AIDS, HIV TESTING, AND MEDICAL CONFIDENTIALITY

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That grounded maxim
So rife and celebrated in the mouths
Of wisest men; that to the public good
Private respects must yield.[1]

Introduction

A policy of strict confidentiality in respect of HIV-positive and AIDS patients[2] has been promoted in New Zealand by the Health Department,[3] the National Council on AIDS,[4] and the AIDS Foundation,[5] and is rigorously adhered to by infectious diseases specialists.[6] There are, however, cases where an exception to confidentiality of HIV-related information is indicated. A New Zealand Medical Association protocol recognises the limits of the duty of confidentiality owed by a doctor to an HIV-positive

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1 Dalila to Samson in Milton, *Samson Agonistes* (1671) lines 865-868.
2 The acronyms HIV and AIDS refer to human immunodeficiency virus and acquired immune deficiency syndrome. I use the term HIV-positive patient to describe a patient who has tested positive for antibodies to HIV and the term AIDS patient to refer to a patient who has been diagnosed as having AIDS. The term HIV-related information is used to refer to information (1) that an identifiable individual has been the subject of an HIV test; or (2) that an identifiable individual is HIV-positive or negative; or (3) that an identifiable individual has AIDS; or (4) from which any of the above conclusions can reasonably be inferred (cf Turkington, "Confidentiality Policy for HIV-Related Information: An Analytical Framework for Sorting Out Hard and Easy Cases" (1989) 34 Vill L Rev 871, 876).
3 *Hepatitis B and HIV Transmission – Prevention in Health Care Settings* (Department of Health, 1989) para 3.1: "Given the likelihood of discrimination or inappropriate reaction, particularly with HIV infection, confidentiality of information is particularly important."
4 *The New Zealand Strategy on HIV/AIDS* (National Council on AIDS, 1990) 48, 49. The National Council on AIDS is a committee appointed to advise the Minister and Department of Health on HIV/AIDS issues in New Zealand.
5 Interview with Tony Hughes, Research Director, New Zealand AIDS Foundation, 27 August 1991. The AIDS Foundation is the main community-based organisation working to prevent the spread of HIV in New Zealand.
6 Dr Janet Say, venereologist in charge of the sexually transmitted diseases (STD) clinic at Auckland Hospital, is reported as saying she would rather go to prison than divulge any client information to anyone else: "Doctors' AIDS dilemma: to tell or not to tell", *New Zealand Doctor*, 21 May 1990, p 1.

patient,[7] and the majority of state legislatures in the United States have enacted legislation to clarify the position.[8] The purpose of this article is to examine the ethical and legal basis of the duty of confidentiality owed by a doctor to a patient, and to consider the limits of confidentiality in relation to HIV-related information in New Zealand. The potential liability of a doctor who fails to disclose HIV-related information to a third party at risk of infection will also be considered.

HIV/AIDS in New Zealand

It is important at the outset to describe the history of the AIDS epidemic in New Zealand. AIDS was added to the list of notifiable diseases under the Health Act 1956 in 1983.[9] As at 30 September 1991, 300 people had been notified as having AIDS in New Zealand and 196 of these individuals were known to have died of AIDS.[10] Although HIV is not a notifiable disease, a tally of positive HIV antibody test results is kept; as at 31 August 1991, 693 people had been reported to have tested positive for HIV antibodies.[11] Excluding those cases where the mode of transmission is not known, the likely mode of HIV transmission in 88.9% of notified AIDS cases is homosexual contact.[12] This pattern of transmission is also found in Australia, North America, and Western Europe.[13]

The primary focus of the AIDS prevention campaign in New Zealand has been on education of homosexual and bisexual men, and intravenous drug users. The emphasis has been on encouraging such individuals to adopt safe practices: "safe sex" (eg, non-penetrative sex or sex using condoms) and non-sharing of drug needles and syringes. The availability of voluntary testing and counselling has also been stressed, particularly in light of research which suggests that early treatment with azidothymidine (AZT) may delay the onset of AIDS in an asymptomatic HIV-positive person with a low T4 cell count.[14] Government policies have generally been

7 Policy adopted by New Zealand Medical Association National Assembly, 12 September 1990, Wellington.

8 A useful summary of state legislation relating to the confidentiality of HIV-related information may be found in 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 Dick L Rev 435, 457-463. See also Curran, Gostin and Clark, *AIDS: Legal and Regulatory Policy* (1988) ch 1.

9 The Infectious Diseases Order 1983 (SR 1983/146) inserted AIDS in the list of notifiable infectious diseases in Section B of Part I of the First Schedule to the Health Act 1956.

10 Based on data published by AIDS Epidemiology Group in *AIDS – New Zealand* (Issue 11, November 1991).

11 Idem. The figure may include some repeat tests and thus be over-inclusive.

12 Supra n 10.

13 Kirby, "Will Law Fail the AIDS Test?" in *9th Commonwealth Law Conference Papers* (1990) 482; see also Werdel, "Mandatory AIDS Testing: The Legal, Ethical and Practical Issues" (1990) 5 Notre Dame J L Ethics & Pub Pol 155, 162.

14 Volberding, Lagakos, Koch et al, "Zidovudine in Asymptomatic Human Immunodeficiency Virus Infection" (1990) 322 N Eng J Med 941; Friedland, "Early Treatment for HIV" (1990) 322 N Eng J Med 1000. In New Zealand, AZT is available from public hospitals for HIV-positive patients with a T4 cell count of 500 or lower: interview with Dr Mark Thomas, infectious diseases specialist, Auckland Hospital, 11 October 1991.

supportive of an educative approach.[15] Funding for community education has been provided through the Health Department to the New Zealand AIDS Foundation, community-based intravenous drug outreach workers, the Te Roopu Tautoko Trust, the Haemophilia Society, and the New Zealand Prostitutes Collective.[16] A National Council on AIDS, with a broadly based membership, has been established to advise the Government on HIV/AIDS-related issues and in 1990 published a comprehensive report entitled *The New Zealand Strategy on AIDS.*

The legislative response to AIDS in New Zealand has been mixed. The need for strict confidentiality of HIV-related information has been recognised in the statutory form for notification of an AIDS diagnosis to the Medical Officer of Health: the patient is identified only by initials, sex, and date of birth.[17] In an enlightened attempt to inhibit the spread of HIV amongst intravenous drug users, the Misuse of Drugs Act 1975 has been amended to allow the introduction (with the cooperation of community pharmacists) of a needle and syringe exchange programme.[18] Also laudable is the staying of the legislative hand in relation to specific criminal offences targeted at the wilful or reckless transmission of HIV.[19]

Less satisfactory is the 1989 amendment to the Penal Institutions Act 1954. Section 36C(1) provides that an inmate may be required to submit to an HIV test if the medical officer of a penal institution "considers that, having regard to the personal circumstances of the inmate, it is desirable

15 "Education is our best strategy for the prevention of HIV infection": Mr Bill Dillon MP, "Government Policy on AIDS" in Paterson (ed), *Legal Implications of AIDS* (Legal Research Foundation, 1989) 31, 38.

16 Ibid, 33.

17 The Health (Infectious and Notifiable Diseases) Regulations 1966, Amendment No 5 (SR 1989/281), reg 2.

18 See s 13(1)(aa) (inserted by the Misuse of Drugs Amendment Act (No 2) 1987, s 3) and the Health (Needles and Syringes) Regulations 1987 (SR 1987/414).

19 The wide "endangering" provisions in cls 130 and 132 of the Crimes Bill 1989 would, if enacted, have applied to HIV transmission cases: see Rickett, "AIDS, sexually transmitted diseases and the criminal law" (1990) 20 VUWLR Monograph 3, 183, 210-211. Sir Robin Cooke has suggested the need for specific legislative amendment to provide for criminal liability in relation to the transmission of AIDS: "The Crimes Bill 1989: A Judge's Response" [1989] NZLJ 235, 236. The inappropriateness of such legislation is noted by Gostin, "A Decade of a Maturing Epidemic: An Assessment and Directions for Future Policy" (1990) 5 Notre Dame J L Ethics & Pub Pol 7, 10:

> Biting, splattering or even donating HIV contaminated blood is certainly irresponsible, indeed callous behaviour. But the risk of transmitting the virus approaches zero . . . . It is understandable for society to draw a bright line around truly dangerous behaviour it will not tolerate such as repeated sexual intercourse when a person knows he is infected with HIV. However, society seems prepared to deprive HIV-infected persons of their liberty, under the mantle of public health, for taking remote risks. The exercise of compulsory powers is often based upon unproven fears, perhaps prejudice, and not upon a rational assessment of scientific facts.

Gostin's cogent views on the criminalisation of HIV transmission are fully developed in "The Politics of AIDS: Compulsory State Powers, Public Health, and Civil Liberties" (1989) 49 Ohio State LJ 1017, 1038-1057. See also the comment of Justice Kirby, "Legal Implications of AIDS" in Paterson, op cit n 15, 1, 4, that "[c]riminal offences, which have only a minor symbolic value and are rarely prosecuted with success, may actually prove counterproductive because they discourage test-taking".

that the inmate have such a test". If the inmate refuses to be tested, he or she may be dealt with administratively as if HIV-positive. The rationale for selective classification of inmates as candidates for an HIV test is protection of the health of staff and inmates.[20] Yet prison health might be promoted more effectively by educative measures and a policy of "universal precautions" in handling difficult inmates. As one American scholar has noted, "hatred of homosexuals and distaste for drug abusers masquerade as purportedly necessary public health proposals for coercive HIV testing and the inevitable terminus of the logic of mandatory testing, quarantine. A potentially disastrous failure of imagination is occurring."[21]

The failure of legislative imagination is nowhere more clearly seen than in the failure to enact legislation to prohibit discrimination on the basis of health status or sexual orientation. Section 19(1) of the New Zealand Bill of Rights Act 1990 states that "[e]veryone has the right to freedom from discrimination on the ground of colour, race, ethnic or national origins, sex, marital status, or religious or ethical belief". Freedom from discrimination on the basis of health status or sexual orientation is not covered. In a singular act of political hypocrisy, the Labour Government waited until the last day of the 1990 parliamentary session (and the very end of its two terms in office) to introduce legislation which would, if enacted, have extended the prohibited grounds of discrimination under the Human Rights Commission Act 1977 to cover discrimination on the basis of health status (defined to include "(ii) having in the body organisms that might cause disease"[22]) or sexual orientation. The National Government claims to have a similar legislative proposal in the pipeline.

The need for such anti-discrimination legislation has been well documented. Discrimination on the grounds of sexual orientation and HIV/AIDS is common in New Zealand,[23] and is believed to be a major deterrent to homosexual men who might otherwise undergo an HIV test.[24] Many commentators have noted that people with HIV or AIDS are subject to a double dose of discrimination; the public fear of a fatal disease and the identification of AIDS as a "gay plague" mean that "a diagnosis of AIDS

20 See Dillon, supra n 15, 36.
21 Barnes, "AIDS and Mr Korematsu: Minorities at Times of Crisis" (1988) 17 St Louis U Pub L Rev 35, 40.
22 The Human Rights Commission Amendment Bill 1990, cl 3.
23 See New Zealand AIDS Foundation (NZAF) Submission to the Justice and Law Reform Commission on the Human Rights Commission Amendment Bill 1990, chs 4-6. A rare New Zealand instance of a legal challenge to discrimination based on rumoured homosexual orientation may be found in *Balfour* v *Attorney-General* (CA 170/89, 12 October 1990), noted [1991] NZ Recent L Rev 69-71. The Court of Appeal's decision is notable for its judicial pusillanimity: the claim was dismissed "with some regret", there being "many injustices . . . for which the law can provide no redress" (pp 1, 12). The Court also expressed the misguided view that, had the claimant (a schoolteacher) admitted to being homosexual, the Department of Education's discrimination might have been justified in the interests of the safety of children. (The myths that homosexuals are likely to proselytise and molest children have long been discredited by research: see NZAF Submission (supra), para 10.1.10). It seems clear that one must look to the legislature, not the courts, for a lead in fighting discrimination.
24 NZAF Submission, ibid, para 7.7.

can become a 'diagnosis' of *social* marginality".[25] Significantly, low self-esteem among gay men has been identified as one of the reasons why some individuals continue to engage in "high risk" activities.[26] Anti-discrimination legislation is essential if New Zealand is to foster a climate in which the social stigma of homosexuality is removed, so that individuals may accept their sexual orientation and develop the self-esteem necessary to protect the health of themselves and others.

The backdrop of legitimated discrimination is crucial to an understanding of the importance of confidentiality of HIV-related personal information. For the individual who contemplates consulting a doctor for an HIV test, the implicit assurance of confidentiality is not simply an abstract placebo; it is a necessary safeguard against the very real possibility of prejudice and loss of employment or accommodation if information relating to the consultation is leaked. In recognition of the importance of confidentiality, New Zealand AIDS Foundation clinics guarantee anonymous testing. Client files can be accessed only by a code reference, knowledge of which is limited to the individual client. Files record the client's date of birth, sex, ethnic affiliation, and a first name (clients are free to give a pseudonym).[27] At first glance the rigid adherence to anonymity may seem extreme. But in a world where personal information is routinely leaked, and in a context where the results of leaks may be catastrophic for the affected individual, preventing the written compilation of such information is a sensible and effective response.[28]

It is far more difficult to control the flow of information stored in the minds of individual doctors. A patient who reveals his or her identity to a doctor (understandably, some individuals who approach a general practitioner for an HIV test choose to use a pseudonym) must rely on the doctor not to breach confidentiality by divulging personal information to third parties. The patient approaches the doctor *cum fidei,* trusting that personal secrets will be kept. Is the patient's faith justified? To answer this question requires an examination of the ethical basis of a doctor's duty of confidentiality to a patient. In what circumstances may it be ethically correct for a doctor to divulge HIV-related information about a patient to a third party?

25 Dolgin, "AIDS: Social Meanings and Legal Ramifications" (1985) 14 Hofstra L Rev 107, 201; see also Brandt, "AIDS: from Social History to Social Policy" (1986) 14 Law, Med & Health Care 231, 234-236.

26 Horn, Chetwynd & Kelleher, "Changing Sexual Practices amongst Homosexual Men in Response to AIDS: Who Has Changed, Who Hasn't, and Why?" (Department of Health, 1989).

27 Interview with Joe Kelleher, Senior Therapist, Burnett Clinic, Auckland, 14 October 1991.

28 As noted by Gostin, supra n 19, 18, "Collection of information creates a demand for its use". Concerns have been voiced about the confidentiality of information identifying AIDS patients in New Zealand public hospitals: Perry, "Access to AIDS data decried", *The Dominion,* 15 August 1988, p 15. The risk is that "information can seep into general circulation and . . . beyond protection": Dickens, "Legal Limits of AIDS Confidentiality" (1988) 259 JAMA 3449, 3451, citing media disclosures following the death of the entertainer Liberace.

Ethics and Medical Confidentiality

The obligation of confidentiality is a cornerstone of medical practice. It is customary to refer to the ancient Hippocratic Oath which states:

> Whatsoever things I see or hear concerning the life of men, in my attendance on the sick or even apart therefrom, which ought not to be noised abroad, I will keep silence thereon, counting such things to be as sacred secrets.

The undertaking is repeated in the Declaration of Geneva ("I will respect the secrets which are confided in me, even after the patient has died") and in the New Zealand Medical Association's Code of Ethics ("Keep in confidence information derived from a patient, or from a colleague regarding a patient, and divulge it only with the permission of the patient, except when the law requires otherwise").

The ethical basis for a rule of medical confidentiality may be seen to lie in the consequences which flow from such a rule, or alternatively in the moral principles which the rule expresses.[29] The utilitarian/consequentialist approach points to the benefits, in terms of diagnosis and treatment, promoted by confidentiality:[30]

> Since the layman is unfamiliar with the road to recovery, he cannot sift the circumstances of his life and habits to determine what is information pertinent to his health. As a consequence, he must disclose all information in his consultations with the doctor – even that which is embarrassing, disgraceful or incriminating. To promote full disclosure, the medical profession extends the promise of secrecy . . . .

In relation to HIV/AIDS, confidentiality is important to the individual patient not only because of therapeutic benefits, but also because of the potential harm from discrimination if HIV-related information is leaked. However, the utilitarian argument for confidentiality is not based solely on benefits (including the avoidance of harm) to the individual patient; rather, it is said to be of great general benefit that a rule of medical confidentiality be adhered to universally.[31] The claim is frequently made that the public health interest in preventing the spread of AIDS demands a rule of strict confidentiality:[32]

> In the long run, 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. Consequently, confidentiality is vital to secure public as well as private health . . . .

Although there is a great deal of anecdotal evidence for the claim that people who suspect they may have been exposed to HIV may not seek testing unless they can expect test results to remain confidential, the claim

29 See, generally, Beauchamp and Childress, *Principles of Biomedical Ethics* (3rd ed 1989) 333-334.

30 *Hammonds* v *Aetna Casualty & Surety Co* 243 F Supp 793, 801, per Connell CJ (ND Ohio 1965).

31 Lesser and Pickup, "Law, Ethics, and Confidentiality" (1990) 17 J L & Soc 17, 24.

32 *X* v *Y* [1988] 2 All ER 648, 653, per Rose J.

does not appear to have been adequately tested by empirical studies.[33] It does, however, seem likely that, absent a guarantee of confidentiality, some individuals will be deterred from seeking an HIV test for fear of discrimination both on the basis of the test result and because of identification with stigmatised groups.[34]

An alternative, deontological approach to medical confidentiality is to examine the moral principles which underpin the concept. Beauchamp and Childress identify the relevant moral principles as respect for personal autonomy (and privacy), and fidelity, especially to implicit or explicit promises.[35] The principle of autonomy recognises that confidentiality is central to respecting the patient's human dignity. The point is well made by Brody:[36]

> If someone now proceeds to violate our confidentiality by revealing private information about us without our consent, that person has effectively taken control of our lives and our identities away from us in one important sense. If that person chooses to reveal that information to others, that person, not us, is determining who shall be (to some extent) in a relationship of intimacy with us. If that person uses that information toward some goal that is his, not ours, we and our very identities are being made use of in an undignified and disrespectful way. This account, better than any benefit analysis, shows why fundamental human dignity hinges upon confidentiality.

The unauthorised disclosure of HIV-related information about a patient is a particularly egregious disregard of that individual's autonomy and invasion of his or her privacy. Turkington notes that "[i]t is difficult to imagine information more intimate than the fact that someone has been infected with HIV. The fact that someone has an infection that is communicable, incurable and almost certainly fatal, reflects upon that person's most basic sense of identity and security."[37]

The principle of fidelity lends further support to a rule of confidentiality. The patient trusts the doctor not to reveal her personal secrets. Seldom, of course, will the doctor give an express undertaking to this effect, although such an assurance may well be sought in an HIV/AIDS-related consultation. More likely, the patient will simply assume that "it goes without saying" that her confidence will not be breached.[38] The finding of an implicit, if not express promise of confidentiality may be supported

33 Beauchamp and Childress, op cit n 29, 334, note that empirical studies in the psychiatric context suffer from the methodological flaw of using hypothetical questions to gauge probable responses to breaches of confidentiality.

34 Tahmindjiis notes, in "The Legal Response to AIDS in Australia" (1989) 13 Community Health Studies 410, 414, that there was a 50% drop in testing in New South Wales when new notification provisions were announced. There is also evidence that in Colorado, which requires positive HIV test results to be reported and contacts to be traced, voluntary HIV testing at clinics for gay men has decreased: see Price, supra n 8, note 248 and accompanying text.

35 Op cit n 29, 335.

36 "The Physician/Patient Relationship" in Veatch (ed), *Medical Ethics* (1989) 65, 84.

37 Supra n 2, 881.

38 The patient's faith may well be misplaced: see Weiss, "Confidentiality Expectations of Patients, Physicians, and Medical Students" (1982) 247 JAMA 2695 and Seigler, "Confidentiality in Medicine — A Decrepit Concept" (1982) 30 New Eng J Med 1518.

by the argument that, absent an express disavowal by the doctor, the patient is entitled to rely on the doctor's public oath of confidentiality.[39] If we accept that upholding medical confidentiality is an aspect of holding people to promises, the focus inevitably shifts to an analysis of the circumstances in which this sort of promise may justifiably be broken.[40]

Medical ethicists seem to agree that, both from a utilitarian and a deontological perspective, the duty of confidentiality is not an absolute one. A utilitarian will accept that there may be reasons of utility (ie, more beneficial consequences such as saving life) which outweigh the disadvantages of not always keeping confidentiality; a deontologist will recognise that in the deontological framework, confidentiality is derivative from other more basic principles (ultimately, respect for persons) and that the duty to prevent a probable and serious harm to a third party may outweigh the duty to avoid potential harm to a patient if confidentiality is breached. Indeed, the Hippocratic Oath is limited to a pledge of silence only in respect of that "which ought not to be noised abroad".

In the AIDS context, the issue of the limits of a doctor's duty of confidentiality has been debated in relation to the following hypothetical case:[41]

> A 39 year old man goes to his family doctor with a dry persistent cough which has lasted three or four weeks and a 10 day history of night sweats. He admits that he is bisexually active. He is tested and found to have antibodies to HIV virus . . . . In the setting of this clinical picture he must be considered to have the disease. He is told of his condition and also, in the course of a prolonged interview, of the risk to his wife and of the distinct possibility of his children aged one and three years old being left without parents should she contract the disease. He refuses to allow her to be told of his condition. The doctor finally accedes to his demand for absolute confidentiality. After one or two initial illnesses which are successfully combatted he dies some 18 months later. Over the last few weeks of his life he relents on his former demands and allows his wife to be informed of his problem. She is tested and, although asymptomatic, is found to be antibody positive. A year later she goes to the doctor with fever, dry cough and loss of appetite. Distraught on behalf of her children, she bitterly accuses the doctor of having failed her and them by allowing her husband to infect her when steps could have been taken to diminish the risk had she only known the truth.

The intuitive response to this worst-case scenario is that the doctor was wrong not to intervene. Gillett, the author of the hypothetical example, supports this conclusion. He argues that "the infected, deceitful individual is 'free-loading' on a climate of mutual care and respect by exploiting medical confidentiality and endangering his partner".[42] The implication is that

39 Beauchamp and Childress, op cit n 29, 335. In *Hammonds* v *Aetna Casuality & Surety Co*, supra n 30, Connell CJ observed that "[a]lmost every member of the public is aware of the promise of discretion contained in the Hippocratic Oath, and every patient has a right to rely on this warranty of silence".

40 See Bok, "The Limits of Confidentiality" (1983) 13 Hastings Center Rep 24, 25.

41 Gillett, "AIDS and Confidentiality" (1987) 4 J Applied Philosophy 15. Similar worst-case scenarios are posited by other writers, eg, Casswell, "Disclosure by a Physician of AIDS-Related Patient Information: An Ethical and Legal Dilemma" (1989) 68 Can Bar Rev 225, 226.

42 Gillett, "AIDS: The Individual and Society", in Paterson, op cit n 15, 101, 108. For the full argument, see Gillett, supra n 41.

the patient, as a "moral intransigent",[43] has forfeited his right to confidentiality. Yet it is surely unaccceptable to suggest that the infected patient's moral standing should be a consideration in the doctor's decision to breach confidentiality. A more convincing ethical justification is that, as explained above, both a utilitarian and a deontological approach support the conclusion that the doctor owed a duty to warn the wife, and that his obligation to do so outweighed his duty of confidentiality.[44] The obligation to the wife is derived from the fact that she was an identified person facing a high risk of serious harm, which could probably have been avoided by disclosure. Although the risk of HIV transmission from an infected male to an uninfected female is low for a single act of vaginal intercourse, it increases with repeated sexual encounters.[45] In assessing the potential risk to the wife, it is relevant that, being unaware of her husband's bisexuality, she could not be expected to protect herself from an unforeseeable risk of infection;[46] equally, the husband's duplicity made it unlikely that he would protect her himself, even if counselled to do so.[47] The case for disclosure does not seem to depend on whether the wife was also a patient

43 Gillett, supra n 41, 19.

44 Beauchamp and Childress, op cit n 29, 339-340.

45 See Casswell, supra n 41, 238-239, for a useful discussion of the probability of HIV transmission via heterosexual intercourse. (Even if the female sexual partner is already HIV-positive, there may be benefit to her in finding out her status, since she may then adopt lifestyle changes or take medication such as AZT. She will also be enabled to prevent transmission of HIV to other individuals.) The extent of the risk is a key determinant of whether it is right to breach confidentiality. The point is well made by Gillon, "AIDS and Medical Confidentiality" (1987) 294 BMJ 1675, 1676:

> In the context of a just society strong evidence of likely and preventable death or severe injury to others can afford justification for overriding confidentiality, including the passing on of information between doctors and to new contacts. But such circumstances will be extremely rare. In most cases the probability of preventing death or severe injury by breaking confidentiality about HIV status will be low . . . .

46 Price comments that "[u]nlike members of high risk groups, some people may not suspect the imminent danger of infection that exists in their case": supra n 8, 471. Although public education campaigns in New Zealand have ensured that the majority of the community is aware of the risk of HIV infection and the means to avoid it, a female sexual partner in what she believes to be a monogamous relationship with a heterosexual male would have no reason to suspect that she was at risk of infection (cf Neave, "AIDS – Confidentiality and the Duty to Warn" (1987) 9 U Tasmania L Rev 1, 5). Conversely, in light of public awareness that most cases of HIV transmission in this country result from male-to-male sexual contact, a male sexual partner (even if he is in what he believes to be a monogamous gay relationship) ought to be aware of the possible risk and of the need to protect himself.

47 The Gillett hypothetical case does not state whether the doctor counselled the husband not to have unprotected sexual intercourse with his wife. The reality, of course, is that a husband who has maintained a secret "double life" during his marriage, and who is unwilling or unable to tell his wife that he is HIV-positive and bisexual, is unlikely to risk detection by suddenly adopting "safe sex" practices in the marital bed. Guttmacher notes that "a drug addict or sexually active person with AIDS may experience considerable desire to continue those practices most likely to infect others": "HIV Infection: Individual Rights v Disease Control" (1990) 17 J L & Soc 66, 72.

of the doctor, although it may be easier to find a duty to warn her *qua* patient.[48]

It should be noted that, on the above analysis, the doctor does not simply have a liberty to breach confidentiality; he is duty-bound to do so. Disclosure to the wife was not merely permitted; it was ethically mandated. As Beauchamp and Childress observe, "[t]here is no right or privilege to infringe confidences . . . unless there is also an obligation to do so".[49] So to the extent that the doctor's duty of confidentiality to the husband is outweighed by the duty to warn the wife, the former duty is delimited. Within these limits, however, the obligation of confidentiality remains strict. Thus the doctor would have no liberty to warn other third parties, such as the husband's employer or the patrons of a gay sauna frequented by the husband: the doctor has no "special" (eg doctor/patient) relationship with those parties, and the risk is either negligible (the employer) or foreseeable by them (the male sexual partners).

On the stated facts, the husband extracted a promise of absolute confidentiality from the doctor. Even if he had not sought and obtained such an assurance, he may simply have assumed that he could expect total confidentiality from his physician. For a deontologist, principles of autonomy and fidelity suggest that the doctor should inform the patient, at the outset of the relationship, of the exact parameters of the obligation of confidence.[50] Giving advance warning of "a pre-emptive duty to prevent harm befalling his patients"[51] is consistent with autonomy (since the patient is free to end the consultation if the terms are unaccceptable) and with fidelity (the doctor has spelt out the limits of the trust promised to the patient). Perhaps more importantly, the sharing of the moral dilemma may lead to greater openness between doctor and patient, thereby maximising mutual trust, and promoting the therapeutic alliance.[52]

What of the utilitarian objective of minimising the spread of HIV by insisting on an absolute duty of confidentiality, even in the face of irresponsible patients? A rule of confidentiality which permits doctors to warn sexual partners at risk of infection may compromise more lives in the long run. There is a danger that the fear of breaches of confidentiality will scare off those individuals who are hardest to reach in any AIDS prevention campaign: closeted bisexual men.[53] These are the very men who, having consciously or unconsciously adopted a pattern of duplicity in their personal

48 In *C* v *D* [1925] 1 DLR 734, 738, Riddell J stated that a doctor "owes a moral duty to *those for whom he is family physician* to warn them of danger of venereal infection concerning which he has credible information" (emphasis added). Cf Kuschner, Callahan, Cassell and Veatch, "The Homosexual Husband and Physician Confidentiality" (1977) 7 Hastings Center Rep 15-17.

49 Beauchamp and Childress, op cit n 29, 336.

50 See Lesser and Pickup, supra n 31, 27.

51 Gillett, supra n 41, 20.

52 Lesser and Pickup, supra n 31, 27-28. Contrast the concern expressed by Annas as to the unforeseeable effects of a shift towards making the "physician-healer" the "physician-public protector": "Confidentiality and the Duty to Warn" (1976) 6 Hastings Center Rep 6, 8.

53 National Council on AIDS, *The New Zealand Strategy on HIV/AIDS* (1990) 100-101.

lives, may be most reluctant to reveal their HIV-positive status, particularly to a spouse. Yet it is reported that the majority of bisexual men who test positive will, following counselling, act responsibly and inform their sexual partners.[54] The potential to reach these men, and to counsel them to disclose their sexual orientation and seropositive status to their sexual partners, may be thwarted if there is a threat of exposure as a result of coming forward for an HIV test.

The counter-argument is that, if it is known that confidentiality of HIV-related personal information will be breached only under strictly limited conditions (viz, to warn third parties known to be at high risk of infection from the infected patient), individuals will not be deterred from seeking testing and medical attention.[55] This view is propounded by Gillett:[56]

> Clearly, if the attitude were ever to take root that the medical profession could not be trusted to 'keep their mouths shut', then the feared effect would occur. I believe that where agencies and informal groups were told of the *only* grounds on which confidentiality would be breached and the *only* people who would be informed then this effect would not occur.

Gillett further claims that, since doctors ordinarily have a strong tendency to protect their patients and keep their confidences, we would not begin to slide down the slippery slope of breaching confidentiality.[57] Even if Gillett is right in his prediction about the likely conduct of doctors, his claim that threatened breaches of confidentiality will not act as a deterrent to HIV testing seems dubious.[58]

To conclude this ethical discussion, it appears that both deontological and utilitarian considerations give support to the conclusion that in limited circumstances it is ethically correct for a doctor to divulge HIV-related information about a patient to a third party. For the deontologist, it will be preferable if the limits of confidentiality are spelt out to the patient at the outset of the consultation, but even if no advance warning has been given there will be a duty to avoid probable and serious harm to the third party. For the utilitarian, the risk of a deterrent effect if confidentiality is known to be less than absolute may suggest that the possibility of breaching confidentiality should not be mentioned to individual patients, or even publicised at all.

The Law and Medical Confidentiality

The doctor's duty not to disclose confidential information about a patient is recognised in law as well as in ethics:[59]

54 Interview with Joe Kelleher, Senior Therapist, Burnett Clinic, Auckland, 14 October 1991. It is, however, unclear what proportion of bisexual men seeking HIV tests approach NZAF clinics, given the clinics' identification with the gay community.

55 Support for this view is sparse in the literature about HIV testing and confidentiality. A notable exception is Glenney, "AIDS: A Crisis in Confidentiality" (1989) 62 S Cal L Rev 1701, 1722-1723.

56 Supra n 41, 20.

57 Supra n 41, 19, citing Williams, "Which slopes are slippery?" in Lockwood (ed), *Moral Dilemmas in Modern Medicine* (1985) 126.

58 The evidence seems to point the other way: supra nn 24, 34 and accompanying text.

59 Gurry, *Breach of Confidence* (1984) 148.

> [I]n common with other professional men, for instance a priest . . . the doctor is under a duty not to disclose [voluntarily], without the consent of his patient, information which he, the doctor, has gained in his professional capacity . . . .[60]

New Zealand case law confirms that the duty is founded on medical ethics: "[t]here rests with a doctor a strong ethical obligation to observe strict confidentiality by holding inviolate the confidences and secrets he receives in the course of his professional ministerings".[61] However, the ambit of the legal obligation of medical confidentiality is determined by the law: ". . . any duty which may be owed by the doctor at common law is not the duty which is imposed on him by the Hippocratic Oath, or by any code of professional ethics . . .".[62]

The importance of medical confidentiality is reflected on the New Zealand statute books. Provisions in the Hospitals Act 1957[63] and the Area Health Boards Act 1983[64] prohibit (subject to limited exceptions) the disclosure of medical information about any hospital patient without the patient's consent; both these statutes[65] and the Health Act[66] provide for strict security in relation to access to, and use of, personal information stored in a health computer system. These provisions would apply to any person who has an HIV test at an STD (sexually transmitted diseases) clinic at a public hospital, or who receives hospital treatment for HIV/AIDS; they do not, however, protect the majority of New Zealanders who test for HIV in a non-hospital setting.[67] [68]

A clear indication of the importance the legislature attaches to medical confidentiality in New Zealand may be found in sections 32 and 33 of the Evidence Amendment Act (No 2) 1980.[69] These provisions extend statutory privilege to any "protected communication" made by a patient to a registered medical practitioner (or a clinical psychologist); such a communication may not be disclosed in any civil or criminal proceedings without the patient's consent. Significantly, the definition of "protected communication" is restricted to information the patient tells the doctor,[70] and does not cover information which the doctor discovers from a physi-

60 *Hunter* v *Mann* [1974] 1 QB 767, 772, per Boreham J (with whom Lord Widgery CJ and May J agreed).
61 *Duncan* v *Medical Practitioners Disciplinary Committee* [1986] 1 NZLR 513, 521, per Jeffries J.
62 *Furniss* v *Fitchett* [1958] NZLR 396, 401, per Barrowclough CJ.
63 Section 62.
64 Section 50.
65 The Hospitals Act 1957, ss 62A-62E, and the Area Health Boards Act 1983, ss 51-51D.
66 Sections 22B-22F.
67 Most HIV tests in New Zealand are arranged through general practitioners: interview with Joe Kelleher, Senior Therapist, Burnett Clinic, Auckland, 14 October 1991.
68 Casswell states, supra n 41, 253-254, that a patient's claim to confidentiality may be stronger if the doctor's duty is required by statute and not merely based on the common law; *sed quaere*.
69 The provisions broaden the statutory privilege which was contained in the Evidence Act 1908, in light of recommendations made by the Torts and General Law Reform Committee in its *Report on Medical Privilege* (1974), published as Appendix I to its report *Professional Privilege in the Law of Evidence* (1977).
70 See the definitions in s 32(3) (civil proceedings) and s 33(3) (criminal proceedings).

cal examination or a blood test.[71] Nevertheless, the existence of statutory medical privilege is an explicit recognition of the importance of confidentiality in the doctor-patient relationship; no such privilege existed at common law.[72]

A doctor who breaches the legal obligation of confidentiality owed to a patient faces the possibility of liability in damages for breach of confidence.[73] The jurisprudential basis of the action for breach of confidence has long been debated.[74] It has variously been thought to be derived from contract, tort, property and equity.[75] Yet it may be difficult to establish a contract between a patient and a hospital or clinic doctor;[76] the notion that a breach of confidence is a tort seems artificial,[77] except in the unusual case where the patient suffers foreseeable physical harm as a result of an unauthorised disclosure;[78] and the concept of property rights in confidential information is problematic.[79] It may be more realistic to speak of an equitable obligation of confidence, founded on the trust reposed by a patient in a doctor. Cooke P has observed (in the solicitor/client context) that "breach of confidence is usually classified as a subject of equitable jurisdiction",[80] and in the leading New Zealand case on medical confidentiality Jeffries J described the doctor/patient relationship as a fiduciary one.[81]

71 *Pallin* v *Department of Social Welfare* [1983] NZLR 266, 271, per Cooke J.

72 Mathieson, *Cross on Evidence* (4th NZ ed 1989) para 10.33.

73 The Court of Appeal has recognised that common law damages may be available for breach of an equitable duty of confidence: *Aquaculture Corp* v *New Zealand Green Mussell Co Ltd* [1990] 3 NZLR 299, 301.

74 For a nineteenth century discussion of the jurisdiction, see *Morison* v *Moat* (1851) 9 Hare 241, 255; 68 ER 492, 498, per Turner V-C. A contemporary example of judicial uncertainty as to the basis of the jurisdiction may be found in *McKaskell* v *Benseman* [1989] 3 NZLR 75, 88, per Jeffries J.

75 Laster, "Breaches of Confidence and Privacy by Misuse of Personal Information" (1989) 7 Otago L R 31, 33, Gurry argues, op cit n 59, 58, that the action for breach of confidence is *sui generis* and has a composite jurisdictional basis. Cf the comment of Somers J, in *Day* v *Mead* [1987] 2 NZLR 443, 458, that "the equitable and common law obligations as to disclosure, use of confidential information, and want of care discernible in the cases are now but particular instances of duties imposed by reason of the circumstances in which each party stands to the other . . .".

76 In *Duncan* v *Medical Practitioners Disciplinary Committee,* supra n 61, 520, Jeffries J observed that "[o]n a strict analysis of legal relationships, [medical confidentiality] is probably contractually based". This analysis works for the fee-paying patient in a private consultation, but does not satisfactorily account for individuals who seek free HIV testing at an NZAF or STD clinic, or who are treated for AIDS in a public hospital.

77 Notwithstanding the commonalities between negligence and breach of confidence, adverted to by Laster, supra n 75, 39.

78 For example, the successful plaintiff who recovered damages for nervous shock in *Furniss* v *Fitchett,* supra n 62, for the doctor's negligent breach of confidence.

79 In the criminal law context, see the Supreme Court of Canada decision in *R* v *Stewart* (1988) 50 DLR (4th) 1 (confidential information not "property" capable of "theft") and Hammond, "Theft of Information" (1984) 100 LQR 252, (1988) 104 LQR 527. Similar conceptual problems arise in the medical law context: see Kennedy and Grubb, *Medical Law: Text and Materials* (1988) ch 6; Lesser and Pickup, supra n 31, 22.

80 *Day* v *Mead,* supra n 75, 451.

81 Supra n 61.

The jurisdictional issue is of less significance, for present purposes, than the ambit of the duty of medical confidentiality defined by law. In what circumstances is a doctor entitled to disclose information about a patient without that patient's consent? A clear case for disclosure exists where a statute compels a doctor to disclose patient information; a New Zealand example is the duty to report notifiable diseases to the Medical Officer of Health.[82] Significantly, HIV is not a notifiable disease under the Health Act 1956, and although AIDS is a notifiable disease the patient's name is not disclosed on the statutory form of notification.[83] There is no statutory requirement for a doctor in New Zealand to reveal HIV-related information about an identifiable patient. However, there is a second category of case where the law permits a doctor to disclose information about a patient, without that patient's consent. The common law recognises a "public interest" exception to the duty of confidence, described by Lord Goff, in the *Spycatcher* case, in the following terms:[84]

> [A]lthough the basis of the law's protection of confidence is that there is a public interest that confidences should be preserved and protected by law, nevertheless that public interest may be outweighed by some other countervailing public interest which favours disclosure. This limitation may apply . . . to all types of confidential information. It is this limiting principle which may require a court to carry out a balancing operation, weighing the public interest in maintaining confidence against a countervailing public interest favouring disclosure.

English courts have taken a relatively broad view of the scope of the public interest exception and dicta in several cases suggest that a breach of confidence may be justifiable where it is necessary to protect public health.[85] In relation to HIV/AIDS, it is clear that the exception does not permit disclosure of confidential information to the public at large. In *X* v *Y*,[86] Rose J granted an injunction to prevent a newspaper from publishing the names of two doctors with AIDS who were continuing in general practice. The information had been leaked from the hospital where the doctors were being treated. The judge ruled that the public interest in preserving the confidentiality of hospital records identifying patients with AIDS outweighed the public interest in the freedom of the press to publish such information. Since the proposed disclosure was very wide, and the "very small theoretical risk"[87] to patients was in practice removed by counselling the doctors to take precautions, this was not a case where the

82 The Health Act 1956, s 74.

83 The Health (Infectious and Notifiable Diseases) Regulations 1966, Amendment No 5 (SR 1989/281), reg 2.

84 *Attorney-General* v *Guardian Newspapers Ltd (No 2)* [1990] 1 AC 109, 282.

85 In *Beloff* v *Pressdram Ltd* [1973] 1 All ER 241, 260, Ungoed-Thomas J noted that "[t]he defence of public interest clearly covers . . . disclosure justified in the public interest, of matters . . . medically dangerous to the public". Similarly, in *Schering Chemicals Ltd* v *Falkman Ltd* [1981] 2 All ER 321, 337, Shaw LJ stated that "[i]f the subject matter is something which is inimical to the public interest or threatens individual safety, a person in possession of knowledge of that subject matter cannot be obliged to conceal it although he acquired that knowledge in confidence".

86 [1988] 2 All ER 648.

87 Ibid, 656.

public interest required disclosure. Moreover, Rose J's affirmation of the "paramount importance"[88] of medical confidentiality to AIDS patients, and his recognition that "confidentiality is essential to secure public as well as private health",[89] suggest that only in an extreme case will the public interest exception be made out, so as to sanction a disclosure of HIV-related patient information.

Two New Zealand cases on medical confidentiality have discussed the application of the public interest exception. In *Furniss* v *Fitchett,*[90] Barrowclough CJ made the following obiter comments:[91]

> I cannot think that [the] duty [of confidence] is so absolute as to permit, in law, not the slightest departure from it. Take the case of a doctor who discovers that the patient entertains delusions in respect of another, and in his disordered state of mind is liable at any moment to cause death or grievous bodily harm to that other. Can it be doubted for one moment that the public interest requires him to report that finding to someone? . . . But public interest requires that care should be exercised in deciding what shall be reported and to whom. Publication or communication of the report to other than appropriate persons could still be a breach of the duty owed by the doctor . . . .

In the *Furniss* case, there was no imminent risk of serious harm to the husband (a patient), to whom Dr Fitchett gave a letter stating that Mrs Furniss (also a patient) exhibited symptoms of paranoia. The doctor was held to have breached his duty of confidence to the wife, and was found liable for damages in respect of the nervous shock suffered by the wife when the husband's solicitor subsequently produced the letter in separation proceedings.

The invocation of the public interest exception, where third parties' lives may be at risk, was directly in issue in *Duncan* v *Medical Practitioners Disciplinary Committee.*[92] A patient had had a successful triple coronary artery bypass operation and his surgeon had certified him fit to drive passenger service vehicles. His doctor, Dr Duncan, heard that the patient was about to drive a bus on a charter trip and told a prospective passenger, and the local police constable, that the patient was not fit to drive and that he had a heart condition. The doctor subsequently made similar statements to the national news media. In upholding the Disciplinary Committee's finding of professional misconduct, Jeffries J commented as follows:[93]

> There may be occasions, they are fortunately rare, when a doctor receives information involving a patient that another's life is immediately endangered and urgent action is required. The doctor must then exercise his professional judgment based on the circumstances, and if he fairly and reasonably believes such a danger exists then he must act unhesitatingly to prevent injury or loss of life even if there is to be a breach of confidentiality. If his actions later are to be scrutinised as to their correctness, he

88 Idem.
89 Ibid, 653.
90 [1958] NZLR 396.
91 Ibid, 405-406.
92 [1986] 1 NZLR 513.
93 Ibid, 521.

> can be confident any official inquiry will be by people sympathetic about the predicament he faced.

It was unreasonable for Dr Duncan to conclude that there was an imminent danger to the lives of passengers (he should have ascertained that the patient's surgeon had certified him fit to drive), and in any event disclosure had not been made to "a responsible authority".[94]

The *Duncan* case provides useful guidelines to determine when the public interest requires a doctor to disclose information about a patient. It appears that two conditions must be fulfilled to establish a case for disclosure: (1) the risk perceived by the doctor must be a major one, ie a risk of immediate danger to the life of a third party;[95] and (2) the doctor's belief must be fairly and reasonably held. If a case for disclosure is made out, the doctor is duty-bound to disclose the relevant information; the doctor does not merely have a liberty to warn of the danger. This statement of the law accords with the conclusion, noted above,[96] that the ethical duty of medical confidentiality yields only to a superior duty. A final comment is that the judge's statement that "a doctor who has decided to communicate should discriminate and ensure the recipient is a responsible authority",[97] although understandable on the facts of the *Duncan* case, is unduly restrictive. It is not difficult to imagine a situation where the risk of loss of life can be avoided only by immediately contacting the third party. In such a case a prompt and direct approach to that person would seem the sensible course of action.

The public interest exception to medical confidentiality was successfully invoked in the 1989 decision of the English Court of Appeal in *W* v *Egdell*.[98] A patient had shot and killed five people in 1974 and was detained in a secure hospital. His solicitors retained a psychiatrist, Dr Egdell, to examine him and prepare a report which it was hoped would support an application for transfer to a regional secure unit (the first step in a return to the community). The psychiatrist did not support the application, and his report noted the patient's long-standing interest in home-made bombs. Not surprisingly, the patient instructed his solicitors to keep the report secret. However, Dr Egdell, concerned about the patient's dangerousness, sent copies of the report to the hospital's medical director and the Home Office. The patient's action for breach of confidence failed, since the Court held that the balance of the public interest favoured disclosure:[99]

> A consultant psychiatrist who becomes aware, even in the course of a confidential relationship, of information which leads him, in the exercise of what the court considers a sound professional judgment, to fear that decisions [which may lead to the release of a committed patient from hospital] may be made on the basis of inade-

94 Idem. The Disciplinary Committee's charge stated that Dr Duncan, as a "junior doctor", should have sought advice from a "senior colleague" (ibid, 519).
95 No requirement is stated that the third party be a patient of the doctor.
96 See text accompanying n 49, supra.
97 [1986] 1 NZLR 513, 521.
98 [1990] Ch 359.
99 Ibid, 424, per Bingham LJ.

> quate information and with a real risk of consequent danger to the public is entitled to take such steps as are reasonable in all the circumstances to communicate the grounds of his concern to the responsible authorities.

Two features of the *Egdell* decision are of particular interest. First, the Court accepted that disclosure in the public interest may be appropriate even where there is no immediate danger to the public, provided that there is a real risk of danger in the future. The lack of emphasis on the immediacy of the danger is, however, explicable on the basis that the patient in *Egdell,* as a former multiple killer, posed an extreme (albeit potential) risk. Secondly, the judges in the *Egdell* case referred to the entitlement of the psychiatrist to breach confidentiality. This approach is perhaps indicative of judicial reluctance to impose a positive duty to warn on a psychiatrist faced with the sort of dilemma which confronted Dr Egdell. Yet in both the *Furniss* and *Duncan* cases the judges spoke in terms of a duty to breach medical confidentiality, which is consistent with the ethical position discussed above.[100] The case for a legal duty (as opposed to a liberty) to warn a third party of a medical danger will be considered below.[101]

What are the implications of the public interest exception to medical confidentiality in relation to disclosure of HIV-related information? The nature of the risk of HIV transmission to a sexual partner, and the foreseeability of such risk by the partner, have already been discussed.[102] It is submitted that it would be reasonable for a doctor to believe that the life of an acknowledged sexual partner of an HIV-positive patient is immediately endangered if, following counselling, the patient refuses to notify the partner of his or her HIV status or to protect the partner by adopting "safe sex" practices. A doctor would be legally justified in taking urgent action to avoid the risk of the patient's infecting the partner; in particular, it would seem permissible for the doctor personally to notify the partner of the risk. If, on these facts, the patient sued the doctor for breach of confidence, a court would almost certainly hold that the doctor could rely on the public interest exception as a complete defence. In New Zealand, such a conclusion would be bolstered by reference to the pronouncements of professional, governmental, and other expert bodies in relation to confidentiality of HIV-related information.[103]

A Legal Duty to Warn?

I have argued that in limited circumstances a doctor has an ethical duty, and is legally entitled, to divulge HIV-related information about a patient to a third party. Is the ethical duty matched by a legal duty to warn the third party at risk of infection? This question has spawned a wealth of

100 See text accompanying n 49, supra.
101 Infra pp 395-400.
102 Supra nn 45, 46 and accompanying text.
103 Infra nn 171, 180, 181 and accompanying text.

commentary by legal academics, particularly in the United States,[104] many of whom find support in the case law for the existence of a legal duty to warn. In contrast, Commonwealth writers have doubted whether the common law recognises such a duty.[105] What is the position in New Zealand law?

The common law has traditionally been reluctant to impose duties of affirmative action.[106] As Fleming observes, "it is still important to advert to the distinction, deeply rooted in the common law and common sense causal notions, between misfeasance and non-feasance, between active misconduct working positive injury to others and passive inaction, failing merely to take positive steps to benefit others or to protect them from some impending harm".[107] In the medical context, a doctor is under no legal obligation to come to the aid of a stranger, even in an emergency,[108] although a recent statement from the Medical Council of New Zealand confirms that a doctor has an ethical obligation to render assistance in an emergency.[109] The position seems to be different if the endangered person is a patient of the doctor, since in such a case the special relationship between the parties may support a legal duty of affirmative care.[110] It is one thing, however, to impose a duty on a doctor to assist a roadside accident victim who happens to be a patient; it is quite another to impose a duty to warn a potential victim of the risk of harm from the conduct of a patient. A duty to warn has usually been imposed only where it is incidental to a duty to control the conduct of another person, for example in the case of a mental hospital where a dangerous patient is confined.[111] It is hard to see that an HIV-positive patient is in the control of a doctor in any sense, let alone

104 The articles on HIV/AIDS and the duty to warn are too numerous to list. Some of the most valuable contributions to the debate in the United States are: Piorkowski, "Between a Rock and a Hard Place: AIDS and the Conflicting Physician's Duties of Preventing Disease Transmission and Safeguarding Confidentiality" (1987) 6 Geo LJ 169; Hermann and Gagliano, "AIDS, Therapeutic Confidentiality and Warning Third Parties" (1989) 48 Md L Rev 55; Turkington, "Confidentiality Policy for HIV-Related Information: An Analytical Framework for Sorting Out Hard and Easy Cases" (1989) 34 Vill L Rev 871; 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 Dick L Rev 435.

105 An excellent Canadian contribution is Casswell, "Disclosure by a Physician of AIDS-Related Patient Information: An Ethical and Legal Dilemma" (1989) 68 Can Bar Rev 225. Neave, "AIDS – Confidentiality and the Duty to Warn" (1987) 9 U Tasmania L Rev 1, offers a useful Australian perspective. For an English view in support of a duty to warn the current sexual partner of an HIV-positive patient, see O'Dair, "Liability in Tort for the Transmission of AIDS: Some Lessons from Afar and the Prospects for the Future" [1990] CLP 219, 232-241.

106 Neave, ibid, 24.

107 *The Law of Torts* (7th ed 1987) 133-134.

108 See, generally, Gray and Sharpe, "Doctors, Samaritans and the Accident Victim" (1973) 11 Osgoode Hall LJ 1.

109 "The doctor's obligation to render assistance in an emergency", statement from the Medical Council of New Zealand, September 1990.

110 Fleming, op cit n 107, 136. The examples listed (eg employer/employee, driver/passenger) seem to be premised on a relationship of care and protection between the parties. It may be difficult to establish such a relationship between a doctor and a patient, at least outside the surgery.

111 *Holgate* v *Lancashire Mental Hospitals Board* [1937] 4 All ER 19. See also Neave, supra n 105, 25.

in the conduct of his or her sexual relations.[112] Even if the endangered individual is a patient of the doctor, in the absence of a duty to control the infected patient, it may be doubted whether the special relationship (between the doctor and the patient at risk) gives rise to a duty to warn.[113]

Commentators on HIV/AIDS and confidentiality invariably cite the landmark case of *Tarasoff* v *Regents of the University of California*[114] in support of a doctor's legal duty to warn a third party at risk. The *Tarasoff* case arose out of a series of tragic events at the University of California at Berkeley during 1969. A student, Prosenjit Poddar, was infatuated with a fellow student, Tania Tarasoff. In the course of therapy as a voluntary outpatient at the University hospital, Prosenjit confided to his psychotherapist, Dr Moore, that he intended to kill an unnamed woman, readily identifiable as Tania, upon her return from summer vacation. Dr Moore notified the campus police, who took Prosenjit into custody, interviewed him, and released him. No further action was taken by Dr Moore, who knew Prosenjit was at large, and two months later Prosenjit made good his threat to kill Tania. The Supreme Court of California upheld her parents' claim that Dr Moore owed Tania a duty to warn of the danger posed by his patient.

In delivering the majority judgment, Trobiner J expressed the duty as follows:[115]

> [O]nce a therapist does in fact determine, or under professional standards reasonably should have determined, that a patient poses a serious danger of violence to others, he bears a duty to exercise reasonable care to protect the foreseeable victim of that danger.

The duty is a broad one: it covers risks which ought to have been appreciated,[116] and extends to identified and identifiable[117] potential victims.

112 It is possible, however, that a doctor who attempts to exercise some control over the conduct of the infected patient may be held to have undertaken a duty of care. Thus if a doctor carelessly gives a patient inaccurate advice about the risk of transmission of HIV to a sexual partner, in the knowledge that the advice will be relied upon, the partner may have a claim in negligence against the doctor if he or she becomes infected as a result. See *DiMarco* v *Lynch Homes – Chester County* 559 A 2d 530 (Pa Super Ct 1989), where a doctor who gave a patient inaccurate advice about the risk of transmitting hepatitis B virus to her sexual partner was held liable in negligence to the partner, who became infected.

113 Fleming, op cit n 107, 140. Contrast s 315(b) of the *Restatement (Second) of Torts* (1965), which states that "[t]here is no duty to control the conduct of a third person to prevent him from causing physical harm to another unless . . . a special relation exists between the actor and the other which gives rise to a right of protection". It has been suggested that the s 315(b) "special relationship" exception would support a duty to control an HIV-positive patient likely to infect a sexual partner who is also a patient of the doctor: Ensor, "Doctor-Patient Confidentiality versus Duty to Warn in the Context of AIDS Patients and their Partners" (1988) 47 Md L Rev 675, 681.

114 551 P 2d 334 (Cal 1976).

115 Ibid, 345.

116 The American Psychiatric Association, in an *amicus curiae* brief, had submitted that a therapist's ability to predict dangerousness is too unreliable to be valid: ibid, 344-345.

117 Trobiner J suggested that if "a moment's reflection will reveal the victim's identity", the victim is foreseeable: ibid, 345.

Trobiner J was conscious that a duty to warn makes inroads into patient-psychotherapist confidentiality, but concluded that this was justified:[118]

> The protective privilege ends where the public peril begins. Our current crowded and computerized society compels the interdependence of its members. In this risk-infected society we can hardly tolerate the further exposure to danger that would result from a concealed knowledge of the therapist that his patient was lethal.

Clark J delivered a strong dissenting judgment in which he concluded that "overwhelming policy considerations weigh against imposing a duty on psychotherapists to warn a potential victim against harm".[119] Such a duty would "cripple the use and effectiveness of psychiatry"[120] (patients would be deterred and, if they did seek treatment, would withhold information and be distrustful of the therapist[121]), "invade fundamental patient rights",[122] and result in "a net increase in violence"[123] (since fewer dangerous individuals would be successfully treated).

The *Tarasoff* ruling, despite criticism from lawyers and psychiatrists,[124] has been followed and extended in subsequent decisions in the United States.[125] With the onset of the AIDS epidemic, commentators have looked to the *Tarasoff* duty to see if a similar duty to warn is incumbent upon doctors consulted by HIV-positive and AIDS patients. Indeed, the majority judgment in *Tarasoff* referred to case law holding that a doctor has a duty to warn potential contacts of a patient who is the carrier of a contagious disease.[126] The following dicta, from *Gammill* v *United States*[127] (a case concerning a patient infected with hepatitis A), are illustrative of the contagious diseases line of authority in the United States:[128]

> A physician may be found liable for failing to warn a patient's *family, treating attendants,* or other *persons likely to be exposed* to the patient, of the nature of the disease and the danger of exposure . . . . It would appear that at the bare minimum the physician must be aware of the specific risks to specific persons before a duty to warn exists.

The contagious diseases cases provide a doubtful analogy to the HIV/AIDS situation. In contrast to diseases like hepatitis A or tuberculosis, HIV is not casually transmitted; the virus which causes AIDS is generally

118 Ibid, 347.
119 Ibid, 358.
120 Ibid, 360.
121 Ibid, 359.
122 Ibid, 358.
123 Ibid, 361.
124 See Hermann and Gagliano, supra n 104, 62-64, for a summary of the response from the psychiatric profession.
125 The subsequent case law is summarised by Price, supra n 104, 452-454.
126 Ibid at 344. The cases cited by Trobiner J are in fact all distinguishable from the failure to warn under consideration in *Tarasoff* and in the HIV/AIDS context: see Casswell, supra n 105, note 71.
127 727 F 2d 950 (10th Cir 1984).
128 Ibid, 954, per Barrett CJ. The contagious diseases line of authority is analysed by Price, supra n 104, 448-451.

described as infectious but not contagious.[129] The *Tarasoff* scenario does, however, have obvious parallels.[130] The relationship between a doctor and an HIV-positive patient is, like that between a psychotherapist and patient, highly confidential. Both the infected patient who threatens to continue to have unprotected sexual intercourse with an uninformed partner, and the psychiatric patient who threatens to harm another, involve difficulties of predicting dangerousness. In some respects there is a stronger case for warning an acknowledged sexual partner of HIV infection than a potential victim of a psychiatric patient: a sexual partner can more readily take protective measures, and a chain of infection may thereby be avoided. Perhaps the key distinguishing feature of the HIV/AIDS situation is that the doctor is not normally dealing with a mentally disordered patient.[131] This point is made by Hermann and Gagliano, who note that the *Tarasoff* ruling would have to be extended to impose a duty of disclosure in respect of a "competent, fully informed patient".[132]

Many commentators have assumed that the *Tarasoff* ruling would be applied by a court in the United States to impose liability on a doctor who failed to warn a sexual partner at risk of HIV infection from a patient. A New Zealand court might also find a duty to warn in such a situation.[133] Admittedly, the common law tradition denying affirmative duties of care would indicate against such a duty.[134] So, too, does the recent decision in *Murphy* v *Brentwood District Council*,[135] albeit in the rather different context of local body negligence. In *Murphy*, the House of Lords rejected its own *Anns* test,[136] which imposes a duty of care on the basis of proximity and foreseeability of harm, in the absence of contrary policy considerations. However, the New Zealand Court of Appeal has been a strong proponent of the *Anns* test and has to date shown no inclination to depart from "a not inconsiderable body of indigenous New Zealand case law" on negligence.[137] The decision in *Brown* v *Heathcote County Council*[138] is instruc-

129 Interview with Dr Robert Beaglehole, Department of Community Health, University of Auckland School of Medicine, 18 October 1991.

130 I am indebted to Price, supra n 104, 454-456, for his insightful discussion of the similarities and differences.

131 Presumably, if the HIV-positive patient is diagnosed as psychopathic, the analogy with the *Tarasoff* situation is more compelling: cf Gillon, supra n 45, 1676.

132 Supra n 104, 69.

133 O'Dair suggests (supra n 105) that an English court would similarly find a duty. Cf the tentative conclusions of Casswell and Neave (idem) that Canadian and Australian courts respectively would not find a legal duty to warn.

134 Supra nn 106-107 and accompanying text.

135 [1991] AC 398. In rejecting the *Anns* test, Lord Oliver noted (at 483) that "[t]he complaint was not of what the defendant had done but what it had not done". The comment suggests a revival of the act/omission distinction: see Todd, "The Law of Negligence in New Zealand after *Murphy*" in *Negligence after Murphy* v *Brentwood DC* (Legal Research Foundation, 1991).

136 [1978] AC 728, 751-752, per Lord Wilberforce.

137 *Brown* v *Heathcote County Council* [1986] 1 NZLR 77, 79, per Cooke P. In its recent decision in *South Pacific Manufacturing Co Ltd* v *NZ Security Consultants & Investigations Ltd* (CA 14/90, 29 November 1991), the Court of Appeal concluded that *Murphy* should not lead to any changed approach to negligence law in New Zealand.

138 Supra n 137. The decision was upheld by the Privy Council: [1987] 1 NZLR 720.

tive. The Court held that a local authority which had made a practice of advising, in relation to building permit applications, of possible flood risks, owed a duty to warn applicants of any unusual flooding risk of which it was (or ought to have been) aware. Cooke P noted that "there is not normally a duty to volunteer advice",[139] but that having adopted the practice, the defendant owed a duty to warn parties in a relation of "marked and distinctive proximity"[140] for whom a "very real risk"[141] of loss was reasonably foreseeable if no warning was given.

Quite apart from the factual dissimilarities between the *Brown* case and the HIV/AIDS situation, it is clear that the local authority's duty to warn was premised on its past practice of warning affected persons. However, if a New Zealand court was attracted by the *Tarasoff* ruling it might impose a duty to warn, in light of policy statements from expert bodies endorsing a practice of limited disclosure to sexual partners at risk of HIV infection.[142] Certainly, the elements of proximity and foreseeable harm are present in the HIV/AIDS scenario, and public policy considerations do not necessarily militate against the imposition of such a duty. A legal duty to warn would be consistent with a doctor's ethical duty and with dicta in the *Furniss*[143] and *Duncan*[144] cases, which speak of a duty to breach confidentiality in limited circumstances.

Liability for Failure to Warn

A plaintiff who succeeds in showing that a doctor breached a legal duty to warn her[145] of the risk of HIV infection faces further obstacles to recovery. These relate to problems of causation, the possible defences of *volenti non fit injuria* and contributory negligence which may be pleaded against her, and the effect of the Accident Compensation Act 1982. These difficulties will be addressed in turn.

A plaintiff may, for a number of reasons, find it difficult to prove on the balance of probabilities that she became infected with HIV as a result of a doctor's failure to warn. First, she may be unable to show that she was not already infected at the time the doctor failed to warn her. Even if she had a negative HIV test result at that time, the "window period" before HIV antibodies are detectable[146] means that she could already have

139 [1986] 1 NZLR 77, 81.

140 Ibid, 82.

141 Idem.

142 Notably, the protocol adopted by the New Zealand Medical Association (infra n 171 and accompanying text) and the statement from the National Council on AIDS (infra n 180).

143 Supra n 90.

144 Supra n 92.

145 I shall assume that the plaintiff is female, since I have argued that a female sexual partner has a stronger case for a duty to be warned of the risk of HIV infection: see supra n 46.

146 The possibility of a prolonged period of latent HIV infection (up to 35 months) is discussed by Imagawa, Lee, Wolinsky et al, "Human Immunodeficiency Virus Type 1 Infection in Homosexual Men Who Remain Seronegative for Prolonged Periods" (1989) 320 New Eng J Med 1458 (see Haseltine, "Silent HIV Infections" (1989) 320 New Eng J Med 1487 for editorial comment). In most cases, HIV antibodies will be detectable within 6 weeks of infection: interview with Dr Mark Thomas, infectious diseases specialist, Auckland Hospital, 18 October 1991.

contracted the virus. The possibility of prior infection is obviously greater if she was a past or current sexual partner of the patient at the time of his HIV diagnosis. Thus a partner like the wife in the hypothetical example discussed above,[147] who has a strong claim to a duty to be warned, may find it impossible to prove that her husband had not already infected her. Conversely, a new sexual partner may more easily prove that the patient infected her post-diagnosis, assuming that she can discount other sources of prior infection.[148] Obviously a plaintiff will need to establish that she would have avoided the risk of infection had the doctor warned her (by abstaining from sexual intercourse or taking protective measures), but that should not be difficult; few individuals would deliberately expose themselves to the risk of infection from a sexual partner known to be HIV-positive.

Aside from the problem of factual causation, to succeed against the silent doctor, a plaintiff will have to prove that the failure to warn was a proximate cause of her HIV infection. It may be argued that the patient's non-disclosure was the effective cause of her injury. Piorkowski comments that "[i]f, as a policy matter, courts desire to protect the confidentiality of an HIV diagnosis, they could impose primary responsibility on the infected individual to warn third parties".[149] However, given that in the hypothetical HIV/AIDS dilemma under consideration the patient has signalled his intention not to disclose the infection to his sexual partner, it is circular reasoning to suggest that the doctor's liability for failure to avoid foreseeable harm to a proximate third party should be avoided because the harm eventuated in the manner foreseen. On this analysis, no problem of intervening cause arises.

Even if a plaintiff proves that the doctor's failure to warn was the factual and proximate cause of her HIV infection, the doctor may invoke the defences of *volenti non fit injuria* (no harm is done to one who consents) and contributory negligence.[150] A *volenti* defence absolves a defendant from liability on the basis that the plaintiff knowingly and freely accepted the risk of the particular harm.[151] In the context of consensual sexual relations, the distinction must be drawn between consenting to the sexual act, and

147 Supra n 41 and accompanying text.

148 Cf Piorkowski, supra n 104, 188-189.

149 Supra n 104, 189. An infected person who wilfully or negligently transmits HIV to a sexual partner may be liable in tort. See Brigham, "You Never Told Me . . . You Never Asked; Tort Liability for the Sexual Transmission of AIDS" (1986) 91 Dick L Rev 529, for discussion of possible tort liability for battery, deceit or negligence; in the case law, see *Kathleen K* v *Robert B* 198 Cal Rptr 273 (Ct App 1984) (genital herpes transmission) and *CAU* v *RL* 438 NW 2d (Minn Ct App 1989) (HIV transmission). Labowitz comments that "[t]he horror of AIDS infection transcends the ability of the average individual to compensate another for the infliction of that horror" and suggests that plaintiffs may prefer to look to the deeper pockets of the medical profession: "Beyond *Tarasoff:* AIDS and the Obligation to Breach Confidentiality" (1990) 9 St Louis U Pub L Rev 495, 497-498.

150 Few commentators advert to the possible application of *volenti* and contributory negligence defences in the HIV/AIDS context: exceptions include Piorkowski, supra n 104, 190-191, and Brigham, supra n 149, 549-550.

151 Todd (ed), *The Law of Torts in New Zealand* (1991) para 21.3.

consenting to the risk of HIV infection.[152] Unless a plaintiff knew that that her partner was at high risk of HIV infection but nevertheless continued to have unprotected sexual intercourse with him, a defendant doctor would be unable to prove the plaintiff had accepted the risk; one cannot be *volens* without being *sciens*.[153]

A contributory negligence defence may be a more effective shield to a doctor's liability. Section 3 of the Contributory Negligence Act 1947 provides:

> Where any person suffers damage as the result partly of his own fault and partly of the fault of any other person or persons, a claim in respect of that damage shall not be defeated by reason of the fault of the person suffering the damage, but the damages recoverable in respect thereof shall be reduced to such extent as the Court thinks just and equitable having regard to the claimant's share in the responsibility for the damage.

"Fault" is defined in section 2 to include any "act or omission which . . . would, apart from the Act, give rise to the defence of contributory negligence".

A plaintiff's conduct will amount to contributory negligence if she did not take reasonable care for her own safety and contributed, by this lack of care, to her injury.[154] One commentator on HIV/AIDS has posed the question: "As with cigarette packet warnings, can any sexually active adult be ignorant of the risks inherent in unprotected intercourse?"[155] Courts have held that failing to wear a seatbelt or crash helmet when driving constitutes contributory negligence.[156] In light of public education campaigns in New Zealand, which have compared having unprotected sexual intercourse to jumping out of an aeroplane without a parachute, there is an obvious possibility that lack of self-protection could amount to contributory negligence. Once again, the defence would be more likely to succeed if the plaintiff had a particular reason to be aware of the risk of HIV infection.[157] Even if successful, a contributory negligence defence does not absolve the defendant from all liability; rather, the plaintiff's damages are reduced "to such extent as the Court thinks just having regard to the claimant's share in the responsibility for the damage".[158] Thus a court which held that a doctor had breached a duty to warn a plaintiff of the risk of HIV infection might nonetheless reduce the plaintiff's damages in a proportion which reflected its assessment of the extent of her failure to take reasonable care to protect herself against a foreseeable risk.

152 Cf *R* v *Clarence* (1888) 22 QBD 23.

153 Fleming, *The Law of Torts* (7th ed 1987) 273.

154 *Helson* v *McKenzies (Cuba Street) Ltd* [1950] NZLR 878, 920, per Gresson J.

155 Labowitz, supra n 149, 498.

156 *Froom* v *Butcher* [1976] QB 286 (seatbelt); *Capps* v *Miller* [1989] 1 WLR 839 (unfastened crash helmet).

157 For example, if she knew her partner was at risk of infection, or if her doctor had counselled her to protect herself against the risk of infection. Gauthier points out, in "HIV Testing and Confidentiality" (1990) 2 BioLaw S:349, S:356, that a partner who is also a patient of the doctor could be encouraged to consent to testing and counselled regarding risky sexual behaviour as part of a regular office visit.

158 Contributory Negligence Act 1947, s 3.

A final obstacle to a doctor's liability for failure to warn, peculiar to New Zealand, is the possible application of the Accident Compensation Act 1982. An individual who suffers "personal injury by accident" in New Zealand has a claim to compensation under the Act, but is barred from bringing a claim in a New Zealand court for "damages arising directly or indirectly out of the injury".[159] Does a "personal injury by accident" occur if someone contracts HIV infection in New Zealand as a result of a doctor's failure to warn? The point is not free from difficulty. Bodily damage caused exclusively by disease or infection is excluded by paragraph (b)(ii) from the definition of "personal injury by accident" in section 2, except where the damage is a physical consequence of a personal injury by accident and thus included, by paragraph (a)(i), in the definition. In *Accident Compensation Corporation* v *Booth*,[160] Holland J reconciled the statutory provisions as follows:[161]

> [T]he exception of the provisions of paragraph (a) [from the general rule of exclusion of cover in cases of disease or infection] was intended solely to ensure that where there was an injury by accident in the generally accepted meaning of the term such as an open cut or wound, and infection and disease followed, such as gangrene, then the victim should be entitled to compensation for the original injury and the gangrene. The words of exception . . . can be given a meaningful interpretation if they are applied only to cases where there has been a personal injury by accident independently of the subsequent or even contemporaneous disease or infection.

The judge referred to "infection obtained by contact with a person carrying an infection unknown to the donee" as an example of a case where the infection is not a physical consequence of an accident (and thus not covered by compensation), even though the infection is "an unlooked-for mishap neither expected nor designed" by the claimant.[162]

This analysis is consistent with the "Personal Injury By Accident/ Disease" guidelines issued by the Accident Compensation Corporation in 1982,[163] which instance a disease resulting from an accidental wound as an example of disease as a physical consequence of the accident (thus qualifying as "personal injury by accident").[164] The Corporation has adopted a policy of accepting that "personal injury by accident" has occurred if HIV infection results from a transfusion of contaminated blood,[165] there being a "medical misadventure"[166] in such a case; compensation would also be available in cases of infection from a needle-stick injury during medical or surgical treatment,[167] or from a sexual violation

159 Section 27(1).
160 [1990] NZAR 529.
161 Ibid, 536-537.
162 Ibid, 536.
163 [1982] NZACR 411.
164 Ibid, 412.
165 Todd, op cit n 151, 54, note 70.
166 Paragraph (a)(ii) of the s 2 definition of "personal injury by accident".
167 Medical or surgical staff who become HIV-positive following such an injury would be covered under s 28(1), since the infection is due to the nature of their employment.

or criminal assault.[168] However, it seems that a claim by an individual who has contracted HIV through consensual sexual intercourse would not be accepted by the Corporation.[169]

It follows that a plaintiff who contracts HIV as a result of a doctor's failure to warn is not barred from bringing court proceedings in New Zealand. If she can establish that the non-warning was a factual and proximate cause of her infection, and that the defences of *volenti* and contributory negligence do not apply, the doctor may be liable in damages for breach of a duty to warn her.

New Zealand's Response to the HIV/AIDS Dilemma

I have suggested that a doctor may, in limited circumstances, have an ethical and a legal duty to divulge HIV-related information about a patient to a third party, and that there may be tortious liability for breach of the duty to warn. How have the medical profession, interested bodies, and the legislature in New Zealand responded to the so-called HIV/AIDS dilemma?[170]

The New Zealand Medical Association (NZMA) has adopted the following protocol in relation to HIV status and patient confidentiality:[171]

1. Take all reasonable steps to educate, counsel and support the HIV-positive person to discuss his or her HIV status with sexual and intravenous drug sharing partner/s.
2. If that person then refuses to discuss their HIV status with their sexual partner/s and there is clear risk to an acknowledged sexual partner/s, the medical practitioner should discuss with a senior colleague, or the Central Ethical Committee if necessary, whether confidentiality should be maintained.
3. The matter should be discussed with the practitioner's medical protection or defence advisor.
4. Having reached a decision the practitioner should then consult with the HIV-positive person advising them if it is the practitioner's intention to disclose the information to the third person and to present them with written confirmation of this.
5. A final opportunity should be given to the patient to change their stance and inform the third party of their condition.
6. If the patient again refuses to respond, the practitioner should notify the third party of the risk. This would involve opportunity for a consultation and to initiate steps to provide the third party with appropriate counselling and medical advice.

The NZMA protocol is clearly a sensitive response to the HIV/AIDS dilemma. A number of specific comments may be made. The emphasis

168 Actual bodily harm which results from an offence of sexual violation or wilfully infecting with disease, in terms of ss 128 and 201 respectively of the Crimes Act 1961, is covered by para (a)(iv) of the s 2 definition of "personal injury by accident".

169 Interview with Margaret Vennell, member of the Board of Directors of the Accident Compensation Corporation, 19 October 1991.

170 See headline, "Doctors' AIDS dilemma: to tell or not to tell", *New Zealand Doctor*, 21 May 1990, p 1.

171 "HIV Status and Patient Confidentiality" Policy, adopted by NZMA National Assembly, Wellington, 12 September 1990. The protocol was prepared by Dr Tony Baird, member of the National Council on AIDS. The American Medical Association has issued similar guidelines (see Hermann and Gagliano, supra n 104); so too has the Canadian Medical Association (see Casswell, supra n 105, 227).

on counselling and the stipulation that the patient receive advance notification of the intention to disclose are commendable. In my view, in keeping with the moral principles of autonomy and fidelity, doctors should be directed to inform patients, at the outset of the consultation, of the disclosure obligations that may arise in the event of a positive HIV test.[172] The requirement that there be a "clear risk to an acknowledged sexual partner" is consistent with the ethics and law of medical confidentiality. It may be noted that the third party need not also be a patient of the doctor and that no distinction is drawn between male and female sexual partners.[173] However, the doctor is not required to play the role of detective, since the duty arises only in relation to *acknowledged* sexual partners. It is not clear whether this includes past, as opposed to current, sexual partners.[174] Presumably, if the doctor is satisfied that the patient will henceforth engage only in "safe sex" with the sexual partner the risk is not a "clear" one and disclosure is not justified.[175] Finally, it is interesting to note that, if the stipulated conditions are fulfilled, the doctor "should notify the third party of the risk". This suggests that the doctor has a duty to warn, and that the warning should explain the risk that the partner has been, or may become, infected with HIV. The protocol does not require the doctor to identify the source of the risk, though in practice that may be readily identifiable by the notified partner; so far as is practicable, the doctor should not reveal the source of the risk.[176] The third party should also be directed not to make further disclosure of the information, unless it is necessary to notify another person at risk of infection from the third party.[177]

172 Cf Hermann and Gagliano, supra n 104, 75.

173 It is also noteworthy that although the protocol refers to the need to counsel the HIV-positive person to discuss his or her HIV status with an intravenous drug sharing partner, it does not deal with disclosure to such a partner. Casswell argues that "intravenous drug sharers should be considered similarly, since reference to both sexual partners and intravenous drug sharers emphasises that there are modes of HIV transmission other than sexual activity": supra n 105, 228, note 10. It is arguable that an intravenous drug sharing partner is in a similar position to a male sexual partner: if either partner engages in an unsafe practice (ie shares needles for injecting drugs, or has unsafe sex), the risk of infection from such behaviour should be foreseeable, in light of widespread public education. It has been argued above (n 46) that there is a weaker case for an ethical duty to warn a male (as opposed to a female) sexual partner. However, if the NZMA is prepared to sanction disclosure to male sexual partners, it should extend similar protection to intravenous drug sharing partners.

174 O'Dair argues (supra n 105, 239) that there is a stronger case for a duty to warn current partners of the infected patient.

175 Belitsky and Solomon state that "[i]f the physician believes that sex will be practised safely . . . the presumption should be in favour of confidentiality": "Doctors and Patients: Responsibilities in a Confidential Relationship" in Dalton, Burris and the Yale AIDS Law Project (eds), *AIDS and the Law* (1987) 201, 207. However, it may be doubted whether a doctor can rely on the assurances of a patient who deceives a sexual partner about HIV status: see Stroud, "An Indiana Doctor's Duty to Warn Non-Patients at Risk of HIV Infection from an AIDS Patient" (1989) 22 Ind L Rev 587, 609.

176 This is consistent with recommendation 6-12 of the United States *Report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic* (1988). Cf New York legislation, noted by Price, supra n 104, 461, to the effect that the identity of the protected individual must not be revealed at the time of disclosure.

177 Cf Dunne and Serio, "Confidentiality: An Integral Component of AIDS Public Policy" (1988) 7 St Louis U Pub L Rev 25, 33.

An obvious criticism of the NZMA protocol is that the various steps envisaged could take several days to complete; the sexual partner may be at risk of infection by the patient during that time interval. As noted in the *Duncan* case,[178] the legal basis of the public interest exception to the duty of confidentiality is the existence of immediate danger which requires "urgent action".[179] It is submitted that, if the risk is such that a case for disclosure is made out, the doctor should act promptly and any consultations (with colleagues or a defence society) should be made by telephone, as a matter of urgency.

The response of the medical profession to the HIV/AIDS dilemma is consistent with the approach of the National Council on AIDS[180] and with New Zealand AIDS Foundation (NZAF) policy on contact tracing.[181] Clients testing HIV-positive at NZAF clinics receive full counselling and are encouraged personally to notify sexual partners who have been, or may be, at risk of infection.[182] The experience of counselling staff is that clients will almost invariably act responsibly and ensure partner notification.[183] It is important to stress that skilled counselling is likely to provide the most effective solution in a situation where an HIV-positive person initially refuses to make disclosure to an acknowledged sexual partner. The NZMA protocol appropriately recognises the crucial role of counselling in this context.

The New Zealand Parliament has not, to date, responded to the HIV/AIDS dilemma. The fact that HIV is not a notifiable infectious disease under the Health Act 1956,[184] and that AIDS is notifiable only in a form which ensures patient anonymity,[185] reflects legislative sensitivity to the importance of confidentiality of HIV-related information. The lack of specific legislation on HIV-related information suggests that the legislature has been content to see the issues under discussion resolved by profes-

178 Supra n 92.

179 Supra n 92, 521.

180 The Council states, in its report *The New Zealand Strategy on HIV/AIDS* (1990) 48-49, that "situations may arise where the practitioner, or other health professionals involved in the case of an HIV-positive person, has a duty to warn a third party about HIV positivity if the person refuses to discuss his or her status with sexual or drug sharing partners".

181 The Foundation's policy document "NZAF Policy: Partner Notification (Contact Tracing)" (August 1990) notes that "[o]nly after exhausting the options for the index case advising partners should a third party — medical practitioner or counsellor — consider intervention" (text to principle 2.1) and then only following "close consultation with peers or supervisor" (text to principle 4.0).

182 This method of contact tracing is referred to as patient or index person referral.

183 Interview with Joe Kelleher, Senior Therapist, Burnett Clinic, Auckland, 14 October 1991.

184 Section 2(1) and First Schedule to the Health Act 1956. HIV is not even specified as an infectious disease under the Act. A case may be made, on epidemiological grounds, for notifiability of non-identifying data in respect of all positive HIV test results: see Price, supra n 104, 471-474. Hodgson recommends that cases of HIV infection as well as AIDS should be reported on an anonymous basis to the Department of Health pursuant to a compulsory legal requirement: "The Legal and Policy Implications of Human Immunodeficiency Virus Antibody Testing in New Zealand" in Paterson, op cit n 15, 39, 65.

185 The Health (Infectious and Notifiable Diseases) Regulations 1966, Amendment No 5 (SR 1989/281), reg 2.

sional ethics and the common law. New Zealand's existing public health legislation is outdated and generally inappropriate to HIV/AIDS. For example, it is an offence under section 80(1)(b) of the Health Act 1956 for someone who knows he has an infectious disease to enter any public conveyance. Section 79(1) of the Health Act provides that the Medical Officer of Health or any Inspector of Health may order the hospitalisation and isolation of any person who there is "reason to believe or suspect . . . is likely to cause the spread of any infectious disease". Although the statutory form of notification of AIDS cases does not identify the patient by name or address, it would presumably be possible for a medical practitioner to advise the Medical Officer of Health that a named AIDS patient intended to have unprotected sexual intercourse without disclosing his infection to partners. In such a case the quarantine powers in section 79(1) could be exercised. However, since HIV is not specified as an infectious disease under the Health Act, there is no statutory power to quarantine an intransigent HIV-positive person.[186]

Finally, it should be noted that the Privacy of Information Bill 1991 will, if enacted,[187] establish statutory "information privacy principles" in relation to "personal information". The proposed legislation is far-reaching, since it extends to "personal information" (which means "information about an identifiable individual"[188]) held by an "agency" (which includes any person in the public or private sector[189]). It would thus cover HIV-related information held in the files or in the mind of any general practitioner.[190] Information privacy principle 14(1)(f) permits an "agency" to disclose information to a third party where "[t]he agency believes on reasonable grounds that the disclosure is necessary to prevent or lessen a serious and imminent threat to the life or health of . . . another individual". This provision would clearly authorise a doctor to warn a third party at risk of HIV infection from a patient, in those circumstances in which I have suggested that a doctor has an ethical and legal duty to warn.

Conclusion

Academic commentators routinely call for legislative clarification in areas where the law is in a state of uncertainty. Predictably, the HIV/AIDS

186 Neither HIV nor AIDS appear in the list of infectious diseases in the Second Schedule to the Health (Infectious and Notifiable Diseases) Regulations 1966 (SR 1966/87), and thus reg 10 (compulsory medical examination of contacts and carriers) and reg 11 (quarantine of contacts and carriers) are not applicable. This omission doubtless reflects the fact that HIV is not casually communicable. Nor do the broad powers for compulsory medical examination of notified contacts of patients with communicable venereal diseases apply to HIV/AIDS, which is not a venereal disease: the Venereal Diseases Regulations 1982 (SR 1982/215), regs 2, 7(2) and 8(1).

187 The Government on 21 November 1991 announced its intention to modify the Bill: "NZ 'at bottom' over privacy", *The New Zealand Herald*, 23 November 1991, p 5.

188 Clause 2 definition of "personal information".

189 Clause 2 definition of "agency".

190 For a discussion of the application of Canada's privacy legislation to HIV-related information, see the Privacy Commissioner of Canada's report, *AIDS and the Privacy Act* (1989).

dilemma has not been immune from calls for legislation.[191] The majority of state legislatures in the United States have enacted special statutes protecting the confidentiality of HIV-related information.[192] Although the earlier statutes provide for strict confidentiality, with no liberty or duty for doctors to warn third parties, later statutes permit, but do not require, disclosure to contacts of the patient.[193] An alternative solution is to provide doctors with immunity from the consequences of either disclosure or non-disclosure.[194] This solution may appeal to the medical profession[195] since, as New Zealand law currently stands, a doctor who breaches patient confidentiality faces the possibility of liability in damages;[196] equally, breach of a legal duty to warn might result in damages liability.[197] [198]

In my view, the solution to the HIV/AIDS dilemma does not lie in legislated confidentiality or duties to warn. The imposition of a duty to warn might even prove counter-productive, since there is a risk that doctors would be deterred from asking questions about the sexual and needle-sharing activities of a patient if doing so could lead to legal liability for failure to warn third parties.[199] A more effective response by the New Zealand legislature would be to enact the provisions of the Human Rights Commission Amendment Bill 1990 prohibiting discrimination on the basis of health status or sexual orientation, and to amend section 19(1) of the New Zealand Bill of Rights Act 1990 to affirm the right to freedom from discrimination on such grounds. As Dickens has observed in the North American context:[200]

> [T]he most effective use of legislation is not simply to seek to enact further protections of confidentiality of data, which would be subject to the same exceptions, but to reinforce laws against discrimination on grounds of an individual's affliction with AIDS . . . or HIV infection.

191 In New Zealand, see Hodgson, supra n 184, 60-61. In the United States, see Talbot, "The Conflict between a Doctor's Duty to Warn a Patient's Sexual Partner that the Patient has AIDS and a Doctor's Duty to Maintain Patient Confidentiality" (1988) 45 Wash & Lee L Rev 355, 380; Gauthier, supra n 157, S:355. Some commentators have even drafted model statutes, eg, Nanula, "Protecting Confidentiality in the Effort to Control AIDS" (1987) 24 Harv J on Legis 315, 345-349 ("Comprehensive AIDS Confidentiality Act"); McVickar, "To Disclose or Not to Disclose the Presence of AIDS: Resolving the Confidentiality Concerns of Patients, Physicians, and Third Parties" (1989) 3 Val UL Rev 341, 368-369 ("AIDS Prevention Through Notification Act").

192 Gostin, "A Decade of a Maturing Epidemic: An Assessment and Directions for Future Policy" (1990) 5 Notre Dame J L Ethics & Pub Pol 7, 28.

193 See Price, supra n 104, 457-463.

194 Cf Ensor, supra n 113, 699-700.

195 "NZMA seeks legal cover for doctors on AIDS", *New Zealand Doctor*, 18 June 1990, p 5. However, there is no evidence to date of a rash of litigation in relation to HIV/AIDS and the medical profession. Cf the comment of Labowitz, supra n 149, 497, that in the United States "no area holds more promise for major litigation involving AIDS than that of HCPs [health care providers]".

196 Supra n 73.

197 Subject to the difficulties discussed supra pp 400-404.

198 A doctor could also face medical disciplinary proceedings for improper disclosure or non-disclosure.

199 Hermann and Gagliano, supra n 104, 69.

200 "Legal Limits of AIDS Confidentiality" (1988) 259 JAMA 3449.

It is precisely because of the stigma and potential for discrimination which attach to HIV-related information that the consequences of its unauthorised disclosure are so troubling. The "moral intransigent"[201] who gives rise to the HIV/AIDS dilemma discussed in this paper might have the courage to reveal his HIV infection to an endangered third party in a world where his disclosure could not be the basis of lawful discrimination. In the meantime, there are no universal rules which dictate the limits of confidentiality of HIV-related information.[202]

201 Gillett, "AIDS and Confidentiality" (1987) 4 J Applied Philosophy 15, 19.
202 Cf Guttmacher, "HIV Infection: Individual Rights v Disease Control" (1990) 17 J Law & Soc 66, 75.