THE IMPLICATIONS FOR THE AFL AFTER HALL'S CASE

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I INTRODUCTION

Science has been aware of the potentially deadly consequences of the Human Immunodeficiency Virus (HIV) and hepatitis for a long time. In fact, these viruses have become household names, with most members of the community associating them with sexually transmitted diseases and drug addicts. However, it is only recently that these viruses have been associated with sport. While some combat sports have already identified the legal issues surrounding HIV and hepatitis, and legislation has been implemented to deal with them, this is not the norm for non-combat sports. Most sports governing bodies remain unsure how to deal with the difficult issues which infectious players create.

The Australian Football League (AFL) has not yet been confronted by the difficulties surrounding players with infectious diseases. Players with HIV or hepatitis could potentially cost the AFL millions of dollars in damages claims. By allowing players with infectious diseases to participate in football, the AFL and its affiliate clubs could be sued in negligence for failing to take care of the players and on-field officials, or vicariously as a result of players' negligent acts. Yet, to exclude such players may amount to discrimination.

To date, there has been only one reported case in which a sports governing body has been held to be acting in a discriminatory manner by excluding an infectious player.[1] The tribunal in *Hall v Victorian Amateur Football Association*[2] (*Hall*), held that the risk of HIV transmission was so low that it was not reasonably necessary to discriminate against the player, and therefore ruled that the Victorian Amateur Football Association had acted in a discriminatory manner by refusing his registration which prevented him from playing. As this landmark case concerned Australian football, it may be regarded by many as the current position in Australia, and

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[1] Dr Margaret Otlowski, 'Association's ban on HIV positive player ruled discriminatory' (1999) 7(8) *Australian Health Law Bulletin* 85.

[2] [1999] VCAT AD 30 1998/153 (Unreported, Kellam J, McKenzie and Scholes MD, 23 April 1999) <www.vcat.vic.gov.au/1999-vcat-ad-30.htm> at 23 November 1999 (copy on file with author).

for that matter, the world. While not precedent, this case is very persuasive and provides some insight as to how the courts will judge the AFL and the methods it uses to prevent infectious disease transmission. However, this case did not consider negligence, and is therefore only persuasive in relation to discrimination.

In light of the risks of HIV or hepatitis transmission, both during the game and in training, it is suggested that the AFL needs to consider a proactive response to deal with the issue. If left unresolved it could lead to serious ramifications for the players, the on-field officials, the clubs and the AFL. One solution offered is a mandatory testing of the players as a condition precedent to taking the field. HIV and hepatitis screening may provide a necessary solution to a difficult problem.

This paper will examine some of the issues that HIV and hepatitis transmission may create and will recommend measures which the AFL could pursue. These recommendations will attempt to minimise both the risk of transmission and the prospect of legal liability. Section II will discuss the means and risk of transmission of the viruses. It then suggests that HIV and hepatitis screening is a cost-effective way to reduce these risks. Section III discusses whether mandatory testing and the exclusion of infectious players amount to discrimination. It also suggests how the AFL may come within certain exceptions to avoid liability. Section IV will consider whether the AFL has a duty of care in the tort of negligence to exclude infectious players. The AFL's position regarding vicarious liability and the defence of inherent risk of sport are then discussed. Section V provides a summary of the *Hall* decision. Section VI analyses the case and considers possible ways the AFL could distinguish it. Based on this, Section VII provides some recommendations for the AFL to minimise both the risk of transmission and legal liability. Section VIII concludes by suggesting it is better to exclude infectious players than potentially transmit the virus and pay damages for a large negligence action.

In essence, the aim of this paper is to analyse the legal problems which may arise from infectious disease transmission and to advise the AFL how to best combat these.

II HIV AND HEPATITIS IN THE AFL

The AFL and each of its 16 clubs owe a duty of care to its players and on-field officials. It is part of that duty of care to minimise the transmission of HIV/hepatitis in connection with Australian Rules Football. In order to minimise transmission of these viruses, a brief description of the possible ways these viruses may be transmitted is provided.

A Transmissibility of HIV and Hepatitis

Transmission of HIV, hepatitis B (HBV) and hepatitis C (HCV) may occur in a number of ways. HIV and HBV transmission requires contact with body fluids. Transmission of these may occur through blood, saliva or wound exudates.[3] Transmission is therefore possible in Australian football via bloody contact between players colliding or contacting. Transmission may also occur through the sweat, urine or saliva of a HIV positive player on to a cut or laceration of another player.[4] However, unlike HIV, HBV may survive on dried surfaces, such as grass, towels or interchange benches for days,[5] therefore leaving surfaces 'contaminated'.[6] Unlike HIV and HBV, the virus is not harboured in all bodily fluids, only blood.[7]

B Laboratory Diagnosis

All three viruses may be identified two weeks to three months after exposure via laboratory diagnosis of antibodies.[8] Therefore, it is conceivable that players could be screened which could prevent or reduce the risk of transmission. This approach is currently taken in professional boxing, which compulsorily tests boxers pursuant to the *Professional Boxing Control Act 1985* (Vic), ss 10, 12 and their equivalents in other States.[9] This serology testing is conducted by a medical practitioner. The test indicates the HIV/HBV/HCV status of the boxer and requires the boxer to sign a release of information to the Professional Boxing Control Board and its officers. The test is conducted twice a year, and in Victoria costs $80, which is paid by the boxer.[10] It is submitted that a similar approach should be adopted by the AFL.

III DISCRIMINATION LAWS

Part of the AFL's duty of care in the tort of negligence is to reduce the risk of HIV/HBV/HCV transmission in Australian football. There are many ways in which this goal can be achieved. As mentioned, one way of reducing the risk of transmission is to test players, and exclude those who test positive. Although this approach evokes many legal and ethical problems, when the gravity of contracting either of

[3] Ibid 1312–1313. See Mark Beers and Robert Berkow, *The Merck Manual of Diagnosis and Therapy* (17th ed., 1999) 380.
[4] E Reiss-Levy et al., 'Acute Fulminant Hepatitis B Following a Spit in the Eye by a Hepatitis B e Antigen Negative Carrier' (1994) 160 *Medical Journal of Australia* 524.
[5] Carol Turkington, *Encyclopaedia of Infectious Diseases* (1998) 130.
[6] M Piazza and V Guadagnino, et al., 'Contamination by Hepatitis B Surface Antigen in Dental Surgeries' (1987) 295 *British Medical Journal* 473.
[7] Beers and Berkow, above n 3, 380. It should be noted that it was suggested in Turkington that HCV may possibly exist in other body fluids, above n 5, 133.
[8] Public Health Division, Victorian Government Department of Human Services, *Management, Control and Prevention of Hepatitis C: Guidelines for Medical Practitioners*, Human Services (1999) 5.
[9] *Boxing and Wrestling Control Act 1986* (NSW) ss 8, 15, 49–51; *Boxing Control Act 1987* (WA) ss 18–20, 48–51; *Boxing Control Act 1993* (ACT) ss 14–16.
[10] Interview with Michael O'Malley, professional boxer (Geelong, 2 December 1999).

these viruses is considered, such an approach appears to be warranted. While not a solution in itself, HIV/hepatitis testing is a necessary part of the equation, and it must therefore be considered whether such a protective measure can be conducted legally.

Firstly, the question arises as to whether it is discriminatory to require footballers to undergo mandatory testing for HIV/HBV/HCV. Secondly, is it discriminatory to exclude a player from the competition because of his HIV/hepatitis status?

A Mandatory Testing

In relation to mandatory testing, s 27(1) of the *Disability Discrimination Act 1992* (Cth) provides that it is unlawful for a club[11] to discriminate on the ground of a person's disability:

> (i) by refusing or failing to accept the person's application for membership; or
>
> (ii) in the terms or conditions on which the club or association is prepared to admit the person to membership.

Furthermore, s 28(1) of the Act provides that:

> It is unlawful for a person to discriminate against another person on the ground of the other person's disability or a disability of any of the other person's associates by excluding that other person from a sporting activity.

Pursuant to ss 4(1)(c) and (d) of the *Disability Discrimination Act 1992* (Cth) 'disability' includes the presence in the body of organisms causing or capable of causing disease or illness. As a result, HIV/HBV/HCV are disabilities.

Sections 27 and 28 of the Act are silent as to whether mandatory testing is allowed. However, as this testing is to be used as a necessary precursor to exclude players from competition, it may in fact be discriminatory. Mandatory testing may breach s 27(1)(i) of the Act, as if the players fail to test negative, their application for membership would be refused. Mandatory testing may also be in breach of s 28(1) as a positive HIV/HBV/HCV status would mean the exclusion of that player. Therefore, compulsory testing appears to be of little value as the AFL will be prohibited from imposing special terms upon the players based upon these tests. It is also arguable that excluding players who refuse to undergo the test amounts to discrimination as it necessarily imputes the disability to the player.

The AFL may, however, be able to show that the above-mentioned forms of discrimination are lawful pursuant to s 48 of the Act. Section 48 provides:

> This Part does not render it unlawful for a person to discriminate against another person on the ground of the other person's disability if:

[11] A 'club' includes its committee of management and the members of the committee.

(a) the person's disability is an infectious disease; and

(b) the discrimination is reasonably necessary to protect public health.

Section 48 may provide the means by which the AFL can justify mandatory testing, although a similar defence was raised unsuccessfully in the *Hall* decision.[12]

Another way the AFL could avoid the potential liability which mandatory testing creates would be to acquire the players' consent. The possible ways of acquiring consent and the legal ramifications of each will be discussed below.[13]

B *Excluding a Player from Competition*

An important issue that the AFL must consider is whether it is discriminatory to exclude a player from competition because of his HIV/hepatitis status?

Sections 27 and 28 of the *Disability Discrimination Act 1992* (Cth)[14] state that a person who excludes another because they suffer from HIV/HBV/HCV may be acting unlawfully.[15]

The AFL may, however, rely on s 48 of the Act.[16] To show that the exclusion of infected players is 'reasonably necessary to protect public health', the risk of transmission would need to be sufficiently high. While proper procedures, such as a well implemented AFL blood rule,[17] may be able to reduce the risk of transmission, it does nothing to eliminate the transmission from an actual collision.[18] Even then, surfaces may remain contaminated with HBV for extended periods.[19] Further, if the risk of transmission of HIV is estimated by some eminent medical researchers[20] to be as high as 1:6000, when both HBV and HCV are also considered, the risk becomes significantly higher and may be sufficient to justify the exclusion of players. Further, when it is considered that the rates of HIV/HBV/HCV in the community have increased in recent years[21] and the knowledge of the means by which they can be transmitted has expanded, HIV/hepatitis screening is much more likely to be permitted.

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[12] *Hall v Victorian Amateur Football Association*, above n 2.

[13] The issues surrounding the acquiring of player consent are discussed in Section VII(B) below.

[14] These provisions were previously discussed in Section III(A).

[15] *Hall v Victorian Amateur Football Association* stated similar under s 65 of the *Equal Opportunity Act 1995* (Vic), the Victorian equivalent to ss 27 and 28.

[16] This provision was previously discussed in Section III(A) above.

[17] The AFL has in place a blood bin policy whereby players who draw blood are ordered off the field until the bleeding is contained and the wound cleaned. The blood rule also requires bloody clothing to be replaced.

[18] The blood rule is only effective in preventing post-accident transmission.

[19] M Piazza and V Guadagnino, above n 6, 473.

[20] Dr Mijch, head of the Alfred Hospital HIV AIDS services, in *Hall v Victorian Amateur Football Association*, above n 2, [7].

[21] Australian Bureau of Statistics, *1999 Year Book Australia*, 282.

The exclusion of HIV/hepatitis-infected players may also amount to discrimination under s 15(2) of the Act. This section provides:

> It is unlawful for an employer or a person acting or purporting to act on behalf of an employer to discriminate against an employee on the ground of the employee's disability...:
>
> (c) by dismissing the employee.

In response to such a claim, the AFL may be able to rely on s 15(4) of the Act which provides:

> Neither paragraph (1)(b) nor 2(c) [of s 15] renders unlawful discrimination by an employer against a person on the ground of the person's disability, if ... the person because of his or her disability:
>
> (a) would be unable to carry out the inherent requirements of the particular employment; or
>
> (b) would, in order to carry out those requirements, require services or facilities that are not required by persons without the disability and the provision of which would impose an unjustifiable hardship on the employer.

This defence was successfully raised in the recent case of *X v The Commonwealth.*[22] In that case, McHugh J held that the inherent requirements of the job 'go beyond the physical capacity to perform the tasks or skills...'[23] His Honour went on to say that 'in determining whether a person with a disability is able to carry out the inherent requirements of a particular employment, regard can be had to the health and safety of co-employees and others.'[24] Further, he stated, when determining whether the disability prevents the employee from carrying out the inherent requirements of the employment, it must be asked whether the disability poses a real risk to the safety or health of others.[25] This requires consideration of the degree of the risk and the consequences of the risk being realised. It is suggested that despite the opinion of the tribunal in *Hall,* the risk of a player transmitting HIV/HBV/HCV is real, and should be considered high enough to warrant a conclusion that either of these infections prevents a player carrying out the inherent requirements of their employment.[26] It appears, therefore, that the AFL could successfully raise the s 15(4) defence. The AFL could argue that the inherent requirements of employment as a footballer include the requirement to have regard to other players' and on-field officials' health and safety. This requirement means that a HIV/HBV/HCV infected player may be lawfully excluded from competition. However, as the court

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[22] (1999) 167 ALR 529.
[23] Ibid 536 (McHugh J).
[24] Ibid 541 (McHugh J).
[25] Ibid 539-40 (McHugh J).
[26] This paper will endeavour to prove that the risk of transmission is high enough to justify the exclusion of a player.

said in *Qantas Airways Ltd v Christie,*[27] the identification of the inherent requirements of a job is a matter of objective fact to be determined in all the circumstances of a particular case. Therefore, it is a matter which cannot be definitively resolved, as each particular case will differ. As a general observation, it appears that the AFL could successfully use s 15(4) of the Act to avoid any liability under s 15.

As noted above, even if extra measures are taken, there is nothing that can be done to avoid the risk of transmission from an actual collision. The AFL blood rule is only used as a preventative measure for post-collision transmission. This practically renders s 15(4)(b) redundant for the present purpose. For this reason, s 15(4)(a) can be read alone in relation to excluding a HIV/hepatitis-infected player from competition.[28]

It should be noted that similar provisions to those identified in the *Disability Discrimination Act 1992* (Cth) also exist in State legislation.[29]

If the AFL was to conduct mandatory testing for HIV/HBV/HCV and exclude players who tested positive, such conduct may be unlawful under discrimination legislation of both the States and the Commonwealth. Three potential heads of liability under the *Disability Discrimination Act 1992* (Cth) have been identified. Although on the face of each of these, it appears that the AFL does not have the ability to conduct HIV/HBV/HCV screening legally, it may be empowered to do so by ss 48 and 15(4). Therefore, it is suggested that the AFL conduct HIV/HBV/HCV screening in an attempt to avoid potential negligence actions.

IV NEGLIGENCE

Negligence issues may arise when considering whether the AFL can legally conduct HIV/hepatitis screening. For example, is the AFL obliged to conduct HIV/hepatitis screening in order to provide a safe playing environment? Could it be liable in a negligence action by failing to exclude an infected player? These duties may arise from the general duty of care under the tort of negligence owed by an AFL club to players in its team or league.[30]

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[27] (1996) 138 ALR 19.

[28] In *X v The Commonwealth* (1999) 167 ALR 529, McHugh J at 538–9 with whom Gummow and Hayne JJ, stated that s 15 (4) must be read as a whole. The three justices were of this opinion as the object of the sub-section is to prevent discrimination being unlawful whenever the employee is discriminated against because he or she is unable either alone or with assistance to carry out the inherent requirements of the particular employment. However, this argument is not applicable for the present purposes as a player cannot be assisted whilst playing, and current preventative measures are undertaken after the collision has occurred.

[29] The Commonwealth and State legislation are similarly worded and a grievance can be lodged under either. The State equivalents are: *Equal Opportunity Act 1984* (Vic); *Equal Opportunity Act 1984* (SA); *Equal Opportunity Act 1984* (WA); *Discrimination Act 1991* (ACT); *Anti-Discrimination Act 1977* (NSW); *Anti-Discrimination Act 1991* (Qld); *Anti-Discrimination Act 1992* (NT).

[30] Roger Magnusson and Hayden Opie, 'HIV and Hepatitis in Sport: A Legal Framework for Resolving Hard Cases' (1994) 20(2) *Monash University Law Review* 239.

A Duty of Care

A duty of care in the tort of negligence arises when (i) a reasonable person in the defendant's position could foresee that its actions would cause harm,[31] and (ii) the plaintiff was within the class of persons to whom that duty was owed.

Once a duty of care has been established, the plaintiff must show that the defendant breached that duty. To do this, the standard of care must be determined. This is done by balancing the factors which form the calculus of negligence. These factors include: (i) the degree of probability of the risk inherent in the defendant's conduct occurring; (ii) the gravity of the risk; and (iii) the practicability of taking precautions or of taking alleviating action.[32] It must then be proven that the defendant's wrongful breach was the legal cause of the damage in respect of which the plaintiff is seeking damages.

The steps that the AFL must take to avoid liability will, therefore, be determined by what a reasonable sports governing body in similar circumstances would have done. For the purpose of this exercise, it can be assumed that a reasonable sports governing body would only guard against risks which are foreseeable,[33] not those which are 'far-fetched or fanciful'.[34] While it is established in the *Hall* case[35] that the risk of HIV/hepatitis transmission is very small, it cannot be dismissed as far-fetched or fanciful.[36] Consequently, it is suggested that the courts would regard the risk of HIV/hepatitis transmission in AFL as foreseeable. Assuming the existence of a foreseeable risk, the AFL would need to protect against such risk and may be liable if it omits to take precautionary measures.

When examining the calculus of negligence, the small chance of contracting HIV/HBV/HCV in Australian football must be weighed against the life-threatening consequences of contracting HIV or hepatitis.[37] In *Paris v Stepney Borough Council*,[38] it was held that because the defendant knew that the plaintiff, a mechanic, only had one good eye, a higher standard of care was owed. Even though the chance of damaging the other eye was very low, the court held that the defendant should have taken precautions and provided the plaintiff with goggles. As the courts place significant emphasis on the gravity of the injury, it is reasonable to assume that the potentially grave consequences of contracting HIV/HBV/HCV would be sufficient to impose a positive duty on the AFL to take precautions. Further, the expense,

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[31] *Donoghue v Stevenson* [1932] AC 562

[32] There are other factors, but these are only relevant factors for this thesis.

[33] *Wyong Shire Council v Shirt* (1980) 146 CLR 40, 47.

[34] Ibid; *Overseas Tankship (UK) Ltd v The Miller Steamship Co Pty Ltd (the Wagon mound (No 2))* [1967] 1 AC 617.

[35] *Hall v Victorian Amateur Football Association*, above n 2, [6]-[7].

[36] Similar to *Chomentowski v Red Garter Restaurant* (1970) 92 WN (NSW) 1070 where employee robbed and injured and defendant tried to argue that risk was so small that a reasonable man in his position would have ignored it. It was held that although the possibility of plaintiff being attacked was small, it was reasonably foreseeable.

[37] For consequence of contracting HIV, HBV or HCV refer to above Sections II(A)–(C) respectively.

[38] [1951] AC 367.

difficulty and inconvenience of alleviating the risks are extremely small when weighed against the gravity of transmission.

Player education is one measure which a reasonable sports governing body could be expected to take. This may involve incorporating provisions of the *Infectious Diseases Policy* of the Australian Sports Medicine Federation (ASMF) into AFL procedures. This requires strict personal hygiene, not spitting or urinating in team areas, not participating in communal bathing, not sharing towels or shaving razors, drink containers and the proper execution of the existing 'blood rule'. However, there is a prospect that transmission may occur notwithstanding such measures.

The only difficulty for a player attempting to establish an action in negligence would be proving transmission. Even if the AFL were to undergo sideline testing for players involved in a bloody collision, there is the window period during which the virus cannot be identified. However, while causation is a question of fact to be proven on the balance of probabilities, if it can be linked to a specific incident, the player may be able to overcome this obstacle as the attribution of causation is ultimately a matter of common sense.[39]

To avoid liability in negligence and fulfil the duty to take reasonable care, it is suggested that the AFL take proactive measures beyond those already outlined, making HBV vaccination and a negative HIV/hepatitis status preconditions to competition. Both of these measures are of relatively minor expense.[40] Some believe that in a contact sport such as Australian football, taking reasonable care amounts to a duty to exclude infected players.[41]

B Negligence and the Employment Relationship

Negligence issues may also arise due to the special relationship which exists between the AFL, the AFL clubs and the players. Generally, athletes playing sport for a club are employed under a contract of service, as such, the players would be considered to be employees.[42] An employment relationship is also evidenced in the requirement that each player sign the AFL–AFLPA Standard Playing Contract. As a result of this relationship, the players are owed various non-delegable duties by their employer.[43] For this reason, it could be argued that a failure by the AFL to establish the HIV/hepatitis status of its members, and to act upon such findings, would amount to a breach of this special relationship. Further, this employment

[39] *March v E & MH Stramare* (1991) 99 ALR 423.

[40] HIV/Hepatitis testing is currently provided free of charge by government hospitals around Australia. The charge associated with HBV vaccination is approximately $36, which consists of three $12 injections. Testing and vaccination could be made the responsibility of the player.

[41] Magnusson and Opie, above n 30, 239–240.

[42] *Adamson v West Perth Football Club (Inc)* (1979) 27 ALR 475; *Commissioner of Taxation v Maddalena* (1971) 45 ALJR 426; *Adamson v NSW Rugby League Ltd* (1991) 31 FCR 242, 260.

[43] *Cotter v Huddart Parker Ltd* (1941) 42 SR (NSW) 33, 37-8; *Kondis v State Transport Authority* (1984) 154 CLR 672.

relationship may also place a statutory duty[44] on the AFL club to conduct HIV/hepatitis screening.[45]

The AFL club, as employer, may not only be liable for its own negligent acts, it may also be liable for the negligent acts of the players. This could mean that if a player is liable for transmission of an infectious disease which is in connection with his employment, the AFL club may be held vicariously liable, even if outside the scope of his employment.[46]

C Negligence or Inherent Risk of Sport

In *Trevalli Pty Ltd v Haddad* [47] it was held that a duty of care was owed to the plaintiff, a novice skater, as it was reasonably foreseeable that she could be accidentally pushed and consequently injured if placed in a skating rink with experienced skaters travelling much faster. While the court acknowledged the plaintiff consented to all risks that are inherent in ice skating, it held that consent did not extend to the risk of injury as a result of the defendant failing to control the activity. The court believed that the risk could have been avoided by reducing the number of skaters or the appointment of more supervisors.

Applying the reasoning of the court in *Trevalli*, it appears possible that a court could hold the AFL liable in negligence if a HIV/HBV/HCV positive player collided with a non-infected player and transmitted the virus. Such an accident is foreseeable. Further, it does not appear the AFL could show that the player consented to the risk of such an injury as part of the game. It is suggested that such a fatal collision would not be regarded as an inherent risk of playing Australian football, since it is not the sort of ordinary, accidental or unavoidable injury inherent in the game. Moreover, consent does not extend to injuries caused as a result of the AFL failing to control the game, that is, its failure to exclude HIV/hepatitis infected players.

V HALL V VICTORIAN AMATEUR FOOTBALL ASSOCIATION

Some of the discrimination issues already mentioned were touched upon in the landmark *Hall* case. The *Hall* case was the first case worldwide to deal with the issue of HIV discrimination in sport. Hall played in a Victorian league, and therefore, unlike the AFL's position depicted by this paper, *Hall's* case concerned State legislation. The two are very similar in their wording and, for this reason, the case is extremely important in gaining an understanding of how the courts may lean when dealing with the issues highlighted.

[44] There may be a duty to test under occupational health and safety legislation such as s 21 of the *Occupational Health and Safety Act 1985* (Vic).
[45] Magnusson and Opie, above n 30, 239.
[46] *Canterbury Bankstown Rugby League Football Club Ltd v Rogers* (1993) Aust Torts Reports 81–246.
[47] (1989) Australian Torts Reports 80–286.

A *Facts*

The applicant, Matthew Hall, was an Australian rules footballer in the Victorian Amateur Football Association (VAFA). In January 1996, Hall was diagnosed as being HIV positive and chose not to play football, believing he may pose a risk to others. However, upon receiving expert medical advice, Hall decided to resume playing, on the basis that he posed no real threat to others.

After discussing his HIV positive status with the club President in April 1998, they applied for registration, disclosing Hall's HIV status. The VAFA subsequently refused Hall's application for registration on the basis that such refusal was reasonably necessary to protect the health and safety of other registered players.

Hall made a complaint to the Equal Opportunity Commission which was subsequently transferred to the Victorian Civil and Administrative Tribunal. Hall alleged the VAFA directly discriminated (within the meaning of s 8 of the *Equal Opportunity Act 1995 (Vic)*) against him in the field of sport pursuant to s 65 of the Act. Section 65 provides:

> A person must not discriminate against another person -
>
> (a) by refusing or failing to select the other person in a sporting team;
>
> (b) by excluding the other person from participating in a sporting activity

The VAFA conceded that its decision not to register Hall amounted to direct discrimination on the grounds of impairment. It was submitted that such discrimination was reasonably necessary within the meaning of s 80 of the Act. Section 80(1) of the *Equal Opportunity Act 1995* (Vic) provides:

> (1) A person may discriminate against another person on the basis of impairment or physical features if the discrimination is reasonably necessary —
>
> (a) to protect the health or safety of any person ...;

The VAFA alleged their action was justified, as it was reasonably necessary to protect the health or safety of other players or officials.

B *Reasoning of the Tribunal*

The tribunal noted that there was little precedent to follow when deciding whether s 80 authorised the VAFA to discriminate against Hall. The tribunal stated, 'it is better to determine what those circumstances are from the words of the section itself rather than to attempt to force it into some narrow interpretation which it may not be capable of bearing.'[48] In the opinion of the tribunal, the ban need not necessarily

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[48] *Hall v Victorian Amateur Football Association*, above n 2, [4].

be in absolute terms but must, on reasonable judgement, be necessary for the specified purpose.[49] The tribunal stated the test for what is reasonably necessary is an objective one, although some subjective factors are relevant. It identified seven factors which must be balanced against each other to determine whether or not the ban was reasonably necessary to protect the health and safety of the players and officials. The relevant factors, in the *Hall* case, were set as a series of questions as follows:

1. What is the class whose health and safety are to be protected? What is the size of that class?
2. What is the risk from which that class is being protected? What is the magnitude of that risk? What are the consequences to the class to be protected if the risk becomes reality?
3. To what degree will the ban protect the health and safety of the class? Will it eliminate or reduce the risk to the health and safety of that class?
4. Does the ban contain within itself any risk to the health and safety of the class?
5. Are there measures currently in place to protect the health and safety of the class from that risk? Are they effective to protect the health and safety of that class from the risk? Will the ban give that class a protection from that risk of a kind or degree that those current measures do not give?
6. Are there non-discriminatory alternatives that will give the class protection from the risk that is equal to or better than the ban? If there are, is there any reason why it may be impracticable for the respondent to adopt these alternatives?
7. Did the respondent, at the time of the ban, believe that the ban was reasonably necessary to protect the health and safety of the class? On what information or inquiries was this belief based? What information on the matter was reasonably available to the respondent?

The tribunal then turned to the epidemiological evidence on HIV as the key element in the determination to the above questions. The evidence before the tribunal indicated the range of statistical risk of transmission per player per game was estimated to be between 1:10,000 to 1:125,000,000. The figure of 1:125,000,000 assumed that the HIV status of players in the VAFA was equivalent to that of the general population and the 1:10,000 figure assumed that one player in the VAFA was known to be HIV positive. There was further evidence that if a player plays 20 games per year then the risk increases to approximately 1:6000.[50]

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[49] Ibid.
[50] Ibid [6]–[7].

The tribunal noted that the statistical risk cannot be divorced from other evidence, such as the fact that there are no clearly established cases of HIV transmission occurring during any code of football anywhere in the world.[51]

The tribunal then reconsidered the factors enumerated as necessary to determine whether or not s 80(1)(a) applies.

1 *What is the Class whose Health and Safety are to be Protected and What is the Size of that Class?*

The class of persons that the VAFA claimed it necessary to protect were such members of the VAFA who as players or as on-field officials may come into contact with Hall in the course of him training or playing football. This is approximately 45 people per game. These people will have differing degrees of contact and as such the risk will vary from person to person.[52]

2 *What is the Risk from which that Class is being Protected, its Magnitude and the Consequences of not Providing Protection?*

The risk is the successful transmission of the virus and consequent infection. The state of the epidemiological evidence is not such that it can be applied in a meaningful or precise way. The statistical risk of transmission is estimated to be between 1:6000 and 1:125,000,000 per player per game.[53]

3 *To what Degree will the Ban Protect the Health and Safety of the Class and will it Eliminate or Reduce the Risk to the Health and Safety?*

The banning of Hall, a HIV infected player, would eliminate the risk of him transmitting the virus. However, a ban on Hall would not alter the risk of transmission from any other unknown HIV positive player, leaving the risk to the class as something between 1:6000 and 1:125,000,000 irrespective.[54]

4 *Does the Ban Contain within itself any Risk to the Health and Safety of the Class?*

It was argued that the banning of Hall would deter others who suspected they were HIV positive from seeking assessment or treatment. It was also argued that it would create a relaxing of the blood rule and a general ostracism of HIV sufferers. However, the tribunal noted the speculative nature of such arguments and was

[51] Ibid [7].
[52] Ibid [8].
[53] Ibid [8]–9].
[54] Ibid [9].

unable to conclude on any substantial risk to the health and safety of the class as a result of banning Hall.[55]

5 *Are there Measures Currently in Place to Protect the Health and Safety of the Class from that Risk?*

The VAFA has an infectious diseases policy which was adopted in August 1992, in consultation with medical experts. There was evidence that the policy had not been consistently or vigorously applied by the VAFA.[56] The tribunal was of the opinion that if the policy were properly applied it would significantly protect all players and officials from HIV and hepatitis B and C transmission from other unknown players. Further, the tribunal found it logical to conclude that the proper application of the VAFA's policy gives the class a protection from risk that the mere banning of Hall does not.[57]

6 *Are there Non-discriminatory Alternatives that Give the Class Protection from the Risk that is Equal to or Better than the Banning of Matthew Hall?*

The tribunal was of the opinion that the proper application of the present VAFA policy would give protection to the class which the banning of Hall does not. Further, evidence from the Managing Director of the VAFA's insurer outlined the vigorous procedures necessary for the VAFA to continue being covered, but, the tribunal dismissed these, believing no greater precautions than those in the current policy were necessary.[58]

7 Did the Respondent, at the Time of the Ban, Believe that the Ban was Reasonably Necessary to Protect the Health and Safety of the Class?

The tribunal formed the opinion that the VAFA had a genuine belief that the ban was reasonably necessary and that such belief was based on information reasonably obtained by it.[59]

On balance, the tribunal formed the opinion that while the risk of HIV transmission from Matthew Hall to other players can be eliminated by excluding Matthew Hall, the risk is so low that it is not 'reasonably necessary' to discriminate against him by banning him from playing football. Moreover, the tribunal believed the health and safety of the players and officials is better protected by an understanding of and the implementation of the infectious disease policy, than by banning Hall. Conse-

[55] Ibid.
[56] Judy Bourke, 'HIV Footballer wins discrimination case' (1999) 9(2) *ANZSLA the Sports Law Association* 9. Otlowski, above n 1, 88.
[57] *Hall v Victorian Amateur Football Association*, above n 2, [12].
[58] Ibid [13]–[14].
[59] Ibid [14]–15].

quently, the tribunal held that the VAFA had not satisfied s 80(1) and consequently contravened s 65(b) of the Act.

VI ANALYSIS OF THE *HALL* CASE FOR THE AFL

The recent decision in the *Hall* case provides some insight as to how the courts will judge the AFL and the methods it uses to prevent HIV transmission. As the only precedent concerning HIV transmission in sport, the decision would be highly persuasive. However, the decision in *Hall* is only persuasive, as it comes from a tribunal, and a court may find otherwise. This is particularly evident upon a critique of the case.

Hall's case presents a number of differences which may be necessary for the AFL to distinguish in future cases. Firstly, in the *Hall* case, the tribunal focused, perhaps excessively, on the low risk of transmission. In doing so, it neglected to sufficiently emphasise the gravity of contracting the virus. Secondly, the tribunal only considered the risk of transmission during the 100 minutes of the game. However, it is submitted that a player's exposure is much greater. Thirdly, the AFL may be able to show some significant differences between itself and the VAFA which could help distinguish the case. Finally, the AFL's conduct may not be discriminatory if its infectious disease policy is strictly enforced. Each of these factors will now be discussed.

A *Gravity of Contracting Viruses*

To prove the AFL or an AFL club has been negligent, it must be shown that the requisite standard of care has been breached. As outlined above, this involves a balancing of the factors which form the calculus of negligence. Each must be weighed against the other. It is respectfully submitted that the tribunal ignored this requirement focusing only on one of these elements, the risk of transmission. Other factors which should be considered include the gravity of consequences and the practicability of taking precautions.

While the tribunal in the *Hall* case may have been justified in placing a significant emphasis on the risk of transmission as that case did not require consideration of the question of negligence, it would be wrong to discard the other factors which encompass the calculus of negligence for present purposes.[60] The possibility of a negligence action is always present.

When a balancing of the calculus of negligence occurs, it is suggested that if the AFL or an AFL club allowed a player they knew to be HIV/HBV/HCV positive to

[60] It is not evident from *Hall v Victorian Amateur Football Association*, nor was any justification given, as to why the tribunal placed so much emphasis on the risk of transmission and failed to consider the gravity of contracting the virus. A possible explanation may be that the gravity of contracting HIV is irrelevant to a discrimination case as the legislation simply refers to the virus as a disability, the fact that one disability is more sever than another may be irrelevant.

take the field they would quite possibly be acting negligently. The risk of HIV transmission has been sufficiently highlighted above in the *Hall* case. It is suggested that the risk of transmission for HBV and HCV, whilst not precisely calculated, are much higher as both are much more prevalent in the Australian community.[61] Moreover, HBV may be transmitted in a greater number of situations than HIV, as it may contaminate surfaces for a number of days.[62] It is believed, on the other hand, that HCV can only be transmitted by blood inoculation, although, there is the possibility of transmission through other bodily fluids.[63]

The gravity of contracting each of these viruses is quite severe.[64] All three viruses may ultimately result in death. However, it is not only the physical consequences that must be considered. Each of these viruses carries certain ostracism, particularly by players afraid of contracting the virus.

The other factor in the calculus of negligence which must be considered is the cost of alleviating the risk. It is suggested that the AFL could alleviate the risk by conducting mandatory HIV/HBV/HCV screening, as suggested above.[65] Whilst no precise estimate of screening costs is provided, it is suggested that it would be between $51.40[66] and $80 per test.[67] Notwithstanding the cost, the screening of players appears necessary when weighed against the gravity of contracting the viruses.

Therefore, while the tribunal in the *Hall* case placed considerable importance upon the risk of transmission in its decision, another tribunal or court may have placed more emphasis on the gravity and perhaps have come to a different decision. Therefore, if the AFL was faced with a negligence action, the fact that a precise estimate of the risk of transmission could not be provided may not be considered as harshly as in the *Hall* case.

B Exposure to Risk

One of the ways the AFL could distinguish the *Hall* case could be to prove that the risk of infection is significantly higher in the AFL than in the VAFA. This can be done in two ways. Firstly, in the *Hall* decision, evidence given on the risk of transmission was calculated per player per game.[68] Those giving evidence in *Hall*[69] all failed to consider the possibility of the virus being transmitted outside the 100 minutes of play. It is suggested that the exposure to risk is much greater, and must

[61] Australian Bureau of Statistics, above n 21, 282.
[62] Turkington, above n 5, 130. Piazza and Guadagnino, above n 6, 473.
[63] Turkington, ibid, 133.
[64] See above Section II.
[65] Screening Players for HIV/HBV/HCV is discussed in above Section II(D), III.
[66] Interview with Renato Raimondi, Business Manager, *VIDRL* (Melbourne, 20 January 2000). This figure is the sum of $18.00 (HIV screening), $16.70 (HBV screening), $16.70 (HCV screening). These figures are provided in the *Medicare Benefits Schedule*, November 1999.
[67] Interview with Michael O'Malley, professional boxer (Geelong, 2 December 1999).
[68] *Hall v Victorian Amateur Football Association*, above n 2, [6].
[69] Dr Grulich, Mr Cumpston and Dr Peter Stanley.

also include time spent training, as well as pre- and post-match activities such as warm up and showering. Players at all levels train at least one day a week, with players in the AFL training five days a week, 46 weeks of the year. Thus, while footballers only play 100 minutes of football a week, the risk must be calculated from a much greater base. Consequently, players' real exposure to the risk of transmission is much higher than the tribunal in *Hall* considered. Being a professional football player is not about playing football for 100 minutes per week. The combat and collisions during tackling sessions, and other training techniques mean that the real exposure to transmission is substantially higher. Consequently, it is suggested that the risk of transmission given in the *Hall* case was underestimated. Moreover, a higher possibility of transmission could have a major impact on the tribunal decision which focused heavily on the fact that the risk was so low that it was not reasonably necessary to discriminate.

Secondly, the *Hall* case dealt only with discrimination in relation to banning a HIV positive player. If the AFL has a case which involves a player who is HBV or HCV positive it may be able to show that the viruses are very different and in fact distinguish the case in this way. As well as having different symptoms, the risks of transmission vary greatly for each.

The risk of contracting either HBV or HCV is higher than the risk of contracting HIV. While HBV and HIV are transmitted in a similar manner, unlike HIV, HBV may survive outside the body for days and therefore contaminate surfaces. When the possibility of contracting HCV is added to this, the exposure of players in the AFL must be considered substantially greater than in the *Hall* case where only HIV was considered.

Using the reasoning in *Hall*, the AFL may be able to show that its conduct is reasonably necessary to protect the health and safety of players and on-field officials. As the risk of transmitting HBV and HCV are substantially higher, the AFL would appear to be justified in the mandatory testing of players and in excluding infected players from competition, pursuant to s 48 of the *Disability Discrimination Act 1992* (Cth). Unlike in the *Hall* case, the risk of transmission from the one infected player would not be so low that it is not reasonably necessary to discriminate against the player. The exclusion of that player in the AFL, where the infectious policy is strictly enforced, would make a substantial difference. Consequently, it would appear that the AFL may be justified in testing and excluding players who test positive when the three viruses are considered together.

When HIV, hepatitis and training are all considered together, the exposure to risk appears to be much higher than taken into account in the *Hall* case. Thus, it is more probable that a future court or tribunal would find that the risk of contracting HIV/HBV/HCV from Australian football is sufficient to discriminate against an infected player pursuant to s 48 of the *Disability Discrimination Act 1992* (Cth). Therefore, it would appear that the AFL may legally conduct screening and exclude players that test positive.

C AFL v VAFA

Another way in which the AFL could distinguish the *Hall* case may be to point out the differences between the VAFA, the subject of the *Hall* case, and the AFL. The former involves amateurs and is restricted to Victoria, where as the latter is an Australian league and therefore of a higher standard. However, the differences extend further.

At AFL level the players tend to be stronger, fiercer and more dedicated than at VAFA level, as their livelihood depends upon their performance. Consequently the tackles are harder, creating a much higher risk of bodily contacts which create blood and other bodily fluid spillage.

Further, as pointed out above, players at AFL level train five days a week, 46 weeks of the year, as opposed to one or two training sessions a week in the VAFA for about 35 weeks of the year. Moreover, a tackle session in the AFL may be considered so intense and tough and the collisions so severe as to warrant intervention. This form of intervention currently occurs in boxing where a pre-fight fitness test is necessary before a boxer can compete. For this reason, there should be little problem in a court recognising the greater exposure to bleeding whilst at training to warrant the exclusion of HIV-infected players as non-discriminatory.

D Strictly Enforced Infectious Disease Policy

In the *Hall* case, it was suggested that because the VAFA did not strictly enforce its infectious disease policy, and there would always remain other unidentified HIV positive players, the exclusion of Hall from competition would not alter the risk of contracting HIV. This tended to suggest that the exclusion of Hall was not reasonably necessary. In the circumstances of the *Hall* case, such a decision was warranted. However, it is suggested that the outcome may be different if the infectious disease policy was strictly enforced and screening conducted, as the inclusion of one HIV/hepatitis positive player would increase the risk of transmission. It is also suggested that yet another difference between the AFL and the VAFA is the professionalism of the AFL. One of the benefits of this is that the infectious disease policy is treated a lot more seriously in the AFL and as a result its regulations are strictly enforced.

A counter argument suggested in the *Hall* case, is that all that is required to reduce the risk of transmission to a level where it would be unlikely that HIV transmission would occur, would be to strictly enforce the infectious disease policy. While this may seem reasonable, it fails to take into account the greater exposure to the risk of transmission discussed above and the possibility of death that could ensue from HIV/HBV/HCV transmission. These factors appear sufficient to justify not only a reduction of the risk, but instead, its elimination.

VII RECOMMENDATIONS

The decision in the *Hall* case has left the AFL in an unclear position. Should it allow HIV/HBV/HCV infected players to compete in its competition or should it exclude them and protect the interests of the non-infected players? To overcome some of the difficulties the *Hall* decision has imposed upon the AFL, a number of recommendations are offered. The advantage of implementing these recommendations is that if a situation does arise where the AFL is sued by either an HIV/HBV/HCV positive player or a non-infected player it should be able to avoid liability, by showing that it has taken more than reasonable precautions to eliminate the risk of transmission or that its actions were reasonably necessary to protect public health.

A *HIV/Hepatitis Screening*

HIV/HBV/HCV screening could be a necessary measure to ensure that exclusion of an infected player is not held to be discriminatory. In the *Hall* case, it was suggested that the statistical risk of transmitting the virus during a game did not alter whether or not Hall participated, as there remained a risk from other unidentified HIV/HBV/HCV infected players. Consequently, Hall's exclusion was not reasonably necessary to protect public health and was therefore held to be discriminatory. It is submitted that if every player were tested twice a season and those who tested positive were excluded, it would not amount to discrimination. Screening in this manner would mean that the risk of contracting the viruses would significantly increase if an infectious player were allowed to participate. As a result, screening would, unlike in the *Hall* case, be reasonably necessary to protect public health.

In order to carry out HIV/hepatitis screening, the AFL is subject always to the anti-discrimination legislation,[70] and other State provisions.[71] HIV testing, however, requires the AFL Medical Officer or another doctor taking blood for the test to provide pre- and post-test counselling[72] and other requirements including confidentiality measures.[73] Further, HIV testing has the additional common law requirement of obtaining player consent.

B *Consent to HIV/Hepatitis Testing*

[70] Anti-discrimination legislation was discussed in above Section III.

[71] An example of a provision which prohibits HIV/Hepatitis Screening is the *HIV/AIDS Preventive Measures Act 1993* (Tas).

[72] *Health Act 1958* (Vic) s 127; *Public Health Act 1991* (NSW) s 12 and *Public Health Regulations 1991* (NSW) r 4; *HIV/AIDS Preventive Measures Act 1993* (Tas) ss 14–15; *Notifiable Diseases Act 1981* (NT) s 10.

[73] Confidentiality measures in Victoria include the prohibition on medical practitioners requesting an HIV test using information which would identify the test subject, although epidemiological details such as age, sex and transmission category must be provided: *Health Act 1958* (Vic) s 130(4)–(5). Similar provisions apply in Tasmania pursuant to *HIV/AIDS Preventive Measures Act 1993* (Tas) ss 17–18, and in New South Wales pursuant to the *Public Health Act 1991* (NSW) s 17(1)(b) and *Public Health Regulations 1991* (NSW) r 7(1).

If the AFL were to make a negative HIV/hepatitis status a precondition to participation, it may require the player's consent to be tested. Player consent may be obtained through the existing AFL–AFLPA Standard Playing Contract. Alternatively, the AFL may have to include a specific clause in the contract which obtains a player's consent and authorises the mandatory testing of all players. It is unclear whether a general acquiescence to medical treatment will provide the necessary consent to HIV/hepatitis testing, or whether specific consent is required.

There is a strong argument that HIV/hepatitis screening may already be authorised under the current AFL–AFLPA Standard Playing Contract. Clause 4 of the contract is headed Player's Duties. It states,

> **The player shall for the Term: —**
>
> 4.3 Comply with Reasonable Directions and Requirements
>
> Obey all lawful and reasonable directions of the Senior Coach, Chief Executive, General Manager, Football Manager and Board of Directors/Management of the AFL Club …

It is believed by some[74] that clause 4.3 authorises the AFL to conduct HIV/hepatitis screening.

It is also submitted that a player's consent may be found in clause 4.9. That section reads:

> **4.9 Physical Examination**
>
> Submit to a complete physical examination upon the request of the AFL Club and at the AFL Club's expense prior to the start of each AFL Season. The player acknowledges and agrees with the AFL Club that a failure to achieve a reasonable level of physical fitness necessary to play Australian Football on any occasion when the player is required to submit to a complete physical examination, shall, …operate to suspend the payments and benefits that would otherwise have been paid or provided by the AFL Club to the player under this Contract …

It could be argued that clause 4.9 includes the requirement that players be HIV/HBV/HCV negative. While the viruses are symptomless and don't affect a player's direct ability to gather, mark and dispose of the football, the viruses do affect the players' 'level of physical fitness necessary to play Australian football'. Such an interpretation is possible, as the level of physical fitness required to play Australian football goes beyond a player's physical capacity to perform the skills of the game. A part of the 'physical fitness necessary to play Australian football' includes the ability to perform the skills of the game while having regard to the health and safety of other players and on-field officials. Such an interpretation can

[74] Magnusson and Opie, above n 30, 228.

be justified as Australian football is a team sport, and not one where the players can be isolated from each other. To participate, every player must be able to perform the essential skills of the game, and do so, in the context of a team sport. Thus, if this is what the phrase a 'level of physical fitness necessary to play Australian football' is interpreted to mean, then a player must be non-contagious to participate. Therefore, not only must the player submit to a HIV/hepatitis test, he must also, according to clause 4.9, forgo 'payments and benefits that would otherwise have been paid or provided'.

Player consent may also be found in clause 10 which provides:

> **10. RULES**
>
> **10.1 Comply with AFL Rules**
>
> The player and the AFL Club agree with the AFL to comply with and observe the AFL Regulations, the AFL Player Rules, the Code of Conduct, the Memorandum and Articles of Association of the AFL and any determinations or resolutions of the AFL Commission which may be made or passed prior to or at any time after the execution of this Contract ('the AFL Rules')...
>
> **10.3 Obey AFL Club Rules**
>
> The player shall comply with and observe all Rules and Regulations of the AFL Club, the Memorandum and Articles of Association of the AFL Club and any determinations or resolutions of the AFL Club which may be made or passed prior to or at any time after the execution of this Contract, provided that the player is notified of the resolution or determination.

Clauses 10.1 and 10.3 of the AFL Standard Playing Contract appear to allow the AFL or the Club respectively to make any resolutions at any time which will be binding on the player. It would appear that if the AFL were to alter the Rules and Regulations to make HIV/hepatitis testing mandatory, these clauses would provide the necessary player consent and therefore authorise the players to undergo the testing.

However, the player consent identified is by no means expressly stated and, as such, may be rejected by the courts. Such a view forms the majority of current academic opinion.[75] Further, current case law suggests that it is the player's responsibility to decide for himself whether or not to submit to the test.[76] Therefore, it is suggested that the AFL include an express term in the contract which obtains player consent to HIV/hepatitis testing.

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[75] Ibid; John Godwin and Julie Hamblin and David Patterson et al, *Australian HIV/AIDS Legal Guide* (2nd ed, 1993) 181–2; Julie Hamblin, 'Health Care; Rights and Responsibilities' (1992) *Law Society Journal*, 66–67; Andrew Grubb and David Pearl, *Blood Testing, AIDS and DNA Profiling* (1990) 3–27.

[76] *Rogers v Whitaker* (1992) 175 CLR 479, 486 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).

The inclusion of an express term could also incorporate the players' consent to the disclosure of the test results to the AFL and therefore avoid the complicated legal difficulties associated with disclosure of results. Currently, there is a specific clause which gains players' consent to undergo drug testing.[77] A similar clause may also be effective to obtain player consent to HIV/hepatitis testing. Such a clause could read as follows:

> **4.12 HIV/Hepatitis Testing**
>
> Submit himself twice per season to a HIV/HBV/HCV test at the request, expense and under the direction of the AFL. The player and the AFL Club agree with the AFL to provide all reasonable assistance and comply with all directions of the AFL Medical Officer who will conduct the test. The results will be held in confidence by the AFL. Any player testing positive agrees to remain out of competition and training until the League otherwise advises.

The addition of such a clause may effectively provide the AFL with the player consent necessary to conduct compulsory testing of players.

C *HBV Vaccination*

The AFL should attempt to eliminate HBV transmission by making HBV vaccinations a condition precedent to playing Australian football as suggested by the ASMF *Infectious Diseases Policy.* To achieve this, the AFL would require consent to conduct vaccination on players unable to produce evidence of their last vaccination from HBV.

The AFL may arguably already be authorised to conduct HBV vaccination under the current AFL Standard Player Contract. Clause 4 of the contract is headed Player's Duties. Under this it states, The player shall for the Term:-

> **4.7 Fitness**
>
> Do everything reasonably necessary to obtain and maintain the best possible physical condition so as to render the most efficient service to the AFL Club
>
> ...

This clause may provide the AFL with the player's consent to HBV vaccination. HBV vaccination is but one of the necessary means of maintaining the best possible physical condition, as it would ensure players had a negative HBV status. It could be argued that a negative HBV status is part of the best physical condition of a footballer, as a failure to impose this condition may result in transmission which could have been prevented.

[77] Clause 4.11 of the AFL/AFLPA Standard Playing Contract.

Further, it could be argued that the players consent to HBV vaccination is also attained by clause 4.3.[78] This clause requires that players 'obey all lawful and reasonable directions of the Senior Coach, Chief Executive, General Manager, Football Manager and Board of Directors/Management of the AFL Club…'

Also, if the AFL or AFL Club were to adjust its rules to include compulsory HBV vaccination, player consent may be given pursuant to clauses 10.1 and 10.3.[79] These clauses state that the player agrees to comply with AFL Rules and to observe all AFL Club rules respectively.

D Strictly Enforced Infectious Disease Policy

A more effective infectious disease policy was held to be sufficient in reducing the risk of transmission to an acceptable level in the *Hall* case as to allow an infected player to compete. It is suggested that if the AFL strictly enforces its infectious disease policy, it may be able to show that the exclusion of a HIV/HBV/HCV infected player significantly reduces the exposure to risk of non-infected players. This suggests that the exclusion of a player testing positive would not amount to discrimination, as it comes within the sport exception,[80] as discussed above.

E Reducing AFL's Exposure to Liability

The implementation of the above-mentioned recommendations may be necessary both from a legal and economic standpoint. Legally, by adopting these recommendations the AFL would be making a statement to the courts that it is doing all in its power to prevent the transmission of these diseases in Australian football. By adopting these recommendations the AFL would be acting in a non-discriminatory manner, while still fulfilling its obligations in negligence to HIV/HBV/HCV negative players and on-field officials. While the implementation of these recommendations may initially be economically burdensome for the AFL with seemingly little benefit, this expense may potentially save millions in damages and at the same time establish the AFL as a world leader for infectious disease control in sport. The adoption of these recommendations would also set an example for other sporting leagues and associations throughout Australia and internationally. More importantly, the AFL would be able to stand up to any player who contracted either of the viruses while competing, and know that it had done all that was possible.

The suggested approach may also act as insurance for new heads of liability which may arise. For example, it would protect the AFL from claims such as those made in *Hyde v Agar; Worsley v Australian Rugby Football Union Ltd* [81] where the league was sued for negligence because their rules didn't provide sufficient attention to players' safety.

[78] This provision was previously extrapolated in above Section VII(B).
[79] These provisions were previously extrapolated in above Section VII(B).
[80] Sport exception is contained in s 48 *Disability Discrimination Act 1992* (Cth). Explained above.
[81] *Hyde v Agar; Worsley v Australian Rugby Football Union Ltd* (1999) Aust Torts Reports 81–495.

It should be noted that the AFL may possibly seek an exemption from the Commission under s 55(1) of the *Disability Discrimination Act 1992* (Cth). The operation of this exemption is, however, vague, with little assistance from case law. Consequently, it is unclear whether this exemption would be of benefit to the AFL.

VIII CONCLUSION

The AFL is in a precarious position regarding HIV positive players. As it currently stands, the AFL may not be truly fulfilling its duty of care to other players and on-field officials and this may result in successful negligence suits against it. Alternatively, if it excludes a HIV positive player, it may be acting in a discriminatory manner. The *Hall* decision would suggest that the AFL should protect HIV positive players' as their exclusion would not alter the already low risk of contracting the virus. However, when HBV and HCV are considered, the position is somewhat different as the exposure to infection becomes much greater. This makes it difficult to predict the outcome of any future case. However, by adopting the recommendations outlined throughout this thesis, the AFL can minimise its possible liability in a number of ways. First, the AFL would significantly reduce the risk of transmission and therefore result in fewer cases being brought against it. Secondly, it is suggested that such an approach would mean the AFL's activities would not be seen to be discriminatory. Finally, the approach recommended would indicate to a court that the AFL had done all that was reasonably necessary and more to reduce the risk of transmission and therefore it would take a harsh court to convict on a negligence claim. The implementation of all these recommendations are practical, as they are economically viable. However, even if costs were larger than anticipated, implementation would be well justified when the gravity of contracting HIV/HBV/HCV is considered.

Although at present the risk of HIV/HBV/HCV transmission in football is clearly low, there are occasions during which the risk of transmission between the infected player, other players and on-field officials who assist him on the playing ground could arise.[82] It is evident from the above information that the risk is real, and not too remote to consider, as suggested in *Hall*. Due to the presence of this risk, it is necessary to follow a series of health rules, the aim of which is to guarantee the welfare of all concerned and avoid potential liability to the AFL and its clubs.

Infectious disease screening is certainly not the only solution to the growing concern of HIV/hepatitis transmission in the AFL, but, it does provide a good starting block and an effective means of drastically reducing the chance of transmission to both players and on-field officials.

[82] In fact, infection notifications and hence the chance of transmission in contact sport are now higher then in 1994 when Magnusson and Opie concluded that screening may be necessary in Magnusson and Opie, above n 30, 267. Rates of infection are identified in Australian Bureau of Statistics, above n 21, 282.

In conclusion, it is suggested it is better to exclude infectious players and potentially be sued for discrimination than risk transmitting the virus, receiving bad publicity for the sport, and suffering the potential massive damages in negligence if a death were to ensue. Further, it is unlikely that a court would award damages to an excluded player when such measures had been taken. This was evidenced by Matthew Hall's recent dismissal of appeal for damages. Moreover, by implementing these recommendations and excluding infectious players, the AFL is doing all within its power to reduce the transmission of these viruses.