AIDS - CONFIDENTIALITY AND THE DUTY TO WARN

By Marcia Neave *

1. INTRODUCTION

Outbreaks of infectious and contagious disease have threatened social order and provided a major challenge to medical and scientific knowledge throughout most of the world's history. By the middle of the twentieth century, however, medical scientists believed that improvements in public sanitation, universal vaccination and new drugs had finally eradicated epidemics in Western society.[1] This optimism was brought to an end by reports of the first AIDS cases in the United States in 1981, followed by later recognition of the world wide spread of the human immuno-deficiency virus (HIV).[2] By May 1988, 846 cases of AIDS had been diagnosed in Australia. Of these, 417 men and 24 women had died of the disease.[3] Although future progress of the pandemic is difficult to predict, health authorities believe that there may be up to 40,000 healthy but infected individuals in Australia.

Tragically, most of the victims of the disease are relatively young. Loss of their productive lives, coupled with the burden of treatment and palliative care, will impose significant costs on the community. These costs cannot be quantified solely in financial terms. The HIV virus is communicated by penetrative sexual contact and many of the first cases were diagnosed among homosexuals. For some fundamentalist preachers and the less responsible sections of the media, the combination of youth, sex and death was irresistible. In the early stages of the epidemic, misinformation about AIDS and its characterization as the 'gay disease' led to a backlash against those who were infected or suspected of being at

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[1] Macfarlane Burnet, *The Natural History of Infectious Diseases* (3rd edition, 1962), 3, 84. Cf comments in (4th edition, 1972), 14.

[2] AIDS (acquired immuno-deficiency syndrome) is a lethal condition caused by the human immuno-deficiency virus (HIV) which destroys the body's immune system exposing the patient to cancer and infection by other organisms. People who are infected by sexual contact or contact with the blood of another person, may initially suffer a mild flu-like illness, but appear to recover completely and may remain healthy for a period of years. (This is known as category C AIDS.) Some infected individuals progress to category B AIDS. This group develops a variety of symptoms including signs of immuno-deficiency, swollen glands and malaise (lymphadenopathy syndrome or AIDS-related complex - ARC). Finally some people progress to AIDS Category A, with generalized break down of the immune system. See K Kay (ed) *AIDS Virus Infection: A Comprehensive Reference Manual on the Human Immuno-Deficiency Virus* (1986), Section 4.

[3] Commonwealth Department of Community Services and Health, *Communicable Diseases Intelligence Bulletin* No 88/10, (Cases reported to 10 May 1988).

risk of contracting the disease.[4] People with AIDS and their families have not only had to deal with the harsh knowledge that the disease is almost inevitably fatal, but have also faced stigma and discrimination from school friends, employers, co-workers, landlords and even some health care providers. As has been the case with other epidemics, community fear of AIDS carries with it the risk of scape-goating and victimization, when those who are part of the mainstream culture seek to protect themselves against those who are perceived as 'different'.[5]

Public health authorities are faced with the imperative of preventing the spread of the HIV virus, while at the same time preventing discrimination against sufferers and unnecessary infringements on individual rights to privacy and freedom. The justification for this approach is pragmatic as well as humanitarian. Traditionally outbreaks of infectious disease have been controlled by ensuring that patients are accurately diagnosed, by tracing their contacts and identifying those who may be asymptomatic carriers and by isolating infected individuals until the disease has run its course. These strategies have limited value in preventing the spread of the HIV virus.

People who are infected may remain asymptomatic for many years and some may never become ill. Routine population screening cannot prevent transmission, as a person who tests negative may not yet have produced antibodies to the disease, or may be uninfected at the time of the test but come into contact with the virus shortly afterwards. The costs of isolating tens of thousands of infected, but outwardly healthy, individuals would be prohibitive, even if they could be accurately identified. Since the normal medical approach to disease control is unlikely to halt the epidemic, the co-operation of infected individuals is vital. Such co-operation is unlikely to occur if those who are infected are not protected against unwarranted discrimination.

The need to protect uninfected people from infection, while at the same time safeguarding the rights of those who have already contracted the virus, creates legal and ethical dilemmas for those involved in the treatment and care of people who are infected. An issue which has given rise to particular concern is the extent to which it is ethically justifiable or legally necessary to breach the confidentiality which normally exists between doctor and patient, in order to protect third parties who may be infected by vaginal or anal intercourse or by contact with contaminated blood (for example during surgery, provision of emergency care, or the sharing of needles).

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[4] For a detailed discussion of this problem see D Altman, *AIDS and the New Puritanism* (1986), Chapter 2. See also MD Kirby, 'AIDS Legislation - Turning up the Heat', (1986) 60 ALJ 324, 325 ff.

[5] See for example PH Curson, *Times of Crisis* (1985).

One view is that the protection of third parties from infection should take priority over the preservation of doctor-patient confidentiality. Advocates of this approach argue that the lethal nature of the AIDS virus justifies a departure from the normal obligation of confidence. A patient who infects another person may be condemning that other person to death and a doctor should be permitted (and possibly legally obliged) to take steps to protect the third party. Such an approach may also be seen as a means of breaking the chain of transmission and slowing the spread of the HIV virus. A warning given to a wife, for example may ensure she does not give birth to an HIV infected child. This approach is consistent with that traditionally taken in venereal diseases legislation,[6] which often required a warning to be given to the fiance of a person infected with a sexually transmitted disease.

The alternative argument is that the characteristics of the AIDS epidemic require greater, rather than less, protection of individual privacy. A guarantee of confidentiality may be essential to ensure that people who are ill are accurately diagnosed, and that those who are asymptomatic seek testing and counselling. Fear that information will not remain confidential may prevent diagnosis of AIDS or related conditions. Patients infected with the virus present with a variety of symptoms including swollen glands, thrush or atypical pneumonias. A doctor who is unaware that the patient has engaged in activities (such as anal intercourse) exposing him or her to the risk of infection may not recognize the desirability of antibody testing and the case may go unrecognized for some time. Individuals who are concerned about preservation of confidentiality may not be prepared to discuss their sexual behaviour with their doctors, particularly in those States where such sexual behaviour remains a criminal offence. Failure to diagnose accurately those infected with the virus may result in further spread of the disease.[7]

Fear that their condition will be disclosed to others may deter some people who suspect they are infected from being tested. This effect is likely to be significant in the context of AIDS because of the stigma and discrimination experienced by those whose antibody status becomes widely known. It seems likely that a general practice of warning contacts would significantly reduce the numbers of people who seek medical help. It is less clear whether the warning of third parties in exceptional circumstances would discourage people from seeking testing or counselling.

Unfortunately there is little empirical evidence bearing upon this difficult policy question. The extent to which preservation of doctor-patient confidence affects the willingness of individuals to seek medical help or to provide information about their sexual behaviour to their

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[6] See for example *Venereal Diseases Act* 1958 (Vic) s 10(2) and (3). Note that the warning was given by the Chief Medical Officer, not the patient's doctor.

[7] See footnote 66.

doctors is not really known. In the United States several studies have attempted to analyse the impact of changes to legal rules governing the obligation of confidentiality which normally exists between the psychotherapist and patient.[8] Perhaps because the general community is often unaware of the precise legal situation, such studies have been unable to demonstrate a reduction in the number of patients seeking psychotherapy following the introduction of exceptions to the duty of confidence. Findings about other effects of these legal changes upon the psychotherapist-patient relationship (such as the frankness of patients during interviews) have also been inconclusive. It is a matter of speculation whether the results of these studies can be extrapolated to the area of AIDS, where patients may have stronger reasons for ensuring that their antibody status remains private.

Those who argue that the normal obligation of confidentiality should apply in cases where a patient is infected with HIV also suggest that breach of this duty may reduce the effectiveness of the counselling offered to infected patients. Behavioural studies suggest that voluntary antibody testing accompanied by counselling is an important strategy in the fight against HIV infection.[9] Individuals who are aware of their antibody status and who have received counselling about the means of avoiding the infection of others seem more likely to refrain from sexual activities which carry the risk of infection than those who have not been tested or counselled.

The level and effectiveness of counselling depends on the personality and skills of the particular medical practitioner. Traditionally the medical curriculum contained little information on sexual behaviour and some doctors find it stressful to discuss these matters with their patients. Where a patient is HIV infected a routine practice of warning third parties could have unexpected consequences. Doctors may feel that their responsibility is discharged by warning the third party, rather than by counselling the patient. But a warning can only prevent the infection of the patient's known sexual partners. In the long run it may be more important to persuade the patient to modify his or her behaviour so that others are protected. Placing emphasis on protecting *known* third parties

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[8] See for example Comment, 'Functional Overlap Between the Lawyer and Other Professionals, Its Implications for the Privileged Communications Doctrine' (1962) 71 *Yale Law Journal* 1226; T Wise, 'Where the Public Peril Begins: A Study of Psychotherapists to Determine the Effect of Tarasoff' (1978-79) 31 Stanford Law Review 165; D Shuman and M Weiner, 'The Privilege Study: An Empirical Study of the Psychotherapist - Patient Privilege' (1982) 60 *North Carolina Law Review* 893.

[9] Ross MW 'The Relationship of combined AIDS counselling and testing, testing, counselling, and no intervention to safer sex and condom use by Homosexual Men' [1988] *Community Health Studies* 12: (In press).

Joseph JG, Montgomery SB, *et al*, 'Magnitude and Determinants of Behavioural Risk Reduction: Longitudinal Analysis of a Cohort at Risk from AIDS', (1987) 1 *Psychology and Health*, 73.

from infection may be an ineffective means of preventing the spread of the virus.

Finally, it has been suggested that reliance on the warning of third parties as a means of preventing spread of the virus overlooks the vital role of community education. Public campaigns have now ensured that the vast majority of the community is aware of the risk of infection and the means of avoiding it. In these circumstances it may be counter-productive for doctors to adopt a *general practice* of warning known third parties who may be infected by the patient. Instead it may be more important to reinforce the view that all members of the community should protect themselves. The same objection cannot necessarily be made to the warning of a third party in exceptional circumstances, for example where the third party mistakenly believes that his or her sexual partner is monogamous and could not be infected with the HIV virus.

The purpose of this article is to discuss three areas of the law which bear upon these issues. These are -

* The statutory provision relevant to confidentiality.
* The extent of the duty of confidence which exists between doctor and patient.
* The tortious liability of a doctor who fails to warn a third party.

The difficult policy questions outlined above are relevant to each of these problems.

2. STATUTORY PROVISIONS

Legislation in all Australian jurisdictions requires reporting of certain contagious and infectious diseases. These provisions enable health authorities to map the extent and distribution of disease, to reach conclusions about its aetiology, to ensure that patients receive proper treatment, and where necessary, to isolate them to prevent the spread of infection. Following diagnosis of the first AIDS cases in Australia, all States and Territories amended health legislation to require notification of AIDS. In some jurisdictions this was extended to cover lymphadenopathy syndrome (a group of symptoms suffered by some people infected with the AIDS virus) and/or the condition of having antibodies to the HIV virus.[10]

[10] NSW: *Public Health Act* 1902, s 50G; *Public Health (Infectious and Notifiable Diseases) Regulations* s 34D (AIDS, lymphadenopathy syndrome, antibody positivity).

Vic: The present provisions are found in *Health Act* 1958, s 3. Under Proclamation of 19 December 1984 'Human retro-virus infection, whether or not manifest as Acquired Immune Deficiency Syndrome; Acquired Immune Deficiency Syndrome-Related Complex or Lymphadenopathy Syndrome' is declared an infection disease. See also *Health (Infectious Diseases) Regulations* 1984. Changes to these provisions will be made by the *Health (General Amendment) Act* 1988 (see s 118) and regulations made under that Act. The Act has not yet been proclaimed.

Qld: *Health Act* 1937-1987, ss 5, 60 (AIDS). It appears that s 60 is intended to cover antibody positivity since it provides that 'a person who is shown to have a .. virus ... that

The consequences of notification vary from State to State. Generally inclusion of AIDS or AIDS-related conditions within the scope of health legislation confers certain powers on health authorities which they may exercise in order to prevent the spread of the virus.[11]

In States and Territories with relatively small numbers of AIDS cases, these amendments occurred with little debate. These jurisdictions appear to have assumed that the traditional medical weapons of testing and isolation were the most effective means of halting the epidemic. No special provisions were enacted to ensure that the identity of infected persons did not become known, or to protect them from the discrimination which might occur if their condition were disclosed.[12]

A different approach was taken in New South Wales and Victoria, the States with the largest number of AIDS cases. In these States the medical model for disease control was challenged by groups which argued that the nature of HIV infection, and the discrimination suffered by its victims, required a novel public health response. These groups suggested that

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causes or is likely to cause a particular venereal disease shall be deemed ... to be suffering from that disease'. It is doubtful whether this provision achieves its intended effect, since the antibody test indicates antibodies to the virus, rather than presence of the virus itself.

SA: *Public and Environmental Health Act* 1987, s 30, First and Second Schedule. (AIDS, AIDS-related complex and lymphadenopathy syndrome).

WA: *Health Act* 1911, ss 3, 248. Order in Council, 11 Jan 1985 (AIDS, AIDS-related complex, lymphadenopathy syndrome, HTLV III infection).

Tas: *Public Health Act* 1962, s 3, 13; Statutory Rules, 1983, No 152 (AIDS).

ACT: *Public Health Ordinance* 1928, *Public Health (Infectious and Notifiable Diseases) Regulations* 1980, s 3(1) and (3) (AIDS). Note that s 3(3) is in similar form to Qld, s 60 (see above).

NT: *Notifiable Diseases Act*, s 5, schedule 3 (AIDS).

[11] See for example:

Qld: *Health Act* 1937-1987, ss 53, 56 (requiring a person who suspects he or she is infected to consult a doctor and permitting compulsory examination).

WA: *Health Act* 1911, ss 251, 257 (compulsory examination, testing, isolation, quarantine, or removal to a hospital).

Tas: *Public Health Act* 1962, ss 17, 28 requiring medical examination, isolation, quarantine and removal to hospital.

The results of this automatic extension are often anomalous. For example in WA under Public Health Act 1911, s 251(8) a person with AIDS may be prohibited from leaving the district and under s 265 the owner or driver of a public vehicle which has been used to convey a person with AIDS has an obligation to disinfect the vehicle.

[12] Some of these States specifically require patients' names to be given. See for example

Qld: *Health Act* 1937-1987, s 54(5)(e) but see 59, which enjoins secrecy of 'Every person who acts or assists in the administration of the provisions of the Act relating to venereal diseases'.

ACT: *Public Health (Notifiable and Infectious Diseases) Regulations* 1980, s 4(1), 4A, 4B and schedule.

NT: *Notifiable Diseases Act*, s 8 (where this appears to be implied).

greater emphasis should be placed on counselling infected people and educating the community about the means of avoiding infection. In both these States, support groups for gay men and people with haemophilia played an important role in providing assistance and information to their members during the early stages of the epidemic. AIDS Councils, which originally represented homosexual men but later expanded to cover other groups, lobbied public health authorities and politicians to express the concerns of their members about privacy and discrimination. In Victoria in particular, health bureaucrats and community groups co-operated in designing strategies to fight the epidemic. Inevitably this meant that health authorities were more sensitive to concerns about individual rights.

In New South Wales proposals to require notification of antibody positivity and to create a statutory offence of knowingly transmitting the disease were attacked on the grounds that they would discourage people who suspected they were infected from seeking testing or treatment. Ultimately, the amendments emphasized the importance of counselling as a means of preventing spread of the virus and introduced a procedure to safeguard the privacy of people who were infected. Section 50M of the Public Health Act 1902, introduced in 1985, provides that -

> As soon as practicable after a medical practitioner becomes aware, or acquires reasonable grounds for believing, that any patient whom the practitioner is attending or has been called in to visit has [AIDS, lymphadenopathy syndrome or is antibody positive] the practitioner shall provide the patient with such information concerning the disease as is required to be provided by the regulations.

A medical practitioner who knows or has reasonable grounds to believe that a person has AIDS, lymphadenopathy syndrome, or antibodies to the HIV virus must record certain particulars including the name and address of that person. The medical practitioner is required to notify the case to the Secretary of the Health Department,[13] but the certificate forwarded by the practitioner must not state the name and address of the patient.[14] If the Chief Officer of the Department of Health has reasonable grounds for believing that a person is infected and 'that ascertaining the identify of that person is necessary for the purpose of safeguarding public health' an application may be made to the District Court for an order that the medical practitioner supply the name and address of the patient.[15] Following the disclosure of the name of the infected person, he or she may be confined to hospital or isolated elsewhere.[16] It is an offence for any person who is aware or has reasonable grounds for believing that a person is infected, to disclose any

[13] *Public Health Act* 1902, s 50H; Public Health Regulations, s 34E. A code number is to be used on the prescribed form. The record must be retained for 10 years.

[14] Section 50 I.

[15] Section 50 K, L.

[16] *Public Health Act* 1902, s 32A.

information which would identify that person, except in specified circumstances.[17]

Recent amendments to the Victorian Health Act 1958, (which have not yet come into operation) were also drafted after extensive community consultation. The new provisions represent a careful attempt to balance protection of individual rights against the need to prevent the spread of HIV infection. As amended, section 127 of the Health Act 1958 will penalize a medical practitioner who orders or authorises an antibody test without providing information to the patient about the social and medical consequences of the test, and its possible results. If the test is positive, the results must be communicated by or in the presence of a medical practitioner or a trained counsellor and the infected person must be given information about the medical and social consequences of the test and ways to prevent infecting others.

A medical practitioner who requests an HIV antibody test must not inform the testing laboratory of the identify of the person whose blood is being tested.[18] A person in charge of a laboratory which carries out antibody tests must record certain information about people who are antibody positive but must not keep information which could enable the identification of a person whose blood has been tested.[19] A medical practitioner may be required to supply the Chief General Manager with information about the 'age, sex and category of risk behaviour' of a patient newly diagnosed as infected with the HIV virus but this provision expressly excludes 'particulars by which a patient may be identified'.[20]

The privacy of people who are infected or suspect they may be infected is further protected by a statutory requirement that -

> A person who, in the course of providing a service, acquires information that a person has been or is required to be tested for HIV virus or is infected with HIV, must take all reasonable steps to develop and implement systems to protect the privacy of that person.[21]

Finally, it should be noted that if the Chief General Manager believes that a person is infected with the HIV virus, and is likely to transmit that disease to others, the Chief General Manager may order that the patient be examined or tested or undergo counselling. The Chief General Manager may also order that the person be isolated at the place and in the

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[17] *Public Health Act* 1902, s 50 Q.

[18] *Health Act* 1958 (as amended by *Health (General Amendment) Act* 1988 s 20, inserting s 130(5) in *Health Act* 1958.

[19] Section 130(6).

[20] Section 130 (7).

[21] Section 128.

manner stated by the order.[22] A person who is isolated has a right of appeal to the Supreme Court.[23] Because medical practitioners are not permitted to notify the Chief General Manager of the name and address of a patient, these powers would not normally be invoked as the result of a doctor warning the health authorities about a particular person. However, where a doctor had reason to believe that a patient had been infected as the result of contact with another person, the doctor could notify the health authorities of the identity of that other person (provided he or she is not also a patient) so that the Chief General Manager could order examination and testing. The Victorian provisions clearly reflect the judgment that the protection of doctor-patient confidentiality is an important means of encouraging patients to seek testing and treatment.

South Australia has also enacted new provisions to deal with AIDS. The Public and Environmental Health Act 1987 requires notification of AIDS, AIDS-related complex and lymphadenopathy syndrome, but not antibody positivity.[24] The decision to exclude antibody positivity from the category of 'proclaimed diseases' was based on the concern that this could discourage individuals who suspected they were infected from seeking testing.[25] Where these conditions are notified, no special provisions have been enacted to protect the anonymity of the infected person.[26] The Act contains a general provision requiring a person who acquires medical information relating to another person 'in the course of official duties' to keep that information confidential, except in specified circumstances,[27] but the provision does not appear to bind private medical practitioners. The Health Commission may require a person who is or may be suffering from AIDS, AIDS-related complex or lymphadenopathy syndrome to be medically examined or quarantined, or may require the person to satisfy certain directions.[28] Provision is made for an appeal from such a direction.[29]

Two further points should be noted in this review of statutory provisions. First, several States have created a statutory offence of knowingly transmitting the HIV virus although the form of these provisions is not consistent.[30] Secondly, no State deals expressly with the

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[22] Section 121.

[23] Section 122.

[24] *Public and Environmental Health Act* 1987, s 30, First and Second Schedules.

[25] South Australian Health Commission, *South Australia's AIDS Strategy* (1987), 17.

[26] Health Regulations 1968-1982, s 86 requires notification of name and address.

[27] *Public and Environmental Health Act* 1987, s 42.

[28] *Public and Environmental Health Act* 1987, ss 31, 32, 33.

[29] *Public and Environmental Health Act* 1987, ss 32(3), 34.

[30] Vic: *Health Act* 1958, s 120, inserted by *Health (General Amendment) Act*, 1988.

NSW: *Public Health Act* 1902, s 50N.

Qld: *Health Act* 1937-1987, s 54(12).

SA: *Public and Environmental Health Act* 1987, s 37(1).

power or duty of a medical practitioner to warn a third party who may be infected by contact with a patient. This matter is left to the common law.

3. THE DUTY OF CONFIDENTIALITY

Traditionally, medical ethics have recognized that effective diagnosis and treatment requires trust and candour between doctor and patient. The rationale for this protection is well expressed in *Hammonds v Aetna Casualty and Surety Co*[31] -

> 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 his doctor - even that which is embarrassing, disgraceful or incriminating. To promote full disclosure, the medical profession extends the promise of secrecy ... .

The doctor's obligation of confidentiality is expressed in the modern version of the Hippocratic Oath, contained in the Declaration of Geneva adopted by the World Medical Association - 'I will respect the secrets which are confided to me, even after the patient has died'. Similarly, the 1984 Edition of the Code of Ethics of the Australian Medical Association comments that (subject to certain qualifications discussed below) -

> It is the practitioner's obligation to observe strictly the rule of professional secrecy by refraining from disclosing voluntarily without the consent of the patient (save by statutory sanction) to any third party information which he [*sic*] has learnt in his professional relationship with the patient.
>
> The complications of modern life sometimes create difficulties for the doctor in the application of the principle, and on certain occasions it may be necessary to acquiesce in some modification. Always, however, the overriding consideration must be the adoption of a line of conduct that will benefit the patient or protect his interests.
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> The principle of professional secrecy still applies as between husband and wife but there are times when consent if not actually given by a spouse could be reasonably inferred. The decision whether to divulge the information to the other spouse, when consent has not been obtained, would be a matter for the discretion of the attending practitioner which he must exercise with the greatest care and for which he must accept full responsibility at all times. He must adopt a line of conduct that will benefit the patient and protect the patient's interest. Moreover, if he does anything

[31] (1965) 243 F Supp 793, 801 per Connell, CJ. see also *Pacyna v Grima* [1963] VR 421, 428.

which damages the patient's interest he renders himself liable to an action at law.

Breach of this duty of confidentiality may amount to professional misconduct as illustrated by the recent New Zealand case of *Duncan v Medical Practitioners Committee.*[32]

Despite this ethical obligation the common law does not permit a doctor to refuse to testify in court proceedings about confidential information[33] obtained in the course of treating a patient. There has been considerable discussion about whether this rule should be modified. Those who support extension of privilege to cover the doctor-patient relationship suggest that it would further the public interest by protecting patient privacy, encouraging people to seek medical help and ensuring candour during the course of treatment - arguments which have a reminiscent ring in the context of AIDS.[34] Three Australian States have apparently accepted these arguments by enacting legislation which privileges doctor-patient communications in civil proceedings, subject to some qualifications.[35] The Australian Law Reform Commission, in its Report in Evidence, rejected the arguments in favour of automatically privileging all doctor-patient communications, preferring instead to confer a general discretion on the court to protect communications made in circumstances where one of the parties is under a legal, moral or ethical obligation to keep information confidential.[36]

A patient who is affected by a doctor's disclosure of confidential information has a variety of courses of action available, including breach of contract, negligence, breach of statutory duty, and an action based on the equitable duty of confidence. Although there is no direct authority on the matter, it appears that a term forbidding disclosure without the patient's consent will normally be implied in the contract between doctor and patient.[37] The ethical obligations which have traditionally been

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[32] [1986] 1 NZLR 513 (discussed in more detail below).

[33] *Duchess of Kingston's Trial* (1776) 11 St Tr 198; Australian Law Reform Commission, *Evidence* (Report No 26, Interim) (1985) Volume 2, 247.

[34] The arguments are discussed at length in Australian Law Reform Commission, *Evidence* (Report No 26, Interim) (1985), Volume 1, 509-514. See also S Rodgers-Magnet, 'Common Law Remedies for Disclosure of Confidential Medical Information' in S Rodgers-Magnet and F Steel (eds) *Issues in Tort Law* (1983) 265, 266-278.

[35] Vic: *Evidence Act* 1958, s 28(2).

Tas: *Evidence Act* 1910, s 96(2).

NT: *Evidence Act*, s12.

[36] Australian Law Reform Commission, *Evidence* (Report No 38) (1986), 116-7, Draft Evidence Bill 1987, cl 109.

[37] *AB* v *DC* (1851) 14 Dunlop 177; *Furniss v Fitchett* [1958] NZLR 396, 400. Cf *Tournier v National Provincial and Union Bank of England* [1924] 1 KB 461, 479-481; *Parry-Jones v Law Society* [1969] 1 Ch 1, 7 per Lord Denning MR. See also S Rodgers-Magnet, 'Common Law Remedies for Disclosure of Confidential Medical Information' in F Steel

imposed on doctors, together with the reliance which patients place upon the protection of their privacy, support the view that such a term could be implied by custom.

The equitable duty of confidence may also assist a patient who is seeking a basis for action against the doctor. Although the doctrinal basis for the principle is not entirely clear,[38] for at least the past two hundred years[39] legal protection has been extended to confidential information obtained in the course of certain relationships, including the relationship of doctor and patient.[40] Equity will enforce the duty of confidence even where no contract exists (as for example where the doctor is a salaried employee of a hospital).[41] Some commentators have argued that the principle is now sufficiently developed for breach of confidence to be regarded as a tort,[42] an approach which is increasingly being taken in United States courts.[43]

Whether or not a general duty of confidence is protected by the common law as well as equity, some breaches of doctor/patient confidentiality may give rise to liability in negligence. In *Furniss v Fitchett*[44] Dr Fitchett was the regular medical attendant of Mr & Mrs Furniss. Mrs Furniss believed that her husband was 'doping her' and that he was insane. Not surprisingly, the couple were having matrimonial problems. Dr Fitchett had been asked by Mr Furniss's solicitor whether

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and S Rodgers-Magnet, (eds) *Issues in Tort Law* (1983) 265, 283-4. Cf *Hammonds v Aetna Casualty and Surety Company* (1965) 243 F Supp 793, 801.

38 G Jones, 'The Restitution of Benefits Obtained in Breach of Another's Confidence', (1970) 86 *LQR* 463.

39 For a discussion of the origins of the doctrine see Law Commission, *Breach of Confidence* (1981) (Law Com No 110), Part III.

40 *Halls v Mitchell* [1928] SCR 125, 136; *Furniss v Fitchett* [1958] NZLR 396, 400; *Hunter v Mann* [1974] QB 767, 773; *Slater v Bassett* (1986) 85 FLR 118,121; and see P Finn, *Fiduciary Obligations* (1977), 309.

41 *Prince Albert v Strange* (1849) 1 H & Tw 1; 47 ER 1302; (drawings and etchings kept for private use). *Duchess of Argyll v Duke of Argyll* [1967] Ch 302, 322 (marital confidences); *AG v Jonathan Cape Ltd.* [1976] 1 QB 752, 769-770 per Lord Widgery (details of Cabinet meetings); *Foster v Mountford* (1977) 14 ALR 71 (Aboriginal secrets). Quaere whether a contract exists between doctor and patient where the patient is 'bulk-billed' under Medicare arrangements.

42 PM North advances this view in 'Breach of Confidence, Is there a New Tort?' (1972) 12 *Journal of Society of Public Teachers of Law* 149. See also S Ricketson 'Confidential Information - A New Proprietary Interest?' (Part II) (1978) 11 *MULR* 289, 296, where the relevant case law is ably analysed.

43 The doctrinal basis for the principle in the United States is also unclear see 'Breach of Confidence: An Emerging Tort' (1982) 82 *Columbia Law Review* 1426; see also 'To Tell or Not to Tell: Physicians' Liability for Disclosure of Confidential Information About a Patient' (1982-1983) 13 *Cumberland Law Review*, 617 and for an interesting recent case *Humphers v First Interstate Bank of Oregon* (1985) 696 P2d 527.

44 [1958] NZLR 396.

Mrs Furniss could be certified, but had indicated she was not sufficiently ill to justify committal. Dr Fitchett was approached by a distraught Mr Furniss who wanted a medical report on his wife's mental state to give to his solicitors. After some thought he wrote Mr Furniss a report indicating that Mrs Furniss was suffering from delusions and exhibiting symptoms of paranoia. Later this report was introduced by the husband's lawyer in separation proceedings. As a result of this sudden disclosure of her doctor's opinion of her medical condition Mrs Furniss suffered from nervous shock and brought an action against the defendant seeking damages to negligence.

Barrowclough J expressed the view that a contractual relationship existed between plaintiff and defendant and that the contract contained an implied term requiring confidentiality but his judgment in favour of the plaintiff was not based on this ground. Relying on the general *Donoghue v Stevenson*[45] principle, he held that Dr Fitchett could have foreseen that the provision of the certificate to Mrs Furniss' husband would harm her and accordingly he owed the plaintiff a duty not to harm her by releasing confidential medical information. Hence he was liable for her nervous shock. By analogy, a patient who suffered nervous shock as the result of the disclosure of his or her HIV infection to a third party could cite *Furniss v Fitchett* in support of a claim for damages.

Where the breach relates to infection with the HIV virus, an action for breach of statutory duty may also be available. It has been seen that New South Wales and Victorian legislation requires information relating to AIDS to be kept confidential. Section 50Q of the New South Wales *Public Health Act* 1911 provides that -

> A person who, because of the operation of this Part, is aware or has reasonable grounds for believing that another person has a proclaimed disease shall not disclose any information which may identify the other person except -
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> (a) with the consent of the other person;
> (b) where it is necessary to do so in connection with the administration of execution of this part;
> (c) where ordered to do so by a court or by any other body or person authorised by law to examine witnesses; or
> (d) in such circumstances as may be prescribed.
> Penalty: $2,000.

Arguably, breach of this provision could confer a right of civil action. It is conventionally stated that the availability of a remedy for breach of a statutory duty depends upon the court's view of the intention of the

[45] [1932] AC 562.

legislature, revealed by the language of the legislation,[46] although this approach has been criticized as a legal fiction.[47] Industrial safety legislation is generally presumed to confer private rights,[48] but courts have been less willing to take the same approach to other regulatory provisions.[49]

It is difficult to predict when courts will be prepared to hold that a statutory provision confers a private right of action. Matters which have been said to assist in establishing that a statute confers private rights have included the fact that the provision prescribes a specific precaution for protecting the safety of others in an area where there is already a general duty of care,[50] the fact that the statute is designed to protect a specified group of individuals, rather than the community as a whole[51] and the fact that the provision imposes particular, rather than general, duties.[52] It has also sometimes been said that courts will presume that a fine or other penalty for non-observance, raises a presumption against civil liability, although this presumption has also been criticized.[53] None of these factors are decisive and policy considerations probably determine the final outcome. One writer has commented that -

> The courts can and do pick and choose amongst [the principles] and manipulate them to reach results on grounds not usually expressed even if they exist.[54]

The purpose of section 50Q is to protect the privacy of a particular class of individuals, (those tested for or infected with the HIV virus) rather than to protect the privacy of the community as a whole. This would support the argument that the section confers a private right to sue for damages. The precision of the obligations imposed on medical practitioners by the New South Wales legislation would also assist a plaintiff seeking to claim damages under the statute. The privacy requirements contained in the Victorian Act are less clearly defined and it

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[46] *Sovar v Henry Lane Pty Ltd* (1967) 116 CLR 397, 405 per Kitto J. For a general discussion of actions for breach of statutory duty see F Trindade and P Cane, *The Law of Torts in Australia* (1985), Ch 22.

[47] See for example H Luntz, D Hambly and P Hayes, *Torts, Cases and Commentary* (2nd ed 1985), 532.

[48] *O'Connor v SP Bray Ltd* (1937) 56 CLR 464, 478 per Dixon J.

[49] Cf *Cutler v Wandsworth Stadium* [1949] AC 398.

[50] *O'Connor v SP Bray Ltd* (1937) 56 CLR 464, 478 per Dixon J.

[51] *Phillips v Britannia Hygienic Laundry* [1923] 2 KB 832, 838 per Bankes LJ but cf Atkin LJ at 841.

[52] *Cutler v Wandsworth Stadium* [1949] AC 398, 417 per Lord Reid.

[53] *Haylan v Purcell* (1949) 49 SR (NSW) 1 and see also *O'Connor v SP Bray Ltd* (1937) 56 CLR 464, 486 per Evatt and McTiernan JJ; *Phillips v Britannia Hygienic Laundry Co.* [1923] 2 KB 832, 838-9 per Bankes LJ; *Sovar v Henry Lane Pty Ltd* (1967) 117 CLR 397, 405.

[54] F Trindade and P Cane, *The Law of Torts in Australia*, 583.

may be more difficult to argue that a Victorian doctor who warns a third party is in breach of a particular statutory duty.

Although there are a variety of actions open to a plaintiff complaining of breach of doctor-patient confidentiality, the available remedies are less satisfactory. In some cases the patient may become aware that the doctor proposes to warn a third party. Subject to normal equitable principles an injunction may be available to restrain a threatened breach of confidence[55] whether that action is based on a breach of an implied contractual term, the equitable duty of confidence, or *(semble)* breach of statutory duty.[56]

The situation is more difficult for a patient who discovers that a doctor has already breached the duty of confidence by warning a third party. Where the action is based on breach of an implied term in the contract, damages will be assessed on a contractual basis and could include financial harm suffered by the patient as a result of the disclosure. In the case of AIDS however, the patient is more likely to be concerned about mental distress and embarrassment caused by the breach. Generally speaking contractual damages do not include a component for mental stress or embarrassment[57] but some inroads have been made into this principle in recent years.[58] Where the very purpose of the implied contractual term is to protect the privacy of the patient and to prevent the embarrassment which may occur when personal facts are revealed, it is strongly arguable that damages could include a component for mental distress.[59] If, however, the action was based on negligence (as in *Furniss v Fitchett*) or breach of statutory duty, damages could not include a component for

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[55] *Duchess of Argyll v Duke of Argyll* [1967] 1 Ch 302; *Foster v Mountford* (1977) 14 ALR 71; *Fraser v Evans* [1969] 1 QB 349, 361 per Lord Denning MR. Of course the injunction may be refused in the exercise of the court's discretion; see for example *Woodward v Hutchins* [1977] 1 WLR 760.

[56] Cf *Duchess of Argyll v Duke of Argyll* [1967] Ch 302, 341.

[57] *Fink v Fink* (1946) 74 CLR 127, 144.

[58] McDonald, Greig and Davis, *The Law of Contract* (1987), 1412; *Jarvis v Swan Tours* [1973] QB 233; *Athens-McDonald Travel Service Pty Ltd v Kazis* [1970] SASR 264.

[59] Cf *Silberman v Silberman* (1910) 10 SR (NSW) 554; *Heywood v Wellers* [1976] QB 446. In the first of the cases the court held that a wife was entitled to recover damages for breach of a non-molestation clause contained in a separation deed, although she suffered no pecuniary loss.

In the second case, the plaintiff recovered in an action for breach of contract against a legal firm, the employee of which had failed to take effective action to prevent a third party from molesting the plaintiff. Again damages covered the mental distress and upset suffered by the plaintiff.

Note that in *Woodward v Hutchins* [1977] 1 WLR 760, 764 per Lord Denning MR, 765 per Bridge LJ, it was suggested that damages would be appropriate in a contractual action for breach of confidence where the information was 'personal'.

mental anguish unless this caused the patient some physical harm or nervous shock.[60]

The situation is less clear when the patient's claim is based on the equitable duty of confidence. Remedies for breach of equitable duty reflect its historical origin and are generally designed to prevent the defendant profiting from the breach of confidence. They are not particularly useful when the information is not of commercial value. Such remedies include an action for account of profits; damages in addition to or substitution for an injunction under *Lord Cairns' Act*;[61] and possibly damages awarded independently of *Lord Cairns' Act*.[62] There is no authority on whether such damages could include a component for the mental distress which the disclosure has caused the plaintiff.

The duty of confidentiality is not unqualified. Exceptions include disclosures made with the patient's consent, disclosures required by statute or court order,[63] disclosures made for the purposes of protecting the patient,[64] and disclosures which are 'in the public interest'. The exception in favour of disclosures required by law would not assist a doctor who warned a third person that a patient was infected with the HIV virus. State notification requirements discussed above require doctors to provide information to health authorities, but none of these provisions *require* the warning of third parties.

In some cases (for example where a patient has brain lesions as the result of infection with the HIV virus) the doctor may argue that warning a third party is necessary for the protection of the patient or is in the patient's interest, since if the patient's judgment had been unimpaired he or she would have wished to protect that third party. This argument

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[60] *Hinz v Berry* [1970] 2 QB 40, 42; *Re Gollan* (1979) 21 SASR 79.

[61] Note that Meagher, Gummow and Lehane, *Equity - Doctrines and Remedies* (2nd Ed, 1984), 617, argue that damages under *Lord Cairns Act* are not available when the right in question is purely equitable but cf *Talbot v General Television Corporation Pty Ltd* [1980] VR 224. For a very good general discussion of the area see Ricketson, 'Confidential Information - a New Proprietary 'nterest?' (1977) 11 *MULR* 223, 290 ff. Even if it is accepted that *Lord Cairns' Act* permits the award of damages for breach of the *equitable* duty of confidence it is not entirely clear whether damages can be awarded where the court, in the exercise of its discretion, would refuse an injunction (for example because the disclosure has already been made, so that an injunction is futile). *Malone v Commissioner of Police No 2* [1979] 2 All ER 620 suggests that an injunction would not be available in such circumstances. For the contrary argument see F Gurry *Breach of Confidence* (1984), 430 ff.

[62] *Seager v Copydex No 1* [1967] 2 All ER 415; *Seager v Copydex No 2* [1969] 2 All ER 718 but see F Gurry, *Breach of Confidence* (1984), 435.

[63] *Hunter v Mann* [1974] QB 767.

[64] Australian Medical Association, *Code of Ethics* (1984) para 6.2.2. No direct authority exists on this proposition, but the ethical exception would presumably be applied by the courts.

might succeed in an extreme case, but would not seem to justify a breach of confidentiality in the majority of situations.

The 'public interest' exception gives the court a greater opportunity to balance the competing demands of the patient to have his or her privacy protected, and the need to protect the public from harm. Early cases established that equity will not protect confidences relating to actual or contemplated crimes or frauds, since 'there is no confidence as to the disclosure of iniquity'.[65] This restriction on the duty of confidentiality exists whether the action for breach of confidence is based on an equitable duty of confidence or upon an implied contractual term. However it is available only where disclosure is made to a person with a proper interest in receiving the information. For example in the case of a contemplated criminal offence, it may be proper for the confidant(e) to inform the police, rather than to make the information available to the public or warn the victim.[66]

Regrettably, involvement in homosexual acts remains a criminal offence in Tasmania, Western Australia and Queensland[67] and all States criminalize intravenous drug use. Deliberate or reckless infection of a third party may amount to murder and would also be covered by statutory provisions making it an offence to infect third parties.[68] Thus a patient who tells a doctor that he has been involved in homosexual acts in the past, or intends to inject illegal drugs in the future, is confessing to an actual or contemplated criminal activity. Nevertheless, it may be argued that the doctor should not have breached the confidence by warning the third party, but rather by notifying the health authorities or the police.

Reliance on the 'crime' aspect of the public interest exception seems both distasteful and unrealistic. Patients are unlikely to deliberately intend to infect others, and even if they form such an intention, they will not confide it to their doctors. The fact that homosexual acts are illegal in some States should not be the decisive factor which determines whether a doctor can warn a third party without attracting legal liability. For our purposes the important question is whether the 'public interest' exception extends to cover warning a third party that a patient is infected with the HIV virus. Unfortunately, case law does not provide a clear answer.

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[65] *Gartside v Outram* (1857) 26 LJ Ch 113, 114 per Wood V-C; see also *Weld-Blundell v Stephens* [1919] 1 KB 520 (where the principle was not extended to include a confidential communication which was libellous); *Malone v Commissioner of Police No 2* [1979] 2 All ER 620; *Kelly v Hawkesbury Pty Ltd No 3* (1988) ACLD 199.

[66] *Initial Services Ltd v Putterill* [1967] 3 All ER 145, 148 per Lord Denning MR citing *Gartside v Outram* (1857), 26 LJ Ch 113, 114 per wood, V-C; *Malone v Commissioner of Police No 2* [1979] 2 All ER 620, 634.

[67] WA: *Criminal Code* ss 181, 184.

Tas: *Criminal Code Act*, 1924, ss 122, 123.

Qld: *Criminal Code*, ss 208, 211.

[68] See footnote 29.

Defamation law may provide some assistance on this issue. A doctor who provides inaccurate information about a patient to a third party may invoke the defence of qualified privilege if he or she is sued for defamation. This defence requires the defendant to establish that he or she was under a legal, social or moral duty to make the statement and that it was made to a party who had a corresponding interest in receiving it.[69] In the 1925 Ontario case of *C v D*[70], a false statement that a patient was likely to be infected with syphilis was held to come within the doctrine of qualified privilege. In that case the doctor was the family physician of the woman's employer and told the employer that precautions should be taken to prevent infection of the family. He also told the woman's father that she must attend for treatment. Communication to the employer was privileged because the woman was a domestic servant, and warning was regarded as necessary to prevent spread of the disease to other members of the household, while notifying her father was regarded as necessary to ensure that she was examined and treated. While the decision reflects an outdated view of the powers and responsibilities of fathers *vis a vis* their daughters, it suggests that warning a third party that a patient is infected with a sexually transmitted disease could be justified in the public interest.

A more rigorous approach was taken to the protection of doctor-patient confidence in the leading Canadian case of *Halls v Mitchell*,[71] where the issue of protecting third parties did not arise. The plaintiff, Halls, worked for the Canadian National Railways, and applied for workers compensation after he suffered an eye ailment which he ascribed to a blow from a swinging door. His condition was assessed by Mitchell, the assistant chief medical officer for the railways. Halls had been Mitchell's patient some years previously, and Mitchell incorrectly interpreted his own records as indicating that Halls had told him that he had previously suffered from a venereal disease. Halls communicated this information to *inter alia* an army doctor from whom he was seeking information about Halls' medical record whilst in the army, and to an independent physician who was examining Halls for the purposes of his claim. As a result, Halls' workers compensation claim was unsuccessful. On an action for defamation brought by Halls the court rejected the doctor's claim of qualified privilege. Duff J delivered a judgment which strongly asserted the principle of doctor-patient confidentiality.[72]

> Nobody would dispute that a secret so acquired is the secret of the patient, and normally, is under his control, and not under that of the doctor. *Prima facie* the patient has the right to require that the

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[69] J Fleming, *The Law of Torts* (7th ed, 1987), 538.

[70] [1925] 1 DLR 734, 738. The case is criticized in G Sharpe, *Law and Medicine in Canada.*

Note that a false statement that a person is infected with a sexually transmissible disease is actionable without proof of damage.

[71] [1928] SCR 125.

[72] [1928] SCR 125, 136.

> secret shall not be divulged; and that right is absolute, unless there is some paramount reason which overrides it. Such reasons may arise, no doubt, from the existence of facts which bring into play overpowering considerations connected with public justice; and there may be cases in which reasons connected with the safety of individuals or the public, physical or moral, would be sufficiently cogent to supersede or qualify the obligation *prima facie* imposed by the confidential relationship.

There was no necessity for Mitchell to disclose information about Halls' medical condition in the course of seeking army records. Nor was there any justification for the comments to the independent physician, which had gone far beyond what was necessary to obtain his medical opinion. Mitchell's duty to ensure that the Workmen's Compensation Board received accurate information did not require him to betray professional confidences to third parties.

In the cases with which we are concerned, defamation will not normally be an available cause of action, since the basis of the patient's complaint is that the doctor has accurately disclosed the patient's condition to a third party.[73] Nevertheless the court may argue by analogy from the qualified privilege defence for the purpose of determining the extent of the public interest exception.

When the issue arises in the context of an action for breach of confidence English courts have tended to take a relatively broad view of the extent of the public interest exception[74] and dicta in several cases suggest that breach of confidence may be justifiable where it is necessary to protect the public from medical danger. In *Hubbard v Vosper*[75] for example, the Court of Appeal (Lord Denning MR, Megaw and Stephenson LJJ) refused an interlocutory injunction based on a claim for breach of copyright and breach of confidence where the publication in question exposed the cult of scientology. Lord Denning MR suggested that it might be in the public interest to expose 'medical quackeries'[76] which could be dangerous to the public, but Megaw LJ preferred to rest his decision on the fact that the plaintiff did not come to equity with clean hands. In *Beloff v Pressdram Ltd*[77] Ungoed-Thomas J took a more restricted view of the extent of the public interest exception, commenting

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[73] In some States both truth and 'public interest' must be established as a defence to defamation.

[74] For the first example of this extension see *Initial Services Ltd v Putterill* [1967] 3 All ER 145 and for the high water mark of this approach see *Woodward v Hutchins* [1977] 1 WLR 760. There is no direct authority on the disclosure of information relevant to public health, but a number of dicta suggest that the public interest exception could operate in these circumstances.

[75] [1972] 2 QB 84, see also *Church of Scientology v Kaufman* [1973] RPC 635.

[76] [1972] 2 QB 84, 96.

[77] [1973] 1 All ER 241, 260.

that it did not 'extend beyond misdeeds of a serious nature and importance to the country ... recognisable as such'. Nevertheless he explicitly recognised that disclosure of matters medically dangerous to the public[78] could be in the public interest. In similar vein in *Schering Chemicals Ltd v Falkman Ltd*[79] Lord Justice Shaw commented that -

> if 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.[80]

Australian courts have taken a less generous view of the scope of public interest,[81] but again dicta suggest that it may be in the public interest to disclose matters 'medically dangerous to the public'.[82]

Further light on the question is provided by the 1986 decision of the New Zealand High Court in *Duncan v Medical Practitioners Committee*[83] Duncan was a medical practitioner in a small country town who had treated Henry, the local bus-driver, for heart trouble. Eventually Henry had a triple coronary by-pass operation and after he recovered his surgeon gave him a certificate enabling him to renew his licence to drive buses. Shortly before Henry proposed to take the bus on a charter trip, he was phoned by Duncan who told him he should not drive. Apparently Duncan was unaware that Henry had obtained the medical certificate from his surgeon. Even before this conversation, Duncan had told a passenger that Henry should not be driving because of his medical condition. Later he attempted to persuade the police to withdraw the licence, and asked another patient to organize a petition to have Henry barred from driving.

Henry complained about the breach of confidence to the Medical Disciplinary Committee which held that Duncan was guilty of professional misconduct. Upon an application to review, the Committee's view of the law was upheld by Jeffries J in the High Court of New Zealand, although

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[78] *Ibid.*

[79] [1981] 2 WLR 848, 869.

[80] In that case the Court of Appeal did not accept that the public interest required the use in a television programme of confidential information relating to a drug which allegedly caused birth deformities, where the drug had already been withdrawn from the market. Cf also *Distillers Co (Biochemicals) Ltd v Times Newspapers Ltd* [1975] 1 All ER 41, 48-52.

[81] In *Castrol Australia Pty Ltd v Emtech Associates Pty Ltd* (1980) 33 ALR 31, 53-57. Rath J criticized the view that the public interest extended so far as to include a general interest in 'the truth being told', an approach which had been advocated by Lord Denning in *Woodward v Hutchins* [1977] 1 WLR 760. He preferred the more rigorous approach of Ungoed-Thomas J in *Beloff v Pressdram Ltd* [1973] 1 All ER 241. See also Meagher, Gummow and Lehane, *Equity - Doctrines and Remedies* (2nd Ed, 1984), 835 - 836.

[82] *Castrol Australia Pty Ltd v Emtech Associates Pty Ltd* (1980) 33 ALR 31, 55.

[83] [1986] 1 NZLR 513.

Duncan succeeded in the High court on procedural grounds.[84] In the course of his judgment Jeffries J discussed the extent of the confidentiality principle, including the circumstances in which it might be proper for a doctor to warn a third party. In his words[85] -

> 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 upon 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 can be confident any official inquiry will be by people sympathetic about the predicament he faced. However, that qualification cannot be advanced so as to attenuate, or undermine, the immeasurably valuable concept of medical confidence. If it were applied in that way it would be misapplied, in my view, because it would be extravagant with what is essentially a qualification to the principle. Some might say that is line-drawing and if they do then so be it. The line-drawing is not arbitrary but based upon reason and experience, and is the exercise of professional judgment which is part of daily practice for a doctor.

Although Jeffries J accepted that disclosure might be justified to protect another person's life, he emphasized that communication should be confined to exceptional circumstances, and 'to a responsible authority'.[86] Duncan had breached confidentiality by warning a passenger and by approaching another patient, rather than by warning the responsible authorities. The Committee had not erred in holding him guilty of professional misconduct.

A court which was called upon to determine whether it was in the public interest for a doctor to warn the sexual partner of a patient infected with the AIDS virus would need to weigh the importance of protecting that individual from the possibility of contracting a potentially fatal disease, against the importance of preserving doctor/patient confidentiality in the circumstances of the AIDS epidemic.[87] The

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[84] The Disciplinary Committee appealed against this aspect of the judgment and succeeded in the Court of Appeal. [1986] 1 NZLR 513, 537.

[85] [1986] 1 NZLR 513, 521.

[86] *Ibid.*

[87] Cf *Castrol Australia Pty Ltd v Emtech Associates Pty Ltd* (1980) 33 ALR 31, 53; *Lion Laboratories Ltd v Evans* [1984] 2 All ER 417, 422-423. It should be noted that a different approach is taken to the use of confidential government information. Courts will not normally restrain the disclosure of government information unless disclosure will *harm* the public interest. See *AG v Jonathan Cape Ltd* [1976] 1 QB 752; *Commonwealth of Australia*

arguments in favour of protection of the therapeutic relationship have been discussed above. The outcome of a claim for breach of confidentiality would depend on the precise circumstances in which the disclosure that a person was infected with the AIDS virus was made to the third party. In the majority of cases, where the doctor has no reason to believe that the patient will act in such a way as to infect others, disclosure may not be justified. Because of the stigma and discrimination often associated with AIDS, breach of confidentiality may have serious consequences for the patient (for example loss of employment and marriage breakup) without providing any appreciable benefit to other. As is recognized by the New South Wales and Victorian legislation, counselling the patient on the consequences of illness and the risk and means of transmission of the virus may be a more effective means of preventing its spread than notifying his or her known sexual partners.

The ethical dilemma for the doctor is more acute if he or she has evidence suggesting that the patient is continuing to behave in such a way that others are exposed to the risk of infection. This may occur when the patient refuses to accept that he or she is infected with the virus or when brain lesions caused by the disease have affected the patient's judgment. Although this hypothetical hard case is unlikely to be litigated the courts would be reluctant to hold a doctor liable for warning a third party when there is no other practical way of protecting that person from infection. But even in this situation, it will be relevant for the court to consider the statutory provisions which have been enacted to prevent transmission of the AIDS virus. The court may take the view that the doctor should inform the health authorities enabling them to exercise their powers of isolation, rather than take the step of warning a particular individual. Sympathy for a medical practitioner in this difficult situation of ethical conflict should not be regarded as justifying a wide public interest exception authorising doctors to warn routinely the sexual partners of those who are infected with the HIV virus. It may be preferable to provide special legislative procedures capable of dealing with exceptional cases, rather than to take the view that the life threatening character of the disease justifies a general departure from the confidentiality principle.

Finally, it should be noted that there is some doubt about the effect of the public interest exception. Almost all the reported cases concern claims for interlocutory or final injunctions to restrain publication of confidential information. It is not clear whether the public interest defence applies in an action for damages for breach of contract or is simply a discretionary matter to be taken into account by the court in the

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v John Fairfax and Sons Ltd (1981) 147 CLR 39, 51-52 per Mason J; *A-G (UK) v Heinemann* (1987) 75 ALR 353, 416, 420 per Kirby P, 454 per McHugh JA

Some of the English cases come close to this approach, even for non-governmental information: see for example *Woodward v Hutchins* [1977] 2 WLR 760 at 764.

exercise of its equitable jurisdiction.[88] However, it has been held that it is not a breach of an implied term of contract to disclose a confidence relating to actual or contemplated crime.[89] By analogy, similar reasoning could apply to a breach of confidentiality justified on the grounds of 'medical danger'. There seems to be no scope for the introduction of a public interest exception to an action for breach of statutory duty.[90] The relative inflexibility of the action for breach of statutory duty, and its inability to take account of a public interest defence, could influence courts to hold that statutory confidentiality requirements do not give rise to civil rights of action.

4. TORTIOUS LIABILITY FOR FAILURE TO WARN

Subject to a public interest exception of uncertain width, the previous section suggested that a doctor who warns a third party that a patient is infected with the HIV virus may be in breach of his or her duty of confidence. This section discusses whether a doctor who is aware that a patient is antibody positive owes a duty of care to third parties so that failure to protect them from infection may give rise to liability in negligence. If such a duty does arise, and if the public interest exception to the duty of confidentiality is interpreted narrowly, the doctor is confronted with an insoluble dilemma. Warning the third party may give rise to an action for breach of confidence. Failure to do so may expose the doctor to liability for negligence. Obviously this result would be indefensible.

There are conceptual difficulties in resolving the potential conflict between a patient's right of confidentiality and a doctor's duty to protect third parties, in the context of an action for negligence. Some torts are structured in such a way as to permit the balancing of public rights and interests against the rights of the plaintiff. In defamation, for example, the defence of qualified privilege requires the court to consider whether the importance of protecting the plaintiff's reputation is outweighed by the public interest in permitting certain kinds of communication.[91] By contrast, in a negligence action, the competing arguments in favour of protecting confidentiality or requiring the doctor to take action to protect third parties are likely to be addressed when the court is determining whether the doctor owes the third party a duty of care. The arguments in favour of protecting confidentiality (and hence not requiring the doctor to warn third parties) are based on public interest considerations. The defendant doctor is likely to suggest that observance of the duty of confidence is essential to prevent the spread of the HIV virus, since it will

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[88] In *Woodward v Hutchins* [1977] 2 WLR 760, 764 Lord Denning MR suggested that the plaintiff might have a remedy in damages, despite the refusal of an interlocutory injunction.

[89] Cf *A v Hayden* (1984) 156 CLR 532, 551, per Mason J 563 per Murphy J

[90] But cf the US case of *Simonsen v Swenson* (1920) 9 ALR discussed in S Rodgers-Magnet, 'Common Law Remedies for Disclosure of Confidential Medical Information' in F Steel and S Rodgers-Magnet (eds), *Issues in Torts Law* (1983), 265, 297.

[91] JG Fleming, *The Law of Torts* (7th ed, 1987), 133.

ensure that infected individuals are not deterred from seeking testing and counselling. If the court is persuaded by this argument it necessarily accepts that the interests of the infected third party must be sacrificed to the wider community interest in halting the epidemic. Australian and English courts may be reluctant to articulate the policy considerations relevant to denying or extending liability,[92] instead preferring to state their reasons in more formalistic terms. Even if it is held that the doctor owes a duty to the third party, arguments relating to standard of care and causation may be used as the basis for refusing recovery. The latter arguments are not discussed in detail in this paper.

The main basis for denying liability is likely to be the common law's traditional reluctance to impose duties of affirmative action.[93] This principle would act as a barrier to a third party who sought to recover damages for a doctor's failure to warn. The distinction between positive action which injures others, and inaction, which simply fails to prevent harm, lies in the historical origins of torts law, but can also be defended on policy grounds. Three justifications have been advanced in support of the principle.[94] First, it is sometimes difficult to identify the particular individual who should be liable. (For example, this would be the case where a crowd watched a person being attacked without intervening or calling the police.) This objection is irrelevant to the case where a doctor who is treating an AIDS patient fails to warn a third party. Secondly, it is often argued that the law should not require people to act altruistically. The second objection gains strength where the discharge of a duty to act positively requires the defendant to expose himself or herself to physical injury or expense. Again this argument has limited relevance to the failure of a doctor to warn a third party, unless at the same time that such a duty was imposed, the doctor were also to be held legally liable to the patient for breach of confidentiality. Thirdly, there are often greater difficulties in establishing a causal link between inaction and a consequent harm, than in establishing a connection between positive action and injury. These difficulties may be seen as justifying a relatively broad denial of liability for inaction. This third argument has greater relevance to the doctor's duty to warn, since it may be difficult to prove affirmatively that the third party would have acted differently if the warning had been given. However this difficulty could be overcome by holding that a duty to warn does arise, and determining the issue of causation at a later stage of the proceedings.

Despite the general reluctance of the common law to impose duties of affirmative action, it has been recognized that the special nature of the relationship between the defendant and another person may require the defendant to protect that person from injury, or to prevent that person

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[92] See however, *McLoughlin v O'Brian* (1983) 2 AC 520; *Jaensch v Coffey* (1984) 58 ALJR 426.

[93] H Luntz, D Hambly and D Hayes, *Torts - Cases and Materials* (2nd ed, 1985), 793

[94] H Luntz, D Hambly and D Hayes *Torts - Cases and Materials* (2nd ed, 1985), 426-7.

from injuring others.[95] Thus, for example, it has been held that parents must exercise reasonable care in supervising the activities of their children, to prevent them from harming others[96], that schools have a similar duty of care in relation to their students[97], that prison authorities must take reasonable care to prevent prisoners from injuring other prisoners, or from escaping and causing harm to others in the vicinity of the prison[98], and that mental health authorities owe a duty to those who may be injured as a result of negligence in controlling a patient.[99]

For our purposes, the question is whether the relationship between doctor and patient, or doctor and third party gives rise to a duty to take positive action to prevent the third party from being infected by the patient. The common theme which appears to link the situations described above is that the defendant has some practical ability or legal rights to control the action of the person to prevent that person causing harm to third parties.[100] Prison authorities, for example have the legal right to control, discipline and confine the inmates of prisons. By contrast doctors do not normally have the right to control the behaviour of patients outside mental institutions, a factor which could influence the court to hold that no duty is owed to third parties.

A number of United States cases have held that a doctor is liable to a third party who has contracted an infectious disease such as tuberculosis or smallpox as the result of nursing or living in the same house with a patient. None of these cases have concerned a disease transmitted by sexual contact. In some of these decisions liability to the third party has been based upon the negligent failure of the physician to diagnose the disease accurately, or to warn the patient of the infection, so that the patient is ignorant of his condition and cannot avoid infecting others.[101] In other decisions liability has been based on the doctor's failure to advise family members or those nursing the patient that the disease was infectious, or how infection should be avoided.[102] These cases do not

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[95] JG Fleming, *The Law of Torts* (7th ed, 1987) 135 ff.

[96] *Smith v Leurs* (1945) 70 CLR 256.

[97] *Carmarthenshire County Council v Lewis* [1955] AC 549; *Richards v State of Victoria* [1969] VR 136; *Johns v Minister of Education* (1981) 28 SASR 206.

[98] *Ellis v Home Office* [1953] 2 All ER 149; *L v Commonwealth* (1976) 10 ALR 269; *Home Office* v *Dorset Yacht Co Ltd* [1970] 2 All ER 294.

[99] *Underwood v United States* (1966) 356 F2d 92. Cf *Holgate v Lancashire Mental Hospitals Board* [1937] 4 All ER 19.

[100] See for example *Home Office v Dorset Yacht Co Ltd* [1970] 2 All ER 294, 307 per Lord Morris, 321 per Lord Pearson; *Perl v Camden London Borough Council* [1984] 1 QB 342, 349 per Waller LJ; 354 per Olliver LJ

[101] *Hofmann v Blackmon* (1970) 241 So 2d 752; *Wojcik v Aluminum Company of America* (1950) 183 NYS 2d 351. Cf *Heafield v Crane, The Times*, 31 July 1937.

[102] *Davis v Rodman* (1921) 227 SW 612 (physician attending a typhoid fever patient had a duty to notify nurses of the nature of the disease, the danger of infection and the means of avoiding it);

consider whether the doctor owes a duty to a third party where the patient is aware of the nature of the illness and able to take steps to avoid infecting others. However an analogous issue arose in the Californian case of *Tarasoff v Regents of the University of California.*[103]

In that case a student, Prosenjit Poddar, had been treated for a mental health condition as an outpatient at the University hospital. In the course of psychotherapy Poddar told his psychologist, Moore, that he intended to kill an unnamed woman when she returned from overseas. This woman could have been identified by Moore as Tatiana Tarasoff. Moore decided that Poddar should be committed to a mental hospital for observation, and asked the campus police to take him into custody. Poddar was detained by the police, interviewed, but released when he promised to keep away from Tatiana. Later Moore's superior asked the police to return Moore's letter requesting their assistance, directed that copies of the letter and Moore's clinical notes should be destroyed, and ordered that no action should be taken to place Poddar in custody. Two months later Poddar murdered Tatiana. Her parents brought an action for wrongful death against the campus police, the psychologists and the University Regents. The California Superior Court held that the psychotherapists had no duty to warn or protect third parties, so that the claim disclosed no cause of action. The plaintiffs appealed to the Supreme court of California which, in *Tarasoff No 1*[104] reversed this decision, holding that the psychotherapists owed a duty to warn Tatiana, or others who could be expected to warn her, about Poddar's threats. This duty arose from the special relationship between the therapists and Poddar and also from the fact that the defendant therapists had take affirmative, but ineffectual, steps to control Poddar. Following criticism of its decision, the Supreme Court took the unusual step of granting a petition for rehearing filed by the defendant and several *amici*. In the second hearing the court did not rely on the affirmative action taken by the therapists as the basis for a duty of care, preferring to rely on the existence of the special relationship of psychotherapist-patient as the source of the duty. In wider terms than those used in *Tarasoff No 1*, the majority held that a psychologist who was aware, or should have been aware that a patient presented a serious risk of danger to another, had a duty to take reasonable care to protect the intended victim. Depending on the circumstances, this duty could be discharged by warning the victim, notifying the police, or confining the patient. The psychologists were protected from liability for failing to confine Poddar, by a statutory provision conferring immunity in relation to

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Skillings v Allen (1919) 173 NY 663 (physician held liable for negligently advising parents that it was safe to visit a child suffering from scarlet fever and to take her home. Parents unaware of danger of infection);

Jones v Stanko (1928) 160 NE 456 (physician owed a duty to inform family and neighbours nursing a patient with smallpox, of the nature of the disease and the danger of infection). Cf *Evans v Liverpool Corporation* [1906] 1 KB 160.

103 (1976) 551 P 2d 334.

104 (1974) Cal Rptr 129.

commitment decisions, but this provision did not protect them against liability for their failure to warn. The Supreme Court did not determine the issues of breach or causation and the case was remanded for further proceedings.

In the Supreme Court, Trobriner J, delivering the majority judgment, accepted that the common law does not generally impose a duty on one person to control the conduct of another or to warn those who might be endangered by such conduct, but recognised an exception where 'the defendant stands in some special relationship to either the person whose conduct needs to be controlled or in a relationship to the foreseeable victim of that conduct'.[105] By analogy to the decisions concerning infectious diseases (discussed above) he held that the relationship between psychologist and patient gave rise to a duty to protect third parties from harm caused by the patient.

Trobriner J rejected several policy arguments against the imposition of liability. The defendants relied on Section 5328 of the Californian Welfare and Institutions Code which provided that -

> all information and records obtained in the course of providing services ... to either voluntary or involuntary recipients of services shall be confidential.[106]

Although the section enumerated a number of exceptions, these did not authorize the warning of a third person. Trobriner J interpreted the provision narrowly, holding that 'services' did not cover the psychotherapy provided by Moore. The majority was not prepared to interpret the confidentiality provision in the *Code* as governing the disclosure of all information flowing between patient and therapist.

It was also argued that public interest demanded the protection of patient-therapist confidences. Trobriner J accepted that patients often made threats of violence which were never carried out and that effective psychotherapy required patients to confide in their therapists. Nevertheless he held that the desirability of protecting the therapeutic relationship between patient and psychologist was outweighed by the necessity to protect third parties from harm. In his words -

> In this risk-infested 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. If the exercise of reasonable care to protect the threatened victim requires the therapist to warn the endangered party or those who can reasonably be expected to notify him, we can see no sufficient societal interest

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[105] (1976) 551 P 2d 334, 343.

[106] Cited in (1976) 551 P 2d 348.

> that would protect and justify concealment. The containment of such risks lies in the public interest.[107]

In reaching this view Trobriner J found support in a provision of the *Californian Evidence Code* which privileged communications between psychotherapists and their patients, but excluded from this privilege communications made to protect the patient or others from danger.

An *amicus curiae* brief expressing the views of the American Psychiatric Association and other professional bodies argued that it was impossible for mental health experts to predict whether patients would act violently.[108] Implicitly, this suggested that a duty of care should not be imposed, since in the absence of an ability to predict violence, there was no standard against which the performance of a psychologist could be measured. Trobriner J rejected this reasoning, stating that psychologists were required to exercise the degree of skill of the reasonable psychologist.

Clark J delivered a strong dissenting judgment.[109] In his view the legislative scheme governing mental health services in California reflected a clear policy judgment that therapist patient confidences should be protected. Section 5328 of the *Code* (extracted above) required psychologists to protect the privacy of patients except in specified circumstances. The imposition of a general duty to protect third parties would impose 'a Draconian dilemma on therapists - either violate the act thereby incurring the attendant statutory penalties, or ignore the majority's duty to warn thereby incurring potential civil liability'.[110]

Clark J was persuaded by the argument that effective treatment of mental illness required preservation of a relationship between the patient and psychologist in which thoughts, fears and fantasies could be revealed in an atmosphere of trust and confidentiality. The invasion of this therapeutic relationship would discourage patients seeking treatment, and, where treatment was sought, would result in a greater number of patients being confined to mental institutions involuntarily. In the long run, such a duty would run contrary to the public interest by 'frustrating treatment, invading patient rights and increasing violence'.[111] Thus 'overwhelming

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[107] (1976) 551 P 2d 334, 347.

[108] (1976) 551 P 2d 334, 344.

[109] Mosk J concurred in the result but dissented from some of the propositions in the majority judgment. In his view the therapist owed a duty of care to Tarasoff because Poddar actually threatened violence. He was not prepared to accept the majority view that the duty arose where a propensity to violence *should have* been predicted. On this issue he argued that it was impossible to apply a reasonable psychiatrist standard because predictions of violence were inherently unreliable.

[110] (1976) 551 P 2d 334, 358.

[111] (1976) 551 P 2d 334, 358.

policy considerations mandate against sacrificing fundamental patient interests without gaining a corresponding interest in public benefit'.[112]

Clark J's arguments resemble the policy approach advanced by those who oppose the imposition of a duty to warn third parties that a patient is HIV infected. Indeed, the case for protecting psychotherapist-patient confidences may be stronger, since an effective therapeutic relationship may lead to cure of the patient, whilst treatment of HIV infection can only alleviate symptoms and does not prevent the patient infecting others. On the other hand, people with HIV infection may be more concerned about privacy, and less prepared to discuss their sexual behaviour with their doctor, if their privacy is not protected.

Although the *Tarasoff* decision has been vigorously criticized by lawyers and health professionals, it has been followed and extended in the United States. Some State courts have held that the psychologist's duty of care is owed only to people named by the patient or readily identifiable as potential victims. In other States it has been decided that the duty extends to all persons foreseeably endangered by the patient's conduct. In Lipari v Sears, Roebuck & Co for example, the United States District Court for the District of Nebraska held that a psychiatrist was liable to the clients of a night club, who were injured or killed by a patient. Consistently with the majority approach in Tarasoff the duty of care has been held to arise in cases where the patient did not actually threaten violence, but where a tendency to violence was foreseeable. Some States have responded to this judicial expansion of the duty to warn by enacting legislation protecting mental health professionals from liability.

For our purposes, the question is whether Australian courts would follow the *Tarasoff* decision or any of the earlier decisions which impose a duty on doctors to give warnings about contagious diseases[117] and apply these principles to a case where a patient is infected with the HIV virus. English and Australian courts have tended to take a more conservative approach to the extension of liability for negligence than their American counterparts. The principles of duty of care, standard of care, and causation may be manipulated in order to deny recovery.

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112 (1976) 551 P 2d 334, 355.

113 For a recent review of the decisions following *Tarasoff* see GM McLarren, 'The Psychiatrists Duty to Warn: Walking a Tightrope of Uncertainty'. (1987) 56 *University of Cincinnati Law Review* 269.

114 497 F Supp 185, 194 (N Neb 1980) cited in GM McLarren, 'The Psychiatrists Duty to Warn: Walking the Tightrope of Uncertainty' (1987) 56 *University of Cincinnati Law Review* 269, 275. See also the other cases cited in the article.

115 (1976) 551 P 2d 334, 345.

116 See GM McLarren, 'The Psychiatrists Duty to Warn: Walking the Tightrope of Uncertainty', (1987) 56 *University of Cincinnati Law Review*, 269, 286 ff.

117 See footnotes 1 and 2.

A number of factors may be relevant in determining the outcome of such a case. The nature of the relationship between the doctor and the third party is likely to be influential. If the third party is the spouse or known sexual partner of the HIV infected individual, and is also a patient of the doctor, the court may take the view that this doctor-patient relationship imposes a duty of affirmative action on the doctor. Similarly, if the third person is a surgeon, to whom the HIV infected patient has been referred by the defendant, the defendant may be held to owe him or her a duty of care. In this situation, the most appropriate course of action for a doctor may be to refuse to provide a referral unless the patient authorizes disclosure. Where the third party is a physician, so that the likelihood of infection is remote, such a duty may not arise, or it may be held that a reasonable doctor would not regard it as necessary to give a warning. Legislative provisions protecting the privacy of people with HIV infection may be used as the basis for refusing to impose a duty of care, although similar reasoning was not regarded as persuasive by Trobriner J in *Tarasoff*.[118]

If a duty of care is held to arise, it will be necessary to determine how the duty should be discharged. In the States which do not prohibit disclosure of the name of HIV infected people (Queensland, Western Australia, Tasmania and South Australia) it is arguable that the doctor takes reasonable care by notifying the health authorities, so that they can take appropriate action. This may relieve the doctor from any further duty to warn third parties. This approach is not open in Victoria and New South Wales, where disclosure of the name of an infected individual is prohibited. In these States public health authorities may become aware that a person is behaving in such a way as to infect others only after transmission has occurred. These States have made the policy judgment that counselling of people who are antibody positive is the most effective means of preventing the spread of the HIV virus. Such statutory provision should be taken into account by a court determining the question of duty of care. It would be unfortunate if a doctor who satisfied the statutory obligation of confidentiality was also to be held liable to a third party for failure to warn.

5.CONCLUSIONS

This article has described the complex legal and policy issues which arise in considering the extent of the doctor's responsibility in relation to a patient infected with the HIV virus. Unfortunately there are major uncertainties in this area of the law. Because the scope of the public interest exception is not clear, there are doubts as to whether a doctor could be held liable to a patient for breaching the duty of confidence. Similarly, it is not clear whether a doctor in Australia could be held liable for failure to take steps to protect a third party from infection by a patient, whether by warning or by requesting the authorities to exercise their power of isolation.

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[118] (1976) 551 P 2d 334.

On balance the author believes that courts should not take the view that HIV infection requires routine breach of confidentiality to permit warning of third parties. Emphasis should be placed on counselling the patient, and notifying third parties should only be regarded as justifiable in exceptional circumstances. It may be preferable for the health authorities, rather than individual doctors, to determine when this approach is warranted.

It follows that courts should be reluctant to impose any duty on a doctor to warn a third party, particularly in light of the statutory provision in force in New South Wales and Victoria. If such a duty were imposed it would be necessary to determine how it should be discharged. In this area, the 'reasonable doctor' test does not appear to be particularly helpful. There are professional standards against which the treatment of a patient can be measured to determine whether a doctor has behaved negligently. However there is no consensus among the medical profession on the approach to be taken in warning third parties. Some doctors are likely to take a rigorous approach to doctor-patient confidentiality, while others may believe that warning a third party is justified. In the absence of a 'reasonable doctor' standard it is difficult to support the imposition of a duty. One issue which would arise in resolving questions of standard of care is whether a doctor could be held liable for a failure to protect the third party on the basis that he or she should have predicted that the patient would act irresponsibly, or whether liability would be limited to the case where the doctor *knew* that the patient was not taking precautions to avoid infecting others. A requirement that the doctor should make a judgment about the likelihood that the patient would infect others is open to the same criticisms which the American Psychiatric Association made of the *Tarasoff* decision.

It is unsatisfactory that doctors are placed in a situation where their legal obligations are not clear. Health authorities should consider clarifying the answers to these questions by legislation. A possible approach would be to establish an ethics committee with lay and medical members. Doctors could resort to the committee to determine whether it was proper to warn a third party. A decision by the committee that such a warning was in the public interest should be sufficient to protect the doctor from legal liability for breach of confidence.