MEDICAL CONFIDENTIALITY AND THE PUBLIC DISCLOSURE OF HIV STATUS

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Whatever, in connection with my professional practice or not, in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret. (Hippocratic Oath).[1]

In the Pacific Islands the public disclosure of the names of people infected with HIV has, at various times, been proposed as a sound response to the threat of HIV,[2] most recently by a Member of Parliament in Solomon Islands. The news report covering the statement said 'Dr Aumanu said if health authorities continue to hide the identity of the people living with HIV/AIDS, then the disease will continue to be secretly and privately transmitted.'[3] Such proposals, however, violate the privacy of people living with HIV/AIDS. (PLWHA)

This article provides a comparative study of medical practitioners' duty of confidentiality concerning HIV/AIDS in Pacific Island Countries (PICs) and the UK and Australia. The paper intends to analyse the conditions under which medical practitioners can disclose confidential information in different jurisdictions. This is done with a view to identify a possible approach the PICs should take regarding this matter. The research only look at some PICs, namely; Papua New Guinea, Vanuatu, Kiribati, Solomon Islands, Samoa and Fiji.

THE DUTY OF CONFIDENTIALITY GENERALLY

What Constitutes Confidential Information

Confidential information is defined as information disclosed to another in circumstances which give rise to a duty on the part of the confidant not to make unauthorised disclosure of information.[4] Information may be expressly made confidential by agreement. The nature of the relationship between the people (such as a doctor patient or lawyer client relationship) or the subject matter and the circumstances in which the information has come in the hands of a person may also make information be classified as confidential.[5] Protection of confidentiality applies to personal information and information of a private nature, even though the disclosure of this type of confidential information may not lead to pecuniary loss.[6] Incomplete information that may nonetheless give away someone's identity is also confidential.[7]

The legal basis of medical practitioner's duty of confidentiality

The legal basis of the duty to maintain confidentiality arises from both statute and common law. Statutes can make it an offence to disclose patient's information to a third party, while in common law the duty developed in cases where patients sued medical practitioners who have allegedly disclosed confidential information without justification.[8]

Under common law, it has been suggested that the medical practitioner's legal duty to maintain confidentiality is founded in three areas; contract law, equity and torts. In contracts, there exists an express or implied contractual duty of confidentiality between the medical practitioner and the patient. This contractual duty encourages patients to disclose information so that medical practitioners can provide effective health care.[9] In other words, there is a trust in which the doctor will not pass on any information disclose to him, unless prior consent has been granted.[10] Lord Denning stated in the*Parry-Jones* case[11] that

> [the] law implies a term into the contract whereby a professional man is to keep his client's affairs secret and not to disclose them to anyone without just cause.

As a result of this contractual duty, medical practitioners owe a duty of confidentiality to their patients. It is clear that patients have a right of expectation that medical practitioners will not pass on any personal information that they learn in the course of their professional duties, unless the patient gives permission.[12] However, this contractual duty does not apply to public hospitals and doctors who work there. [13]

The duty of confidentiality also exists in equity. It arises when the patient relies in the good faith on the medical practitioner to keep what has been disclosed between them confidential.[14] The rationale behind equitable intervention is that one should not benefit from information that has been received in confidence. The duty of confidentiality exists in equity where

1. the information has the necessary quality of confidence about it,

2. it was given in a situation importing an obligation of confidence, and

3. there was unauthorised use of that information.[15]

In torts law, the duty of confidentiality is considered part of the medical practitioner's duty of care in the law of negligence. It is established under torts law that there is a general duty on the medical practitioner not to cause foreseeable harm to another person that may result in damage. *Furniss v Fitchett*[16] illustrates the use of negligence to obtain a remedy for breach of confidentiality. In this case, the plaintiff (Mrs Furniss) sued her doctor (Dr. Fitchett) for breached of confidentiality. The doctor had disclosed confidential information about the plaintiff to her husband, which was later produce in court against the plaintiff by the husband's solicitor. The judge concludes in this case that:

> [the doctor] ought reasonably to have foreseen that the contents of his certificate were likely to come to the patient's knowledge and he knew that if they did, they would be likely to injure her in her health.

<u>Limits to the duty of confidentiality</u>

However, the duty of confidentiality is not absolute, but rather one that is subject to limitations.[17] As suggested by Justice Everleigh in *Gillick v Norfolk and Wisbech Area Health Authority and Another,*[18] the duty is subject to exceptions which should be maintained at all times. The extent to which these exceptions can be exercised is not clearly identified. It all lies in the ability and judgment of the medical practitioner. Three situations were identified by MacFarlane and Reid which justify the disclosure of confidential information which may be contrary to the express wishes of the patient.[19] The first situation is where statute makes provisions requiring medical practitioners to disclose information concerning a patient. There are statutes that provide statutory rights for certain individuals or bodies to have access to confidential information. A common example is where a statute may require a medical practitioner to

notify the officer of the local authority whenever he is made aware or suspects that a patient is suffering from one of the diseases in a list of notifiable disease.[20]

The second exception to the duty of confidentiality arises where there is an overriding public duty to disclose.[21] Medical practitioners have a common law duty to disclose information to the public if failure will expose the public to a serious risk of death or harm.[22] For example, confidential information may be disclosed where there is a possible threat that the infected person may make attempts to infect other members of the public. Through disclosure of the information, members of the public maybe protected from the risk of death or harm, or the occurrence of any serious crime. In occasion like this, relevant medical authorities may disclose information concerning the health status of the patient to the required bodies or individuals that are entitled to the information.

It was held in the *Tarasoff* case[23] that the failure to disclose information to the required persons has resulted in serious injuries to members of the public. In this particular case the psychiatrist and his employer where held liable for negligence when a client informed the psychiatrist of an intention to assault a third party, which he eventually carried out. The psychiatrist failed to advise the third party despite having knowledge the intended assault. The*Tarasoff* case was discussed at great length in *W v Egdell,*[24] where the court held that a medical practitioner who had slightly relevant information about a patient's condition was justified in passing information to the relevant authorities of a patient's intention to harm a third party.

The third situation in which disclosure of information will not amount to a breach of the duty of confidentiality is where information is sought by a court order.[25] A failure by the party required by the court to disclose information would amount to a contempt of court. These requirements are regulated by legislative provisions.[26]

IMPORTANCE OF THE DUTY OF CONFIDENTIALITY WITH REGARDS TO HIV/AIDS

The duty of confidentiality is important because it encourages people to voluntarily come forward to seek treatment or advice from medical practitioners. The importance of protecting confidentiality was noted in the English case *X v Y*[27]:

> ...in the long run, preservation of confidentiality is the only way of securing public health; otherwise...individual patients will not come forward if doctors are going to sequel on them.[28]

McClelland[29] argues that:

> ...without promises of confidentiality patients are far less likely to share the private and sensitive information required for their care.

It is important that while the law sets out to protect public health, it must also take measures to protect the individual to allow him or her to come forward for testing and any available treatment.[30] The success of the different policies depends entirely on the mutual respect for the confidentiality of the patient care information that flows from the patient to the medical practitioner. For example, a medical practitioner cannot diagnose a patient unless the patient provides all the relevant information. However, relevant information can only be provided if a patient has confidence that such information will not be disclosed.[31]

Also the duty of confidentiality is important because of its assistance in preventing discrimination against

people living with HIV/AIDS. As noted by Godwin, HIV infection brings with it a risk of stigma and discrimination which is not present with the other diseases.[32] The knowledge of a people's HIV status may lead to inferences about their sexual habits, drug taking habits, or social contacts. People living with HIV/AIDS may lose certain benefits when their identity is made known. For example, a direct community result is rejection of the known HIV infected person by members of the community.[33] Besides this, Farmer[34] further argued that there is a likelihood that HIV/AIDS infected people will face a lot of problems, either within their families or communities. These problems include the loss of housing, loss of jobs, and rejection by family members and friends.[35]

Circumstances existing in PICs that give rise for the need to develop the Duty of Confidentiality.

1. Customary Circumstances

In PICs matters of a sexual nature are not openly discussed or talked about in the family or community.[36] People living with HIV/AIDS face severe condemnation for having engaged in activities that are perceived as "anti-custom". HIV is still sometimes perceived as foreigners' disease, and this can also strengthen the notion that becoming infected is against tradition.

Further, under indigenous custom it is difficult to maintain privacy. In Samoa, for example there is a customary duty that requires sharing of information with other members of the society.[37] In other words there is customary duty for members of the public to know about the welfare of a member of the community. This custom contradicts the principles of the duty of confidentiality.

2. Religious Circumstances

There are beliefs that acquiring the disease HIV/AIDS is a punishment by god for wrongs committed. Therefore a situation where information regarding the HIV status of a person is disclosed to the public can lead to religious condemnation, and ostracising of that person. Churches can resist prevention campaigns, particularly those relating to condom use which goes against certain religious teachings. In Solomon Islands the Ministry of Health took a bold stand by rejecting calls from religious groups to ban the campaigns promoting the use of condoms to avoid HIV infection and other diseases.[38]

On the other hand, because of growing awareness, other churches began to work with other Organisations to fight against the spread of HIV/AIDS in the Pacific. The Seventh Day Church approved a Strategic Framework for Action in a meeting held in June 2003.[39]The Church acknowledges its failure to recognise the 'growing reality' and help prevent its impact on the society. The Church called upon its members to address the concerns:

> ...compassionately and intelligently in their homes, places of work and worship, schools and training institutions, clinics and hospitals.[40]

In April 2004 participants of the Pacific Churches Consultation on HIV/AIDS endorsed the open discussion of HIV.[41] Despite such statements by religious leaders, though, on a grassroots level religious condemnation still remains one of the main factors posing a threat to the welfare of people living with HIV/AIDS in the PICs.

3. Social and Economical Circumstances

The smallness of PICs' social structure and societies make it difficult to live with a known HIV status, compared to larger countries where a HIV positive person could remain anonymous despite his or her identity or information being disclosed to the public. In Fiji, for example, people living with HIV/AIDS

tend to live double lives. As MacAlister[42] discovers, people infected with HIV tend to live quite lives with their families. The main fear that they face is the reaction of the community if their HIV status is made known. Such reaction includes rejection from the community. Similar reactions can be identified for all the PICs as well. The small populations and close family networks found in PIC societies make it very difficult to maintain confidentiality. Therefore, strict maintenance of the duty of confidentiality is vital for the survival of HIV infected people in the PICs' communities.

PACIFIC ISLAND COUNTRIES' (PICs) LEGAL APPROACH TO HIV/AIDS

As discussed above, there are limits to the general duty of confidence. The legislature can prescribe limits, courts can order the disclosure of confidential information, and medical practitioners can disclose confidential infomration if, in their judgment, there is an overriding public interest to do so. A failure to protect confidentiality, as discussed above, hinders HIV management efforts as it reduces individual's willingness to gain access to testing and treatment. It should therefore be clear that general public disclosure of names of PLWHA does not serve any public interest, and is therefore in breach of the duty of confidentiality.

There is, however, justification for a much more limited exception to the duty of confidentiality. The most difficult area for practitioners is, maybe, deciding whether the duty of confidentiality overrides the public interest in notifying the spouse of an HIV positive patient. This tension arose in *Mr X v Hospital Z.*[43] There the Supreme Court of Canada held that although the doctor-patient confidentiality was important and is an integral part of medical ethics; a patient's right to confidentiality was not enforceable in a situation where the patient is HIV positive, and he or she stood the risk of spreading it to his or her prospective spouse. Since the outcome of HIV can be fatal, and the life of the spouse must be saved, the court concluded that the right to privacy of the patient is not absolute in situations like this and may be restricted.

Given the difficulties that circumstances in PICs create in relation to HIV, it makes sense that legislatures take the lead in defining more precisely exactly how far an HIV positive person's right to confidentiality extends. So what does the law in PICs say?

PICs have no specifically developed legal approach towards the issue of HIV/AIDS. Nearly all the public health laws are remnants of colonial laws and policies.[44] Therefore, the laws are inappropriate to the growing issue of managing HIV/AIDS. The *Regional Strategy for the Prevention and Control of STD/AIDS in Pacific Island Countries and Territories*[45] highlights the need to include law reform as one of the measures PICs should take in responding to HIV by stating that:

> ...policies and laws that are based on an ethic of compassion for people infected with HIV will increase the effectiveness of prevention programmes. Alienating people with HIV breeds indifference and low self-esteem, creating perfect conditions for the spread of the virus, and discouraging voluntary changes in behaviour. A supportive social and legal environment encourages people infected with HIV and/or STD and people whose behaviours might put them at risk of HIV and STD, to respond to education campaigns and resources, and to make use of services such as STD clinics and counselling.

The same call was raised in Guideline 3 of the *International Guidelines on HIV/AIDS and Human Rights*[46] which states that:

> States should review and reform public health legislation to ensure that they adequately address the public health issues raised by HIV/AIDS, that their provisions applicable to casually transmitted diseases are not inappropriately applied to HIV/AIDS and that they are

> consistent with international human rights obligations.

Therefore, PICs have been encouraged to identify and review laws that are inappropriate or inadequate for the reduction of the disease HIV/AIDS. There have not been wide scale legislative changes, however. The current status of PICs in relation to their public health acts are stated in the following subsections.

Papua New Guinea

Papua New Guinea identified its first HIV positive case in 1987[47] and to this day it has the highest number of HIV positive people in the region.[48] There are a number of health policies and developments in law with regards to HIV/AIDS in the country.

Legislation and Health Policies

The Medical practitioners *Medical Code of Ethics* of PNG states that medical practitioners owe a duty of absolute secrecy to patients for information confided to them.[49]The existing *Public Health Act*[50] of PNG does not provide any specific provision in respect to HIV/AIDS; instead it has provisions that dealt with infectious diseases,[51] venereal diseases,[52] and other special provisions for diseases such as typhoid, Hansen's disease, and malaria. It is both an offence and a professional misconduct under the *Public Health Act* for a medical practitioner to disclose particulars of a person suffering from a venereal disease other than in accordance with the Act.[53]

A specific Bill called the *HIV/AIDS Management and Prevention Bill 2002* was drafted in 2002, and later passed by Parliament in 2003.[54] This Act has not yet been gazetted, however, so has not been commence. The preamble states that the Act was purposely made to give effect to the basic rights that were stated in the Preamble of the Constitution.[55] It revokes the application of the*Public Health Act* by stating in section 3 that HIV infections and AIDS are not infectious or venereal diseases.[56]

Section 18 makes provisions for the confidentiality of information. It states that

> [a] person who during the course of his duties, acquire information about the HIV status of another person shall take reasonable steps to prevent disclosure of such information to any other person.

Subsection *18 (2)* provide exceptional circumstances whereby information can be disclosed. These exceptions include where, *(a)* consent has been granted;[57]*(b)* by order of a court; and *(c)* where information is only required for statistical purposes, and to the extent authorised by the Act or any other laws.

The *Act* also provides for partner notification. The medical practitioner may notify the sexual partner of the HIV infected person on occasions where, *(a)* the person infected with HIV requested that the partner be notified;[58]*(b)* where in the opinion of the medical practitioner the person infected with HIV posed a real risk to his or her sexual partner;[59] or *(c)* where the person is dead or unconscious to give consent.[60]

Besides the laws, there are various health policies and strategies that were created on HIV/AIDS with regards to confidentiality. For example, there is a National Strategy for HIV/AIDS control in the country which draws various ways of approaching the problem. The National AIDS Council is responsible for the implementation of these strategies and policies.[61]

Vanuatu

Vanuatu recorded its first HIV positive case in September 2002.[62] Based on the earlier strategic plans, the Department of Health had worked on a policy and strategic plan for 2003-2007 which was released in early 2003. The authorities recognise the damage that the disease will have on the population of Vanuatu if appropriate measures are not taken.

Legislation and Health Policies

Vanuatu still has no legally enforceable *Public Health Act*; though two attempts had been made with two separate Public Health Acts, none has been fully gazetted yet. One of them, the *Public Health Act* of 1994 did make some reference to HIV/AIDS by including it in the definition of notifiable diseases in schedule 1.[63] Article 11, which deals with notifiable diseases provides for compulsory testing on any person suspected with the disease. Similarly, Article 13 provides for infected people to notify owners of premises such as shops and buses of their notifiable disease status before entering these premises or vehicles. Only parts of this Act have ever been gazetted, however, and the sections relating to notifiable diseases have yet to come into force.[64]

A draft Act called the *Public Health Act 2000* was prepared in 2000. The Bill makes specific reference to HIV, especially in sections 13 to section 23. This include HIV/AIDS education,[65] confidential testing for HIV,[66]duty of the STD counsellor upon learning of a positive HIV test result,[67] duty to inform the sexual partner of HIV status,[68] and work place testing for HIV.[69]However, due to lack of support from politicians the Bill is yet to be passed by Parliament and gazetted.[70]

Both the parts of the *Public Health Act* of 1994 that relate to HIV and the *Public Health Bill* of 2000 are only proposals that are yet to be passed and gazetted. Therefore, at present Vanuatu is still without any public health laws in this area, unless any laws were adopted from England at the time of Independence.

The Department of Health formulated a National HIV/AIDS policy and strategic plan for 2003-2007, which built on the 1988 strategic plan.[71] Confidentiality is one of the big areas highlighted in that policy statement. It states that it should be a government policy that notification of cases of HIV/AIDS be made without disclosing the names of the HIV/AIDS infected people.[72] The rationale of such policy is to maintain the confidence established between the medical practitioners and HIV/AIDS patients.

Kiribati

The Secretariat of the Pacific Community report for 31st December 2001 reported that there are a total of 38 HIV/AIDS cases in Kiribati.[73]

Legislation and Health Policies

Kiribati has no existing law or legal framework with respect to HIV/AIDS. The *Public Health Ordinance*[74] does not have any provision relating to HIV; nor does it provide provisions for disclosure of confidential information. It provides means of notification of infectious diseases, but it is mainly on sanitary diseases. The only guidelines that are currently being enforced are base on existing laws with respect to human rights and medicinal ethics.[75] Therefore, Kiribati relied on the duty of confidentiality that is implemented in the Code of Practice of Medical Practitioners of Kiribati for the protection of patient information.

Solomon Islands

At the end of 2002 Solomon Islands had reported no new cases since it reported its first HIV case in 1995.

However authorities acknowledge that poor screening facilities may conceal the real situation.[76] The news of the first HIV case was met with public anger, but the authorities were able to calm the anger, while it maintained the identity of the victim secret.[77]

Legislation and Health Policies

Following the uproar, the government adopted a policy of repatriation of expatriates that are found to be HIV positive.[78] Similarly, foreign nationals that are found to be HIV positive are not allowed into the country.

Solomon Islands has adopted various national AIDS policies. The policies, inter alia, uphold the duty of confidentiality concerning patient information and conditions. The 1978 *Public Health Act*[79] does not include specific provisions for HIV/AIDS, though there are provisions on venereal disease and notifiable diseases. It also authorises doctors and health workers to do what is appropriate for the patient and the public interest. Besides the respect for confidentiality provided in the *Public Health Act*, the *Medical Practitioners Code of Practice*[80] of Solomon Islands respect and uphold the patient's right to confidentiality.

The Ministry of Health and Medical Services of Solomon Islands launched it first Strategic Plan on HIV/AIDS and other STD diseases in August 2003.[81] It provides a clear plan of action for the country's future in combating the disease. This involves the recognition of the duty of confidentiality as an important aspect of the doctor-patient relationship.

Samoa

Samoa recorded it first HIV case in 1990. By the fall of 2001 the country had recorded a total of 12 reported HIV cases.[82]

Legislation and Health Policies

Samoa still holds on to its 1959 *Health Ordinance*. The Act was amended and gazetted in 1988 with the inclusion of HIV/AIDS in the list of infectious diseases. Various provisions within Part VI of the Act made special provisions which deals mainly with infectious disease. Sections 29 and 36 gives power to the Director of Health to give orders wherever necessary to require people to submit themselves for medical examination, to isolate them or to detain them until such a time when they are cured. [83]

Samoa developed the National HIV/AIDS Prevention and Control Program in 1987. The aim of this program is to promote public awareness about HIV/AIDS.[84] A National AIDS Co-ordinating Council and technical AIDS Committee was established in 1987 and 1988 respectively to co-ordinate the prevention of the spread of HIV/AIDS in Samoa. However, it is sad to note that confidentiality of information is not included in the theme values emphasised by the National HIV/AIDS policy.[85]

Fiji

Fiji detected it first HIV case in 1989 and by August 2002 the Ministry of Health has reported about 104 HIV/AIDS.[86] However, there is feeling that this figure could be higher than estimated, given the fact that sex related issues are still considered a taboo and cannot be discussed openly.

Legislation and Health Policies

Fiji has no specific legislation that deals with HIV/AIDS. As in other Pacific Island Countries, the primary

focus of the *Public Health Act*[87] is on the control of infectious and venereal diseases. HIV/AIDS is not mentioned or even referred to in the Schedule as an infectious disease.

Fiji also faces similar challenges as other PICs with laws relating to HIV/AIDS. Justice Fatiaki summarised the situation in Fiji by stating that;

> [the] law reform, particularly in the Health field, has been subject to procrastination, bringing in its wake a reluctance to what is in place and a total disregard of the role of law in the Health Sector...the two priorities in the health law field are to review and update the laws and to allocate adequate resources for their effective implementation[88]

The National Strategic Plan for HIV/AIDS and STDs was implemented in 2002.[89]The duty of confidentiality was recognised as one of the key elements surrounding HIV testing of people. The rationale behind this is to strengthen the public trust that people have in the medical service and encourage people to come forward for testing.

Weaknesses in the laws

The weaknesses of the laws range from human rights abuses to the lack of specific recognition of the disease HIV/AIDS. In cases where HIV/AIDS has been included as an infectious disease the provisions are inappropriate with regards to HIV/AIDS and give rise to the potential for human rights abuses. For example, notifiable diseases laws give permission for the Director of Health to make orders to detain or isolate people with infectious diseases. The fundamental issue is for how long will people with infectious diseases be detained or isolated. For other infectious diseases such as gonorrhoea, a person is able to live a normal life after being cured. However there is no cure for AIDS. And if strictly applying the provision of the *Public Health Act*, people living with HIV/AIDS may be shut out from everybody and the community for the rest of their lives.

In countries that have clear Codes of Ethics for medical practitioners the duty of confidentiality is left entirely on the good will of the medical practitioner to maintain. There is little legal backing to ensure the Code is adhered to.

Even Papua New Guinea, that has a new model law, has not commenced this law yet, so effectively there is no change in the laws there, as yet.

Are there any Cases dealing with HIV/AIDS in PICs?

So far none of the PICs has any existing case law that deals with HIV/AIDS and the duty of confidentiality. A USP Project team doing studies on that area confirmed that there are still no case laws dealing with HIV/AIDS in the Pacific.[90] The research was conducted for PICs, which inter alia, include Fiji, Kiribati, Samoa, Solomon Islands, PNG, Tonga, and Vanuatu. Therefore, PICs still have no case law to test the legal status of HIV patients in the court.[91]

This does mean that there is no breach of the duty of confidentiality regarding HIV/AIDS information. There are incidences that may occur, but the people involved may not know what procedures to take in reporting these issues. For example, one Fijian health worker stated that there is evidence that there have been several cases of breach of confidentiality concerning hospital staff disclosing information relating to the HIV status of individuals. However, these individuals will not seek redress on such occasions for fear of further discrimination.[92]

THE UK AND AUSTRALIAN APPROACH

United Kingdom

The UK *Public Health (Infectious Disease) Regulations (12)* of 1985 does not make any reference to HIV/AIDS as a notifiable disease. The reason is that the disease is not particularly infectious. To do so would definitely place unacceptable restrictions on those infected.[93] For example, the nature of infectious diseases differs from HIV/AIDS in the sense that they can be cured, making restrictions temporary. On the other hand, reference was made to HIV/AIDS in the *Public Health (Control of Disease) Act* of 1984. The Act allows *exceptional circumstances* of compulsory examination of patients that are believed to have HIV/AIDS. Patients that are tested HIV/AIDS positive will be taken to hospitals and detained.[94]

The UK *General Medical Council Guidelines* permits the disclosure of confidential information where *'public interest'* demands it.[95] In this instance, a public interest is something done for the interest of the society as a whole as compared to specific sectors of the community or individuals.[96]However there are steps that must be taken by the doctors prior to any form of disclosure. These steps include persuading the HIV/AIDS patient to tell those at risk of his or her status, or otherwise give consent for the medical practitioner to do it on his or her behalf. Also the medical practitioner is required to look at the probabilities of risk against the patient's interest and the risk to other individuals.[97] For instance, where a medical practitioner is certain that the non-disclosure of the confidential information poses a real risk of harm to other parties, he or she should take measures to warn them. This often applies to the spouses of those with HIV/AIDS when they are at a risk of contracting the disease themselves.

The UK *National Health Services (Venereal Disease) Regulations 1974* makes a specific exception to the duty on health authorities to ensure that the identities of STD sufferers are kept secret where another person can be treated or the disease can be prevented from spreading. Only those who are in high risk categories need to be told to others; such as family members and friends, but not to the extent of informing employers or insurers.

The case of *X v Y and others*[98] illustrates the approach of the UK courts to the question of the public interest in disclosure of HIV status. In this case a newspaper company obtained information that two practicing doctors in one particular hospital were HIV positive but were allowed to continue their practice. Upon knowledge of this information leakage, the hospital sought and obtained an injunction restraining the newspaper from using that information. The newspaper went on to publish the information in a number of articles. The plaintiff brought the matter to court, seeking a further injunction from disclosure of the names of the doctors.

The Court held that the public interest in preserving the confidentiality of hospital records identifying actual or potential AIDS sufferers outweighs the public interest in the freedom of the press to publish such information. Justice Ross rules in this case that;

> the public interest in preserving the confidentiality of hospital records identifying actual or potential AIDS sufferers outweighed the public interest in the freedom of the press to publish such information, because victims of the disease ought not to be deterred by fear of discovery from going to hospital for treatment, and free and informed public debate about AIDS could take place without publication of the confidential information acquired by the defendants.

This is because victims of the disease should not be deterred from going to hospitals for treatment. Also the court held that free and informed public debate about AIDS could take place without publication of the confidential information acquired by the defendants.

Australia

In Australia, different states have incorporated into their public health laws provisions that made specific references to HIV/AIDS and measures regulating the duty of confidentiality. The basic principles of importance to the public health laws of the different states of Australia concerning the duty of confidentiality with regards to HIV/AIDS is; *(1)* the importance of the duty of confidentiality; *(2)* penalties for unauthorised disclosure; and *(3)* exceptions to the duty of confidentiality.

The importance of the duty of confidentiality is recognised in all the Australian States. In some states it is recognised that medical practitioners are required to safeguard information concerning a persons HIV status from disclosure. The states recognising this include New South Wales,[99] Tasmania,[100] Victoria[101] and Northern Territory.[102] For example, section 128 of the*Health Act* of Victoria provides that "a person who acquires information during the course of providing services, that a person has or is required for HIV testing, or is infected with HIV, must take all reasonable steps to protect the identity of that person."

On the same principle, other states also recognise the duty of confidentiality; but with reference to notifiable diseases and venereal diseases instead of focussing specifically on HIV/AIDS. These states include Queensland,[103] South Australia,[104] Western Australia,[105] and ACT.[106] For instance, Section 49(1) of the*Health Act (1937)* of Queensland provides that

> every person who acts or assist in the administration of the provision of the Act relating to controlled notifiable diseases must preserve and aid in secrecy all matters which comes to his/her knowledge in an official capacity except in the performance of the person's duties[107]

Almost all the Australian states make it a punishable offence for unauthorised disclosure of confidential information. For example, the *Public Health Act* of New South Wales states in section 17(2) that the unauthorised disclosure or failure by any medical practitioner to observe requirements stated in the Act relating to the disclosure of confidential information is guilty of committing an offence.

With regards to the exceptions to the duty of confidentiality, all the states of Australia provide statutory exceptions for the disclosure of confidential information. Most of these exceptions almost identically exist in all the state laws. The exceptions as identified in the New South Wales *Public Health Act* are that confidential information may be disclosed;

(a) with the consent of the person;[108] or

(b) in connection with this or any other Act;[109] or

(c) by order of a court or a person authorised by law to examine witnesses;[110] or

(d) as a normal duty as a consequence of providing the services in the course of which the information was obtained;[111] or

(e) in such circumstances as may be prescribed by the Act.[112]

The *Public Health (Schedule Medical Conditions) Regulations* of New South Wales further provides that information may be disclosed by any person to the Director-General in circumstance that the person has reasonable grounds to believe that the other person is behaving in such a way that the health of the public is at risk. A similar provision can be found in section 56(5) of the *Health Service (Consequential Provisions) Act 1990* of the Australian Capital Territory (ACT) which requires a person to disclose information to the court where the Minister certifies that it is necessary for the public interest that the information be disclosed.

There are also other statutory exceptions that are not in the New South Wales *Public Health Act,* but have been identified in the other states' Public Health Laws. The Queensland *Health Act of 1937* provides in section 49(1) that;

> [T]he Director-General may give such information to another government official or Department as considered necessary for the purpose of the Act, or may give information to the Commonwealth or official who has a legitimate interest in processing the information.

Similar exceptions can be identified in the *Public Health Acts* of Victoria,[113] Australian Capital Territory (ACT),[114] and in Northern Territory.[115]

Along with all the provisions making specific reference to HIV/AIDS and the duty of confidentiality, the Australian Medical Association's (AMA) *Code of Ethics* also make reference to the duty of confidentiality. The AMA *Code of Ethics* states that:

> It is the practitioner's obligation to observe strictly the rule of professional secrecy by refraining from disclosing voluntarily without the consent of the parties (save with statutory sanction) to any third party information which he has learnt in his professional relationship with the patient.[116]

This provides the recognition medical practitioners have towards the importance of maintaining a duty of confidentiality with the patient in Australia.

ANALYSIS

Australia and the UK have advanced in their legal approach towards the disease in terms of their statutes and cases. Both countries had gone through a process of incorporation of HIV/AIDS related provisions in the public health laws and the expansion of cases discussing the legal issues surrounding HIV/AIDS.[117] The cases play an important role by raising the duty of confidentiality in courts. For example, the court decisions have inter alia, assisted by defining the legal issues pertaining to the duty of confidentiality that exists between a HIV/AIDS infected person and the medical practitioner. They provide clear guidelines on the medical practitioners' duties and the exceptional circumstance where confidential information relating to the HIV status of an infected person can be disclosed.

On the other hand, the PICs are still in the early stages of the epidemic in their respond to HIV/AIDS.[118] Few people are affected, and the governments and people are slow in formulating policies and laws to deal with the problems arising with HIV/AIDS infections. Thus, compared with the UK and Australia, the PICs lagged behind in having recourse to measures for contravention of Health laws.

Problems Pacific Island Countries (PICs) face vis-à-vis the Laws.

There is evidence that most of the public health laws of PICs were created before independence and with the influence of the colonial masters.[119] Since then nothing has done to amend this laws vis-à-vis the current public health issues. The available Public Health laws do not have specific provisions for HIV/AIDS.[120] For example, in Solomon Islands medical practitioners still rely on provisions for venereal and notifiable diseases for HIV/AIDS related matters. As discussed in earlier parts of this research, the venereal and notifiable disease related provisions are inappropriate to HIV/AIDS because of their different natures. For instance, contagious diseases like tuberculosis and cholera differ from HIV/AIDS in terms of their mode of transmission and whether they can be cured.

Therefore PICs need to reform their public health laws. Models that were developed for other jurisdictions

may not necessary apply in PICs, though they may have specific coverage of the disease. What PICs need is laws that suit the specific conditions, requirements, and manpower capabilities of PICs.[121] For example, PICs should create laws that encourage individuals to come forward for HIV testing as well as to guarantee the confidentiality of their information.

Also the introduced formal legal system lacks the recognition of the PICs' indigenous cultures as part of it.[122] The introduced formal laws tend to push customary law into sub-ordination. As a result, the formal laws lack the recognition and authority they need to function effectively. Jowitt[123] summarised the status of Formal Laws by saying "many people see the formal laws as largely irrelevant" to their way of living. One particular example is that the formal laws fail to recognise the cultural attitudes of indigenous people on the subject of sex. Culturally, sex is considered a taboo and cannot be discussed in open gatherings or in the family. They also fail to recognise customs that may make it hard to maintain confidentiality.

Likewise, HIV/AIDS is seen by the indigenous people as a disease of outsiders, and let alone to be discussed. As the Minister of Health for Samoa, Honourable Retzlaff, then summarised

> [A]ny legislation to combat HIV/AIDS cannot succeed, if not culturally sensitive.[124]

Therefore, given the outside existence of the law and the disease (HIV), it is hard to draw a positive outcome from the people.

Inadequacies of the Public Health Laws to address the problem

The public health laws in most of the PICs do not provide appropriate legal mechanisms to address HIV/AIDS related.[125]HIV/AIDS still remains in the category of the casually transmitted diseases like venereal diseases. For example, the *Public Health Act* of Solomon Islands does not have any specific HIV/AIDS provision; instead it is left to the medical practitioners to apply the same procedures that were made for venereal and notifiable diseases. In Vanuatu HIV/AIDS is considered a notifiable disease under the interpretation of a notifiable disease in its *Public Health Act*.

The processes and procedures that were made generally for notifiable and venereal diseases are not adequate or appropriate for HIV/AIDS. There is a need to provide a system to protect the duty of confidentiality in relation to HIV/AIDS. For example, Guideline No.3 of the *International Guidelines on HIV/AIDS (UN)* states that;

> States should review and reform public health laws to ensure that they adequately address public health issues raised by HIV/AIDS that their provisions applicable to casually transmitted diseases are not inappropriately applied to HIV/AIDS and that they are inconsistent with international human rights obligations.[126]

This guideline should give PICs something to think about and reconsider their position with regards to HIV/AIDS.

CONCLUSION

The Public Health Laws of the PICs were almost all enacted a long time ago and do not take into account modern challenges to health. As can be seen, the current status of Public Health Laws in the PICs are inappropriate and irrelevant to the application of HIV/AIDS vis-à-vis the duty of confidentiality.

There are two possible options that PICs could take in their legal approach to HIV/AIDS. The approach taken by most of the Australian and UK Public Health Laws provide the first option. In this option, PICs

have the opportunity of reform by incorporating specific HIV/AIDS related provisions into the existing public health acts. The other option is the one taken by Tasmania and PNG, which involved the development of a 'stand alone' legislation that deals mainly with HIV/AIDS. The advantage surrounding this approach is that it avoids the lengthy process that PICs might take in amending all individual legislation to incorporate HIV/AIDS related provisions.

The UK and Australia have also shown to PICs that there are available means of litigation where aggrieved HIV/AIDS infected people can rely on for redress. These are avenues that we should consider to ensure that the duty of confidentiality is protected. Otherwise, the duty of confidentiality will be dismissed as just another hindrance to the efforts taken to maintain the spread of HIV/AIDS.

Writing nine years ago, Jayasuriya stated that;

> as more and more countries become sensitised to the role of legislation in AIDS prevention, it is likely that there will be more legislative activity.[127]

Nine years down the road, the trend still remains the same. It is now time that PICs put their acts together and pay closer attention to their Public Health Laws; especially to the issue of confidentiality with regards to HIV/AIDS.

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[1] Translation Francis Adams, http://www.wecke.com/webra/jur_e_02.shtml (Accessed 12 June 2004).

[2]The idea of public disclosure of names has often been linked with proposals for compulsory testing. See, i.e. Pacific Islands Report 'Fiji Ministry of Health Studies Compulsory HIV/AIDS Tests"'http://166.122.164.43/archive/2002/July/07-29-14.htm (Accessed 12 June 2004). See also 'Call for Naming AIDS Sufferers in Tuvalu' AIDSTOK Discussion list 13/2/2004 http://lyris.spc.int /read/messages?id=29053 It should be noted that proposals to name people with HIV in Tuvalu were *not* proposed or supported by the government.

[3] PACNEWS email list 'MP suggests doing away with HIV/AIDS confidentiality' Mon 21 June 2004.

[4] John Godwin *et al*., *Australian HIV/AIDS Legal Guide* (2nd ed, 1993) 67.

[5] *Ansell Rubber Co. Pty Ltd. v Allied Rubber Industries Pty Ltd.* [1967] VR 37 at 40.

[6] G v Day [1982] 1 NSWLR 24.

[7] The PQ v Australian Red Cross Society and Others ([1992] 1 VR 19) case stated that 'a person is not entitled to give any item of acquired information if from the whole of the acquired information which is given the patient could be identified.'

[8] L Skene, *Law and Medical Practice: Rights, Duties, Claims and Defence* (1998) 196.

[9] *Attorney General v Guardian Newspapers Ltd (No 2)* [1988] 3 WLR 776 at 807, per Lord Goff.

[10] S Humber, *Patient Confidentiality: Breach of Clinical Confidence,* (2001) p2. It should be noted here that this is not a duty to keep all information secret, but rather it is a duty to use the information only for the purposes for which it was provided and not for any other purpose. The usage of information for other

purposes will be made only with the consent of the patient or in accordance with any of the exceptions. See also J Hamblin and D Bell *Confidentiality* (1994) part 20.7[6].

[11] *Parry-Jones v Law Society* [1969] 1 Ch 1 at 7.

[12] S Humber, above n 10, 2.

[13] There are other occasions when such contract does not exist. For example, these occasions includes where a person is unconscious person. See *X v Y* [1988] 2 All ER 648; Also see *Duchess of Argyl v Duke of Argyl* [1967] Ch 302 for the express or implied nature of the contractual duty.

[14] *Breen v Williams* (1996) 186 CLR 71.

[15] T.S. Kian, 'Medical Confidentiality: Ethical Legal Issues' (1999). http://www.med.nus.edu.sg /sur/lecture3/medicalconfidentiality.htm (Accessed August 2003) p.3.

[16] [1958] NZLR 396.

[17] Attorney General v Guardian Newspapers Ltd (No 2) [1988] 3 WLR 776 at 807; Lord Goff stated that the most important limiting principle in the medical context is the necessity of 'balancing the public interest of maintaining confidence and the countervailing public interest favouring disclosure.'

[18][1986] 1 AC 112.

[19] MacFarlane and Reid, *Queensland Health Law Handbook* 139.

[20] S Humber above n 10, 3.

[21] MacFarlane and Reid explained that a ... 'public interest disclosure involves a balancing of the importance of maintaining confidential disclosure with the importance of protecting members of the public from harm.' MacFarlane and Reid, above n 19, 197

[22] McMahon 'The Ritual of Confidentiality' in Ian Freckelton and K Petersen (eds.), *Controversies in Health Law* (1999) 153.

[23] *Tarasoff v Regents of University of California,* 131 Cal. Reporter 14 (Sup. Court 1976).

[24] (1990) 1 All ER 835. This is a classic breach of confidence case between a patient and his doctor. In this case the patient (who was responsible for five deaths) was detained in a secured hospital indefinitely. After serving ten years, he sough a discharge or removal to a regional secure unit. For the purpose of his application to the mental health tribunal, a psychiatrist was instructed to examine him and report about him. The psychiatrist was independent of the hospital where the patient was detained, and he gave an unfavourable report. The patient's solicitor withdrew the application, and a copy of the report did not reach the Tribunal. When the psychiatrist become aware of this, he sent a copy to the hospital with a request that a copy be sent to the Secretary of State for the Home department.

The patient brought a claim for breach of confidence against the psychiatrist. The court rejected the claim on the ground that though the psychiatrist owed a duty of care to the patient; he also had to take into account the public interest. In the circumstances of this case, the public interest prevails as the patient was a multiple murderer and the psychiatrist's information was highly relevant to the patient's dangerousness. Without the information being available to the authorities, decisions could not properly be made with

regards to the patient's future.

[25] MacFarlane and Reid, above n 19. 143.

[26] An example of this requirement where it is consistent with the requirement for confidentiality can be found in the *Health Services Act (1991)* of Queensland. Section 63 of the Act provided that information is not to be disclosed 'except where required by law.'

[27] [1988] 2 All ER 648. This case involved an application for an injunction (equitable remedy) to restrain a newspaper from publishing confidential medical information.

[28] MacFarlane and Reid, above n 19, 131.

[29]R McClelland, R., 'Confidentiality and Security Issues surrounding Clinical Information Management' (2001) Royal College of Psychiatrists, http://www.rcpsych.ac.uk/college/sig/comp/docs/confidentiality_mcclelland.pdf (Acc. 23 Aug. 2003) 2.

[30]A Orr., *AIDS: Society, Ethics and the Law* (2000) 169.

[31] Jurgens stated in the *HIV Testing and Confidentiality Report for Canada* that often physicians cannot accurately diagnose and treat the patient without being provided with all the relevant information by the patient, and that in turn the patient will not be inclined to provide such full disclosure of information unless he or she has absolute trust and confidence that all such information will remain confidential. Ralf Jurgens, *HIV Testing and Confidentiality: Final Report* (1998) 211.

[32]John Godwin *et al*., above n 4, 63.

[33] E. Farmer, 'AIDS and the Community' *The National, Port Morseby* 1996 214-217.

[34] Ibid. Farmer relayed an incident where a young man he knew (who was HIV positive), who was a chef in a public owned catering facility, whose boss, while declaring compassionate support, drew up such demanding work rosters requiring the young man to work long hours (this comes after he was tested positive). The young man's health was seriously undermined, and he was forced to resign before he was emotionally and psychologically ready to do so. The experience broke the young man's spirit and he died very quickly.

[35] Some instances of discrimination in the Pacific have been detailed in Chetan Lakshman, 'HIV and Human Rights in the Pacific Islands' (2004) http://www.un.or.th/ohchr/issues/hivaids/ExperMeeting_2004/index.html (Accessed April 2004).

[36] South Pacific Commission, *Regional Strategy for the Prevention and Control of STD/AIDS* (1997) p.10.

[37] Tufuuga and Seuseu, 'HIV/AIDS in Samoa: The Legal Framework' (1995) *Pacific Health Dialog* 2(2) 67.

[38] Church news, 2002, *Radio Australia News*, 9/11/2002.

[39] B Manners, 2003, 'South Pacific: Strategy will help tackle HIV/AIDS' June 17 2003. http://www.adventist.org/news/data/2003/05/1055857550/index.html.cu (acc. on 15 Sept. 2003)

[40] Ibid.

[41] AIDSTOK Discussion list, 14/4/04.

[42] A MacAlister, 'HIV/AIDS: Overcoming stigma in Suva' (2002) *Newsletter of New Zealand Red Cross* 90(4) p.4: In his research he discovered that in families where the husband is tested positive, the information remains only with them. They fear rejection from the community at large. Also, they fear for the welfare of the other members of the family. For example, one wife of a HIV infected person stated that she feared that the husbands of her married daughters will reject her daughters or not visit them if the know that their father has contracted the disease.

[43] [1998] 8 SCC 296.

[44] D. Fatiaki, 'HIV/AIDS and Law reform in the Pacific' (1995) *Pacific Health Dialog* 2(2) 84.

[45] South Pacific Commission, Noumea, 1997, p.35.

[46] UNAIDS, *Handbook for Legislators on HIV/AIDS, Law and Human Rights* (1999) 36.

[47] K. Pamba, 'Health-Papua New Guinea: Friends for people living with HIV/AIDS', *Inter Press Service* September 26, 1999 http://www.aegis.com/new/ips/1999/1P9909.html_ (acc. on 22nd July 2003)

[48] Data reported as of December 2002 reported that there 4792 HIV cases, including AIDS. Published in Anita Jowitt, 'Effective Response to Regional Issues- A Pacific Perspective on HIV', (2002) http://www.gaje.net.au/jowitt.htm (acc. on 22nd July 2003)

[49]Christine Stewart, *Law, Ethics and HIV/AIDS: Existing Laws of PNG,* (1993) p8.

Stewart identified that there are some exception to the bond of secrecy. These exceptions include; *(1)* where the patient gives consent*, (2)* in the interest of all concerned, *(3)* where required by law, and *(4)* where there is a question of danger to society.

[50] [Cap] 226.

[51] It provides provisions for the proclamation of infectious diseases.

[52] Section 48 provides that 'venereal disease' means gonorrhoea, gleet, gonorrhoeal ophthalmia, syphilis, soft chancre, venereal warts or venereal granuloma. There is not mention of HIV or AIDS.

[53] Section 56(3) of the *Public Health Act.*

[54] The author is unable to obtain a copy of the Act; therefore for the purpose of this research the author is using the *Bill* instead of actual Act. However, the author belief the content of the Act should remain the same as the *Bill.*

[55] In particularly, inter alia, subsections;

(f) the prevention of the spread of HIV/AIDS; *(g)* the management of the lives and the protection from discriminatory practices of people who are infected or affected by HIV/AIDS; and *(h)* the protection of public health.

[56] Section 3 “(1) HIV infections and AIDS are not-

(a) infectious or venereal diseases for the purpose of the Public Health Act (CAP 226);

(4) Where a provision of any other Act is inconsistence with a provision of this Act in relation to matters for which provision is made in this section, this Act prevails to the extent of that inconsistency.”

[57] Where a person is 12 years or less and consent to testing is given by parent or guardian, then information can be disclosed with the consent of the parent or guardian.

[58] Section 20(1) (a) where notification person is requested by the infected person to do so.

[59] Section 20 (1) (b).

[60] section 20 (1) (c).

[61] The National AIDS Council statement stated that; "as the main advocator for national action on HIV/AIDS, the National AIDS Council will lead, strengthen and support and expand responses aimed at preventing the further transmission of HIV, provide leadership and guidance through a multi-sectoral response to reduce the vulnerability of individuals and communities to HIV/AIDS, minimising the impact of the epidemic in Papua New Guinea." Anglican Church Report, 2000, *HIV/AIDS: Situation in PNG*, http://www.nacs.org.pg/nac.html

[62]Diana Sant Angelo, D*2003-2007 HIV/AIDS policy and Strategic Plan,* Department of Health, Vanuatu, p1.

[63] Schedule 1 of the *Public Health Act No.22* of 1994. Article 1 provides the interpretation of notifiable diseases as specified in Schedule 1 to include HIV/AIDS.

[64] Anita Jowitt, (2000), “Creating a framework for legal change in the South Pacific” *XV International Aids Conference,* Barcelona, July 2002 p.3.

[65] Section 13.

[66] Section 18.

[67] Section 20.

[68] Section 22.

[69] Section 23.

[70] In a discussion between Jowitt and the author, Jowitt stated that it is still uncertain whether the Bill will be passed in the next 2 or 3 years. This is due to the lack of support that the Bill has from the politicians. There is a need to let the politicians aware of the importance of the Bill. In another discussion with Angelo (from the Vanuatu Ministry of Health), she agreed that it will take more than 2 years before the bill could be passed by the Parliament (Wednesday 8 October 2003. Interview her through the telephone).

[71]Diana Sant Angelo, Department of Health, Vanuatu (Private interview on 9 October 2003).

[72] Toka, E., (1997), "South Pacific Health: Aids a ticking Bomb", *InterPress News Service (IPS);* Sunday, 24 August 1997 http://www.aegis.com/news/ips/1P970808.html (acc. on 31st July 2003)

[73] Diana Sant Angelo, Department of Health, Vanuatu (9 October 2003). She reproduces some statistics that were published by from the SPC statistics division.

[74] [Cap 80]- Revised edition 1977.

[75] T Kienene, 'HIV/AIDS in Kiribati' (1995) Journal of Community Health and Clinical Medicine for the Pacific 2(2).

[76]Afeau, P., and Nukuro, E., 'Solomon Islands HIV/AIDS programme' (1995) *Journal of Community Health and Clinical Medicine for the Pacific* 2(2) p.62-64.

[77] E Toka, above n 72.

[78] Ibid.

[79][Cap 99]; It is important to note that the Act was created before the disease HIV/AIDS was first reported in Solomon Islands. Thus, it explained why HIV/AIDS was not included in the definitions of venereal or infectious diseases.

[80] [Cap 102].

[81] Maka'a, J. 2003, *National HIV/AIDS Strategic Plan launch for Solomon Islands,* via AIDSTOK website; The main contents of the Strategic plan were not available to the author for the purpose of this research. However, the necessary areas are identified from the above source.

[82] Statement by Dr Potoi, the Deputy Director General of Health of Samoa at the 2001 26th Special Session of UN Assembly on HIV/AIDS.

[83] Sections 29 and 36 particularly.

[84] Dr Potoi,2001, *Statement at the 2001 26th Special Session of UN Assembly on HIV/AIDS*; This include *(a)* the mode of transmission, and *(b)* short and long term consequences on the individual, families, communities and nation as a whole.

[85]Ibid. The Theme values stated included *(a)* access to quality services, *(b)* professionalism, *(c)* partnership, *(d)* equity, *(e)* sustainability, *(f)* faithfulness, *(g)* love, and *(h)* compassion.

[86] A MacAlister, above n 42, 6.

[87] *Public Health Act CAP 111*- Part VIII of this Act deals with venereal diseases. However, the definition of venereal diseases provided in Schedule 1 does not include HIV or AIDS.

[88] Fatiaki, above n 44, p.84.

[89] "Implementation finally for the National HIV/AIDS Strategic Plan," *Fiji Government Online,* May 1st 2002.

[90] Lakshman, C, Pacific HIV/AIDS Project- IJALS, AIDSTOK DISCUSSION WEBSITE, 2003.

[91] A potential case was identified in Samoa. This is the case where Peati Maiava took the Progressive Insurance Co. Ltd. to court for wrongful dismissal as a result of his HIV/AIDS status. However, this matter was settled out of court. Thus, the matter never has the chance of reaching the court; Lakshman, C., @ AIDSTOK DISCUSSION BOARD, 2003.

[92] Jane Keith Reid, @ AIDSTOK DISCUSSION BOARD, 2003.

[93]A Orr, above n 30*,* p.170.

[94] Ibid p.170.

[95] Ibid p.171.

[96] *Re Lubin, Rosen and Associates Ltd*. [1975] 1 WLR 122 at 129.

This case referred to the term 'public at large' as similar to the idea of a society as a whole.

[97] Orr, above n 30*,* p.171.

[98] [1988] 2 All ER 648.

[99] *Public Health Act 1991.*

[100] *HIV/AIDS Preventive Measures Bill of 1990* and *HIV/AIDS Preventive Measures Bill of 1993*

[101] *Health Act of Victoria,* as amended by *Health (General Amendment) Act 1988* and *Health (General Amendment) Act 1989.* See also *Health Services Act 1988.*

[102] *Notifiable Diseases Act (1981).*

[103] *Public Health Act* of 1937.

[104] *Public and Environment Act* (1987).

[105] *Health Act* (1911); by virtue of the *Infectious Diseases Order 1983* and *dangerous Infectious Diseases Order 1983, Infectious Diseases Order 1985* and *Dangerous Diseases Order 1985,* was gazetted by the Government of Western Australia in 1991. Note: HIV/AIDS is classified as infectious diseases and dangerous infectious diseases under this Act.

[106] *Public Health (Infectious and Notifiable Diseases) Regulations No.8 of 1992.*

[107] Goodwin, J. *et al.,* above n 4, p.81.

[108] Also found in the *Public Health Acts* of South Australia (*Public and Environmental Health Act 1987);* Tasmania (*HIV/AIDS Preventive Measures Bill 1990);* Victoria (*Health Services Act 1988);* and ACT (*Health Services Act 1990)*.

[109] Also found in Tasmania (*HIV/AIDS Preventive Measures Bill 1990).*

[110] Also found in the *Public Health Acts* of South Australia(*Public and Environmental Health Act 1987);* Tasmania(*HIV/AIDS Preventive Measures Bill 1990);* Victoria(*Health Services Act 1988);* Northern Territory (*Notifiable Diseases Act 1981);* and ACT(*Health Services Act 1990)*.

[111] Also found in South Australia (*Public and Environmental Health Act 1987).*

[112] Also found in ACT (*Health Services Act 1990)*; and Northern Territory (*Notifiable Diseases Act 1981)*

[113] *Health Services Act 1988;* section 141*(3) (h).*

[114] *Health Services (Consequential Provisions) Act 1990;* section *56 (4-5).*

[115] *Notifiable Diseases Act 1981;* section 29.

[116]L Skene, above n 8, p.195.

[117] The only exception is the State of Tasmania in Australia which has developed a specific legislation for HIV/AIDS.

[118] For example, HIV/AIDS has yet to be considered the number one cause of death, unlike in the African and other countries where HIV/AIDS was the main cause of death. The only PIC that is close to that stage is PNG.

[119] D Fatiaki, above n 44, p.84

[120] HIV/AIDS was not yet detected in PICs in the wake of their independence. It was in the latter part of the 1980s that HIV/AIDS was first reported. By that time nearly all PICs are independent and had adopted various Public Health laws that were either drafted by the colonial powers or with their influence.

[121] DC Jayasuriya, 'A comparative review of AIDS legislation in Asia and the Pacific' (1994) *International and Comparative Law Quarterly* 43(2)*,* p.394.

[122] Anita Jowitt, above n 48, p.4.

[123] Ibid.

[124] M.T. Retzlaff, 'AIDS and the Law. Does Protection exist for AIDS victims?' (1999) Paper presented at the 12th annual Commonwealth Law Conference, Kuala Lumpur, September 1999 p.4.

[125] Except PNG which has already developed a specific HIV/AIDS oriented legislation.

[126] These Guidelines are not binding on members, but provide a guide for states to ensure that their responses to HIV are consistent with human rights law. The author viewed the guideline through a paper prepared by Jowitt, A., *Discrimination, Stigma, and Human Rights Workshop,* Pacific Regional Youth Congress, Sept. 2002.

[127] Jayasuriya, above n 121, p.404.

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