A DECADE OF HIV TESTING IN AUSTRALIA

PART 1: A REVIEW OF CURRENT LEGAL REQUIREMENTS

ROGER S MAGNUSSON*

I. INTRODUCTION

Ever since its introduction into Australia in 1985, the HIV antibody test has been the subject of considerable and ongoing debate. A decade later, HIV testing is regulated by an increasingly complex and rapidly evolving body of legislation of which health care workers (HCWs) and their advisers need to be aware. Legislative regulation is particularly detailed in New South Wales, Victoria and Tasmania.

The HIV legislation reviewed in Part 1 of this article variously relates to compulsory testing, consent to testing, counselling requirements, notification and contact tracing, disclosure of information, privacy, and discrimination. Particular attention will be given to legislation relevant to the practice of medicine in hospitals, sexual health clinics, and private practices. Responsibility for health services rests primarily with the States, rather than the Commonwealth, and there are considerable variations in the law between each State and Territory. Law

* 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.

reform is an ongoing process, and the likely introduction of new Public Health Acts in Western Australia, Tasmania and the ACT in 1995, as well as amendments to Notifiable Diseases legislation in the Northern Territory, may affect the legal regulation of HIV testing to greater or lesser degrees.[1] Against the background of current legislation reviewed in this part, Part 2 will offer a legal perspective on some of the current debates surrounding HIV testing, and the disclosure of HIV test results.

II. THE HIV TESTING PROCESS

HIV testing in Australia is closely linked with the doctor/patient relationship. 'Over-the-counter' or 'do-it-yourself' HIV test kits are not sold in Australia,[2] thereby ensuring that the testing process includes an opportunity for pre- and post-test counselling by the medical practitioner who draws the blood sample, and who later receives back the HIV test result and communicates it to the patient. Blood samples and accompanying HIV test request forms are forwarded, either directly or via a private pathology firm, to licensed HIV testing laboratories. Most public sector HIV testing laboratories perform both initial screening (HIV antibody) and confirmatory ('Western Blot') HIV tests; some, however, only perform antibody tests. In some States (including Victoria and South Australia), private pathology firms are authorised to perform HIV antibody tests. 'Western Blot' tests, however, are carried out at designated State reference laboratories, usually attached to public hospitals.

III. MANDATORY AND COMPULSORY TESTING

Australian federal Government policy advocates voluntary HIV testing.[3] Thankfully, early demands for broad population screening have not been followed, and HIV testing remains, in most cases, voluntary.[4] However, compulsory HIV testing is required by legislation at both State and federal levels in some circumstances.

Applicants for migration to, or for permanent residency in, Australia, as well as some other categories of applicant have been required to undergo HIV testing

---

1 The proposed ACT legislation affecting infectious diseases is likely to be modelled on the *Public and Environmental Health Act* 1987 (SA); see Australian Capital Territory Department of Health, *The Reform of Public Health Legislation in the ACT*, 1994.

2 For details of legislative regulation, see Intergovernmental Committee on AIDS (IGCA), Legal Working Party, *Therapeutic Goods and HIV/AIDS*, April 1992 at 21-8, and more recently, in Tasmania: *HIV/AIDS Preventive Measures Act* 1993 (Tas), ss 40-41.

3 Commonwealth of Australia, *National HIV/AIDS Strategy (The White Paper)*, August 1989 at 38; Commonwealth of Australia, *National HIV/AIDS Strategy 1993-94 to 1995-96*, October 1993 at 10.

4 This may have more to do with the good sense of legislators than with public opinion: as late as February 1991, polls found that almost 50 per cent of Australians wanted persons with AIDS to be quarantined: "Half Want AIDS Sufferers Quarantined, Survey Finds" *Age* (Melbourne), 21 February 1991, p 3; "Many Want AIDS Sufferers Quarantined, Study Shows" *Sydney Morning Herald*, 21 February 1991, p 7.

since December 1989, in order to determine whether they satisfy the 'health requirement'.[5] The compulsory testing of defence forces recruits and selected classes of serving personnel has been authorised since 1989.[6] Legislation in most jurisdictions requires[7] or encourages[8] the testing of donated blood and tissue for HIV, and such testing has in fact been carried out throughout Australia since April 1985.

The HIV testing of prisoners is authorised in all Australian jurisdictions, either specifically,[9] or through general provisions.[10] In practice, Victoria has a 'voluntary' HIV testing program (with a 99.6 per cent level of participation by prisoners);[11] in Western Australia only prisoners considered to be 'high risk' are tested; and in the remaining Australian States and Territories, compulsory HIV testing is carried out at various times, including upon admission.[12] In New South Wales, mandatory HIV testing of prisoners is carried out, although the regulation requiring this[13] is due to be repealed early in 1995, and thereafter a voluntary HIV/hepatitis testing program will operate as part of an induction program for new prisoners. Most jurisdictions provide for the use of reasonable force to obtain a blood sample,[14] and these powers may be activated where compulsory testing

---

5 The health requirement, which is one aspect of the public interest requirement, excludes entry to applicants carrying a disease likely to require significant use of Australian health and welfare services: see *Migration (1993) Regulations* 1993 (Cth), Schedule 4, cl 4005-4008. The classes of visa for entry into Australia are set out in Schedule 2 to the Regulations, and where the applicant must satisfy the health requirement, this is indicated. Note, however, that HIV positive status may be a basis for the granting of refugee status: P Blair, "Refugee Status Granted on Grounds of HIV" (1994) 5(4) *HIV/AIDS Legal Link* 3. For a useful summary, see J Godwin, J Hamblin, D Patterson, D Buchanan, *Australian HIV/AIDS Legal Guide*, Federation Press (2nd ed, 1993) pp 341-58.

6 Testing has taken place in accordance with instructions issued pursuant to s 9A of the *Defence Act* 1903 (Cth); see Intergovernmental Committee on AIDS (IGCA), Legal Working Party, *Legislative Approaches to Public Health Control of HIV-Infection*, February 1991 at 28; M Alexander, "HIV Discrimination Complaints Put Spotlight on Australian Defence Force" (1994) 8(8) *National AIDS Bulletin* 42; MJ Flynn, "HIV in the Australian Defence Forces 1985-1993" (1993) 9(2) *Australian HIV Surveillance Report* 1.

7 In the following jurisdictions, legislation requires the screening of blood and blood products for HIV: *Blood Contaminants Act* 1985 (SA), s 4(1)(b); *Blood Transfusion (Limitation of Liability) Act* 1986 (Tas), s 4; *HIV/AIDS Preventive Measures Act* 1993 (Tas), ss 8-9; *Blood Donation (Acquired Immune Deficiency Syndrome) Act* 1985 (ACT), s 5(1)(b); *Notifiable Diseases Amendment Act* 1985 (NT), s 26A(2).

8 In the following jurisdictions, suppliers and hospitals are not liable for injuries caused by the transfusion of contaminated blood where donors have made the prescribed declaration excluding risk factors and the blood has been screened for HIV: *Health Act* 1958 (Vic), ss 132-133; *Human Tissue Act* 1983 (NSW), s 21DA; *Blood Donation (Limitation of Liability) Act* 1985 (WA), ss 9-10.

9 *Prisons (General) Regulation* 1989 (NSW), reg 34A(1) made pursuant to the *Prisons Act* 1952 (NSW), s 50(j4)-(j5); *HIV/AIDS Preventive Measures Act* 1993 (Tas), s 46 (inserting s 17A-17D into the *Prisons Act* 1977 (Tas).

10 *Corrections Act* 1986 (Vic), s 29; *Corrective Services Act* 1988 (Qld), s 50; *Corrective Services Regulations* 1985 (SA), reg 65(1) made pursuant to the *Corrective Services Act* 1982 (SA), s 23; *Prisons Act* 1981 (WA), s 39 and *Prisons Regulations* 1982 (WA), reg 38(c); *Prisons (Correctional Services) Act* 1985 (NT), s 75(2); *Remand Centres Act* 1986 (ACT), s 19.

11 See "Government Urged to Act on Jail AIDS" *Age* (Melbourne), 7 June 1994, p 9.

12 J Godwin et al, note 5 *supra*, p 272.

13 *Prisons (General) Regulation* 1989 (NSW), reg 34A(1) made pursuant to the *Prisons Act* 1952 (NSW), s 50(j4)-(j5).

14 *Corrections Act* 1986 (Vic), s 23; *Corrective Services Act* 1988 (Qld), s 51; *Correctional Services Act* 1982 (SA), s 86; *Prisons Act* 1981 (WA), s 45; *HIV/AIDS Preventive Measures Act* 1993 (Tas), s 46,

programs are in operation and a prisoner refuses to be tested. There is at least one documented case of HIV transmission in an Australian prison,[15] and there is also legitimate concern that prisons may become reservoirs of HIV infection, given continuing prohibitions in most jurisdictions on institutionalised access to condoms and sterilising solutions for injecting equipment.[16]

Public health legislation in each State also authorises the compulsory medical examination of individuals thought to be HIV infected as a first step under legislative schemes providing for the testing, counselling, and eventual isolation and quarantine of persons whose infection or behaviour creates a risk to public health.[17] Health Department guidelines in New South Wales, Victoria, South Australia, and Western Australia provide for the staged exercise of these powers where an HIV infected person continues to share injecting equipment, or to engage in unprotected penetrative anal or vaginal sex.[18] The Western Australian Health Department policy, for example, moves from counselling, education, and support, to the formation of an HIV case management panel convened by the Commissioner of Health, to restriction of the client's activities and finally to eventual isolation of the recalcitrant HIV infected individual, if all other attempts to influence behaviour fail. The difficult issues faced by doctors whose HIV infected patients continue, despite counselling, to pose a risk to third parties will be discussed in Part 2 of this paper.

---

inserting s 17A(3) into the *Prisons Act* 1977 (Tas); *Prisons (Correctional Services) Act* 1985 (NT), s 75(3).

15 K Dolan, W Hall, A Wodak et al, "Evidence of HIV Transmission in an Australian Prison" (letter) (1994) 160 *Medical Journal of Australia* 734; "Doctors Discover First Prison HIV Infection" *Age* (Melbourne), 6 June 1994, p 4.

16 K Dolan, "HIV in Prison", presented at the 6th Australasian Society for HIV Medicine Conference, Sydney, 4 November 1994; The Honourable Justice Michael Kirby, "HIV in Australian Prisons" (1994) 8(5) *National AIDS Bulletin* 8; J Dwyer, "Minimising the Spread of HIV within the Australian Prison System", presented at the Australian Institute of Criminology Conference, *HIV/AIDS and Prisons*, Melbourne, 19-21 November 1990. A recent action by prisoners claiming a right to condoms was dismissed, although the prisoners are considering an appeal, and the New South Wales Government is seeking advice and may in future join the ACT in making condoms available to prisoners.

17 See *Public Health Act* 1991 (NSW), ss 22-23 (as amended by the *Health Legislation (Miscellaneous Amendments) Act* 1994 (NSW), inserting s 23(3A) into the principal Act); *Health Act* 1958 (Vic), s 121; *Health Act* 1937 (Qld), s 36; *Public and Environmental Health Act* 1987 (SA), ss 31-33; *Health Act* 1911 (WA), s 251(5); *HIV/AIDS Preventive Measures Act* 1993 (Tas), ss 10(3), 20-21, 23; *Notifiable Diseases Act* 1981 (NT), ss 11, 14; *Public Health (Infectious and Notifiable Diseases) Regulations* 1991 (ACT), reg 5.

18 In August 1989 a Sydney prostitute 'Charlene' was detained at the Prince Henry Hospital under s 32A of the (then) *Public Health Act* 1902 (NSW); see "Govt Orders AIDS Prostitute Held in Hospital" *Sydney Morning Herald*, 1 August 1989, p 1. In March 1991, Melbourne police charged an HIV infected transsexual prostitute with "conduct endangering life" after the Health Department refused to exercise its powers under the *Health Act* 1958 (Vic), ss 121-122; see "Prostitute with AIDS Charged by Police" *Age* (Melbourne), 26 March 1991, p 1. A second prostitute was subsequently charged. Both charges were eventually dropped for lack of evidence. In January 1994, Victorian police allegedly investigated claims that a Queenscliff man knowingly spread HIV: "Detectives Seek Man in Resort HIV Scare" *Australian*, 20 January 1994, p 3. More recently, the Victorian Health Department temporarily detained an HIV infected convicted paedophile at Fairfield Hospital under the *Health Act* 1958 (Vic), s 121; see "HIV Man Detained as a Public Risk" *Age* (Melbourne), 17 September 1994, p 1; "Health Chief to Decide on Man Held over AIDS" *Sunday Age* (Melbourne), 25 September 1994, p 4.

The Tasmanian *HIV/AIDS Preventive Measures Act* 1993 (Tas) authorises compulsory HIV testing in a variety of additional circumstances. These include:

- where a patient is unconscious and a medical practitioner believes an HIV test is clinically desirable in the interests of that person (s 7(2));
- with patient consent, prior to a 'non-urgent' medical or dental procedure (s 12) - although if the patient refuses testing, a HCW unwilling to carry out the procedure must either refer the patient or seek Health Department advice;
- where a person has been charged with a crime of a sexual nature, including rape or indecent assault (s 10(1)); and
- where the testing of a person is necessary to determine the treatment of someone else whom the person may have infected (s 10(2)).

Where a person required to be tested under s 10 refuses to do so, the Secretary of the Health Department may apply to a magistrate for an order authorising compulsory testing. The magistrate is not to make such an order unless he or she is satisfied on the balance of probabilities that the public interest requires compulsory testing.[19]

A provision similar to s 10(2) in the Tasmanian legislation also exists in Victoria. Under the *Health Act* 1958 (Vic), ss 120A-120D, the Health Department may order a person to be tested where he or she has exposed a medical practitioner, nurse, dentist, ambulance officer, police officer, or prison officer to the risk of infection. Like the Tasmanian provision, this would authorise HIV testing following needlestick injuries suffered by ambulance officers and HCWs and after physical assaults upon prison guards and police, although the Tasmanian provision is not limited to these categories of people.

Although not required to by legislation, under the Life Insurance Federation of Australia's *Code of Practice*, applicants seeking life cover in excess of a threshold amount (typically $250 000) and applicants who cannot sign the block declaration excluding risk factors are required to undergo HIV testing.[20] Commonwealth legislation provides that the testing and exclusion of persons found to be HIV positive is not discriminatory provided it is based on reasonable, actuarial, or statistical data.[21]

---

19 *HIV/AIDS Preventive Measures Act* 1993 (Tas), s 11.

20 See Life Insurance Federation of Australia (LIFA), *Life Insurance Industry - Code of Practice - Underwriting in Relation to AIDS*, 1989. The HIV testing of persons seeking individual life cover is unlikely to change, although the recent *Trowbridge Report* commissioned by the Commonwealth Government suggests that there is no actuarial basis for excluding persons with HIV from superannuation schemes; see T Leach, "Report Highlights Discrimination in Super and Life Insurance" (1993) 4(4) *HIV/AIDS Legal Link Newsletter* 1; M Alexander, "Insurance and Superannuation Industries Negotiate on HIV Exclusion Clauses" (1994) 5(2) *HIV/AIDS Legal Link Newsletter* 14. A working group has been set up to discuss the development of an HIV/AIDS Code of Practice in relation to superannuation, with the LIFA preferred position being that insurers should be free to develop products with or without HIV exclusion clauses, with the market determining the cost of such products. National Mutual, AMP, and LRA have now eliminated HIV exclusion clauses for their group insurance products, and other insurers may follow: M Alexander, "HIV Exclusion Clauses - Big Three Insurers Fall into Line" (1995) 9(1) *National AIDS Bulletin* 2.

21 *Disability Discrimination Act* 1992 (Cth), s 46.

There have been calls for mandatory HIV testing in a variety of other areas. As discussed in Part 2 of this article, the mandatory testing of all hospital or surgery patients has been advocated in order to reduce the risk of occupational HIV transmission within medical contexts, and systematic testing is reported to have been carried out in some States on several occasions.[22] The HIV testing of employees during or prior to employment is not specifically prohibited except in Tasmania[23] and has been known to occur in some areas. Where HIV testing is not authorised by legislation, however, it could potentially conflict with anti-discrimination and privacy legislation.

IV. CONSENT AND COUNSELLING REQUIREMENTS

Where legislation authorises compulsory HIV testing, such testing may legally occur despite the absence of consent of the test subject. In other situations, consent to testing would be required under the common law, and the drawing of a blood sample without consent may constitute an assault. Whether *specific* consent to HIV testing is required under the common law where the patient has consented generally to medical treatment or to the giving of a blood sample is an unresolved issue briefly touched upon in Part 2.

In some jurisdictions, the issue of consent to HIV testing is affected by legislation. In Tasmania, the *HIV/AIDS Preventive Measures Act* 1993 (Tas), s 7(1) requires consent to testing, with special provisions regulating consent procedures when a child or disabled person is involved.

Legislation imposing pre- and post- test counselling requirements, if complied with, will also ensure that the test subject is informed of, and given the opportunity either to refuse or consent to an HIV test. The *HIV/AIDS Preventive Measures Act* 1993 (Tas) requires pre-test counselling on the medical and social consequences of being tested and face-to-face post-test counselling about how to avoid HIV transmission in cases where the test is negative. When the result is positive, the patient must be informed in person and counselled in accordance with Departmental guidelines.[24] A person aware of their HIV infection in Tasmania must take reasonable measures to prevent transmission to others. This includes disclosing one's HIV status (in advance) to sexual contacts and persons with whom needles are shared.[25]

Victorian legislation also requires pre-test counselling about the medical and social consequences of being tested for HIV, although only in respect of persons who have requested the test. When a test is positive, the patient must be

---

22 For example, "Hospital Doctors Decide: HIV Tests for All" *Sydney Morning Herald*, 31 December 1990, p 1; "Secret AIDS Testing Revealed" *Sydney Morning Herald*, 5 May 1989, p 3; L Selvey, P Hogan, I Frazer et al, "Routine HIV Testing before Surgery" (1995) 19 *Australian Journal of Public Health* 107 (letter).

23 See *HIV/AIDS Preventive Measures Act* 1993 (Tas), s 6(2).

24 *Ibid*, ss 14-15.

25 *Ibid*, s 20(1).

counselled about the social and medical consequences of being HIV infected and about how to prevent transmission.[26]

In New South Wales, a medical practitioner must counsel those whom he or she believes to be suffering from a sexually transmissible disease (which would include HIV). By regulation, counselling must include discussion of the means of minimising infection, public health implications of infection, diagnosis and prognosis, treatment options, as well as the statutory obligation owed by infected persons in New South Wales, to inform sexual partners and to obtain their consent to the risk of disease transmission prior to sexual intercourse.[27]

Finally, in the Northern Territory, a medical practitioner who diagnoses or suspects a patient to be infected with a notifiable disease (which includes HIV/AIDS) must advise the patient about the nature of the disease, the measures needed to prevent transmission, and required treatment.[28]

V. REQUESTING AN HIV TEST: PRIVACY REQUIREMENTS

There is evidence that anonymous HIV testing, by ensuring privacy, encourages voluntary testing. One American study reported that after the introduction of anonymous HIV testing services, there was an increase in demand of 125 per cent by homosexual or bisexual men, 56 per cent by female prostitutes, 17 per cent for injecting drugs users, and 32 per cent for other clients.[29]

There is no standard form used in Australia for requesting HIV tests. Some States or area health authorities have developed specific HIV test request forms which provide for patient codes instead of names to protect privacy. A good example is the proforma developed by the Victorian Health Department, which protects privacy by identifying patients through a combination of their birth-date, sex, and a name code constructed from the first two letters of the patient's surname, followed by the first two letters of the given name. The trend is towards coded identification using these identifiers.

Legislation in New South Wales, Victoria, and Tasmania regulates the information which may be included in HIV test request forms. In Victoria, medical practitioners are prohibited from requesting an HIV test using information which would identify the test subject, although demographic information such as age, sex, and transmission category must be provided.[30] Persons in charge of HIV testing laboratories are also prohibited from keeping identifying information on test subjects.[31]

---

26 *Health Act* 1958 (Vic), s 127.

27 *Public Health Act* 1991 (NSW), s 12 and *Public Health Regulation* 1991 (NSW), reg 4. The duty to inform sexual partners is contained in s 13 of the Act.

28 *Notifiable Diseases Act* 1981 (NT), s 10.

29 LJ Fehrs, D Fleming, LR Foster et al, "Trial of Anonymous Versus Confidential Human Immunodeficiency Virus Testing" (1988) 2 *Lancet* 379.

30 *Health Act* 1958 (Vic), s 130(4)-(5). This is to enable laboratories to fulfil their reporting requirements to the Health Department: see s 130(2)-(3).

31 *Ibid*, s 130(6).

In New South Wales, medical practitioners are prohibited from requesting an HIV test using the patient's name or address, unless the patient is in hospital.[32] Persons who, in the course of providing a service, discover the HIV status of a patient or discover that a patient has undergone testing must take all reasonable steps to prevent disclosure of this information to others.[33] This provision applies to medical practitioners, hospital employees, as well as to laboratory staff actually carrying out an HIV test.

In Tasmania, information which would, either directly or indirectly, identify the HIV test subject must also not be included in a test request form, except in accordance with Privacy Guidelines issued with the approval of the Minister.[34] HIV testing laboratories are also prohibited from keeping identifying data, and there is a blanket prohibition on the recording, collection, transmission, or storage of HIV test data otherwise than in accordance with the Privacy Guidelines.[35] No restrictions on name-identifying requests for HIV tests exist in other States.

Data from a recent study suggest that the above legislative requirements have frequently been ignored, particularly by general practitioners who use general pathology forms which contain no provision for patient name-codes. Name-codes are not used in hospitals, nor for insurance, visa, and immigration purposes, although they are used in sexual health clinics.[36] Data from the above study also demonstrated that HIV tests for prisoners may be requested on a name-identifying basis, depending on the request form used. This is unfortunate, since the issue of disclosing the status of positive prisoners to prison officers and medical personnel is obviously very different from the issue of ensuring prisoner privacy within the HIV testing process.

VI. NOTIFICATION OF HIV TEST RESULTS AND CONTACT TRACING

The mandatory reporting of HIV/AIDS to the Health Department is required by public health legislation in all Australian jurisdictions. A key recommendation of the Legal Working Party of the Intergovernmental Committee on AIDS is that uniform notification requirements be adopted throughout Australia, requiring coded reporting of confirmed HIV positive test results by laboratories, and of clinical AIDS diagnoses by doctors.[37] In addition to reporting HIV/AIDS to State Health Departments, HIV laboratories and sexual health clinics also report new cases of HIV infection and AIDS and deaths from AIDS to the National Centre in

---

32 *Public Health Act* 1991 (NSW), s 17(1)(b) and *Public Health Regulation* 1991, reg 7(1).

33 *Public Health Act* 1991 (NSW), s 17(2).

34 The current privacy guidelines issued by Community and Health Services are adapted from the Guidelines included in the Commonwealth of Australia, *Report of the Privacy and HIV/AIDS Working Party*, September 1992. They do not directly address the issue.

35 *HIV/AIDS Preventive Measures Act* 1993 (Vic), ss 17-18.

36 RS Magnusson, "Privacy, Confidentiality and HIV/AIDS Health Care" (1994) 18 *Australian Journal of Public Health* 51 at 52-3.

37 Intergovernmental Committee on AIDS (IGCA), Legal Working Party, *Final Report*, November 1992, Recommendation 2.1.

HIV Epidemiology and Clinical Research located at St Vincent's Hospital, Sydney.

Upon identifying new cases of HIV infection, contact tracing may take place, subject to the co-operation of the index case.[38] In some States, contact tracing is essentially an activity voluntarily undertaken by the doctor with his or her patient; in other States the Health Department supervises the contact tracing process, and Department employed contact tracers may assist the doctor if required.

A. New South Wales and Victoria

Coded notification of patients with HIV or AIDS is required in both States. Medical practitioners are required to report diagnosed cases of AIDS to the Health Department using a name code constructed from the first two letters of the patient's surname and given name.[39] In New South Wales the same obligation attaches to the chief executive officer of hospitals caring for patients with AIDS.[40] In both States, laboratories are required to report HIV positive test results to the Director-General of the Health Department but without disclosing the patient's name and address.[41] A Victorian Health Department proposal to record the names of persons diagnosed with sexually transmissible diseases, including HIV, is currently under consideration, although it has been attacked by community leaders on the basis that it would discourage voluntary testing.[42]

There is no legislation requiring contact tracing. In New South Wales, doctors in general practices or sexual health clinics counsel the patient and negotiate how to inform past and present 'downstream' contacts who might have been exposed to the virus. In extreme situations where the patient refuses to authorise contact tracing and where third parties are in danger of contracting HIV or transmitting it to others, a medical practitioner may, with authorisation from the Director-General of the Health Department, inform third parties of the risk of infection in accordance with contact tracing guidelines, although this does not authorise direct disclosure of the patient's identity.[43] In Victoria, contact tracing is also negotiated between the doctor who diagnoses the new case of HIV and the patient, although the Health Department employs specialist contact tracers, who assist in contact tracing if asked by the doctor.

---

38 See K Sesnan, D Jackson, I Catto et al, "Contact Tracing in HIV Infection" (1989) 2(3) *Venereology* 75; Sydney Sexual Health Centre at Sydney Hospital, *Contact Tracing Manual* (forthcoming).

39 *Public Health Act* 1991 (NSW), ss 14, 17(1) and *Public Health Regulation* 1991 (NSW), reg 5; *Health (Infectious Diseases) Regulations* 1990 (Vic), reg 7. The amended notification form is set out in the *Health (Infectious Diseases) (Notification of AIDS) Regulations* 1993 (Vic).

40 *Public Health Act* 1991 (NSW), s 69 and *Public Health Regulation* 1991 (NSW), reg 81.

41 *Public Health Act* 1991 (NSW), s 16; *Health Act* 1958 (Vic), s 130.

42 "Attack on HIV Names Register" *Age* (Melbourne), 11 August 1994; "Kennett Supports HIV Names Plan" *Age* (Melbourne), 12 August 1994, p 8.

43 *Public Health Regulation* 1991 (NSW), regs 9-10; NSW Health Department, *Contact Tracing Guidelines for the Sexually Transmissible Diseases*, 1993.

B. Queensland

Medical practitioners,[44] HIV testing laboratories,[45] and public hospital superintendents[46] are required to notify the Health Department of new cases of HIV infection. Coded notification is authorised under the *Health Act* 1937 (Qld), s 32A(8), although the Director-General may require nominal notification in order to protect the public against an "outbreak" of HIV (s 32A(9)). Presumably, this might occur if the Department became aware that a person with HIV was placing third parties at risk of HIV transmission.

In practice, HIV laboratories report positive HIV test results by forwarding an HIV test report to the Health Department. Additional nominal information is reported separately by the doctor. The notification forms used for HIV now provide for name codes constructed from the first two letters of the patient's surname and given name.

Under the *Health Act* 1937 (Qld), persons with HIV may be required to disclose to the Department the names and addresses of their contacts.[47] In practice, contact tracing is performed by the doctor, who periodically receives a Departmental questionnaire seeking information on the (name-coded) patient, the number of contacts, and whether they have been informed or have tested positive.

C. South Australia

Medical practitioners[48] and HIV testing laboratories[49] are required to notify new cases of HIV and AIDS to the Health Commission. Notification of HIV is required in a manner and form determined by the Health Commission,[50] which now involves the identification of patients with a name code constructed by the first two letters of the patient's surname and given name. In practice, HIV laboratories report positive HIV test results by forwarding an HIV test report to the Health Commission. Additional epidemiological information is reported separately under code by the doctor.

Contact tracing is authorised by a general empowering provision.[51] As in Queensland, the Health Commission administers a contact tracing program. The notifying doctor can either initiate contact tracing and report progress to the Commission, or can elect for the Health Commission HIV epidemiologist to perform it. Doctors refer contact tracing to the Commission in 80 per cent of cases. In order to carry it out, the Commission epidemiologist then telephones the notifying doctor to find out the patient's name and address before contacting the patient directly. Coded HIV notification therefore serves little purpose. The doctor or epidemiologist performing contact tracing negotiates with the patient as

---

44 *Health Act* 1937 (Qld), s 32A(1).
45 *Ibid*, s 32A(4).
46 *Ibid*, s 32A(2).
47 *Ibid*, s 32B(1)(b).
48 *Public and Environmental Health Act* 1987 (SA), s 30(1).
49 *Ibid*. Laboratory employees are classified as 'medical practitioners' by virtue of the *Public and Environmental Health (Notifiable Diseases) Regulations* 1989 (SA), reg 4(1)(b).
50 *Public and Environmental Health Act* 1987 (SA), s 30(2).
51 *Ibid*, s 41(1).

to how partners are to be contacted and informed. The name of the HIV infected index case is not disclosed when a contact is informed of their exposure.[52]

D. Tasmania

The *Public Health (Notifiable Diseases) Regulations* 1995 (Tas) provide for coded notification of HIV and AIDS by medical practitioners and hospital superintendents and for coded notification of HIV by those superintending HIV testing in laboratories.[53] The *HIV/AIDS Preventive Measures Act* 1993 (Tas) also requires medical practitioners to inform the Health Department of positive HIV test results in a non-identifying form.[54] Laboratories are similarly prohibited from transmitting nominal HIV test results.[55]

Persons with HIV in Tasmania have a duty to take reasonable precautions to prevent further transmission, and the Secretary of the Health Department is required to provide adequate information, counselling, and medical and psychological assessment for this purpose. Persons with HIV may request their doctors to perform contact tracing on their behalf. A person who makes no such request and whose sexual behaviour continues to place others at risk foregoes their right to confidentiality and the Act authorises a doctor, after consulting an HIV specialist practitioner, to inform the patient's sexual contacts in these circumstances of the patient's HIV status.[56]

E. Western Australia

Notification provisions are outdated and an expert committee report dating from 1991 has recommended major amendments to infectious diseases legislation.[57] A new Public Health Act is likely to be introduced into Parliament in 1995, although not all of these recommendations are expected to be included. The notification of HIV and AIDS by medical practitioners[58] is the only legislative requirement currently observed. AIDS is notified by name and address, although HIV infection is notified under code.

F. The Northern Territory

Medical practitioners are required to notify new cases of HIV and AIDS to the Department of Health and Community Services.[59] It is likely that medical pathologists will be required to notify cases of HIV under new amendments.[60]

---

52 For further discussion, see R Waddell, T Davey, "Contact Tracing following Diagnosis of HIV Infection in South Australia" (1994) 10(4) *Australian HIV Surveillance Report* 1.

53 *Public Health (Notifiable Diseases) Regulations* 1995 (Tas), regs 4-5. Note that the *Public Health Act* 1962 (Tas) is to be repealed and an exposure draft of the new Public Health Bill should become available for public comment during 1995.

54 *HIV/AIDS Preventive Measures Act* 1993 (Tas), ss 15(1)(b), 18.

55 *Ibid*, s 17(3).

56 *Ibid*, s 20.

57 Public and Environmental Health Review Committee, Health Department of West Australia, *Infectious Diseases Legislation in Western Australia - Legislative Proposals*, June 1991.

58 *Public Health Act* 1911 (WA), s 276(1)(c).

59 *Notifiable Diseases Act* 1981 (NT), s 8.

60 *Ibid*, s 16. HIV/AIDS will become a Schedule 5 disease.

Most public sector service providers currently use codes for notification, but private practitioners still use names. Legislation currently provides that persons with HIV may be required to disclose the names and addresses of contacts to a medical practitioner or authorised officer for the purposes of contact tracing.[61] However, in practice, Departmental contact tracers only become involved if the notifying doctor desires assistance and the patient has consented to Departmental involvement.

G. The Australian Capital Territory

Medical practitioners, including those attending hospital patients, are required to report cases of HIV infection and AIDS to the Medical Officer of Health.[62] Medical pathologists are also required to notify HIV infection to the Medical Officer of Health.[63] Coded notification using the first two letters of the patient's surname and given name is required in all cases. In view of this, contact tracing is carried out by the individual doctor who negotiates with the patient as to how to inform contacts.

H. Additional Demographic Data

The mode of infection of a patient diagnosed with HIV or AIDS, which would reveal details of sexual preference or drug use, is notifiable either by the laboratory or doctor concerned, in accordance with notification forms prescribed in all States and Territories. Ethnic origin is notifiable in Queensland, racial origin is notifiable in South Australia, one's 'language spoken at home' and country of birth are notifiable in Tasmania, and aboriginality is notifiable in New South Wales, Queensland, Western Australia and Tasmania.

In some jurisdictions, legislation imposes on medical practitioners a duty to notify the Health Department of a death from AIDS in the same way as they would notify a new diagnosis.[64] Quite apart from this, in all jurisdictions, the cause of death must be noted on the Certificate of Cause of Death sent to the Registrar of Births, Deaths and Marriages.[65]

---

61 *Ibid*, s 9.

62 *Public Health (Infectious and Notifiable Diseases) Regulations* (ACT), regs 4, 4B and Schedule 1, Form 2.

63 *Ibid*, reg 4A and Schedule 1, Form 3.

64 *Public Health Act* 1991 (NSW), ss 14(1)(b), 17(1) (prohibiting disclosure of name and address, although the Health Department receives independent nominal notification from the Registrar of Births, Deaths and Marriages: *Public Health Act* 1991 (NSW), s 20 and *Public Health Regulation* 1991, reg 8); *Health (Infectious Diseases) Regulations* 1990 (Vic), reg 7 (name-code required in prescribed form); *Public and Environmental Health Act* 1987 (SA), s 30(1) (current administrative form requires name, address); *Health Act* 1911 (WA) (notify local authority); *Public Health (Notifiable Diseases) Regulations* 1995 (Tas), regs 4-6 (coded notification required); *Notifiable Diseases Act* 1981 (NT), s 15; *Public Health (Infectious and Notifiable Diseases) Regulations* (ACT), reg 4(1)(b).

65 See J Godwin et al, note 5 *supra*, p 337.

VII. CONFIDENTIALITY AND NON-DISCLOSURE OF HIV STATUS

Maintaining the confidentiality of HIV test information is a crucially important aspect of Australia's public health response to HIV/AIDS. Lack of confidentiality will discourage voluntary testing and discredit the educative function of doctors in providing information and encouraging self-protection. Australia's record in this area is a mixed one,[66] although there is a considerable body of non-disclosure and privacy legislation relevant to HIV testing.

This legislation falls into two categories. First, legislation in New South Wales, Victoria, Queensland, and South Australia imposes duties of non-disclosure with respect to medical information acquired by certain categories of health care professionals in the course of their duties - primarily those employed by public hospitals and other government funded facilities.[67] In Victoria and Queensland, these provisions arguably codify the obligations of the prescribed categories of employees, and detailed exceptions (which cannot be reviewed here) are set out.

A second category of legislation specifically regulates the disclosure of HIV information:

A. New South Wales

The *Public Health Act* 1991 (NSW) imposes upon persons who, in the course of providing a service, learn that a person has HIV/AIDS or has been tested for HIV, a duty to "take all reasonable steps to prevent disclosure of the information to another person": s 17(2). Arguably, this provision would apply to medical practitioners, pathologists, and all health care workers who learned of a patient's HIV status in the course of their employment. There are several exceptions, not all of which are mentioned here. A person's HIV status may be disclosed to others who require that knowledge for the purposes of providing care, treatment, or counselling to that person.[68] Also, a person's HIV status may be disclosed to the Director-General of the Health Department if a person is placing public health at risk.[69] The Director-General may obtain a court order *requiring* a medical practitioner to disclose the name and address of a patient with HIV if the doctor does not wish to and if identification is necessary to safeguard public health.[70]

B. Victoria

Under the *Health Act* 1958 (Vic), a person who finds out another person's HIV status in the course of providing a service must take "all reasonable steps to develop and implement systems to protect the privacy of that person": s 128.

---

66 See Commonwealth of Australia, note 34 *supra*; RS Magnusson, note 36 *supra*.

67 *Health Administration Act* 1982 (NSW), s 22; *Health Services Act* 1988 (Vic), s 141; *Health Services Act* 1991 (Qld), s 5.1; *South Australian Health Commission Act* 1976 (SA), s 64. A further category of legislation applies to Health Department employees (or those performing duties under relevant public health legislation). Both categories of legislation are considered in more detail in Part 2, Section VII(B).

68 *Public Health Act* 1991 (NSW), s 17(3)(d), as recently amended.

69 *Ibid*, s 17(3)(e) and *Public Health Regulation*, reg 7(2).

70 *Public Health Act* 1991 (NSW), ss 18-19.

While prohibiting direct breaches of confidence by medical practitioners, the focus of this provision would appear to be to require service providers to implement procedures such as access protocols to ensure the security, and thus the privacy, of HIV information.[71]

C. Tasmania

The *HIV/AIDS Preventive Measures Act* 1993 (Tas) imposes a duty of non-disclosure with respect to HIV test results, HIV status, and information relating to the sexual behaviour and drug use of a test subject: s 19. There are a number of exceptions, including:

- disclosure with written consent (with detailed procedures where a person is incapable of giving written consent);
- disclosure to fellow health care workers directly involved in treating or counselling the HIV infected person;
- disclosure for the purpose of epidemiological research authorised by the Secretary of the Health Department;
- disclosure in court or where disclosure is authorised by the Act.

By way of law reform, the Legal Working Party of the Intergovernmental Committee on AIDS (IGCA) has recommended that public health legislation in each jurisdiction should prohibit health care service providers from disclosing identifiable information on persons with HIV/AIDS without consent except:

- in cases of occupational injury and alleged assault involving the risk of HIV transmission;
- where there is a scientifically based need to know a patient's HIV status for the performance of medical services;
- where a person with HIV is unreasonably creating a risk of infection to others; and
- where the law otherwise requires disclosure.

The Committee has also recommended that, apart from these exceptions, name-identifying HIV data should not be obtainable by Health Departments, and that State and Territory Health Departments should implement the Information Privacy Principles contained in the *Privacy Act* 1988 (Cth).[72] Tasmania has now done this.[73]

---

71 See further, RS Magnusson, note 36 *supra* at 52-4.

72 IGCA, Legal Working Party, note 37 *supra*, Recommendation 2.3.1 - 2.3.3.

73 Community and Health Services (Tas), *Privacy Guidelines Relating to the HIV/AIDS Preventive Measures Act 1993*, 1994.

VIII. HIV/AIDS DISCRIMINATION AND VILIFICATION LAW

There have been numerous documented examples of HIV related discrimination in Australia.[74] AIDS remains a highly stigmatised illness; those with HIV/AIDS suffer not only the uncertainties of an ultimately lethal illness, but also from a socially constructed, "spoiled identity",[75] which feeds upon fear, lack of information, moralising, and the need to create a "comforting and differentiating moral rationale to account for the arbitrary tragedy of illness and death".[76]

The *Disability Discrimination Act* 1992 (Cth), as well as legislation in all States (except Tasmania) and in both Territories, prohibits discrimination on the basis of a real or imputed physical 'impairment' or 'disability' in a variety of different sectors. At the Commonwealth level, and in NSW, Victoria, Queensland, and both Territories, the effect of the legislation is to prohibit discrimination not only on the basis of AIDS or symptomatic HIV infection, but also on the basis of a person's symptomless HIV positive status, since the definition of 'impairment' or 'disability' includes "the presence in the body of organisms causing disease". In South Australia and Western Australia, however, the legislation would only apply to discrimination against asymptomatic HIV carriers if one were to accept that asymptomatic HIV infection had caused a "defect or disturbance" (in WA), or a "malfunctioning" (in SA) in the normal structure and functioning of the person's body.[77] Each Act provides for the lodgment of complaints to a conciliatory body which may refer the matter to a formal hearing if a negotiated settlement is unsuccessful. Provisions authorising representative complaints, or the non-disclosure of the identity of complainants, go some way towards eliminating disincentives to prosecuting claims by persons who wish to preserve their privacy.[78]

Since the burden of HIV within the gay community is high, it should also be noted that discrimination on the basis of sexual orientation is prohibited in New South Wales, Queensland, South Australia, the ACT, and the Northern Territory,[79]

---

74 New South Wales Anti-Discrimination Board, *Discrimination - The Other Epidemic: Report of the Inquiry into HIV and AIDS Related Discrimination*, April 1992.

75 M Abramson, "Keeping Secrets: Social Workers and AIDS" (1990) 35 *Social Work* 169 at 171.

76 WF Flanagan, "Equality Rights for People with AIDS: Mandatory Reporting of HIV Infection and Contact Tracing" (1989) 34 *McGill Law Journal* 530 at 549.

77 Some courts have regarded asymptomatic HIV infection as a 'defect' or 'impairment' under this legislation: *Hoddy v Executive Director of Corrective Services* (1992) EOC [92-397].

78 *Disability Discrimination Act* 1992 (Cth), ss 69, 86-87, 89-92; *Anti-Discrimination Act* 1977 (NSW), ss 88, 110A; *Equal Opportunity Act* 1984 (Vic), ss 44(4), 46(3B)-(3C); *Anti-Discrimination Act* 1991 (Qld), ss 134, 145-147; *Equal Opportunity Act* 1984 (SA), s 93(1); *Equal Opportunity Act* 1984 (WA), ss 83, 121-122; *Anti-Discrimination Act* 1992 (NT), ss 60-62, 99-100; *Discrimination Act* 1991 (ACT), ss 70, 77, 88.

79 *Anti-Discrimination Act* 1977 (NSW), s 49ZG; *Anti-Discrimination Act* 1991 (Qld), s 7(1); *Equal Opportunity Act* 1984 (SA), s 29(3); *Anti-Discrimination Act* 1992 (NT), ss 4, 19; *Discrimination Act* 1991 (ACT), ss 4(1), 7(1)(b). At the Commonwealth level, the *Human Rights and Equal Opportunity Commission Act* 1986 (Cth), ss 20-35 gives the Commission power to inquire into and to conciliate complaints of discrimination on the grounds of sexual preferences (by virtue of the *Human Rights and Equal Opportunity Commission Regulations* 1989 (Cth), reg 4(a)(ix). Tasmania is the only Australian jurisdiction where homosexuality remains a crime (see *Criminal Code Act* 1924, ss 122-123), although the *Human Rights (Sexual Conduct) Act* 1994 (Cth) purports to override this.

but not as yet in the other States, although reform has been foreshadowed in Victoria.[80] Where gay men (and only gay men) are refused treatment unless they undergo an HIV test, it can be argued that HIV discrimination occurs indirectly, albeit on the basis of a person's homosexuality.[81]

While legislation protecting persons with HIV/AIDS from discrimination extends into many sectors, only its application to medical contexts will be noted here. Legislation prohibiting discrimination on the basis of HIV/AIDS in the provision of goods and services would apply to medical treatment and related services provided by the medical profession, given the definition of 'services' in the legislation to include services provided by members of any profession or trade.[82] The refusal of medical treatment to persons with, or assumed to have HIV/AIDS, or, additionally, under the *Disability Discrimination Act* 1992 (Cth), the harassment of a person seeking medical services on the basis of their HIV status[83] are the clearest examples of prohibited conduct.

The imposition of a condition requiring all homosexual patients, or indeed every patient to be tested for HIV prior to treatment would also be considered discriminatory if persons diagnosed as HIV positive were denied services, or were subjected to unreasonable conditions (for example, elaborate and unnecessary infection control procedures) to which persons without HIV were not subjected. Similarly, the refusal to treat a person who refused HIV testing would also be discriminatory, as the refusal of treatment would amount to an act of discrimination on the basis of imputed HIV status (presumably, those whose HIV negative status was known would not be refused treatment). The only relevant exception provided for in the legislation is where discrimination on the basis of a person's 'impairment' or 'disability' is reasonably necessary to protect public health.[84] Obviously, the *refusal* of treatment is not justified under this exception. Whether the *deferral* of treatment would be justified is an issue relevant to current debates about the mandatory HIV testing of surgical or hospital patients, which will be discussed in Part 2 of this article.

As with laws protecting the privacy and confidentiality of HIV test information, anti-discrimination laws protecting persons with HIV/AIDS have sometimes been ignored by health care providers. The New South Wales Anti-Discrimination Board reported in 1992 that:

> The area in which HIV and AIDS related discrimination is most consistently and extensively reported is that of health care... This discrimination is manifest in many ways, including in a refusal to provide health care, in discriminatory standards of health care, in the adoption of infection control measures which are either unnecessary

---

80 "Gay Rights Legislation to Go Ahead" *Age* (Melbourne), 3 May 1995, p 3.

81 See *Ferguson v Central Sydney Area Health Service* (1990) [92-272]; M Alexander, "Homosexuality, Surgery and HIV Testing" (1995) 6(1) *HIV/AIDS Legal Link* 8.

82 *Disability Discrimination Act* 1992 (Cth), ss 4(1), 24; *Anti-Discrimination Act* 1977 (NSW), ss 4(1), 49M; *Equal Opportunity Act* 1984 (Vic), ss 4(1), 29; *Anti-Discrimination Act* 1991 (Qld), ss 4, 46(1); *Equal Opportunity Act* 1984 (SA), ss 5(1), 76; *Equal Opportunity Act* 1984 (WA), ss 4(1), 66A, 66K; *Anti-Discrimination Act* 1992 (NT), ss 4(1), 41; *Discrimination Act* 1991 (ACT), ss 4(1), 20.

83 See *Disability Discrimination Act* 1992 (Cth), s 40.

84 *Ibid*, s 48; *Anti-Discrimination Act* 1977 (NSW), s 49P; *Equal Opportunity Act* 1984 (Vic), s 39(da); *Anti-Discrimination Act* 1991 (Qld), s 107-108; *Equal Opportunity Act* 1984 (WA), s 66U; *Anti-Discrimination Act* 1992 (NT), s 55; *Discrimination Act* 1991 (ACT), s 56.

or excessively rigorous, in non-consensual HIV antibody testing, and in breaches of confidentiality.[85]

The Board noted that the effects of this discrimination, and of the perception of discrimination, were that persons with HIV were delaying in coming forward for treatment and monitoring until later in their illness, until AIDS or other serious conditions had developed.

By way of law reform, the Legal Working Party of the Intergovernmental Committee on AIDS has recommended that:

- Tasmania enact anti-discrimination legislation;
- discriminatory conduct should be extended to include the asking of discriminatory questions (including provision of body samples which may be tested to provide answers to discriminatory questions or requirements); and
- legislation prohibiting discrimination on the basis of 'impairment' should apply to discrimination on the basis of a person's medical record, whom they associate with, imputations, past characteristics, and their occupation.[86]

While not directly relevant to the focus in this article on HIV testing and medical practice, it is worth noting that HIV/AIDS vilification legislation has recently been enacted in New South Wales. The *Anti-Discrimination (Amendment) Act* 1994 (NSW) creates the offence of serious HIV/AIDS vilification for public actions which incite hatred towards, serious contempt for, or severe ridicule of persons on the ground that they have HIV/AIDS: s 49ZXC. The offence extends to:

(i) threats of physical harm to person or property; and
(ii) inciting others to threaten physical harm to person or property, although public acts done for purposes of academic, artistic, scientific, research or religious discussion are exempted, and the Attorney-General must consent to each prosecution.

IX. COMPLIANCE WITH LEGISLATION REGULATING HIV TESTING

The impact of HIV/AIDS upon the law has been considerable. The literature discussing HIV-related legal issues is huge, and the *Australian HIV/AIDS Legal Guide*, already in its second edition (Federation Press, 1993), runs to 527 pages. Only the legislation regulating HIV testing and HIV test information which is directly relevant to health care workers in medical practice has been reviewed in this Part. It is clear, however, that while compliance with this legislation is required as a part of ordinary, professional medical practice, its rapid growth imposes a considerable responsibility upon health care workers to self-educate. If anything, the body of legislation directly regulating the HIV testing process will continue to expand as governments review the operation of legislative schemes

85 New South Wales Anti-Discrimination Board, note 74 *supra* at 30.
86 IGCA, note 37 *supra*, Recommendations 4.2, 4.3.

adopted by other States, and consider (belatedly) the recommendations of the Legal Working Party of the Intergovernmental Committee on AIDS.

Many of the provisions reviewed in this article are regulatory and provide for a monetary penalty upon breach. It is possible that the breach of these provisions could support an action for breach of statutory duty by an aggrieved patient in cases where it could be shown that the legislation evidenced an intention to confer a private right of action for breach of the statutory obligation. The principles for determining this, however, are notoriously vague and will not be discussed here. Alternatively, prosecutions may be brought by the Director-General of the Health Department administering the relevant Public Health Act, following investigation of a complaint brought by an individual who became aware of the statutory breach. In many cases, however, individuals will be unaware that statutory obligations have not been complied with. Educating health care workers providing HIV testing services about legal requirements is therefore an important means of safeguarding the interests of persons with HIV/AIDS and those undergoing HIV tests.

Rarely, actions might arise under the common law for the withdrawal of blood samples without consent or possibly for HIV testing without specific consent.[87] In several jurisdictions, the privacy rights of litigants with HIV are protected by provisions authorising publication restrictions or the closure of the court or tribunal to the public.[88] The Legal Working Party of the Intergovernmental Committee on AIDS has recommended the adoption of these provisions in other States.[89] Similar orders may be made at the court's discretion, and HIV infected plaintiff's may also be permitted to sue anonymously.[90]

In the majority of cases, however, private remedies are likely to be pursued as complaints to Medical Boards and similar professional conduct tribunals which investigate complaints of professional misconduct across a range of medical and paramedical professions. A number of States have also introduced health complaints legislation which provides for the appointment of a Health Care Complaints Commissioner with power to investigate and conciliate complaints against health care providers.[91] The establishment of medical ombudsmen or health complaints authorities was recommended by the Legal Working Party of the

---

87 See Part 2 of this article, Section IV(A); RS Magnusson, "Specific Consent, Fiduciary Standards and the Use of Human Tissue for Sensitive Diagnostic Tests and in Research" (1995) 2 *Journal of Law and Medicine* 206.

88 *Public Health Act* 1991 (NSW), s 35; *Health Act* 1958 (Vic), s 129; *HIV/AIDS Preventive Measures Act* 1993 (Tas), ss 21(7), 42. The New South Wales provision applies only to proceedings relating to scheduled infectious diseases, although the Victorian and Tasmanian provisions would apply to litigation generally, both where the HIV infected person was a plaintiff or a defendant. In *The Herald & Weekly Times Ltd v Braun*, [1994] 1 VR 705, Beach J held that the Victorian provision is to be read in the light of s 119, so that where an HIV infected defendant is charged with actions which have created a risk to public health, he or she may forfeit the right to privacy: *Health Act* 1958 (Vic), ss 119, 129.

89 IGCA, note 37 *supra*, Recommendation 2.3.4.

90 See T Leach, D Buchanan, "Qld Supreme Court Denies Privacy to HIV Litigants" (1993) 4(2) *HIV/AIDS Legal Link* 1 and cases there cited; RS Magnusson, "Public Interest Immunity and the Confidentiality of Blood Donor Identity in AIDS Litigation" (1992) 8 *Australian Bar Review* 226 at 230.

91 *Health Care Complaints Act* 1993 (NSW); *Health Services (Conciliation and Review) Act* 1987 (Vic); *Health Rights Commission Act* 1991 (Qld).

Intergovernmental Committee on AIDS as a means of providing effective practical remedies (apart from formal recourse to the law), for breach of public health and pre- and post- test counselling legislation regulating HIV testing.[92] Complaints of discrimination may, of course, be made to the relevant Board or Commission within all jurisdictions except Tasmania.

X. HIV TESTING, PUBLIC HEALTH AND THE ROLE OF THE LAW

After a decade of HIV testing in Australia, doctors and other health care workers are subject to a complex web of legislation regulating all aspects of the HIV testing process. HIV/AIDS is unique among infectious diseases in the sheer volume of legislation it has generated. The question arises, therefore, whether this legislation is either necessary or desirable. In answering this question, it is important to identify the role which HIV legislation plays within the broader public health strategy adopted by Australian governments at State and federal level.

Australia's response to HIV/AIDS has generally been recognised, in policy terms, as a success. A number of factors are responsible for this, including the vigorous participation of affected communities (particularly the gay community) from the early 1980s, broad political bipartisanship, committed political leadership by Dr Neil Blewett (Federal Health Minister 1983-1990), and Commonwealth funding. This led to an early mobilisation of resources and to education programs targeted to at-risk communities, which reduced the number of transmissions in the mid 1980s.[93] While any talk of success cannot go unqualified (to 31 December 1994 there were 18 782 diagnoses of HIV infection), Australia's position is a lot better than it could have been.

Even so, the history of Australia's policy response to AIDS reveals a tension between opposing models of public health regulation. Speaking of the struggle for policy control in the early 1980s, Ballard writes:

> [o]ne area ripe for dispute lay in two implicit models for programs, a medical contain-and-control model and the community cooperation model, one stressing professional medical determination through traditional public health controls, the other education and peer support.[94]

The struggle for a policy response to HIV/AIDS which embodies one or other of these 'models' of infection control is reflected in some of the still unresolved controversies over HIV testing which will be reviewed in Part 2 of this article. It is also reflected in the by-product of governments' responses to AIDS; that is, in HIV legislation, and in the discrepancies between legislation regulating the HIV testing process in each State and Territory.

---

92 IGCA, note 37 *supra*, Recommendation 2.4.2.

93 See further, J Ballard, "Australia: Participation and Innovation in a Federal System" in DL Kirp, R Bayer (eds), *AIDS in the Industrialized Democracies*, Rutgers University Press (1992) p 134.

94 *Ibid*, p 141.

The models of infection control noted above are 'ideal types' which are useful in focusing attention upon the social policy underlying HIV legislation. Under a 'contain and control' model of infection control, individual interests are subject to the public interest in protecting the community from disease. The law assists the objective of disease control by protecting the uninfected from the infected, through laws criminalising behaviour likely to transmit infection, and by regulating the activities of disease carriers. In contrast, under a 'community co-operation' or 'human rights' model, the voluntary participation of the individual is seen as crucial to the public goal of preventing transmission. The law assists this process by protecting the rights of the infected, and thereafter, by largely 'keeping out'. It is education and social support structures, rather than regulatory schemes, which are of primary importance.

The efficiency of both infection control strategies in slowing the spread of HIV must take account of medical knowledge regarding the means of transmission, the medical consequences of infection, as well as the social construction of the disease itself. There are good reasons for thinking that a model of HIV infection control which tends towards the 'community co-operation' or 'human rights' model is more likely to be effective in slowing transmission than a 'contain and control' model.

The transmission of HIV in Australia, as in many other industrialised countries, has been attributed predominantly to homosexual or bisexual activity and, to a lesser extent, intravenous drug use, rather than to heterosexual and perinatal transmission.[95] While it is important for reasons of prevention and education to stress that HIV is transmitted by specific modes of behaviour, rather than by virtue of membership of a particular group, it is nevertheless true that in a statistical sense, 'risk groups' do exist. The need to encourage safer sexual practices within the gay community is especially important, given the higher risk of infection from unprotected sex, particularly anal sex, within a community where the incidence of HIV is already high. It follows from this, however, that the majority of those with HIV/AIDS, or those most likely to acquire it, are already, to varying degrees, marginalised from mainstream society:

> If they are IV drug users they live in a secret world, apart from society because of the criminal sanctions which attach almost everywhere to IV drug use. If they are homosexuals or bisexuals their lives have, since puberty, been partly cut off from their surrounding community. If they are in the sex industry, they are often despised by 'respectable' citizens.[96]

Since HIV transmission occurs through voluntary behaviour which is often judged as immoral or is criminal, the prevention of HIV transmission is often seen as requiring legal compulsion or as requiring the suppression of *vice*, rather than requiring special protection of the rights of those most likely to transmit the

---

95 See N Crofts, "Patterns of Infection" in E Timewell, V Minichiello, D Plummer (eds), *AIDS In Australia*, Prentice Hall (1992) pp 24, 32-46.

96 The Honourable Justice Michael Kirby, "AIDS: A New Realm of Bereavement", presented at the Third International Conference on Grief & Bereavement in Contemporary Society, The University of Sydney, 4th July 1992 at 7.

virus.[97] Experience teaches, however, that prohibitions or penalties attached to risky sexual activity (and drug taking) are unlikely to be effective, although they are very likely to act as disincentives to individuals who would otherwise come forward for HIV testing, treatment, and education. Put simply, law cannot effectively police the bedroom. An effective public health policy therefore requires the support and co-operation of persons with, or at risk of HIV/AIDS in order to bring about voluntary behaviour changes which will reduce the risk of further HIV transmission.[98]

In the absence of a cure for AIDS, public health policy must focus on prevention. In the HIV/AIDS context, this means education and behaviour modification, particularly in the sexual arena. This involves, as Justice Michael Kirby points out, a paradox: those capable of transmitting HIV or most at risk of acquiring it must be educated without feeling threatened, and health service providers must win their confidence.[99] A co-operative approach will only be achieved, however, if those seeking HIV testing, education, treatment or counselling are not at risk of being treated as criminals, or subject to prejudice, discrimination, or breach of privacy. The need for targeted education and other programs is particularly urgent in the light of recent reports that HIV infection is increasing within the gay community as a result of 'safe sex fatigue'.[100]

Against this background, much of the legislation regulating HIV testing in Australia can be seen to play a constructive role. The consent and counselling requirements and provisions requiring coded identification when requesting HIV tests in New South Wales, Victoria, and Tasmania are important features of the wider infection control strategy, in educating those at risk, and in removing disincentives to voluntary testing. Notification is an important source of information for planning health services and expenditure, although the trend towards coded notification in most jurisdictions is a welcome feature, and health providers in Victoria should not underestimate the extent to which a return to nominal identification of HIV/AIDS would act as a disincentive to HIV testing by gay men, IV drug users, and other high risk groups. Finally, while the benefits of contact tracing are obvious, this process can ultimately only occur with the co-operation of the index case. Current programs must therefore straddle the fine line between the need to ensure that contact tracing is perceived as a non-threatening activity (in order for it to occur at all and in order not to discourage voluntary HIV testing) and the need for Health Departments to follow up potential contacts to avoid further transmission.

---

97 See M Kleiman, "AIDS, Vice and Public Policy" (1988) 51 *Law and Contemporary Problems* 513; G Bloom, "HIV Law: Coercion, Protection and Empowerment", presented at the Australian Institute of Criminology Conference: Law, Medicine and Criminal Justice, Surfers Paradise, 6-8 July 1993.

98 For discussion of the risk-taking practices of homosexually active men in Australia, see Commonwealth Department of Human Services and Health, *Report on Project Male-Call: National Telephone Survey of Men who have Sex with Men*, March 1994.

99 The Honourable Justice Michael Kirby, "AIDS and the Law" (January, 1993)*Commonwealth AIDS Bulletin*, 350 at 351-3.

100 "Health Experts Fear that HIV is on the Rise Again" *Age* (Melbourne), 22 December 1994, p 5; "A New Wave of Death Could Swamp Gay Community" *Age* (Melbourne), 4 February 1995, p 26.

Discrimination provisions in all States except Tasmania, and the HIV-specific non-disclosure provisions which exist in Tasmania, New South Wales, and to a lesser extent in Victoria, should be considered by other States. Quite apart from the public health rationale discussed above, a basic respect for human rights justifies legislation seeking to redress the problems of discrimination, invasion of privacy and breach of confidence which have arisen within the HIV context.[101] As Justice Kirby again has observed:

> Rights matter most when they are to be accorded to minorities, particularly unpopular or stigmatised minorities... The demand for equal protection by homosexuals and intravenous drug users may not seem attractive to many members of the community. Affording the equal protection of the law to such persons...is the test of the seriousness with which our societies adhere to the Rule of Law.[102]

In conclusion, New South Wales, Victoria and Tasmania have, in particular, enacted progressive legislation facilitating voluntary testing which other States should consider. However, the benefit of these provisions can only be delivered if doctors are aware of them and respect them. This suggests that professional medical bodies (such as the Australian Society for HIV medicine (ASHM) through its national HIV education program for doctors) with the assistance of governments should build education about HIV legislation into their continuing education programs.

Some of the criticism directed towards current legislation is aimed not at legislation directly regulating the HIV testing process but at other laws criminalising transmission.[103] Die-hard advocates of the 'human rights' or 'community co-operation' models of infection control sometimes argue that criminal penalties marginalise those at risk, thereby impeding educational efforts and voluntary behaviour change, and for that reason should *never be used.* This argument is more persuasive with regard to homosexuality, prostitution, and drug offences, and less persuasive when dealing with intentional transmission offences. In a climate where infected blood is used as a weapon during robberies,[104] where police suffer from human bites and syringe wounds,[105] and where a small minority of persons with HIV/AIDS knowingly place their sexual partners at risk,[106] it is simply not acceptable to treat the interests of victims of crime as secondary to the 'greater good' as reflected in some wider public health policy. A balance is

---

101 For example, lack of confidentiality of HIV test results of prisoners is a long-recognised problem: eg "Prisoner AIDS Testing not Secret: Inmate" *West Australian*, 28 January 1989, p 41.

102 The Honourable Justice Michael Kirby, "AIDS and the Lawmaker: The Need for a Rigorous Approach and Realistic Goals" in *WHO/Australian Inter-Regional Ministerial Meetings on AIDS - Proceedings*, Sydney, 21-24 July 1987, 253 at 264-5.

103 For example, statutory offences exist in Victoria, South Australia, Queensland and Tasmania for recklessly or knowingly infecting another person with an infectious disease: *Health Act* 1958 (Vic), s 120; *Crimes Act* 1958 (Vic), s 19A (intentionally causing HIV transmission); *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).

104 "Robber Threatens Elderly Woman with Syringe" *Age* (Melbourne), 3 June 1994, p 2; "Post Office Robber Armed with Syringe" *Age* (Melbourne), 11 June 1994, p 5.

105 "Police AIDS Fear from Blood Risk" *Sunday Herald Sun* (Melbourne), 3 July 1994, p 15 (in the 1993-94 year, 125 Melbourne Metropolitan police officers were involved in blood-to-blood incidents, including 47 needlestick injuries, 31 human bites, and 23 incidents where blood was spat into the officer's face).

106 See Part 2 of this article, Section VII(A).

required. The same respect for individual rights given to those with HIV/AIDS should be given to those placed at risk of HIV transmission through irresponsible activity. This rationale also supports mandatory HIV testing where a person's behaviour constitutes a risk to public health[107] and where testing is necessary to determine the status of a victim of a sexual crime or a health care worker involved in a needlestick injury.[108] What remains controversial, however, is the legality and wisdom of HIV testing health care workers and their patients in view of the small risk of occupational transmission. The issues arising from occupational HIV transmission will be considered in greater detail in Part 2 of this article.

107 See note 17 *supra* and accompanying text.

108 See *HIV/AIDS Preventive Measures Act* 1993 (Tas), s10(1)-(2); *Health Act* 1958 (Vic), s 120A-120D.