoming, 1995). HIV testing without specific consent was held not to be unlawful in *Doe v Dyer-Goode* 566 A 2d 889 (1989).

84 *S v S* [1972] AC 24 at 43, 46, 57; *J v N* [1976] 5 WWR 211.

85 *R v Fernando* (unreported, New South Wales Court of Appeal, Priestley, Powell and Clarke JJA, 29 March 1995), Powell JA, Judgment, p 2.

86 In *Lincoln Hunt Australia Pty Ltd v Willesee* (1986) 4 NSWLR 457 at 461, the Court cast doubt on any widening of the public interest defence beyond actions for breach of confidence. However, the term 'public interest defence' is not a term of art and the *Lincoln* case concerned trespass to land.

87 As noted in Part 1, where a needlestick injury does take place, legislation in Victoria and Tasmania would specifically authorise the HIV testing of the patient involved in order to determine the treatment (eg AZT prophylaxis) of a HCW who may have been infected: *Health Act* 1958 (Vic), ss 120A-120D; *HIV/AIDS Preventive Measures Act* 1993 (Tas), s 10(2).

(iii) The refusal of medical treatment to a person who refused to undergo HIV testing would also, prima facie, be unlawful, since it would amount to discrimination on the basis of imputed HIV status.[88]

There have been some unfortunate, documented examples of discrimination against persons with HIV. In one notorious Melbourne example conciliated by the Victorian Equal Opportunity Commission, a patient admitted to casualty requiring urgent surgery was given pethidine and obliged to drive himself to another hospital to obtain treatment.[89]

HIV discrimination is not unlawful if the person subject to the discrimination suffers from an infectious disease and the discriminatory action is reasonably necessary to protect public health.[90] HIV is transmitted primarily through the exchange of body fluids, particularly blood and semen, so the public interest exception would really only be applicable to the screening of surgical patients, or patients undergoing invasive procedures which carry the risk of exposing HCWs to the patient's blood. However, as the definition of 'invasive procedures' in the NSW Health Department guidelines suggest,[91] this is a potentially large category which includes anyone being given injections, suffering traumatic injuries, or undergoing examination of a bodily cavity.

The issue becomes, therefore, whether the public interest exception to the *Disability Discrimination Act* 1992 (Cth) would justify the deferral of surgery pending HIV testing and the right to refuse (indefinitely) *elective* treatment to patients who refuse HIV testing. Such a policy has been advocated both by the AMA and the RACS.[92] As noted in Part 1, only Tasmania gives doctors a *statutory* right to defer medical treatment until a patient has undergone HIV testing, and then only in respect of 'non-urgent' procedures.[93]

There are several reasons why, in the writer's view, the AMA and RACS policies are unlawful. First, the legal effect of refusing elective treatment to patients who refuse to undergo HIV testing is to create an underclass of patients who would be treated like other patients except for the fact that they are not known to be HIV negative. This would be discriminatory under the *Disability Discrimination Act* 1992, since the refusal to treat a patient who refuses to undergo testing amounts to discrimination on the basis of imputed HIV status, and because the Act makes no distinction between elective and non-elective medical treatment. Deferral of treatment pending HIV testing is also an indirect way of forcing

88 The refusal to treat a patient with HIV/AIDS, or a patient who refused to submit to an HIV test, may also breach a doctor's common law duty to treat if the patient presents at casualty, or has been accepted as a patient by the doctor, or if there is a pre-existing relationship between doctor and patient: J Godwin, J Hamblin, D Patterson, D Buchanan, *Australian HIV/AIDS Legal Guide*, Federation Press (2nd ed, 1993) pp 190-1. The refusal to treat may also violate professional ethical codes, as well as other statutes such as the *Medical Practice Act* 1992 (NSW), s 36(h).

89 (1991) 2(2) *National HIV/AIDS Legal Link* at 3-4.

90 *Disability Discrimination Act* 1992 (Cth), s 48. The discussion below deals only with the Commonwealth Act. For similar State legislation, see note 6 *supra*.

91 NSW Health Department, note 36 *supra* at 3.

92 RACS, note 11 supra and AMA, note 26 *supra* and text accompanying notes 30-31 *supra*.

93 *HIV/AIDS Preventive Measures Act* 1993 (Tas), s 12.

patients to undergo HIV testing, which itself is unlawful since HIV status cannot lawfully be used as a basis for refusing medical care.

It is unlikely that the public health exception changes this. On one view, the deferral of treatment pending the HIV screening of patients undergoing invasive procedures could be justified as reasonably necessary to protect public health - in this case, the health of HCWs likely to come into contact with the patient's bodily fluids. It would need to be shown, however, that an HCW's *knowledge* of patient HIV (or HBV/HCV) status was relevant to, and could materially affect, the risk of occupational transmission. The contrary view is that the deferral of treatment of a patient who refused HIV screening would not be reasonably necessary to protect the health of HCWs in view of the fact that (i) universal precautions are widely recommended; and (ii) it is universal precautions, rather than knowledge of a person's HIV status, which ultimately reduces the risk of occupational HIV transmission. This view is more consistent with the policy argument that needlestick injuries occur regardless of knowledge of a patient's HIV status and that to rely on HIV screening rather than universal precautions will lead to a false sense of security, in view of the 'window period' between infection and detection of antibodies. While doctors may feel comforted if they can identify patients who have been confirmed to be HIV positive, the absence of such knowledge affords no right to discriminate unless it can be shown that knowledge of HIV status affects transmission risk, independent of any other infection control measures.

In the absence of data showing this connection, the public health exception to the *Disability Discrimination Act* 1992 (Cth) would not operate, and it would appear that both the RACS and AMA policies advocate practises which breach the Act.[94] In the writer's view, this is hardly a triumph for the human rights of people with HIV/AIDS, but speaks volumes about the state of medical confidentiality, as the disclosure of HIV status to a surgeon would hardly be the issue it is if confidentiality could be assured within the medical setting. Instead, as a recent study found, discussion of HIV information between hospital staff is widespread in some cases, extends beyond a 'need to know' basis, and some of it is gossip. Problems may be exacerbated by practices such as projecting patients' HIV status on computerised theatre screens.[95]

In Tasmania, legislation authorises HIV testing without consent if a patient is unconscious and the doctor believes the test is desirable in the interests of that person.[96] Under the common law, diagnostic testing would also not be discriminatory if conducted in the interests of the patient's health. Thus, if it could be shown that a person's HIV status or level of immunosuppression would be a significant factor in deciding whether to recommend particular forms of major surgery or other therapy, the deferral of surgery or therapy might be justified in view of the doctor's duty of care to provide reasonable medical care.[97] However,

---

94 *Disability Discrimination Act* 1992 (Cth), s 24 (prohibiting discrimination on the basis of a disability in the provision of goods, services and facilities).

95 RS Magnusson, "Privacy, Confidentiality and HIV/AIDS Health Care" (1994) 18 *Australian Journal of Public Health* 51 at 54-6.

96 *HIV/AIDS Preventive Measures Act* 1993 (Tas), s 7(2).

97 See TW O'Connor, note 18 *supra* at 160.

it is unlikely that this argument could be used to justify across-the-board screening practices.

C. Do HIV (or HBV/HCV) Infected Patients Owe a Duty of Care to Disclose their Serological Status to HCWs?

Medico-legal literature focuses almost exclusively upon the legal and ethical duties which HCWs owe to patients, rather than the other way around. This angers many doctors, who argue that the fixation upon patients' rights has gone far enough, in view of the fact that it is they who put their lives on the line when caring for patients with HIV. This section will consider, therefore, whether HIV (or HBV/HCV) infected patients who are aware of their infection owe their doctors a duty of care to minimise the risk of transmission by disclosing their serological status.

As discussed above, the risk of occupational HIV transmission from patient to HCW is low, although significantly higher in the case of HBV. Nevertheless, a duty to take reasonable care to prevent injury may arise even if the risk of injury is remote or extremely unlikely to occur, provided that it is not 'far-fetched or fanciful'.[98] As with the risk of HIV/HBV transmission between athletes engaging in collision, contact, or combat sports,[99] the writer's view is that the risk of infection transmission as a result of needlestick injury or other mishap is a foreseeable risk when HCWs are performing exposure prone procedures upon infected patients. The issue becomes, therefore, whether there is a sufficient relationship of proximity between patient and doctor to impose the duty and whether any policy considerations negative that duty. It is arguable that the physical proximity between doctor and patient during an operation justifies the imposition of the duty. Courts might refuse to recognise a duty to disclose for policy reasons, however, in view of the doctor's professional role and training. As the Superior Court of New Jersey observed in *Behringer's* case:[100]

> [t]he doctor is trained to recognise, diagnose, and avoid contracting the patient's disease... While secretive patients may transmit their diseases to unwary doctors, doctors are responsible for both their own health and the health of their patients.

If one accepts that there is a foreseeable risk of occupational HIV infection and a relationship of proximity between the parties, the question of breach of duty falls to be determined by what the reasonable patient would do in response to the risk. This involves a consideration of:

> the magnitude of the risk and the degree of the probability of its occurrence, along with the expense, difficulty and inconvenience of taking alleviating action and any other conflicting responsibilities which [the patient] may have.[101]

---

98 *Wyong Shire Council v Shirt* (1980) 146 CLR 40 at 48, per Mason J.

99 See RS Magnusson and H Opie, "HIV and Hepatitis in Sport: A Legal Framework for Resolving Hard Cases" (1994) 20 *Monash University Law Review* 214 at 262-5.

100 Discussed in more detail below, note 120 *infra* and text: *Estate of Behringer v Princeton Medical Center* 592 A 2d 1251 (1991) at 1282, quoting G Keyes, "Health Care Professionals with AIDS: The Risk of Transmission Balanced against the interests of Professionals and Institutions" (1990) 16 *Journal of College and University Law* 589 at 605.

101 *Wyong Shire Council v Shirt*, note 98 *supra* at 47, per Mason J.

Within the context of occupational HIV transmission from patient to HCW, the issue of reasonable care really becomes a question of whether the reasonable patient who knew of his or her infection would disclose this to the doctor so that the doctor could be especially careful to avoid transmission when performing invasive or exposure prone procedures.

Where an HCW becomes infected as a result of an occupational exposure in circumstances where a patient had said nothing or had refused to be tested for HIV, issues of causation will arise. In most cases, any occupational exposure to the patient's body fluids will be the result of the HCW's actions, whether from carelessness, fatigue, or by failing to follow universal precautions. A defendant patient might argue that where it cannot be said on the balance of probabilities that the plaintiff (here, the HCW) could have avoided HIV transmission, even if the defendant (here, the patient) had not been negligent (in failing to disclose), courts should not find the defendant liable. This argument appeals to authorities which have stated that in order to establish causation, a plaintiff must prove that the defendant's act or omission was responsible for harm on the balance of probabilities: a possibility or chance of injury is not enough.[102] A patient might argue, therefore, that it was human error on the part of the HCW which caused the injury and that the mere *possibility* that the injury would not have happened if the patient had warned the HCW of his or her infection provides no basis for damages.

On the other hand, courts might well reject the argument that the patient's failure to warn was not causally related to the HCW's injury, if the very purpose of the warning would have been to put the HCW on alert so that he or she could be especially careful. If courts accepted that a warning would have made a difference, approaching the issue of causation as "a matter of ordinary common sense and experience",[103] then they would not regard the HCW's carelessness as the cause of the accident, and accordingly the patient would be regarded as legally liable for the HCW's injury, subject to the issue of contributory negligence on the part of the HCW. The issue of 'whether a warning would have made a difference' is a question of fact; the defendant patient's argument (summarised above), merely involves the claim that a warning probably would not have made a difference and then seeks to defeat the claim on the basis of courts' reluctance to admit liability in an amount (less than 50 per cent) "proportionate to the risk created by each individual agent".[104] In order to show that a warning would have made a difference, a plaintiff would need to show that had he or she known the patient was HIV infected,

(i) the plaintiff would not have operated on the patient; or
(ii) would have adopted more stringent infection control procedures *which would have been effective in preventing transmission*; or
(iii) would at least have been more careful; for example, by consciously slowing down to avoid the risk of error.

---

102 In particular, courts will not assess the chance or percentage (short of probability) that the defendant's act or omission was the proximate cause of injury and award reduced damages to reflect that percentage chance: *Hotson v East Berkshire Area Health Authority* [1987] 1 AC 750.

103 *March v Stramare Pty Ltd* (1991) 171 CLR 506 at 522, per Deane J.

104 J Fleming, "Probabilistic Causation in Tort Law" (1989) 68 *Canadian Bar Review* 661 at 663.

An analogy may be drawn with cases in which the plaintiff claimed for injuries which would not have been sustained if the defendant had provided some form of protection against the risk of mishap. Where there is evidence that the plaintiff would not have used the protection (eg a safety belt) even if it had been provided, courts will conclude that the cause of the plaintiff's injury was his or her own adoption of an unsafe system of work; accordingly, the plaintiff will fail.[105] Frequently, however, courts assume that plaintiffs *will* take advantage of warnings or protective equipment, thus concluding that the provision of a warning or of protective equipment would have prevented the accident.[106] While the issue is uncertain, therefore, it is far from clear that an HCW would be *unsuccessful* in an action for breach of duty of care against an HIV infected patient, following a case of occupational transmission.

V. A REVIEW OF SELECTED LEGAL ISSUES SURROUNDING OCCUPATIONAL TRANSMISSION FROM HCW TO PATIENT

The issue of HIV infected HCWs has attracted widespread publicity. As a political issue, it cannot be ignored, and while it also impacts upon individual rights and livelihoods as well as public confidence in the health care system, it is also largely irrelevant to the public health goal of minimising HIV transmission. If all HIV infected HCWs were excluded from practice, this would have, in numerical terms, virtually no impact upon the epidemic.[107] While the issue deserves attention, therefore, one hopes that it does not overshadow the continuing and difficult issue of achieving behavioural change in sexual and drug-taking practices, because this is what will really make a change to the profile of the epidemic in Australia.

There are several policy options for dealing with the risk of HIV (and HBV/HCV) transmission from HCW to patient. In view of the fact that procedures which are not exposure prone, as defined by the NSW Health Department guidelines,[108] are not considered to pose any risk of HIV transmission, no one seriously suggests that healthy, HIV infected HCWs should be excluded from practising their profession. The main issues surround whether it is legal for HCWs to perform *exposure prone procedures* upon patients without disclosing to patients the risk of HIV transmission or the legality of requiring doctors to be tested periodically for HIV and to refrain from performing exposure prone procedures if infected.

---

105 For example, *Duyvelshaff v Cathcart & Ritchie Ltd* (1973) 1 ALR 125; *McWilliams v Sir William Arrol & Co Ltd* [1962] 1 All ER 623.

106 For example, *Paris v Stepney Borough Council* [1951] AC 267; *Nagle v Rottnest Island Authority* (1993) 177 CLR 423.

107 L Glantz et al, note 43 *supra* at 46.

108 NSW Health Department, note 36 *supra* and text accompanying note 39 *supra* which defined 'exposure prone' procedures.

A. HIV Infected HCWs - A Duty of Disclosure?

The NSW Health Department's draft guidelines on HIV/HBV infected HCWs do not recommend disclosure to patients but prohibit infected HCWs from performing exposure prone procedures. In other States there are no relevant restrictions. The issue arises, therefore, whether infected HCWs who do perform exposure prone procedures owe a duty to disclose the risk of HIV/HBV transmission to their patients. As with transmission from patient to HCW, the risk of HIV/HBV transmission from HCW to any one patient is highly unlikely, although still foreseeable.[109]

The issue of a 'duty to warn' is crucial, since it is largely unrealistic to expect that patients would knowingly consent to treatment given by an infected HCW. There is little chance that news of an HCW's infection would be treated confidentially by patients. Furthermore, in contrast to patients with HIV whose right to receive medical treatment without discrimination is protected by legislation, HCWs whose HIV status is disclosed are likely to suffer loss of privacy and total disintegration of their careers.[110] A legal requirement to disclose thus implicitly "condones the discrimination that will occur as a result of the disclosure".[111]

The doctor's duty to warn of risks associated with medical treatment is well established within medical jurisprudence. Australian courts[112] have rejected the traditionally-held English view[113] that a responsible body of medical opinion will conclusively settle the limits of a doctor's duty to inform patients of risks inherent in a medical procedure. The fact that popular medical opinion may regard the risk of HIV/HBV transmission from HCW to patient as too remote to warrant mentioning may not, therefore, protect a doctor from liability.[114] In Australia, doctors owe a duty to advise patients of *material risks*, and a risk will be material if "a reasonable person in the patient's position would be likely to attach significance to the risk, and thus require a warning".[115]

---

109 *Wyong Shire Council v Shirt*, note 98 *supra* and accompanying text.

110 "HIV Infection, Confidentiality and Discrimination", note 35 *supra*. In this case, an HIV positive trainee surgeon, who worked in a large Sydney metropolitan teaching hospital was admitted to another hospital with an AIDS-defining illness. Within 24 hours, his diagnosis had been discovered and his teaching hospital and supervisors informed. Cf *'Y' v TVW Enterprises Ltd, Hinch and Parry* (unreported, Supreme Court of Western Australia, Wallwork J, 2 February 1990): injunction granted preventing broadcasting of allegations that plaintiff health care worker had HBV.

111 L Gostin, note 65 *supra* at 304.

112 *Rogers v Whitaker* (1992) 175 CLR 479 at 488-9; *F v R* (1983) 33 SASR 189 at 194.

113 See *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 at 587.

114 See *F v R*, note 112 *supra* at 194: "[T]he court has an obligation to scrutinise professional practices to ensure that they accord with the standard of reasonableness imposed by the law." In Australia, however, the Legal Working Party of the Intergovernmental Committee on AIDS has recommended that HCWs should be protected from civil liability for HIV transmission where universal infection control procedures have been complied with: Intergovernmental Committee on AIDS (IGCA), Legal Working Party, *Final Report*, November 1992 at 29 (Recommendation 3.3.1).

115 *Rogers v Whitaker*, note 112 *supra* at 491; *Reibl v Hughes* (1980) 114 DLR (3rd) 1 at 5, 13. Additionally, a risk will be material if the doctor is or should reasonably be aware *that the particular patient*, if warned of the risk, would be likely to attach significance to it: *Rogers v Whitaker*, note 112 *supra* at 490. The discussion below, however, does not directly relate to this situation.

If one assumes that most patients would wish to be informed if there were *any risk* of acquiring HIV (or HBV) from their doctor, the issue becomes whether there is any reason not to conclude that the reasonable person in the patient's position would also wish to be informed, assuming that the doctor or HCW was intending to perform exposure prone procedures.[116] There seems little doubt that, if consulted, most people would regard the risk of HIV/HBV transmission as significant when making treatment decisions, whether because they were unconvinced of the protection afforded by universal precautions or simply because they did not believe current risk assessments.[117] Even if the risk were minimal, reasonable patients might nevertheless choose to avoid the risk by switching doctors. While reasonable patients may accept the risks of failure or of complications inherent to the medical procedures which are performed, it does not follow that they would accept the risk of contracting a chronic (HBV) or ultimately fatal (HIV) infection from their doctor, however remote the risk. Commentators have noted that risks which are familiar and voluntarily assumed are more acceptable to the public than risks which are unfamiliar, uncertain, and assumed involuntarily, even when the latter are far less likely.[118] The social construction of AIDS, the stigma surrounding it, and the fact that it is an awful, lethal condition all suggest that the general public, if given the choice, would be unwilling to 'risk' medical treatment from an HIV infected doctor. On the other hand, if zero risk is the goal, this would require HCWs to stop performing invasive procedures after every potential exposure, for a period of several months until the 'window period' had passed, at which time an HIV antibody test could give a true indication of their own status.[119]

Clearly, the issue cannot be resolved by requiring a doctor or HCW to disclose risks above a certain probability; the conflict is deeper, and revolves around whose perception of the risks, or whose construction of the 'reasonable patient' is determinative. Does the 'reasonable person in the patient's position' share the concerns or fears of the community, or would courts regard such a person as not being influenced by risks which were, in a statistical sense, remote?

Precisely this issue was considered by the Superior Court of New Jersey in *Estate of Behringer v Princeton Medical Center*.[120] Dr Behringer was an ear, nose and throat specialist and a plastic surgeon at the defendant Centre. He fell ill and was admitted to the Centre, where an HIV test was performed, together with a bronchoscopy to determine if he had PCP (an AIDS-defining pneumonia). Dr Behringer's HIV test was positive, and he was also informed that he had AIDS. The HIV test and bronchoscopy results were placed in his chart - which was widely available to medical staff - while he was still in the Centre. As a result, Dr Behringer's diagnosis was leaked and soon became public knowledge; friends and colleagues were informed, and Behringer's practice deteriorated as patients heard of his illness and requested transfer of their files.

---

116 See N Daniels, note 17 *supra* at 29-30.

117 See D Beane, note 47 *supra* at 663-4.

118 B Lo, R Steinbrook, note 43 *supra* at 1101, 1104; L Glantz et al, note 43 *supra* at 56ff.

119 B Lo, R Steinbrook, note 43 *supra* at 1102.

120 592 A 2d 1251 (1991).

Upon learning of the illness, the President of the Centre suspended Behringer's right to practise surgery at the Centre, both to protect Behringer's patients, and to protect the Centre's legal position. The issue was debated before the Board of Trustees which adopted a policy requiring HIV infected physicians not to perform procedures involving any risk of HIV transmission to patients. The Board had previously adopted a policy requiring Dr Behringer to disclose his HIV status to patients and to obtain their consent to any operative or invasive procedure performed by him. Behringer's surgical privileges at the Centre were suspended by the Board under this policy and were not reinstated prior to his death from AIDS two years later.

Dr Behringer's estate sued the Centre for breach of confidentiality and for violation of a New Jersey discrimination statute. It recovered damages for breach of confidence, although the Board's policy requiring Behringer to disclose his HIV status to his surgical patients and its later decision requiring HIV infected physicians not to perform invasive procedures were held not to be unlawful discrimination. The Court reached this decision on the basis that Dr Behringer owed a duty of care to his surgical patients to inform them of his HIV status. This duty was to disclose "material" risks, which "a reasonable patient would be likely to attach significance to...in deciding whether or not to submit to the treatment".[121]

The Court took the view that the risks which the surgery posed by virtue of the fact that it would be performed by an HIV infected surgeon, included not only the risk of HIV transmission, but also the risk of needlestick or other accident subjecting the patient to months of HIV testing to determine whether transmission had occurred. The Court also considered *whose* perception of the risk should determine whether a risk was material. The plaintiff had argued that disclosure was not warranted, as the patient's reaction was likely to be based upon public hysteria, rather than on a rational assessment of actual risk. The Court concluded, however, that "the public reaction to AIDS cannot deprive the patient of making the ultimate decision where the ultimate risk is so significant".[122] Although HIV transmission was unlikely, HIV/AIDS was so serious that any risk should be disclosed to the patient.[123] As the Superior Court of Pennsylvania stated in another case, "it is no consolation to the one or two individuals who become infected after innocently consenting to medical care by an unhealthy doctor that they were part of a rare statistic".[124]

The *Behringer* case is significant for two reasons. First, it held that information not only about the likely success of a medical procedure, but also about the health and competence of the person performing it, will be relevant when disclosing 'material risks' to a patient. It implies that a duty of 'self-disclosure' could also operate where a doctor is HBV/HCV infected, or where the doctor is an alcoholic,[125] or even where the doctor has previously caused injury through negligence or accidental mishap. Secondly, the Court held that commonly held

---

121 *Ibid* at 1278; cf *Rogers v Whitaker*, note 112 *supra* at 490.

122 *Ibid* at 1280.

123 *Ibid* at 1283.

124 *In re Application of the Milton S Hershey Medical Center* 595 A 2d 1290 (1991) at 1296.

125 As in *Hidding v Williams* 578 So 2d 1192 (1991).

fears may constitute 'material risks', at least in circumstances where the harm which the patient will suffer if the risk materialises, is significant. In view of public fears about AIDS, the implication is that an HCW must disclose whenever there is *any risk* of HIV transmission.

The Court's approach on each of the above issues deserves closer scrutiny. The implicit recognition in *Behringer* that commonly held fears may constitute 'material risks' surrenders the right which courts might otherwise have to ensure that the risks which patients are warned about are significant in a scientific sense, or that the duty to warn of risks retains some connection with a rational, reasonable social policy. As seen below, it also comes very close to requiring HCWs to guarantee no risk to their patients. In *Faya v Almaraz*,[126] the Maryland Court of Appeals agreed that a surgeon's failure to disclose to two patients that he had AIDS was unreasonable in view of the foreseeable risk of HIV transmission during surgery. While the plaintiffs did not provide any evidence of anything which might have resulted in transmission, the failure to disclose was enough to state a cause of action for negligence, the injury in this case being insomnia, headaches, and distress caused by fear of contracting HIV between the time the patients found out the surgeon's status and the time they subsequently tested HIV negative.[127] The case amounts to little more than strict liability imposed upon infected HCWs for failure to warn patients of their HIV status, provided that they themselves know of their infection. As a result of the recent California Supreme Court decision in *Potter v Firestone Tire & Rubber Co*,[128] however, it is likely that future courts will be more reluctant to accept claims for fear of contracting AIDS and other diseases, brought in negligence, unless the plaintiff can also show on the balance of probabilities that the disease is likely to occur.

Despite the real concern in the community about HIV transmission, an approach which equates 'material risk' with community concern is ultimately flawed:

> While preserving patient autonomy, public policy and liability for lack of informed consent should have some basis in scientific fact. Otherwise, there is a real danger that courts will generate law that is fatally flawed. Insisting on informed consent concerning issues having nothing to do with treatment risks, but everything to do with public perception, jeopardises the delivery of health care.[129]

The second issue in *Behringer* which deserves closer scrutiny is the assumption that the duty of an HCW to avoid causing harm to a patient by transmitting an

---

126 620 A 2d 327 (1993).

127 Another court held that where a patient inquires whether a doctor is healthy, and the doctor neglects to reveal that he has HIV, an action for battery may exist providing recovery for emotional distress during the 'window of anxiety' between hearing of the HCW's status and testing negative: *Kerins v Hartley* 21 Cal Rptr 2d 621 (1993). An action in negligence was also allowed, although this was remitted for re-hearing and later decided differently as a result of the California Supreme Court decision in *Potter v Firestone Tire & Rubber Co*, note 128 *infra* (discussed in text): see *Kerins II* 33 Cal Rptr 2d 172 (1994). For additional cases and comment, see T LeBlang, "Obligations of HIV-Infected Health Professionals to Inform Patients of their Serological Status: Evolving Theories of Liability" (1994) 27 *John Marshall Law Review* 317; M Logan, "Who's Afraid of Whom? Courts Require HIV-Infected Doctors to Obtain Informed Consent of Patients" (1995) 44 *DePaul Law Review* 483.

128 863 P 2d 795 (1993); noted, H Luntz, "Fear of Disease as Damage in Negligence: The View of the Supreme Court of California" (1995) 3 *Torts Law Journal* (forthcoming).

129 D Beane, note 47 *supra* at 664.

infectious disease is really a part of the duty of an HCW to obtain patient consent to material risks associated with medical treatment. In fact, it is submitted that these two duties are quite different. The latter duty was developed "to assist patients in making decisions about the benefits and risks of medical treatments, and not to protect them against incompetent or dangerous physicians".[130] The Australian High Court, as noted above, has adopted a two-pronged definition of what constitutes a 'material risk',[131] which includes those risks the doctor is or should reasonably be aware *that the particular patient*, if warned of the risk, would be likely to attach significance to.[132] It might be argued, therefore, that this additional definition could extend to risks posed by the HCW, rather than the procedure itself. It is submitted, however, that the duty to warn of material risks is best limited to risks associated with the procedure. *Behringer* would collapse the distinction, although not all courts have taken this view.[133]

There are good reasons why the alleged risk-causing characteristics of a person performing a medical procedure should not be considered relevant to the process of obtaining patient consent. Commentators have argued that (unlike disclosure of the risks of misadventure inherent in a procedure) an alleged duty to self-disclose creates a conflict of interest for the HCW[134] and enables the law of consent to be used as a tool of discrimination, and to destroy the privacy interests of individuals.[135] This is unfortunate not only for the individual, but also for society generally if society is deprived of HCWs who could have continued to provide a service to society for many years, without risk to patients, by adopting appropriate infection control procedures. It is also arguable that if the risk is significant enough to require a patient to consent to it, then the HCW should not practise, regardless of consent. After all, as a matter of general social policy, pilots with heart conditions are disqualified, their passengers are not asked to 'consent' to the risk.[136] The important point, however, is this: to say that doctors have no duty to disclose does not mean that they have no duty to take reasonable care to avoid transmitting HIV or hepatitis to their patients.

Australian courts should therefore reject the emerging American jurisprudence which would require HCWs to reveal their serological status in view of speculative and remote risks causing community fear. While courts should not ignore the legitimate preferences of the community, the perception of risk held by the 'reasonable patient' (although not perhaps by the particular patient whose wishes

---

130 L Gostin, note 65 *supra* at 304.

131 Note 115 *supra* and accompanying text.

132 *Rogers v Whitaker*, note 112 *supra* at 490.

133 See *Kaskie v Wright* 589 A 2d 213 (1991) at 216.

134 C Feldblum, "A Response to Gostin, "The HIV-Infected Health Care Professional: Public Policy, Discrimination, and Patient Safety" (1991) 19 *Law, Medicine & Health Care* 134 at 135.

135 L Glantz et al, note 43 *supra* at 72-3.

136 *Ibid* at 72. As R Zeckhauser and W Viscusi point out, "[i]n a democratic society one should hesitate to override the legitimate preferences of segments of the population, taking care not to dismiss diversity of taste as mere non-rational choice. Where there is a broad consensus on a rational course of action, however, and either the cost of providing information is high or individuals cannot process the information adequately, mandatory requirements may be preferable to risk information efforts": R Zeckhauser, W Viscusi, "Risk within Reason" (1990) 248 *Science* 559 at 561.

are known to the HCW) should ultimately have a rational basis, grounded in science. More importantly, risks posed by HCWs should be regulated in ways other than through the duty to consent a patient to the risks inherent in medical procedures. One way in which the common law regulates that risk is through a quite separate duty incumbent upon HCWs to take reasonable care not to transmit infectious diseases to their patients in the course of medical practice.

B. HIV Infected HCWs - A Duty of Care not to Cause Harm

A foreseeable risk of HIV (or HBV/HCV) transmission from HCW to patient in the course of medical practice calls for a consideration of what the reasonable infected HCW would do in response to that risk. As noted above, this involves a balancing out of:

> the magnitude of the risk and the degree of probability of its occurrence, along with the expense, difficulty and inconvenience of taking alleviating action and any other conflicting responsibilities which the [HCW] may have.[137]

It seems reasonable to argue that when an infected HCW is performing invasive procedures which are not exposure prone, the risk of transmission will be quite far-fetched. Even so, the reasonable infected HCW would arguably take care to minimise as far as possible the risk of exposing patients to his or her bodily fluids by following universal precautions. In view of the fact that these precautions are widely recommended to all HCWs, regardless of their HIV status, and *do minimise the risk of transmission*, it is likely that courts would regard HCW compliance as an integral part of an HCW's duty of care to the patient, regardless of serological status. On this view, if it could be shown that HIV transmission from HCW to patient occurred as a result of failure to comply with universal precautions, this might well be regarded as evidence of breach of duty of care. While the duty of the infected HCW is to take reasonable care to prevent transmission, rather than to guarantee patient safety,[138] the argument that following universal precautions is time consuming and impractical is unlikely to succeed, given that HIV is a serious and lethal illness.

One of the most sensitive issues at present concerns whether compliance with universal precautions would constitute 'reasonable care' when an infected HCW was performing exposure prone procedures or whether the reasonable infected HCW would exclude himself or herself from performing such procedures. It is of concern that, despite the low risk of transmission to any particular patient, the risk of transmission to *a patient* rises over time to become an appreciable risk.[139] On the other hand, strict compliance with universal precautions has been found to reduce the risk of occupational exposures,[140] although further study of these issues may be required. A complicating factor which also needs to be borne in mind, as recognised by the CDC recommendations[141] and demonstrated by the 'clustered' nature of HCW to patient occupational HIV/HBV transmission, is that individual

137 *Wyong Shire Council v Shirt*, note 98 *supra* at 47-8, per Mason J.
138 See *Vozza v Tooth & Co Ltd* (1964) 112 CLR 316.
139 L Gostin, note 54 *supra* and accompanying text.
140 Note 22 *supra*.
141 CDC, note 42 *supra* and accompanying text.

level of skill is just as important to transmission risk as the fact that an HCW is performing exposure prone procedures. The CDC recommendations require infected HCWs performing invasive procedures (and not just exposure prone procedures) to seek guidance from an expert panel which may determine which invasive procedures the particular HCW may continue to perform. Arguably, these recommendations embody a reasonable response to the transmission risk which avoids the substantial social cost of restricting all HIV infected HCWs from performing exposure prone procedures for the rest of their careers.[142]

It appears likely that an HIV infected HCW who transmitted an infection while performing exposure prone procedures without following universal precautions, would be liable in negligence. It is also clear that exclusion or self-exclusion from exposure prone procedures eliminates the transmission risk. Whether courts would hold an HCW liable who transmitted an infection as a result of a mishap despite using universal precautions is difficult to predict, although this could well be influenced by evidence of the HCW's prior infection control record, which may or may not have 'put the HCW on notice' of skill deficiencies requiring re-training, modification of procedures, or self-exclusion from certain procedures. Arguably, it is also part of the duty of care of infected HCWs, like non-infected ones, not to perform procedures if their level of fatigue or state of health is likely to create a significant risk of injury to the patient, and these might also be regarded as relevant factors if a court were asked to determine liability in this situation.

The NSW Health Department guidelines encourage HIV/HBV infected HCWs to notify their employer in order to fulfil their common law duty to show reasonable care toward patients. The underlying rationale is presumably that employers have access to the expert advice available from the Department's Advisory Panel for Health Care Workers infected with Blood Borne Viruses, which may provide case by case advice on infection control procedures and modifying work practices of infected HCWs. Individualised review is a useful feature of the NSW model, although in contrast to the CDC model, infected HCWs are nevertheless precluded from practising exposure prone procedures.

C. HIV Infected HCWs and Discrimination

It is important to distinguish between an HCW's duty to patients, and an employer's duty to HCWs. The risk posed by HCWs to patients is, however, relevant to how an employer may restrict or terminate the employment of an HCW, since the protection enjoyed by HIV (or HBV/HCV) infected HCWs from discrimination in employment[143] is subject to discrimination "reasonably necessary to protect public health".[144]

The first issue which arises is whether it is discriminatory to require HCWs to be periodically tested for HIV/HBV. In NSW, mandatory testing may be required under legislation.[145] Testing could not be discriminatory if it were a requirement

142 For discussion of these costs, see M Barnes et al, note 20 *supra* at 320-1.

143 *Disability Discrimination Act* 1992 (Cth), s 15.

144 *Ibid*, s 48. See note 6 *supra* for State legislation.

145 P Blair, note 41 *supra* and accompanying text.

imposed upon all HCWs[146] and where any consequences following from a positive test, such as counselling and education to minimise the transmission risk to patients, were reasonably necessary to protect public health. It is arguable that the CDC recommendations, which require infected HCWs to be monitored by an expert panel which assesses individual skill and transmission risk on a case by case basis, would come within this category.

In *Leckelt v Board of Commissioners of Hospital District No 1*,[147] a United States Circuit Court of Appeals upheld the dismissal of a gay nurse with IV line duties who had refused to disclose to hospital management the results of an HIV test obtained in another city. The hospital did not impose the testing requirement upon all employees, but only upon the plaintiff, who was the roommate of an AIDS patient currently in the hospital. The plaintiff followed infection control procedures, and there was a dispute concerning whether his duties even involved 'invasive procedures'. The hospital claimed it needed to know the plaintiff's HIV status in order to comply with CDC guidelines, under which the plaintiff could have continued to work, having obtained a medical clearance following review by an expert panel of what procedures he could safely perform. The plaintiff claimed he was dismissed on suspicion of being HIV positive and that this violated federal anti-discrimination law. The hospital claimed that he had been dismissed for insubordination. The Court held that while the plaintiff could have continued to work, following disclosure of a positive test result, by failing to disclose his results he prevented the hospital from administering the CDC policy. Clearly, it was influenced by its assessment of the risk to patients, noting that while the risk of HIV transmission from HCW to patient was "extremely low and can be further minimised through the use of universal precautions, there is no cure for HIV or AIDS at this time, and the potential harm of HIV infection is extremely high".[148] The Court reached the strange result, therefore, that while the plaintiff could not have been lawfully dismissed for testing positive, he was lawfully dismissed for refusing disclosure of test results.

The decision has been criticised as being based upon hearsay regarding sexual orientation, in view of the fact that Leckelt used universal precautions and could not be said to pose a significant risk to anyone.[149] It can hardly be said that the dismissal of an HCW following universal precautions, and not performing exposure prone procedures, is reasonably necessary for public health. The more sensitive issue, however, is whether the public health exception would justify placing restrictions upon infected HCWs (or those who refuse to be tested[150] or to disclose test results) who follow universal precautions but also perform exposure prone procedures. Arguably, in this case, it would need to be shown that the risk

146 Cf the *Leckelt* decision (note 147 infra and discussed below), which in the writer's view is flawed in view of the fact that the testing requirement was imposed upon the plaintiff alone, who was in any event following universal precautions and who was not performing exposure prone procedures.

147 909 F 2d 820 (1990).

148 *Ibid* at 829.

149 L Glantz et al, note 43 *supra* at 66-9; M Barnes et al, note 20 *supra* at 318-19.

150 Note that legislation authorising HIV testing following needlestick injuries exists in some States: *Health Act* 1958 (Vic), ss 120A-120D; *HIV/AIDS Preventive Measures Act* 1993 (Tas), s 10(2).

of HIV transmission to patients despite compliance with universal precautions, was unreasonable. The risk of *a patient* being infected over time by an infected HCW performing many procedures over a career would be a relevant consideration. However, while patients may feel comforted to know that there is no possibility of receiving treatment from an HIV infected HCW, it would be illegal to discriminate against such HCWs by excluding them from performing exposure prone procedures (or invasive procedures) in the absence of evidence that universal precautions are ineffective in protecting public health and that an exclusionary policy was thus reasonably necessary. It is possible that courts might conclude that the uniform exclusion of infected HCWs from performing exposure prone procedures is not reasonably necessary in view of the fact that a less restrictive system, involving individualised inquiry into the transmission risk of infected HCWs as affected by skill level, is sufficient to protect public health.

The legality of the NSW Health Department, RACS, and AMA policies, which would exclude HIV/HBV infected HCWs from performing exposure prone procedures, depends upon these difficult assessments.[151] The decision will, of course, differ in accordance with the relative infectiousness of HIV, HBV, and HCV. Courts may also reach different decisions as evidence of occupational transmission and the effectiveness of infection control procedures continues to accumulate. In view of the criterion of 'reasonableness' which underlies both (i) the public health exception to the *Disability Discrimination Act* 1992 (Cth); and (ii) the response required of an infected HCW to the risk of occupational transmission, it is suggested that the exclusion of infected HCWs from performing exposure prone procedures would only be 'reasonably necessary to protect public health' if the duty of care owed by the HCW also required self-exclusion, and not merely the adoption of universal precautions. These are difficult decisions, although the writer's view is that neither the HCW's duty of care, nor the public health exception in the *Disability Discrimination Act* 1992 (Cth) justify excluding HCWs from performing exposure prone procedures, provided universal precautions are stringently adhered to, and particularly if some form of individualised inquiry system similar to that advocated by the CDC guidelines was in place.

VI. HIV INFECTED HCWS AND PATIENTS: CONCLUSIONS

It is useful to summarise the conclusions reached so far. Anti-discrimination legislation would preclude HCWs from refusing to treat patients of positive or unknown HIV status and from deferring treatment as a way of enforcing testing unless it could be shown that universal precautions were an inadequate way of minimising transmission risk from patient to HCW and that testing was therefore 'reasonably necessary' under the public health exception to the *Disability Discrimination Act* 1992 (Cth). Surreptitious HIV testing without specific consent

151 It should be noted that State legislation purporting to authorise the exclusion of infected HCWs would be invalid in so far as it was inconsistent with the *Disability Discrimination Act* 1992 (Cth).

is unethical, if not illegal, and testing without any consent would be a battery. A review of relevant legal issues does suggest, therefore, that the claimed right of HCWs to know the HIV status of patients before providing medical care is not supported by law. On the other hand, assuming that patients themselves owe a duty to disclose their HIV status to HCWs, it is far from clear that a patient would not be liable if occupational transmission occurred in circumstances where the patient had failed to disclose his or her status.

While HCWs infected with HIV have a duty to take reasonable care to prevent transmission to their patients, it has been argued that they do not owe a duty to disclose their status to patients. Mandatory HIV testing of HCWs by an employer is not illegal *per se*, although its legality would depend upon whether the *restrictions which followed from testing positive were "reasonably necessary to protect public health". HCWs are likely to be held liable if occupational transmission of HIV occurred in circumstances where the HCW had failed to follow recommended infection control guidelines embodying universal precautions. It is possible that current policies preventing infected HCWs from performing exposure prone procedures *at all*, in contrast to a policy requiring infected HCWs to strictly adhere to universal precautions and to undergo an individualised assessment into risk posed by skill deficiencies, go beyond what is necessary to show reasonable care to patients. Current policies may therefore discriminate against HIV infected HCWs, unless it could be shown, essentially, that the evidence demonstrates that the risk of occupational HIV transmission from HCW to patient, over time and despite universal precautions, is unreasonable. These are difficult assessments which may change as evidence accumulates concerning the risk of occupational HIV transmission and of the effectiveness of infection control procedures in reducing that risk. These assessments may well be different in the case of HIV, HBV, and HCV, in view of the differing infectivity of each virus.

VII. CONFIDENTIALITY AND HIV/AIDS HEALTH CARE: ONGOING DILEMMAS

Closely associated with debates over HIV testing are debates over who should be informed of HIV test results. HIV/AIDS has stimulated renewed consideration of the limits of medical confidentiality, in view of the risks and consequences of transmission.

A. 'Hard Cases'

While it is hardly fashionable to say so, the evidence suggests that a small minority of persons with HIV/AIDS will continue to have unprotected sex without informing their partners. Anecdotal evidence of the issues faced by doctors was provided to the author in a study of privacy issues arising within HIV/AIDS health care.[152] In one case, a contact tracer working in an STD clinic reported that for

152 RS Magnusson, note 95 *supra* at 56-7.

three years he had been counselling an HIV positive bisexual male who would not tell his wife of his infection for fear of losing her and custody of their children. The contact tracer said:

> I have got to know this man well, and jokingly, I have suggested that one day legislation may require me as a contact tracer to tell his wife that he is HIV infected... Whenever I have said that, the man has looked me in the eye and said, smilingly, 'the day you do that you will be found dead in the gutter with a knife between your ribs'. The man is deadly serious. At this stage the man says he is using condoms when having sex with his wife since she has problems with contraceptives and I can only accept that. I have asked him what will happen if his wife gets a hysterectomy and he says that he'll face that when he needs to. He says he will commit suicide if he loses his wife and kids - if they leave him. He's healthy now, and full of denial. But what will happen if he gets sick?

In another case, an infectious diseases physician reported how a man came to see him and said: "My lover says he doesn't have AIDS; however, he's got these pills - one says 'AZT'". The man quoted the initials on the pill box, and the physician realised that they belonged to his patient, whom he was treating for HIV illness. In a third case, a registrar in an HIV/AIDS inpatient ward reported how medical staff had been informed by a former lover that a particular inpatient was having unprotected anal sex with lovers without telling them that he was HIV infected. Medical staff were unable to convince the patient to tell his lovers; he merely said, "I have the right to be loved". The patient later disappeared from hospital and did not return.

Numerous other examples or allegations of persons with HIV placing sexual partners at risk through unprotected sex have been reported in the media in Australia,[153] New Zealand,[154] and England.[155] This has resulted in civil litigation in some cases.[156] Statutory offences exist in some jurisdictions for knowingly or

---

153 For example, "AIDS Reveals a Secret, Ends Marriage and Career" *Age* (Melbourne), 7 August 1991, p 3; "The Responsibilities of being Bisexual" *Age* (Melbourne), 15 August 1991, p 13 (reporting on the case of a bisexual man who had casual sex throughout his marriage, who contracted HIV and belatedly informed his wife of his status); "Wife in Dark about AIDS Risk" *Sunday Herald-Sun* (Melbourne), 2 June 1991, p 95 (a letter to advice columnist Carolyn Palliardi by a reader who thought he had AIDS but had not taken an HIV test and had not told his wife because he did not want to lose her).

154 For example, "Mwai Said he had HIV: Neighbour" *New Zealand Herald*, 9 December 1994, p 13; "Mwai 'Unaware HIV so Serious'" *New Zealand Herald*, 10 December 1994, p 12 (reporting on man later convicted for recklessly spreading HIV); "AIDS Man Loose: Health Bosses Try to Defuse Human 'Walking Time Bomb'" *Sunday Star* (Auckland), 29 April 1990; "Teenager Jailed for Torturing AIDS Carrier" *Evening Post*, 27 April 1990; "Teenager Tortures AIDS Carrier" *Christchurch Star*, 26 April 1990; "Tortured Timaru AIDS Virus Carrier Vows to Continue his Sex Life" *The Dominion* (Wellington), 1 May 1990 (reporting on an HIV positive man who had unprotected sex with a 17 year old woman; the same man was subsequently tortured by the woman and by two other men, all three of whom were sentenced to between 18 and 30 months jail. The HIV positive man was not charged but told reporters that he would continue to practise safe sex with condoms).

155 "Man: Set out to Spread HIV" *Guardian*, 23 June 1992, p 1; "Man Derides Claim he Tried to Spread HIV" *Guardian*, 24 June 1992, p 1 (reporting on a man suspected by public health authorities); "It was the End of the World..." *Guardian*, 24 June 1992, p 3 (story on one of four woman who claimed to have been infected by the same man).

156 *Bell-Ginsburg v Ginsburg* (1993) 17 CCLT (2d) 167 (action in negligence/intentional infliction of emotional distress). In 1992, an Adelaide woman applied unsuccessfully for her marriage to be declared void after discovering that her husband knew that he was HIV positive since before the time they met and

recklessly infecting another person with an infectious disease,[157] and public health legislation provides for the eventual isolation or quarantine of individuals whose behaviour poses a serious risk to public health.[158] The application of these provisions has attracted wide publicity in some cases,[159] and some prosecutions have occurred,[160] although these provisions are unlikely to resolve the issues confronting doctors treating infected patients who refuse to tell their regular sex partners of their HIV status.

The current AMA Position Statement on AIDS supports the right of medical practitioners to inform the sexual partners of patients who refuse to disclose their HIV status,[161] although no guidelines are given on when and how doctors should exercise this discretion. The New Zealand Medical Association, however, has adopted a partner notification protocol as part of its HIV/AIDS policy.[162] The protocol authorises a doctor to inform and counsel the sexual or intravenous drug sharing partner(s) of an HIV infected patient if the following criteria are met:

(i) there is a clear risk of HIV transmission to an acknowledged partner;
(ii) the patient has been provided with education, counselling and support to encourage them to disclose their status voluntarily; but
(iii) the patient has failed to do so (ie counselling has failed);
(iv) the doctor has sought advice from colleagues, or an institutional ethics committee;
(v) the matter has been discussed with the doctor's medical protection or defence adviser;
(vi) the patient has been advised in writing of the doctor's intention to disclose the information to the patient's partner; and
(vii) the patient still refuses to inform the party at risk.[163]

This protocol will be referred to again, below.[164]

In Australia, the Legal Working Party of the Intergovernmental Committee on AIDS has recommended that professional care-givers should be protected by legislation from actions for breach of confidence or for breach of the duty of care for *failure* to warn a third party when acting in accordance with partner

---

commenced a sexual relationship: (names suppressed, unreported, Family Court of Australia, Judicial Registrar Forbes, 29 September 1992).

157 *Health Act* 1958 (Vic), s 120; *Crimes Act* 1958 (Vic), s 19A (intentionally causing HIV); *Health Act* 1937 (Qld), s 48; *Public and Environmental Health Act* 1987 (SA), s 37(1); *HIV/AIDS Preventive Measures Act* 1993 (Tas), s 20(2).

158 See Part 1, note 17.

159 See Part 1, note 18.

160 "HIV Man 'Was an Expert Seducer'" *Australian*, 15 April 1994; "HIV Man to Stand Trial for 'Reckless' Sex" *Age* (Melbourne), 2 July 1993; *R v Mwai* (unreported, High Court of New Zealand, Robertson J, 23 December 1994 (Remarks in Sentence)).

161 AMA, note 26 *supra* at [15.3].

162 New Zealand Medical Association, *Policy Relating to HIV/AIDS*, 1990, which includes a policy on 'HIV Status and Patient Confidentiality', adopted by the Assembly 12 September 1990; discussed: "Minister: Like Paedophiles in a Kindergarten" *New Zealand Doctor*, 21 May 1990 at 9.

163 Similar protocols have been advocated in the literature; eg S Erickson, "Counselling the Irresponsible AIDS Client: Guidelines for Decision Making" (1990) 68 *Journal of Counselling & Development* 454.

164 See Section VII(D) below.

notification protocols containing the criteria listed above.[165] Disclosure would also be permitted under the recommended guidelines of the Privacy and HIV/AIDS Working Party chaired by the Privacy Commissioner, although currently these guidelines only have effect (in so far as they differ from the *Privacy Act* 1988 (Cth)), as administrative policy voluntarily adopted by federal (or State) agencies. The guidelines would authorise the disclosure of HIV status where this was:

(i) necessary to protect another person from a serious and imminent risk of HIV infection and was the only reasonable way of reducing that risk;
(ii) the person concerned has refused to consent to disclosure after being given the opportunity to do so; and
(iii) disclosure was made by a counsellor with partner notification experience.[166]

The case of an HIV infected patient having unprotected sex or sharing needles with unsuspecting partners remains the strongest case where HCWs may be tempted to disclose, although other cases also arise. Should the doctor of a patient with AIDS who is managing to hold down a job in a restaurant inform the patient's employers?[167] Should the doctor of a person with HIV who works as a full-time child care worker disclose this to the patient's employers? This issue has generated considerable emotion. In September 1994, the Federal Employment Minister, Simon Crean, analogised HIV infected child care workers to "paedophiles in kindergarten".[168] Finally, should a doctor whose patient is an HIV infected HCW inform the employers of the HCW in view of the risk of occupational transmission?

The legal issues raised by disclosure by an HCW to third parties in order to minimise the risk of HIV transmission have most frequently been discussed within the context of 'recalcitrant' bisexual or homosexual patients who refuse to reveal their HIV status, yet continue to place sexual partners at risk.[169] The legality of disclosure will depend upon two factors:

(i) the scope of the 'public interest' defence or exception which operates in derogation from the usual duty of confidentiality owed by HCWs at common law; and
(ii) the scope of confidentiality legislation which differs from State to State.

---

165 IGCA, note 114 *supra* (Recommendation 2.2).

166 Commonwealth of Australia, *Report of the Privacy and HIV/AIDS Working Party*, September 1992, Guideline 8.

167 In one case, a man with AIDS told the writer that he was sneaking into the back alley to give himself chemotherapy shots each evening between taking orders. He noted that by the time the drug took effect, his shift was finished. He was surprised that his employer never found out.

168 (1994) 5(3) *HIV/AIDS Legal Link* 18.

169 M Neave, "AIDS - Confidentiality and the Duty to Warn" (1987) 9 *University of Tasmania Law Review* 1; R Paterson, "AIDS, HIV Testing, and Medical Confidentiality" (1991) 7 *Otago Law Review* 379; R O'Dair, "Liability in Tort for the Transmission of AIDS: Some Lessons from Afar and the Prospects for the Future" [1990] *Current Legal Problems* 219 at 232-41; D Casswell, "Disclosure by a Physician of AIDS-Related Patient Information: An Ethical and Legal Dilemma" (1989) 68 *Canadian Bar Review* 225; M Beaupré, "Confidentiality, HIV/AIDS and Prison Health Care Services" (1994) 2 *Medical Law Review* 149.

B. Relevant Legislation

In the United States,[170] and in some Canadian provinces,[171] confidentiality statutes specify the persons (including spouses and sexual partners) who may be notified of an infectious disease, including HIV/AIDS. Legislative protocols for the notification of specified third parties may be a preferable approach for Australian States, in view of the confusion caused in some jurisdictions by different categories of provisions which variously relate to:

(i) non-disclosure generally;
(ii) non-disclosure of, specifically, HIV information;
(iii) contact tracing;
(iv) HIV/AIDS reporting; and
(v) public health powers.

Legislation is relevant to three issues in cases where an HIV patient objects to disclosure:

(i) whether an HCW can inform a sexual contact of the HIV patient;
(ii) whether an HCW can inform the Health Department of a 'problem case' involving the HIV patient; and
(iii) whether Health Department officials can inform a sexual contact of the HIV patient.

Health authorities in all jurisdictions are empowered to make public health orders, to require diagnostic testing, and eventually to quarantine persons thought to be carrying infectious diseases whose behaviour presents a risk to public health.[172] Health Department guidelines in four States provide for the staged exercise of these powers.[173] These procedures assist in controlling risk by controlling the activities of the HIV patient himself or herself. However, coercive public health measures are a fairly blunt instrument and are, in practical terms, only useful where the HIV patient is placing multiple, unidentified third parties at risk of HIV transmission. In view of the complexity of Australian provisions, it is useful to summarise the position in each State, beginning with the duties owed by HCWs.

(i) New South Wales

A statutory duty of non-disclosure imposed upon the employees of public sector health organisations operates, although a statutory exception permits disclosure "with lawful excuse".[174] Arguably, this would authorise disclosure where this was justified at common law. A specific duty to take reasonable steps to prevent disclosure of a person's HIV status also applies to HCWs, although a person's HIV status may be disclosed to the Director-General of the Health Department if

---

170 See L Gostin, "Public Health Strategies for Confronting AIDS" (1989) 261 *JAMA* 1621 at 1627-8; D Price, "Between Scylla and Charybdis: Charting a Course to Reconcile the Duty of Confidentiality and the Duty to Warn in the AIDS Context" (1990) 94 *Dickinson Law Review* 435 at 457-71.

171 See D Casswell, note 169 *supra* at 232-34.

172 See Part 1, note 17.

173 See Part 1, note 18 and accompanying text.

174 *Health Administration Act* 1982 (NSW), s 22(d).

the person is placing public health at risk,[175] thereby enabling the Department's public health powers to be activated. It is uncertain whether *unilateral* disclosure by an HCW to the partner of an infected patient would breach the *Public Health Act* 1991 (NSW), s 17(2) which requires HCWs to take reasonable steps to prevent disclosure of HIV information to others and enumerates certain exceptions. This would depend upon whether the legislation was intended to codify HCWs' non-disclosure obligations with respect to HIV information and to exclude the operation of the common law.

(ii) Victoria

A statutory duty of non-disclosure applies to a range of HCWs in the public and private sectors, and does appear to codify the non-disclosure obligations of the relevant categories of HCWs.[176] Disclosure would, however, be permitted where the Minister certifies disclosure to be in the public interest.[177] Unlike NSW, it appears that HCWs subject to the *Health Services Act* 1988 (Vic), s 141 would therefore require ministerial permission to authorise disclosure to Health Department officials in order to activate the Department's public health powers.[178] Similarly, ministerial permission would be required to inform a sexual partner of an HIV patient. In practice, this issue has been largely overcome by the extraordinary hard work of Health Department-employed contact tracers, whose reputation and professionalism in Victoria are well known in the HIV and gay community, so that doctors are able to obtain patient consent before they become involved in counselling. The legality of disclosure by HCWs not subject to the legislation above would depend upon the common law.

(iii) Queensland

HCWs employed by public sector health services are subject to a statutory duty of non-disclosure under the *Health Services Act* 1991 (Qld).[179] Strangely, the Act does not appear to set out any relevant exceptions authorising disclosure to sexual partners or disclosure to the Health Department in order to activate public health powers.[180] However, the *Health Act* 1937 (Qld) provides that the Director-General may require nominal notification of HIV in order to protect the public against an "outbreak" of HIV,[181] and presumably this request would be made if

---

175 *Public Health Act* 1991 (NSW), s 17(3)(e) and *Public Health Regulation*, reg 7(2).

176 *Health Services Act* 1988 (Vic), s 141 (applies to employees of public and private hospitals, nursing homes, community health services, and day care centres).

177 *Ibid*, s 141(3)(h).

178 *Health Act* 1958 (Vic), ss 121-122.

179 *Health Services Act* 1991 (Qld), s 5.1.

180 Disclosure is justified if "required by operation of law": *ibid*, s 5.1(2)(a). Although some judges have spoken loosely of a *duty* to disclose confidential information in the public interest (*W v Egdell* [1990] 1 Ch 359 at 419; *Lion Laboratories Ltd v Evans* [1985] 1 QB 526 at 537; *Duncan v Medical Disciplinary Committee* [1986] 1 NZLR 513 at 521), the availability of the public interest defence at common law has usually been understood as affording the confidee a discretion to disclose which, if exercised, avoids liability for breach of confidence. The public interest exception to breach of confidence does not, therefore, provide an exception under the legislation.

181 *Health Act* 1937 (Qld), s 32A(9).

any problems became apparent when notifying doctors filled out the Departmental questionnaire periodically sent to doctors requesting updates on contract tracing.[182]

(iv) South Australia

HCWs employed by the Health Commission, incorporated hospitals, and health centres owe a statutory duty of non-disclosure, although disclosure is permitted when "authorised or required" by law or by the employer of the HCW.[183] If disclosure to a sexual partner were justified under the common law, it is arguable that it would not breach this legislation. The SA Health Commission may require a person to furnish "such information relating to public or environmental health as it reasonably requires for the purposes of [the *Public and Environmental Health Act* 1987 (SA)]", and any such disclosure by an HCW is not, under the statute, regarded as a breach of law.[184] Since the Health Commission administers a contact tracing program, presumably the Commission could require particulars to be provided to the Commission if a doctor adverted to a problem with a patient in a general way.[185]

(v) Western Australia

There are no relevant statutory duties of non-disclosure in this State. The legality of disclosure 'in the public interest' is determined by the common law.

(vi) Tasmania

A duty of non-disclosure operates with respect to HIV status, sexual behaviour, and drug use under the *HIV/AIDS Preventive Measures Act* 1993 (Tas).[186] However, the Act authorises a medical practitioner to inform any sexual contact of an HIV infected patient of the patient's status, in circumstances where the patient is knowingly placing sexual partners at risk of HIV transmission or has failed to advise sexual contacts in advance of his or her HIV status, or has failed to ask the medical practitioner (or an approved health care worker) to advise sexual partners on the patient's behalf.[187] Strangely, the legislation does not expressly authorise disclosure by an HCW to the Health Department in the same circumstances. However, ss 20-21 of the Act plainly envisage knowledge by the Secretary of the Health Department of cases where an HIV infected patient poses a risk to others, and disclosure to the Secretary of 'problem cases' under s 17(3) in accordance with the *Privacy Guidelines Relating to the HIV/AIDS Preventive Measures Act* 1993 (Tas) (Guideline 8) would, arguably, be legal.

---

182 See Part 1, Section VI.

183 *South Australian Health Commission Act* 1976 (SA), s 64 (applies to officers or employees of the Commission, incorporated hospitals, and incorporated health centres).

184 *Public and Environmental Health Act* 1987 (SA), s 41.

185 See Part 1, Section VI.

186 *HIV/AIDS Preventive Measures Act* 1993 (Tas), s 19. However, the provision is loosely worded and could apply to anyone anywhere, not only HCWs who access this information in the course of their professional duties.

187 *HIV/AIDS Preventive Measures Act* 1993 (Tas), s 20(7).

(vii) Australian Capital Territory

Since the *Health Services Act* 1990 (ACT) was repealed in 1993,[188] the legality of disclosure of a patient's HIV status and sexual behaviour to the Health Department or sexual partners of the patient depends upon the common law. In 1992, Kate Carnell MLA, the former opposition leader of the ACT Legislative Assembly (now the Chief Minister), introduced the HIV Notification (Liability of Medical Practitioners) Bill 1992 (ACT).[189] This legislation would have exempted doctors from liability for breach of confidence actions when informing sexual partners or the Medical Officer of Health of a patient's HIV status. The exemption would have applied when the doctor had counselled the HIV patient about the effects of HIV and its transmission to others and when the doctor nevertheless believed on reasonable grounds that the HIV patient (i) may have transmitted or was likely to transmit the disease to the partner; and (ii) had failed to notify the partner that the HIV patient was suffering from HIV. The legislation would have required 21 days notice to the HIV patient. This is the only proposed Australian legislation the writer is aware of which specifically addresses the notification issue. Since the Liberal Party is currently in Government in the ACT, it is possible that this or similar legislation may be re-introduced in future.

(viii) Northern Territory

The legality of disclosure 'in the public interest' depends upon the common law in the Northern Territory.

(ix) Health Departments and Contact Tracing

The discussion above relates to the statutory duties of HCWs. The statutory duties of Health Department officials should also be briefly considered. As seen above, the disclosure by HCWs to Health Department officials of identifying information relating to a person with HIV who is placing third parties at risk, may sometimes arise as an exception to the usual statutory duties owed by those HCWs. Legislation in Queensland,[190] South Australia,[191] and the Northern Territory[192] also authorises Health Departments to specifically collect nominal information relating to the contacts of persons with infectious diseases, including HIV/AIDS. In jurisdictions with nominal reporting requirements, the Health Department is involved jointly with the treating doctor and the (consenting) patient in the process of tracing contacts of patients with HIV.[193] The legislation does not, however, expressly authorise Health Department officials to notify partners or contacts of persons with HIV/AIDS or other infectious diseases. Indeed, in some jurisdictions, public health officials are themselves subject to statutory duties of confidence with respect to information relating to infectious diseases, including

188 By the *Health (Consequential Provisions) Act* 1993, s 4.
189 Australia, *ACT Government Gazette*, Legislative Assembly, 9 December 1992, 3676.
190 *Health Act* 1937 (Qld), s 32B.
191 *Public and Environmental Health Act* 1987 (SA), s 41(1).
192 *Notifiable Diseases Act* 1981 (NT), s 9.
193 See Part 1, Section VI.

HIV/AIDS, although disclosure is permitted in the course of one's official duties under the Act.[194]

The non-disclosure provisions imposed upon Health Department officials would seem to be intended to replace any discretion which might otherwise exist at common law. It could be argued, therefore, that Health Department officials can only respond to the risk of HIV transmission by subjecting an irresponsible HIV patient to a public health order, and not by disclosing confidential information to the sexual partners of the patient, assuming they could be contacted. On the other hand, it is also arguable that these non-disclosure provisions must be read in the light of other provisions authorising notification of details of sexual contacts to the Health Department. In Queensland, for example, where the provision authorising such notification is unequivocal, there is certainly an argument that disclosure to a sexual contact despite the lack of consent of the person with HIV would be within the official duties of Health Department officials; why else would such details be required to be reported?

(x) Conclusion

The complex web of Australian legislation regulating disclosure to sexual partners of persons with HIV is frequently overlooked when the legality of disclosure is discussed. However, disclosure in accordance with the principles emerging from the cases will be subject to the legislation reviewed above. Two uncertainties are evident in this legislation. It is not always clear whether disclosure of the sexual behaviour of a patient with HIV would be authorised under provisions requiring nominal reporting or contact tracing information. Second, where Health Department officials are informed of 'problem cases' in accordance with legislation, it is not clear whether disclosure by those officials to sexual partners would be within the course of their duties or would, in fact, breach their own statutory duties of non-disclosure.

C. The Discretion to Disclose Confidential Information Granted by the Public Interest Defence to the Action for Breach of Confidence

Subject to legislation, disclosure may be permitted at common law. Judicial recognition of a public interest defence granting a discretion to disclose confidential information 'in the public interest' has arisen in cases where the confider has sought an injunction or other remedies for breach of confidence. In Australia, the scope of the public interest defence remains notoriously vague.[195] Several interpretations of the defence emerge from the Australian and English cases:

(a) The 'clean hands' view. At its narrowest, the public interest 'defence' has been regarded simply as the expression of the doctrine that courts will not

---

194 See *Public Health Act* 1991 (NSW), s 75; *Public and Environmental Health Act* 1987 (SA), s 42; *Health Act* 1937 (Qld), s 49; *Notifiable Diseases Act* 1981 (NT), s 29; see also *Health Act* 1911 (WA), s 314 and the *Public Health Act* 1962 (Tas,) s 47 relating to venereal disease.

195 See PD Finn, "Confidentiality and the 'Public Interest'" (1984) 58 *Australian Law Journal* 497; J Pizer, "The Public Interest Exception to the Breach of Confidence Action: Are the Lights about to Change?" (1994) 20 *Monash University Law Review* 67; RS Magnusson, H Opie, note 99 *supra* at 244-8.

grant equitable remedies (injunctions) to restrain disclosure of otherwise confidential information when the plaintiff comes to equity with 'unclean hands', trying to protect information relating to a crime or fraud.[196]

(b) The 'iniquity' view. On this view, the earliest of several formulations of Lord Denning MR, disclosure will be justified when the otherwise confidential information relates to actual or contemplated "crimes, frauds and misdeeds" of the confider.[197] This category would extend to criminal offences[198] and possibly some civil wrongs.[199]

(c) The 'potential harm to the public' view. In applying the 'iniquity' view, courts were equally free to focus upon the 'wickedness' or gravity of the confider's iniquity, which gave rise to a 'higher duty' to disclose in the public interest,[200] or to focus upon the somewhat different issue of how the public interest would be affected by the likely consequences of disclosure or non-disclosure. In a later formulation of the public interest defence, Lord Denning re-defined the iniquity view as "merely an instance of just cause or excuse for breaking confidence".[201] With the possibility that a confidee may have just cause to disclose confidential information, even in the absence of any iniquitous or illegal conduct on the part of the confider, courts looked increasingly to the consequences of disclosure to determine appropriate limitations upon the public interest. The cases suggest a separate category of case where the potential for harm to the public outweighs the public interest in protecting confidentiality. Factors justifying disclosure may include harm to public health and safety,[202] financial harm,[203] or harm to the public interest in the administration of justice.[204]

(d) The balancing of interests approach. Lord Denning's remark that 'iniquity' was merely an instance of 'just cause or excuse' for breaking confidence foreshadowed the recognition of other countervailing public

---

196 See *Corrs Pavey Whiting & Byrne v Collector of Customs (Vic)* (1987) 14 FCR 434 at 453, 455, per Gummow J; *A v Hayden* (1984) 156 CLR 532 at 545, per Gibbs CJ; *Hubbard v Vosper* [1972] 2 QB 84 at 99-101, per Megaw LJ; *Weld-Blundell v Stephens* [1919] 1 KB 520 at 533-4, 547-8.

197 *Initial Services Ltd v Putterill* [1968] 1 QB 396 at 405.

198 *A v Hayden*, note 196 *supra*; *Brown v Brooks* (unreported, Supreme Court of New South Wales, McLelland J, August 18 1988).

199 See *Initial Services Ltd v Putterill*, note 197 *supra*; *Allied Mills Industries Pty Ltd v Trade Practices Commission (No 1)* (1981) 55 FLR 125 at 166-7; *Castrol Australia Pty Ltd v Emtech Associates Pty Ltd* (1980) 51 FLR 184; cf, however, *Distillers Co (Biochemicals) Ltd v Times Newspapers Ltd* [1975] 1 QB 613; *British Steel Corporation v Granada Television Ltd* [1981] AC 1096 at 1169, 1176.

200 See *Weld-Blundell v Stephens* [1920] AC 956 at 965-6, per Viscount Finlay, and Justice Rath's approving use of the term in *Castrol Australia Pty Ltd v Emtech Associates Pty Ltd*, *ibid* at 212-15.

201 *Fraser v Evans* [1969] 1 QB 349 at 362.

202 For example, *Church of Scientology of California v Kaufman* [1973] RPC 627; *Hubbard v Vosper*, note 196 *supra*; *Beloff v Pressdram Ltd* [1973] 1 All ER 241 at 260; cf *Schering Chemical Ltd v Falkman Ltd* [1982] 1 QB 1.

203 *Protestant Alliance Friendly Society v Australian Financial Press Pty Ltd* (unreported, Supreme Court of Victoria, Marks J, December 8 1988); *Sun Printers Ltd v Westminster Press Ltd* (1982) 126 *Solicitor's Journal* 260; *Church of Scientology of California v Kaufman*, *ibid* at 654, per Goff J; cf *Westpac Banking Corp v John Fairfax Group Pty Ltd* (1991) 19 IPR 513.

204 *Lion Laboratories v Evans*, note 180 *supra*.

interests which might justify disclosure, in addition to those embodied in the established category of 'iniquity' and the emerging category of harm to the public. In later cases, Lord Denning re-affirmed this view, asserting that the legality of disclosure simply depended upon "balancing the public interest in maintaining the confidence against the public interest in knowing the truth".[205] English courts thus dispensed with any control device based upon the *kind* or *category* of countervailing public interest put forward, determining the legality of disclosure simply by balancing the public interest in preserving confidentiality against whatever public interests are served by disclosure. The 'unrestricted' balancing approach has received a cool reception in Australia,[206] where courts are likely to limit the kinds of public interests capable of being balanced against the public interest in preserving doctor/patient confidentiality.

It remains to be seen which of the above views will become most persuasive in Australia. English courts have clearly undermined the 'clean hands' view by recognising and balancing successive categories of public interest in revealing information, in circumstances where the confider may not have acted unlawfully, nor been guilty of any misconduct or iniquity.[207] An approach requiring courts to articulate, and then to balance the public interest factors justifying the protection or non-protection of confidences is both flexible and appropriate, provided limits are placed upon the kinds of countervailing public interests which are regarded as 'eligible' to override confidentiality in an appropriate case. This latter qualification retains the benefits of the 'higher duty' approach, which requires courts to focus upon the gravity of the harm which the confider by his or her actions has caused to the public interest.

The authorities support a public interest in preventing physical injury to members of the public, which may override a doctor's legal duty of confidence in appropriate circumstances.[208] The majority of cases have concerned potentially violent patients. However, English[209] and Australian[210] dicta support the view that the public interest defence extends to "matters medically dangerous to the public". This sub-category arose from the 'scientology cases',[211] which concerned information relating to practices alleged to be dangerous to mental health, although

205 *Woodward v Hutchins* [1977] 1 WLR 760 at 764.

206 For example *Castrol Australia Pty Ltd v Emtech Associates Pty Ltd*, note 199 *supra* at 214-15; *David Syme & Co Ltd v General Motors-Holden's Ltd* [1984] 2 NSWLR 294 at 298-9, 306; *Corrs Pavey Whiting & Byrne v Collector of Customs (Vic)*, note 196 *supra* at 451; *Bacich v ABC* (1992) 29 NSWLR 1 at 16.

207 See *Lion Laboratories Ltd v Evans*, note 180 *supra* at 537-8, 548, 550; *Attorney-General v Guardian Newspapers Ltd (No 2)* [1990] 1 AC 109 at 268-9, 282; *Malone v Metropolitan Police Commissioner* [1979] 1 Ch 344 at 362; *Attorney-General (UK) v Heinemann Publishers Australia Pty Ltd* (1987) 10 NSWLR 86 at 171.

208 *W v Egdell*, note 180 *supra*; *R v Crozier* (1990) 12 Cr App R(s) 206; *Duncan v Medical Disciplinary Committee*, note 180 *supra* at 521; *Furniss v Fitchett* [1958] NZLR 396 at 405-6; *Halls v Mitchell* [1982] SCR 125 at 136; *Schering Chemicals Ltd v Falkman Ltd*, note 202 *supra* at 27.

209 *Beloff v Pressdram Ltd*, note 202 *supra* at 260.

210 *Castrol Australia Pty Ltd v Emtech Associates Pty Ltd*, note 199 *supra* at 213-14; *David Syme & Co Ltd v General Motors-Holden's Ltd*, note 206 *supra* at 298.

211 *Hubbard v Vosper*, note 196 *supra*; *Church of Scientology of California v Kaufman*, note 202 *supra*.

no great leap of principle is required to recognise a general public interest in preventing physical harm to third parties, whether from violence, catastrophe, or disease. The public interest in preventing disease transmission is reflected in statutory reporting requirements. The legality of disclosure by an HCW, informing the patient's sexual partner of the patient's HIV status is likely to be determined, therefore, by balancing the public interest in protecting confidentiality within the doctor/patient relationship with the countervailing public interest in preventing the transmission of serious infectious diseases.[212]

D. Disclosure of Confidential Information to Prevent the Sexual Transmission of Infectious Disease

The public interest in preserving doctor/patient confidentiality is critical where a patient suffers from a stigmatised, infectious disease such as HIV/AIDS. The arguments in favour of weighting this public interest heavily in the equation are the same arguments which support the 'community co-operation/human rights' model of infection control discussed in Part 1.[213] HIV is transmitted most efficiently through voluntary behaviour which is often judged as immoral (anal, homosexual intercourse) or which is criminal (injecting drug use). Public health ultimately requires, therefore, a high degree of legal protection for confidentiality, since the intrinsic sensitivity of HIV information, the stigma of AIDS, and the risk and consequences of discrimination and homophobia are so formidable that already marginalised persons would be discouraged from coming forward for voluntary HIV testing, treatment, education, and counselling if confidentiality were not assured.[214] As Rose J said in the leading AIDS-confidentiality case, *X v Y*:

> preservation of confidentiality is the only way of securing public health; otherwise doctors will be discredited as a source of education, for future individual patients 'will not come forward if doctors are going to squeal on them'.[215]

The above argument is founded upon a consequentialist, or utilitarian ethical basis. However, an argument based upon a deontological ethical basis can also be made. Medical confidences ought to be respected, not only because of the adverse consequences of disclosure, but also because patient privacy and confidentiality is worthy of legal protection in its own right. Judges have recognised that privacy is an important factor underlying the legal protection of confidentiality.[216] Since disclosure derogates from the enjoyment of privacy, the public interest in privacy might also be regarded as weighing in favour of non-disclosure by an HCW.

---

212 It should be noted that although maintaining doctor/patient confidentiality may sometimes be seen as a private interest, courts regard it as a public interest for the purposes of the public interest defence: *W v Egdell*, note 180 *supra* at 415.

213 See Part 1, Section X.

214 See the Honourable Justice Michael Kirby, "HIV Infection: Human Rights, Public Health and the AIDS Paradox" in *HIV Infection and AIDS*, Proceedings of the 1991 Annual General Meeting of the Australian Academy of Science, 81 at 94.

215 [1988] 2 All ER 648 at 653.

216 *Attorney-General v Guardian Newspapers Ltd (No 2)*, note 207 *supra* at 255; *Stephens v Avery* [1988] 1 Ch 449 at 456-7; *Schering Chemicals v Falkman Ltd*, note 202 *supra* at 21; *Duchess of Argyll v Duke of Argyll* [1967] Ch 302.

Balanced against the public interest in confidentiality is the public interest in preventing the transmission of disease to third parties. The two most important factors affecting the strength of this interest in each case will be the likelihood of transmission and the seriousness of the disease.

HIV/AIDS is a stigmatised and ultimately lethal condition. Sexual partners infected with HIV as a result of a patient's refusal to warn or to practise safer sex will therefore suffer the same disadvantages which make the protection of confidentiality so important for the infector. HBV is potentially lethal, although rarely so, and readily transmissible, although its importance has been overshadowed by the media and academic fixation upon AIDS.

Turning to the risk of transmission to third parties, HIV may be transmitted sexually, perinatally, by the transplantation of infected tissue, and by the direct inoculation of infected blood, whether by IV drug use, blood transfusions, or needlestick injuries. In contrast to some STDs, HIV is relatively hard to transmit sexually, although this is balanced by its physical and social consequences. In general terms, the risk of sexual transmission of HIV increases with "higher prevalence of HIV infection among sexual partners, with increase in the number of sexual partners, and with exposure to semen or vaginal/cervical secretions".[217] Research confirms that HIV may be transmitted by vaginal intercourse,[218] with anal receptive intercourse being particularly efficient as a means of sexual transmission.[219] The well-known hypothetical[220] of the unsuspecting partner represents, therefore, a case where the claim for disclosure is especially strong. Indeed, one commentator has argued that failure to protect the interests of an unsuspecting wife against transmission from an infected patient "might be thought to involve a disregard for the interests of women similar to that involved in the immunity of a man against prosecution for the rape of his wife".[221] In view of the risk of condom breakage or failure, use of barrier protection by an HIV infected person during intercourse may be regarded as significantly reducing, but not eliminating, the risk of transmission.[222] In any event, the doctor would need to

217 N Crofts, "Patterns of Infection" in E Timewell, V Minichiello, D Plummer (eds), *AIDS in Australia* (1992) 24 at 30.

218 M Fischl, G Dickinson, G Scott et al, "Evaluation of Heterosexual Partners, Children and Household Contacts of Adults with AIDS" (1987) 257 *JAMA* 640 at 643.

219 J Burcham, B Tindall, M Marmor et al, "Incidence and Risk Factors for Human Immunodeficiency Virus Seroconversion in a Cohort of Sydney Heterosexual Men" (1989) 150 *Medical Journal of Australia* 634; N Padian, L Marquis, D Francis et al, "Male-to-Female Transmission of Human Immunodeficiency Virus" (1987) 258 *JAMA* 788; N Crofts, note 217 *supra* at 29-30.

220 See *Bradley v Jones; Bradley v Adams*, 18 April 1990 (Commonwealth Moot Court Judgment), (July 1991) *Commonwealth Law Bulletin* 872 at 875-9; D Hermann, R Gagliano, "AIDS, Therapeutic Confidentiality, and Warning Third Parties" (1989) 48 *Maryland Law Review* 55 at 69-71.

221 R O'Dair, note 169 *supra* at 224. This 'immunity' against rape within marriage no longer exists: *R v L* (1991) 174 CLR 379; *R v R* [1992] 1 AC 599.

222 See M Fischl, M Dickinson, G Scott et al, note 218 *supra* at 644; Intergovernmental Committee on AIDS (IGCA), Legal Working Party, *Therapeutic Goods and HIV/AIDS*, April 1992 at 9-10 and references there cited.

assess the patient's "reliability, knowledge, and consistency in adhering to 'safer sex' practices".[223]

It is, predictably, uncertain how courts would, in a particular case, resolve the contest between

(i) the public interest in preserving doctor/patient confidentiality; and

(ii) the public interest in preventing transmission of infectious diseases.[224]

In view of the high level of public concern which surrounds AIDS, the need for an impartial assessment of competing public interests using current scientific knowledge of transmission risk is paramount. Old cases, such as *Simonsen v Swenson*,[225] which reflect the heavier weighting of the interest in preventing the transmission of syphilis in an era before antibiotics existed and when casual transmission was assumed are of doubtful authority. Writers have emphasised the counselling role of HCWs in circumstances where a patient is engaging in a risky activity.[226] Some patients, however, as evidenced above, are unresponsive to counselling, and so it is vital, in the writer's view, to recognise that the duty of confidence owed to the patient under the common law will not always be absolute.

It is suggested that the protocol adopted by the New Zealand Medical Association discussed above,[227] represents a responsible balancing of competing interests, and that a doctor would not be liable for breach of confidence for disclosure of a patient's HIV status in accordance with those guidelines, to an identified party either directly or via a Health Department officer, where there was a clear risk of transmission. Under these circumstances, it is suggested that an HIV patient who refused to inform a current sexual partner while continuing to have unprotected sexual intercourse would also be refused equitable relief to enforce the doctor's duty of confidence by virtue of the 'clean hands' principle. However, it is clear that disclosure would only be justified if directed to the party at risk or the Health Department (responsible for protecting public health), and not to the media.[228] The extent to which a private doctor would owe a *duty* to protect third parties at risk is doubtful,[229] although to the extent that such a duty does exist, it would surely be the case that a *discretion* to disclose would also exist under the action for breach of confidence, thus preventing any conflict between the duty to warn in negligence and the duty of confidentiality.

---

223 R Belitsky, R Solomon, "Doctors and Patients: Responsibilities in a Confidential Relationship" in H Dalton, S Burris and the Yale AIDS Law Project (eds), *AIDS and the Law* (1987) 201 at 207.

224 In *Pittman Estate v Bain* (1994) 112 DLR (4th) 257, a physician was held liable for failing to disclose a patient's transfusion-caused HIV illness to the patient, who subsequently infected his wife. In view of the fact that the patient would have informed his wife had he known his status, the Court did not consider whether the physician had an independent duty to inform the patient's wife.

225 177 NW 831 (1920). In this case, a doctor informed a hotel owner that the plaintiff, who was staying at the hotel, was afflicted with a 'contagious disease'. The Nebraska Supreme Court dismissed an action for damages for "alleged breach of duty arising from [the] confidential relationship". One of the reasons given was the "dangerously contagious nature" of the plaintiff's condition.

226 For example, RS Magnusson, "HIV and Confidentiality" (1995 forthcoming) *Medical Journal of Australia*, Monograph Series: 'Managing HIV'.

227 Note 162 *supra* and accompanying text.

228 *X v Y*, note 215 *supra*; *'Y' v TVW Enterprises Ltd, Hinch and Parry*, note 110 *supra*.

229 See, for discussion, RS Magnusson, H Opie, note 99 *supra* at 249-56.

E. Disclosure of Confidential Information to Prevent the Occupational Transmission of Infectious Disease

The author's research on privacy issues arising within HIV/AIDS health care[230] revealed that some HIV patients resent their doctors revealing their HIV status to other HCWs. Typical of the responses was Steven, 25, who had been HIV positive for 6 years with no AIDS-defining illnesses:

> The doctors here have disclosed my HIV status to the specialists they have referred me to. They say that because I'm on AZT they have an ethical obligation to inform others... Once I saw a dermatologist and they disclosed it to him. The skin complaint had nothing to do with HIV. I would prefer to tell people I am referred to myself.
>
> When I've talked to health professionals; nurses, social workers etc, they feel they have the right to know about my HIV status. Nurses say they need to know for their safety. One nurse was outraged to think that she should not be allowed to know, but should rely on taking universal precautions.

On balance, it is suggested that where patients specifically request their doctor not to inform a specialist or surgeon of their HIV status, the low risk of occupational transmission would not justify disclosure. This argument is weaker in the HBV context, since HBV is transmitted more readily. Absent a specific request not to disclose, a patient's consent to disclosure of medically relevant information when referring the patient might otherwise be assumed. However, where a patient with HIV/AIDS is immuno-compromised, this will be relevant to patient management. Whether or not courts would uphold a doctor's refusal to refer a patient in order not to compromise a patient's interests by providing inadequate information in a referral, raises wider issues of paternalism and autonomy within the doctor/patient relationship.

Turning to the situation where the doctor's patient is an HCW performing exposure prone procedures, it is clear that although the risk of HIV transmission to any one patient is minimal, the overall likelihood of transmission to *a patient* will increase over time. The risks of HBV transmission are higher; however, the medical and social consequences of infection are correspondingly lower. Assuming that the doctor was satisfied that the HCW was using universal precautions to minimise the risk of blood or fluid contact with patients, it is argued that disclosure to the HCW's superiors would not be justified. In other words, the public interest in protecting confidentiality would outweigh the public interest in preventing transmission of disease, absent any clear evidence of non-compliance with universal precautions or a needlestick injury creating a transmission risk to patients. Nominal disclosure to the media would obviously not be justified.[231]

The issue of disclosure, following a needlestick injury, of (i) an HCW's HIV status to a patient; or (ii) a patient's HIV status to an HCW, is more difficult. In *In re Application of the Milton S Hershey Medical Center*,[232] a physician, Dr Doe, was accidentally cut by a fellow physician during an invasive surgical procedure. There was no evidence that any of Dr Doe's blood was transferred to the patient. Dr Doe subsequently tested HIV positive in a baseline test, thereby indicating prior

230 Note 95 *supra*.
231 Note 228 *supra*.
232 595 A 2d 1290 (1991).

infection. The Superior Court of Pennsylvania upheld a lower court decision authorising the disclosure of Dr Doe's HIV status to certain colleagues and to over 400 patients Dr Doe had previously been involved with, on the basis that they had a "compelling need" to be told. Arguably, the decision was unreasonable, given the lack of evidence of exposure to the 400 patients as well as the immediate patient.

The Legal Working Party of the Intergovernmental Committee on AIDS has recognised that disclosure of a patient's HIV status where an HCW has been exposed to the patient's blood during a needle-stick injury should be an exception to the usual duty of confidentiality, where the patient's HIV status cannot be disclosed anonymously.[233] Surprisingly, the Working Party did not consider the reverse situation: disclosure of an HCW's status to a patient at risk of HIV transmission. Knowing the status of a person (whether a patient or HCW) who has potentially exposed another to HIV infection is important. If the person's status is known to be negative, this will be reassuring to the person who was potentially exposed. If the person's status is known to be positive, the person exposed may opt for prophylactic treatment.[234]

In view of the fact that anonymous disclosure may be impossible, it is unfortunate that current legislation does not clearly provide for such an exception to statutory duties of confidence.[235] In New South Wales, if a public hospital-employed pathologist were to disclose the HIV status of an HCW who had potentially exposed a patient to the risk of infection to that patient, he or she could be in breach of the *Public Health Act* 1991 (NSW), s 17(3). In Victoria, disclosure with ministerial approval would be legal, although otherwise it might well contravene the *Health Services Act* 1988 (Vic), s 141. Nor is it certain that a Health Department could legally conduct a 'look-back' study if this involved naming the infected HCW. Legislation in some States authorises the disclosure of confidential information to researchers for the purposes of medical research in certain circumstances,[236] but this would not authorise disclosure to the former patients of an infected HCW. Legal authority for Health Department officials to disclose an HCW's status in the course of a 'look-back' study might possibly be based on the argument that such disclosure was within the course of one's official duties under the relevant public health Act.[237] Since the disclosure of confidential information to former patients of an HCW will inevitably result in the loss of career for that HCW, and since former patients would not keep the information in confidence, 'look-back' studies should not be carried out without a proper justification. However, it is important for Health Departments to have adequate

---

233 IGCA, note 114 *supra* (Recommendation 2.3.1).

234 However, the value of prophylactic AZT is debatable: see J Gerberding, "Management of Occupational Exposures to Blood-Borne Viruses", note 15 *supra* at 448-9.

235 See Section VII(B) above.

236 *Health Administration Act* 1982 (NSW), s 23; *Health Act* 1937 (Qld), s 154M-154N; *South Australian Health Commission Act* 1976 (SA), s 64d; *Health Services Act* 1988 (Vic), s 141(3)(g); *Health Act* 1993 (ACT), s 7; *Epidemiological Studies (Confidentiality) Act* 1992 (ACT), ss 4-6.

237 Note 194 *supra*.

powers to carry them out when necessary. In the absence of adequate legislation regulating:

(i) disclosure by HCWs to third parties and the Health Department; and
(ii) disclosure by the Health Department to third parties,

these issues may need to be sorted out by contractual provisions applying to employees of hospitals and health services.

Where legislation does not apply, the issue of disclosure following a needlestick injury will arise at common law. It seems clear that some evidence of exposure to a patient or HCW, and not just a needlestick injury (eg to the HCW alone), would be necessary before courts concluded that the balance of public interest justified disclosure of an HCW's status to a patient. It is suggested, however, that the issue of confidentiality following occupational exposure is best dealt with under a legislative protocol which avoids common law uncertainties.

In view of the lack of evidence of casual transmission,[238] disclosure of HIV status would not be justified where the only risk to a third party was through casual or household contact. Thus there could be no legal justification, on the basis of popular fears, for disclosing to a restaurant proprietor that a waiter had AIDS, or to a local council that a child care worker was HIV positive.

VIII. CONCLUSION

Although Australia is well over a decade into the HIV/AIDS epidemic, many of the legal rights and duties of those with HIV, those treating them, and those at risk of contracting HIV, remain uncertain. This paper has reviewed some current, emotionally charged debates which concern HIV testing and the use of HIV test results, against the background of a substantial body of HIV legislation. The paper has focused in particular upon the legal issues surrounding the risk of occupational HIV transmission. The most important recommendation to emerge is that Health Departments and professional medical organisations should carefully consider current laws and investigate potential discrepancies between the policies they are promoting and current legal requirements. This recommendation applies, for example, to policies which would permit HCWs to refuse to provide elective surgery for patients who refuse to be HIV tested. Secondly, the discussion has also pointed out the limitations of the common law in giving useful answers to many of the current questions which arise concerning occupational transmission, whether the issue be liability or confidentiality. Thirdly, the extent of current legislation to authorise Health Department initiatives, such as 'look-back' studies, should not be overestimated. Current legislation regulating confidentiality is complex and uncertain, and within the medical community, the issue of the disclosure of HIV status to third parties is known to be notoriously uncertain.

---

238 For example, G Friedland, B Saltzman, M Rogers et al, "Lack of Transmission of HTLV-III/LAV Infection to Household Contacts of Patients with AIDS or AIDS-Related Complex with Oral Candidiasis" (1986) 314 *The New England Journal of Medicine* 344.

HIV/AIDS has posed many challenges to the legal system, and this paper suggests that ongoing attention to these challenges is required.