

HIV and Hepatitis in Sport: A Legal Framework for Resolving Hard Cases*

ROGER S MAGNUSSON**
HAYDEN OPIE***

1. INTRODUCTION

The profile of HIV and hepatitis in sport has risen dramatically in recent years. A number of incidents and reports have highlighted that HIV, in particular, has a sporting dimension.

On 7 November 1991, the outstanding and idolised United States professional basketballer, Earvin ('Magic') Johnson, announced that he had HIV, having contracted it through heterosexual contact.¹ Johnson retired immediately, only to indicate within a few months that he was willing and able to be selected for the United States team to compete at the Olympic Games held in Barcelona in 1992. His selection for the so-called 'Dream Team' of professional basketballers of the like never seen before was a foregone conclusion. However, an international furore erupted when some Australian basketballers questioned whether they were at risk of contracting HIV by playing against Johnson.²

In April 1992, Arthur Ashe, the 1975 Wimbledon champion, revealed that he was suffering from AIDS. He had known that he had HIV since 1988, but made the announcement of his condition to forestall its imminent reporting in the media. Ashe probably contracted HIV in 1983 from a blood transfusion administered in connection with heart bypass surgery.³

In July 1992, a Tasmanian Australian rules footballer was banned from playing the sport by the Tasmanian North-East Football Union because he

* An earlier version of this paper was presented to the Third Annual Conference of the Australian and New Zealand Sports Law Association Inc (ANZSLA) at Canberra on 4 December 1993. The authors wish to thank the following people for providing assistance with references and comments: (i) Garry Bail, Manager, Administration and Finance, St Kilda Football Club; (ii) Dr Peter Brukner, Olympic Park Sports Medicine Centre, Melbourne; (iii) Dr Peter Harcourt, Alphington Sports Medicine Clinic, Melbourne; (iv) Terry Sanders, National Executive Director, Australian Sports Medicine Federation Ltd; (v) Dr Hugh Seward, President, Australian Football League Medical Officers' Association; (vi) Jane Tomnay, Infectious Diseases Resource Officer, Victoria Police.

** BA, LLB (Hons) (ANU), PhD (Melb), Postdoctoral Research Fellow, Faculty of Law, University of Melbourne. Dr Magnusson's participation is funded by an AIDS Postdoctoral Research Fellowship paid by the Commonwealth Department of Health, Housing and Community Services.

*** BComm, LLB (Hons) (Melb), LLM (Tor), Senior Lecturer, Faculty of Law, University of Melbourne; President, Australian and New Zealand Sports Law Association Inc (ANZSLA).

¹ *Sports Illustrated* (New York), 18 November 1991, 16.

² 'Fury in US at Call to Boycott Magic', *Age* (Melbourne), 25 January 1992, 1; 'AIDS Risk in Sport Proved Claim Doctors', *Advertiser* (Adelaide), 28 January 1992, 8; 'After the Ridicule, Borner's Views Supported', *Age* (Melbourne), 11 November 1992, 30; J Niall, 'AIDS in Sport', *Inside Sport*, No 16S, April 1993, 14.

³ *Sports Illustrated* (New York), 21 December 1992, 16.

had contracted HIV. It was reported that the Union also withdrew registration of players who had tested positive for Hepatitis B or C.⁴ Finally, in November 1992, it was reported that three world class Canadian figure skaters had died of AIDS in the previous 12 months.⁵

Science has known of HIV for a decade and of hepatitis for much longer. So it may seem surprising that these incidents and reports should have attracted such sensational treatment in the mass media. There are, perhaps, three reasons for this treatment. Firstly, the prospect of transmission of these viruses (especially HIV) via sporting activity has not received significant attention either in medicine or the mass media. Secondly, the traditional high-risk groups for transmission of HIV (male homosexuals, intravenous drug users and haemophiliacs) do not play, or are not perceived as players of, contact sports in particular.⁶ Thirdly, these incidents sharpened the emerging realization that HIV was a more general health threat which could not be dismissed on the basis that only marginalised groups were at risk.

HIV and hepatitis are not, of course, the only infections which may be transmitted in sport. Colds, influenza, impetigo, tinea, herpes simplex and herpes zoster (chickenpox) are just some of the communicable and infectious diseases which may be transmitted, especially in physical contact sports.⁷ However, the valuable consequence of media attention on HIV in sporting contexts has been to bring home to various sectors of the community, arguably more effectively than other publicity measures which have been taken, the need for effective action to control the transmission of infectious diseases. Many sports have been stimulated to develop and implement infectious diseases policies.

This has led to questions of a legal nature being raised about these policies. Many of the legal issues raised are entirely novel, and until the courts and Parliaments deal with them specifically, it will be a case of taking general principles and the experiences gained in other contexts and adapting them to the circumstances of sport.

This paper will discuss some of the legal issues which the transmission, or the potential transmission of HIV and hepatitis raises for sports administrators and their advisers, athletes, team doctors, and others involved with the organisation and management of sport. It should be emphasised that these issues are as relevant to sport played at a community or club level, as to elite sport.

We will examine the issues from the viewpoint of a sports organisation seeking to develop and implement an infectious diseases policy which both

⁴ 'HIV-Positive Footballer Banned', *Age* (Melbourne), 17 July 1992, 5; 'Council Slates HIV Sport Ban', *Australian*, 17 July 1992, 3; 'Top Footy Hope has AIDS!', *Truth* (Melbourne), 6 June 1992.

⁵ 'Ice-skating in Crisis as Top Stars Confront AIDS', *Age* (Melbourne), 20 November 1992, 28; see also, 'Skater Remained True to His Form', *Australian*, 20 April 1994, 13.

⁶ See 'The Full Implications of Martial Arts Legislation (Part 2)' (1991) 14(3) *Australian Fighting Arts* 70.

⁷ R W A Girdwood, 'Infections Associated with Sport' (1988) 22 *British Journal of Sports Medicine* 117; 'Wrestling's Risk', *Hartford Courant* (Hartford, USA), 21 February 1992.

minimises the risk of disease transmission and the prospect of legal liability for such transmission. Section 2 will endeavour to clarify the link between HIV/hepatitis and sport by briefly outlining the means and risk of transmission. In view of this risk, Section 3 will discuss some of the policies adopted or favoured by some Australian sports bodies. This will permit consideration in later sections of specific legal issues raised by various policy options which sports organisations may be tempted to pursue. Section 4 will discuss legal issues relating to the ascertainment of infection within sport such as compulsory testing of participants. Section 5 will consider legal constraints upon sports bodies in seeking to minimise transmission such as discrimination and restraint of trade. Section 6 will examine legal liability for infectious disease transmission within sport contexts. Section 7 will conclude with some general recommendations.

The aim of our discussion is to provide a framework for analysis of the practical legal problems which possible disease transmission in sport creates, and to provoke informed debate. The legal doctrines discussed (duty of care, discrimination, restraint of trade, confidentiality), each have their own internal logic and history of application. We believe that there is potential for conflict between the interests of protection from bodily harm, respect for the privacy of personal health information and the elimination of discrimination. Not only must these tensions be resolved so that sport may be pursued under a clear legal framework, but, in the process of finding a resolution, we believe some light may be shed on the legal issues surrounding infectious diseases in the broader community context. As far as the sports law issues are concerned, we believe that an immediate legislative resolution is highly unlikely. In applying legal doctrines to the novel context of disease transmission in sport, we have steered a course which some may consider controversial.⁸ Those who would apply doctrines such as duty of care or discrimination differently, however, should bear in mind the potential for conflict which we have largely avoided. In this emotive area, the application of legal doctrine to the disease transmission context is made doubly difficult by present statistical and medical uncertainty over sport-related transmission. We recognise that as more medical evidence emerges, the application of the legal principles we identify may lead to different outcomes.

2. THE RELATIONSHIP BETWEEN HIV, HEPATITIS AND SPORT

Sports administrators and their advisers, athletes and others involved in the organisation of sports which involve physical contact each share the common goals of (i) preventing the transmission of HIV/hepatitis within sporting contexts and (ii) avoiding legal liability for such transmission. The potential legal

⁸ After this paper was presented at the Third Annual ANZSLA Conference at Canberra on 4 December 1993, it attracted some critical comment; eg, 'Call for HIV Tests in Contact Sports', *Sydney Morning Herald*, 6 December 1993, 2.

problems arising from HIV/hepatitis in sport arise from, and are limited by, the manner and likelihood of HIV/hepatitis transmission in sport-related contexts. Administrators, athletes and others must put aside personal prejudices, myths and disinformation when considering what action the risk of transmission within their sport requires. Legal, political and policy responses to infectious diseases in sport must be based on scientific fact.

(a) Means and Evidence of Transmission of HIV and Hepatitis in Sport

HIV and hepatitis pose a major threat to public health in Australia.

(i) *Human Immunodeficiency Virus ('HIV')*

HIV infection initially causes an acute viral infection from which subjects invariably recover. Thereafter, the infected subject may suffer no further symptoms for an average of 8 years or more.⁹ While cases of long term symptomless infection suggest that there may be less virulent strains of HIV,¹⁰ it is well known that, on the current level of knowledge, HIV infection will inevitably, after a period of years, progress to AIDS. AIDS refers to the onset of life-threatening illnesses caused by the collapse of the body's immune resistance as a result of HIV infection. The more important examples of these illnesses (often referred to as AIDS-defining illnesses) are pneumonias, opportunistic infections, malignancies and neurological illnesses.¹¹ The mean survival time for patients with AIDS-defining illnesses is 2 to 3 years. There are, as yet, no effective vaccines against HIV. A total of 17 568 Australians have been diagnosed as HIV positive,¹² with 4530 cases of AIDS resulting in 3017 deaths.¹³

HIV may be transmitted sexually (by penetrative vaginal, anal and possibly oral sex¹⁴ involving exchange of body fluids), perinatally, by the transplantation of infected tissue, and by the direct inoculation of infected blood,¹⁵ whether by IV drug use, blood transfusions, needlestick injuries or potentially, by bloody contact between athletes participating in sport. To date, 81.5% of infections have been attributed to male homosexual/bisexual contact, with intravenous drug use (both alone and with homosexual/bisexual contact) accounting for a further 8.1%. Heterosexual contact accounts for 6.4% of infections.¹⁶ Although HIV has been isolated in other body fluids such

⁹ N Crofts, 'Patterns of Infection' in E Timewell, V Minichiello and D Plummer (eds), *AIDS In Australia* (1992) 24, 28.

¹⁰ J Learmont, B Tindall, L Evans, et al, 'Long-Term Symptomless HIV-1 Infection in Recipients of Blood Products from a Single Donor' (1992) 340 *Lancet* 863.

¹¹ A Carr, 'What is AIDS?' in E Timewell, V Minichiello and D Plummer (eds), *AIDS In Australia* (1992) 3, 7-8.

¹² Cumulative diagnoses reported to the National Centre in HIV Epidemiology and Clinical Research, St Vincent's Hospital, Sydney; figures taken from *Australian HIV Surveillance Report*, Vol 10(1) (January 1994) Table 2.1.

¹³ *Id* Table 1.1.

¹⁴ 'AIDS Study Leaves Open Verdict on Oral Sex', *Age* (Melbourne), 29 January 1994, 5.

¹⁵ Crofts, *op cit* (fn 9) 29-32.

¹⁶ *Australian HIV Surveillance Report*, Vol 10(1) (January 1994) Table 2.2.

as saliva and tears,¹⁷ there is no evidence that HIV may be transmitted by ordinary casual or household contact (shaking hands, sharing drinking glasses, using toilet seats, hugging).¹⁸ Over ten years into the epidemic, in the absence of any reported instances, it appears that HIV cannot be transmitted through contact with the sweat or spit of an infected person, or by ordinary physical contact during sporting events, training or physiotherapy not involving blood contact.¹⁹ There have, however, been isolated, reported examples of HIV transmission following a collision on a soccer field which caused severe skin wounds with copious bleeding,²⁰ and following a fist fight at a wedding which caused facial injuries with profuse bleeding.²¹ In another case, a bodybuilder acquired HIV and hepatitis B as a result of sharing needles with other bodybuilders who were all injecting anabolic steroids.²²

(ii) Hepatitis B ('HBV')

In view of the fact that HIV is relatively difficult to transmit, hepatitis presents a far more serious picture. HBV is an escalating problem in Australia. HBV infection follows either of two pathways. *Acute* HBV may be symptomless, or it may cause fever, vomiting, jaundice and other symptoms which frequently require weeks or months of hospitalisation before full recovery. The death rate from acute HBV is less than 1%, with most cases becoming non-infectious in three to six months.²³ *Chronic* HBV, however, may be a symptomless infection which progresses insidiously, leading to liver cancer, cirrhosis and other lethal illnesses. In Australia, as in Northern Europe and the United States, at least 0.1% of the population are estimated to be chronic carriers of HBV capable of transmitting infection, although the carrier rate is unevenly distributed, being much higher in some ethnic communities, and especially so in aboriginal communities where studies have estimated carrier

¹⁷ J E Groopman, S Z Salahuddin, et al, 'HTLV-III in Saliva of People with AIDS-Related Complex and Healthy Homosexual Men at Risk for AIDS' (1984) 226 *Science* 447; L S Fujikawa, S Z Salahuddin, et al, 'Isolation of Human T-Lymphotropic Virus Type III from the Tears of a Patient with the Acquired Immunodeficiency Syndrome' (1985) 2 *Lancet* 529.

¹⁸ G H Friedland, B R Saltzman, M F Rogers, et al, 'Lack of Transmission of HTLV-III/LAV Infection to Household Contacts of Patients with AIDS or AIDS-Related Complex with Oral Candidiasis' (1986) 314 *New England Journal of Medicine* 344.

¹⁹ *World Health Organisation and International Federation of Sports Medicine Consensus Statement from Consultation on AIDS and Sports* (1989) (hereafter referred to as 'WHO Consensus Statement') para 4 (reproduced in (1992) 267 *Journal of the American Medical Association* 1311, 1312).

²⁰ 'Transmission of HIV-1 Infection Via Sports Injury' (1990) 335 *Lancet* 1105. The source of transmission has, however, been questioned: F M Goldsmith, 'When Sport and HIV Share the Bill, Smart Money Goes on Common Sense' (1992) 267 *Journal of the American Medical Association* 1311.

²¹ 'Transmission of HIV-1 Infection After a Fight' (1992) 339 *Lancet* 246.

²² 'AIDS in a Bodybuilder Using Anabolic Steroids' (1984) 311 *New England Journal of Medicine* 1701.

²³ E Walker, 'Herpes Simplex, Hepatitis B and the Acquired Immune Deficiency Syndrome' in 'Infections in Sport' (Proceedings of the Sports Medicine Conference organised by the Edinburgh Post-Graduate Board for Medicine on 4 March 1988) (1988) 22 *British Journal of Sports Medicine* 117, 119.

rates at between 10% and 25%.²⁴ Persons infected as children are much more likely to become carriers than those infected as adults. Carrier infectivity falls over time.²⁵

HBV is present in blood and all body fluids of infected persons. The most efficient means of HBV transmission is vertically, from mother to child.²⁶ HBV may also be transmitted sexually, through infected blood or semen, and by inoculation with infected blood and body fluids.²⁷ While this includes transmission through needle sharing, needlestick injuries, blood transfusions and renal dialysis, HBV may also be transmitted by splashing infectious fluids onto mucous membranes,^{27a} and through relatively minor cases of inoculation through the skin; for example, by sharing razors.²⁸ HBV transmission has been documented after accidents, where infected blood comes in contact with cuts and abrasions on the skin.²⁹ Unlike HIV, which is thought to rapidly succumb upon exposure to open air, HBV may survive outside of the human body for some hours; thus, surfaces may become 'contaminated'.³⁰ An outbreak of Hepatitis B amongst Swedish cross-country runners, for example, was thought to have resulted from competitors cutting and grazing themselves as they navigated untracked woodland, leaving blood adhering to the scrub which later competitors grazed against, and by communal bathing at the finish line.³¹ Finally, however, unlike HIV, a vaccine exists for HBV which provides high immunity at least in the short term.³² Vaccination of health care workers has been recommended, and is clearly one way of decreasing HBV transmission in sport.

²⁴ See D H Campbell, A J Plant, J W Sargent, et al, 'Hepatitis B Infection of Children in a Mixed-Race Community in Western New South Wales' (1991) 154 *Medical Journal of Australia* 253; I D Gardner, X Wan, P A Simms, et al, 'Hepatitis B Virus Markers in Children and Staff in Northern Territory Schools' (1992) 156 *Medical Journal of Australia* 638; C J Burrell, A S Cameron, G Hart, et al, 'Hepatitis B Reservoirs and Attack Rates in an Australian Community' [1983] 2 *Medical Journal of Australia* 492.

²⁵ J W Sheridan, 'Blood-Borne Infections in Sport' in *Sports Performance Through the Ages*, Proceedings of the 27th National Annual Scientific Conference of the Australian Sports Medicine Federation Ltd, Alice Springs, 11-13 October 1990, 461, 462.

²⁶ I D Gust, 'Control of Hepatitis B in Australia' (1992) 156 *Medical Journal of Australia* 819.

²⁷ See R Nisini and M Rizzetto, 'Clinical Types of HBsAg-Positive Hepatitis' (1993) 11 *Vaccine* 511; E Fagan and R Williams, 'Hepatitis Caused by Hepatitis B Virus' (1987) 231 *Practitioner* 371.

^{27a} For example, by a spit in the eye: 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.

²⁸ Royal Australasian College of Surgeons, *Management of AIDS (HIV) and Hepatitis 'B'* (1987) 9.

²⁹ G H Radvan, D G Hewson, S Berenger, et al, 'The Newcastle Hepatitis B Outbreak' (1986) 144 *Medical Journal of Australia* 461.

³⁰ M Piazza, V Guadagnino, et al, 'Contamination by Hepatitis B Surface Antigen in Dental Surgeries' (1987) 295 *British Medical Journal* 473; Walker, op cit (fn 23) 119.

³¹ Sheridan, op cit (fn 25) 2.

³² Gust, op cit (fn 26) 820; Nisini and Rizzetto, op cit (fn 27) 514; Fagan and Williams, op cit (fn 27) 373-7.

(iii) *Hepatitis C ('HCV')*

HCV was first identified in 1988. It is now thought to account for the majority of 'non-A/non-B' hepatitis infections, and in fact to be more common than other hepatitis viruses. It has been estimated that there are five times as many people infected with HCV as HIV, with 15 times as many new infections occurring each year.³³ While it has been estimated that 10% of adult patients contracting HBV, and 98% of newborn children contracting HBV will remain chronic carriers,³⁴ it appears that virtually all persons with acute HCV infection will become chronically infected, leading to chronic liver disease in an average of 67%.³⁵ On the limited knowledge, it is established that many of those with chronic HCV will develop liver disease, with at least 20% progressing to cirrhosis within 20 years.³⁶

There is no vaccine against HCV, nor does previous infection appear to grant immunity to subsequent bouts of acute HCV. HCV was responsible for 90% of post-transfusion hepatitis, although the introduction of HCV screening of blood donations since 1990 now makes this a minimal risk. The sharing of contaminated injecting equipment among injecting drug users is the major factor associated with transmission in Australia: 'overall, about two-thirds of current IDUs have been exposed to HCV, rising to over 90% of people who have injected drugs for more than five years'.³⁷ In contrast to HBV, sexual transmission of HCV is considered low, as is household or social transmission, although community-acquired HCV has been documented, with no known route of infection,³⁸ and in one Australian study, moderate HCV prevalence was found among homosexuals attending a sauna (34.1%), prisoners (30.8%), female prostitutes (10.4%), and homosexual men requesting HIV testing (8.8%).³⁹

(b) Relative Risk of HIV/Hepatitis Transmission in Sport

(i) *Relevant Variables*

The risk of HIV transmission in sport arises, therefore, whenever an uninfected player, official or doctor is inoculated with the blood of an infected player. Theoretically, this may occur whenever a 'bleeding skin wound on an HIV-infected person . . . comes into contact with or rubs against an open

³³ A Wodak and N Crofts, 'Responding to the Spread of Hepatitis C in Australia', paper delivered at the *National Symposium on Hepatitis C*, 9 October 1993, St Vincent's Hospital, Melbourne.

³⁴ Nisini and Rizzetto, *op cit* (fn 27) 513. Fagan and Williams suggest 5–10% and 90%, respectively: *op cit* (fn 27) 372.

³⁵ M J Alter, 'Epidemiology, Transmission, and Natural History of HCV Infection', paper delivered at the *National Symposium on Hepatitis C*, 9 October 1993, St Vincent's Hospital, Melbourne.

³⁶ Wodak and Crofts, *op cit* (fn 33); K Watson, 'Hepatitis C Infection in Australia' (1991) *July Modern Medicine of Australia* 18, 26.

³⁷ Wodak and Crofts, *op cit* (fn 33).

³⁸ Watson, *op cit* (fn 36) 26.

³⁹ C K Fairley, D E Leslie, et al, 'Epidemiology and Hepatitis C Virus in Victoria' (1990) *153 Medical Journal of Australia* 271.

lesion on the skin of the uninfected opponent'.⁴⁰ In addition, a risk of HBV/HCV transmission may arise where infected blood or body fluids come in contact with broken skin, lesions, or membranous tissues of an uninfected player. It should be emphasised, however, that in so far as there is a risk, it will exist not only for opponents, but also for other members of the team to which the infected player belongs and for first aid-workers, trainers, and sports doctors treating injuries. The risk may be greatest for team-mates, who both train and play regularly with the infected player.

As in the case of occupational transmission of infectious diseases within medical settings, it is perhaps ironic that recent concern over transmission in sport has been sparked by HIV, even though hepatitis is far more infectious, and in the case of needlestick injuries, is responsible for many more deaths each year.⁴¹ There has been little work calculating the risk of transmission in sporting contexts. While the risk is certainly low, it is not zero.⁴² Sheridan has argued that the risk of acquiring a blood-borne infection will depend upon the following variables: (i) the estimated carriage rate of the infection in the participants; (ii) the estimated chance of blood to abrasion or blood to mucous membrane exposure; (iii) the infectiousness of the disease; and (iv) the presence or absence of protective immunity.⁴³ The carriage rate of the disease will be influenced by lifestyle (homosexual men at greatly increased risk of HIV/HBV; injecting drug users sharing equipment at high risk of HCV); ethnicity (high prevalence of HBV in some ethnic groups); gender (in Australia, HIV is far more common in males; HBV infection more likely to be chronic in males) and blood transfusion history. The chance of blood to abrasion or blood to mucous membrane exposure will be influenced by the nature of the sport, protection measures and equipment, first aid procedures, age of the participants (children may be less aggressive, and thus less prone to injury) and behaviour as modified by health education and the rules of the sport. Obviously, the number of possible permutations is virtually limitless. Calculations of risk would also have to take into account circumstances such as the increased exposure over time of team-mates of a carrier (relevant in sports where collisions occur) and the varying levels of exposure during a single contest (greater for an opponent matched against a carrier, lesser for an infrequently used substitute).

On the assumption that blood to abrasion transmission in sport carries a similar risk to transmission by needlestick injury, Sheridan has suggested that, in a hypothetical contact sport played responsibly by men in their twenties, whose infection rates are typical of the population, 1.0% of participants would have HBV, 1.0% would have HCV, and 0.25% would have HIV. Assuming that each individual's chance of blood to abrasion contact was one in 50 games, and that contact caused infection in 25% of HBV cases, 16% of

⁴⁰ C Loveday, 'HIV Disease and Sport' in SD W Payne (ed), *Medicine, Sport and the Law* (1990) 81, 83.

⁴¹ See Section 2(b)(iii) *infra*.

⁴² See 'AIDS Risk in Sport Proved, Claim Doctors', *Advertiser* (Adelaide), 28 January 1992, 8; WHO Consensus Statement, *op cit* (fn 19).

⁴³ Sheridan, *op cit* (fn 25) 464.

HCV cases and 0.5% of HIV cases, Sheridan calculates that the risk of acquiring an infection per game would be 1/20 000 for HBV, 1/31 500 for HCV and 1/4 000 000 for HIV. In a hypothetical situation involving the same sport played by participants from an ethnic group with high (10%) HBV carriage rates, the risk per game of acquiring HBV would be 1/2000, with a 1/40 000 chance of chronic infection assuming 5% of infections progressed to chronicity. In a final hypothetical situation in which 25% of participants have used intravenous drugs, 2% have HBV, 20% have HCV and 5% have HIV, and where the chance of blood to abrasion contact is once every four contests, the risk of acquiring an infection per contest would be 1/800 for HBV, 1/125 for HCV and 1/16 000 for HIV. In this situation, assuming that 5% of HBV infections, 25% of HCV infections and all HIV infections become chronic, Sheridan estimates that the risk per individual per sports contest of becoming chronically infected would be 1/16 000 for HBV, 1/800 for HCV and 1/16 000 for HIV.⁴⁴

(ii) *Combat, Contact, Collision and Non-Contact Sports*

Whatever the value of these estimates, it is obvious that the risk of HIV/hepatitis transmission as a result of player contact during sport will be influenced by the nature of the sport. Sports may conveniently be divided into 4 categories according to the nature of the physical contact between players which is permitted, or which inevitably occurs.

In *combat* sports, such as boxing, karate or wrestling, the object of the game is to physically suppress the opponent. The sport *consists of* aggressive physical contact, and bloody injuries may regularly arise. While policies governing the sport may seek to control the risk of infection by interrupting the game or round whenever a player bleeds (until the bleeding has stopped, or until the wound has been covered), the nature of the sport cannot prevent, and indeed almost encourages the occurrence of such accidents. Consequently, if infected players participate in the sport, it is inevitable that blood contact will occur involving the risk of HIV/hepatitis transmission.

In *contact* sports, such as rugby league, rugby union and Australian rules football, aggressive physical contact is permitted under the rules and occurs continuously throughout the game, although the object of the sport is not the physical suppression of other players, but something else, such as the scoring of goals or tries. Again, while 'blood-bin' policies may be helpful in lowering the risk of blood contact after an initial injury, the players involved in the tackle or incident producing the initial injury will not be protected if infected players are participating in the sport. A recent study reported that head and facial lacerations were the most common injuries in rugby league and union played at the elite level (11% and 20%, respectively).⁴⁵

In *collision* sports, by contrast, direct physical aggression or contact between players is not permitted or is severely restricted, although it is still

⁴⁴ Id 467.

⁴⁵ H Seward, J Orchard, H Hazard and D Collinson, 'Football Injuries in Australia at the Elite Level' (1993) 159 *Medical Journal of Australia* 298.

inevitable or inherent in the sport. In soccer, basketball, hockey, netball and cricket, for example, bloody collisions do occur, with greater or lesser frequency, although such sports are sometimes referred to as 'non-contact' sports. The Magic Johnson episode, and the fear expressed by Australian Olympic basketballers, and later by NBA basketballers, about playing against Johnson reflect the fear of HIV transmission even in sports where physical contact is not an ordinarily accepted part of the game.⁴⁶ Dr Ian Gust, chief medical adviser to the Commonwealth on AIDS, has said that the chance of contracting HIV playing basketball is about 'the same as being kicked to death by a duck'. However, 'you have to be honest and say it can happen but it seems to be extraordinarily rare'.⁴⁷ This comment, made at the height of controversy over Magic Johnson's proposed Olympic participation, reflects the uncertainty over the risk of HIV transmission.

Finally, there are *non-contact* sports which are correctly so called, such as tennis, golf, horseracing, cycling, swimming, gymnastics and athletics where direct physical contact between participants would rarely, if ever, occur except perhaps in extraordinary situations, such as where tennis players collide in doubles, or where jockeys collide in a horse pile-up.

It may be noted that the transmission of HIV/hepatitis appears to be less of a problem in women's sports than in men's sports. There are two reasons for this. First, women tend to play sports which are less prone to impacts likely to cause bleeding. Even so, large numbers of women play basketball, hockey and netball. Furthermore, women contestants are to be found in martial arts such as karate. Secondly, in the case of HIV, the infection rate among men is much higher than among women. These factors explain the emphasis in this paper on examples drawn from sports which are played more frequently by men than women.

(iii) *The Analogy with HIV/HBV Occupational Transmission*

The relative risk of bloody contact between participants in a sport, or between players and trainers or doctors, must be distinguished from the risk of HIV/hepatitis transmission as a result of such an incident. The risk of HIV/hepatitis transmission from sport-related collisions may be put into perspective by estimations of transmission through needlestick injuries in medical contexts. In June 1991, it was estimated that some 30–60 health care workers worldwide had been infected with HIV following occupational exposure.⁴⁸ In Australia, recent studies have concluded that the risk of acquiring

⁴⁶ See 'Fear, Not Reason, Pushed a Legend into Retirement', *Age* (Melbourne), 7 November 1992, 35; 'After the Ridicule, Borner's Views Supported', *Age* (Melbourne), 11 November 1992, 30.

⁴⁷ 'AIDS in Sport', *Age* (Melbourne), 2 February 1992, 11.

⁴⁸ See J Elford, R Moodie, A McDonald, et al, 'The VIII International Conference on AIDS — A Report from Amsterdam', *Australian HIV Surveillance Report*, Vol 8, Supp 3 (July 1993) 5.

HIV through occupational exposure is very low,⁴⁹ although there have been several documented cases of HIV transmission from patient to health care worker following needlestick injuries.⁵⁰

Although occupational transmission of HIV has occurred, as a percentage of total health care worker/patient contacts, the risk of transmission is exceedingly low. Gostin has summarised the issue as follows:

There is a range of 0.03 to 0.9 percent probability that a [health care worker] will contract HIV following a documented case of percutaneous (eg a needle-stick or cut) or mucous membrane (eg a splash to the eye or mouth) exposure of HIV-infected blood. This rate of seroconversion compares favourably with the risk of twelve to seventeen percent after accidental percutaneous injection from patients with hepatitis B virus (HBV), even after passive immunization of recipients by immune serum globulin.⁵¹

The United States Center for Disease Control has estimated that 12 000 health care workers are infected with HBV each year by exposure to patients' blood, resulting in 250 deaths annually.⁵² HBV, rather than HIV, is thus the major occupational disease for health care workers.

Some allowance must obviously be made for differences in the kind of blood contact which may take place in a medical context (for example, a needle-stick with a syringe containing infected blood), and in a sports context (for example, a hard tackle in a rugby game involving facial cuts and abrasions to both players, and freely flowing blood). The fact that sport-related transmission is not more frequent may reflect the fact that while a needle-stick transports infected blood directly beneath the skin, a collision causing blood contact between two athletes would cause both of them to bleed out, rather than to bleed in.⁵³ Trainers or sports doctors providing medical assistance to

⁴⁹ Recent studies include: D Marriott, A McDonald, G Dolan, et al, 'Characteristics of Occupational Exposures to Blood and Body Fluids at St Vincent's Hospital, Sydney' *Australian HIV Surveillance Report* Vol 7, Supp 4, October 1991; D Mallon, W Shearwood, S Mallal, et al, 'Exposure to Blood Borne Infections in Health Care Workers' (1992) 157 *Medical Journal of Australia* 592 (Perth study); F Bowden, B Pollett, et al, 'Occupational Exposure to the Human Immunodeficiency Virus and Other Blood-Borne Pathogens: A Six Year Prospective Study' (1993) 158 *Medical Journal of Australia* 810 (Victorian study).

⁵⁰ 'Woman Health Worker Catches AIDS Virus from Patient', *Age* (Melbourne), 1 May 1989, 1; 'Health Care Worker Contracts HIV', *Weekend Australian*, 18-19 July 1992, 3. The Royal Australasian College of Surgeons claims that four nurses, one ambulance officer, one prison warden and one Resident Medical Officer have reported with occupationally acquired HIV: Royal Australasian College of Surgeons, *Infection Control in Surgery and Management of AIDS (HIV) and Hepatitis B*, Policy Document (1994) 14.

⁵¹ L Gostin, 'Hospitals, Health Care Professionals, and AIDS: The "Right to Know" the Health Status of Professionals and Patients' (1989) 48 *Maryland Law Review* 12, 17. This statement suggests that HIV can be transmitted by mucous membrane exposure. It therefore suggests an additional means of transmission to those discussed above in Section 2(a)(i). Gostin refers to three cases where health care workers acquired HIV through substantial exposure of blood to mucous membrane and broken skin, but regards these cases as highly unusual: id 17-18.

⁵² N Daniels, 'HIV-Infected Health Care Professionals: Public Threat or Public Sacrifice?' (1992) 70 *Milbank Quarterly* 3, 14.

⁵³ *Sports Illustrated* (New York), 30 November 1992, 13 referred to in M J Mitten, 'AIDS and Athletics' (1993) 2 *Seton Hall Journal of Sports Law* 5, 10.

infected athletes would obviously run the usual risks of occupational HIV/hepatitis transmission, as discussed above. For players, however, the relative lack of documented cases of transmission, as a percentage of total bloody collisions in sports, suggests that the risk of transmission of HIV, at least, is very low.

Players are far more likely to catch HIV/HBV/HCV from sexual encounters or recreational drug use than from bloody collisions while playing sport. In the Australian Football League ('AFL'), for example, this has led to the setting up of a pilot program which aims to educate players about sexually transmitted diseases, thereby influencing behaviour. In America, it has been suggested that the incidence of infectious diseases may be higher in professional athletes than in the general population; in view of the 'fast-lane lifestyles' of some athletes.⁵⁴ Education programs detailing the risks of infection transmission on and off the field are an integral part of a reasoned policy response to the risk of transmission in sport.

3. CURRENT INFECTION CONTROL POLICIES IN SPORT

The risk of HIV/HBV/HCV transmission in sport may be low, but it is not zero, and its potentially tragic consequences, together with possible legal liability, justify the development and implementation by sporting organisations of considered infectious diseases policies.

The 1989 *Consensus Statement from Consultation on AIDS and Sports*, developed jointly by the World Health Organisation and the International Federation of Sports Medicine states that 'there is no medical or public health justification for testing or screening for HIV infection prior to participation in sports activities'.⁵⁵ The Statement advocates AIDS education for athletes, recommends that skin lesions should be immediately cleansed and covered, and that bleeding players should not participate in sport until bleeding has been stopped and the wound has been cleansed, and covered or occluded. No coercive measures are envisaged; the Statement merely notes that

persons who know they are HIV infected should seek medical counselling about further participation in sports in order to assess risks to their own health as well as the theoretically possible risk of transmission of HIV to others.⁵⁶

The *Infectious Diseases Policy* of the Australian Sports Medicine Federation ('ASMF'), together with the draft *Guidelines for Sport on Infectious Diseases* under preparation by the ASMF Infectious Diseases in Sport Working Party, are consistent with this approach to infection control. The ASMF policy advocates strict personal hygiene, recommends HBV vaccination for athletes playing contact/collision sports under adult rules, prohibits the

⁵⁴ See M Knisley and S Meyerhoff, 'AIDS & Sports', *Sporting News*, 9 November 1992, 12.

⁵⁵ WHO Consensus Statement, op cit (fn 19) para 5.

⁵⁶ Id para 6.

sharing of towels, razors, drink containers, and similar items, and requires that all cuts and abrasions be reported to medical staff. The policy advocates a 'blood-bin' procedure which requires that all bleeding must have stopped, and all contaminated clothing and equipment must be replaced before an injured player resumes participation in the game. The *Policy Statement on Infectious Disease Transmission in Sport* made by the New Zealand Federation of Sports Medicine is in similar terms. Other national and international sports federations have also developed policies.⁵⁷

The ASMF draft guidelines relate to a situation where a sports administrator, team manager, coach or trainer has been informed of an athlete's infection with HIV, HBV, HCV or hepatitis D. Ultimately, these guidelines leave it up to the player whether or not to continue playing the sport, and whether or not to permit fellow players to be informed. The guidelines emphasise education, and support the right of the athlete not to be subjected to discrimination on the basis of HIV or hepatitis infection, in cases where the athlete has consented to other players being informed.

Recently, the Australian National Council on AIDS and the Australian Sports Medicine Federation issued a joint information bulletin setting out guidelines to assist HIV positive people in making decisions about their continued participation in sport. Interestingly, these guidelines strongly recommend that persons with HIV not participate in 'a variety of sports . . . where there is a greater risk of HIV transmission from an exchange of blood splashing on to the face or an open wound'. The examples provided are professional boxing and wrestling.

Despite these responses from peak sports bodies, it is uncertain that all Australian sports bodies will adopt an infection control policy based solely upon the elimination of 'blood contact' between players. There have, in the past, been some indications that HIV/HBV/HCV testing may become an eligibility criterion for participation in some elite sports, and that HIV positivity may be grounds for deregistration.⁵⁸

Mention has been made already of a widely reported incident in Tasmania where the North-East Football Union withdrew the registration of a player who had tested HIV positive.⁵⁹ In 1992, players for St Kilda and Richmond in the AFL were required to be inoculated for HBV, and tested for HIV antibodies under an insurance agreement covering all players in each club.⁶⁰ Players are not, however, tested at regular intervals. Some sports, including the AFL and the New South Wales Rugby League ('NSWRL'), have introduced 'blood-bin' and infection control policies similar to the ASMF Infectious Diseases Policy previously mentioned. In the NSWRL, referees are authorised to, and responsible for ordering bleeding players into the 'blood-

⁵⁷ For example, the International Basketball Federation (FIBA) Regulations on the Prevention of AIDS adopted 21 December 1991; see also A Cohen, 'A Bloodless Victory: Fear of AIDS Prompts Stricter Guidelines' (1994) 11(1) *Sports Lawyer* 8.

⁵⁸ See, eg, 'League AIDS Tests May be Compulsory', *Australian*, 5 February 1992, 23.

⁵⁹ See fn 4 *supra* and accompanying text.

⁶⁰ 'AFL Acts on AIDS', *Age* (Melbourne), 2 February 1992.

bin'. Until recently AFL umpires did not have this right, which was exercised by the team medical officer.^{60a} AFL medical officers, and, vicariously, clubs ran the risk that, by virtue of being on the sideline, they would not be aware when an injury occurred which caused bleeding, although television and communication with trainers reduced this possibility. One AFL medical officer warned privately that doctors who are subject to pressures from coaches and team management may not be as diligent in ensuring that bleeding players are removed from the field.⁶¹ In one reported instance, which occurred during a night game, a player remained on the field throughout the first quarter, despite a bloody wound which 'looked pretty bad'.⁶²

4. ASCERTAINING THE EXISTENCE OF HIV/HEPATITIS INFECTION IN SPORT: LEGAL CONSTRAINTS

While infectious diseases policies such as those advocated by the ASMF seek to reduce the risk of HIV/hepatitis transmission by requiring bleeding players to leave the field, it is clear that the nature of combat, contact and collision sports inevitably leads to bloody contacts and that the initial transmission risk associated with an incident inflicting a bleeding wound cannot be eliminated. While the risk of HIV or HBV/HCV transmission on a basketball court might be no greater than the risk of being 'kicked to death by a duck', it is fair to say, without being sensational, that the risk of transmission on the rugby field, or in the boxing ring deserves serious consideration. The issue arises, therefore, whether sports organisations have the right to control transmission risk in a more proactive way by excluding or controlling the activities of infected athletes. A necessary preliminary to this issue, which will be discussed in this part, is the question of how far a sports organisation can legally go to ascertain which participants in a sport administered by the organisation are HIV/hepatitis infected?

Of course, HIV/hepatitis testing, even if perfectly legal, has its limitations. Taken alone, HIV antibody testing is a dangerously illusory solution to the risk of HIV transmission in sport.⁶³ Persons infected with HIV typically do not show antibodies to the virus for six weeks to three months.⁶⁴ In view of this

^{60a} 'AFL Under Fire Over New Law on Bleeding Players', *Age* (Melbourne), 4 August 1994, 30; 'HIV Rules Require More Players: AFL Coach', *Australian*, 8 August 1994, 3 (commenting on controversial new AFL Rule 9B relating to bleeding players and blood-borne infections).

⁶¹ For discussion of the legal context and consequences of distorted clinical judgments by team doctors under pressure from sports administrators, or subject to 'fan syndrome', see H Opie, 'The Team/Doctor/Athlete Legal Relationship' (1991) 2 *Sports Training, Medicine and Rehabilitation* 287.

⁶² Confidential communication with doctor.

⁶³ This is not, however, because of the risk of false negative results, since the risk of a false negative would be very low in a population of, eg, rugby league players, where the prevalence of undiagnosed HIV infection would already be low.

⁶⁴ Crofts, *op cit* (fn 9) 26. Some studies have shown that in rare cases, the 'window period' may last as long as 3 years: D T Imagawa, M H Lee, S M Wolinsky, et al, 'Human Immunodeficiency Virus Type 1 Infection in Homosexual Men who Remain Seronegative for Prolonged Periods' (1989) 320 *New England Journal of Medicine* 1458.

'window period', it is important that a negative HIV test result should not be regarded as a substitute for infection control standards such as those advocated in the ASMF Policy. A similar window period may occur following HBV infection, prior to the production of HBsAg (Australia antigen), and later HBV 'e' antigen (HBeAg) in the carrier's blood. The incubation period for HCV is highly variable, from two to 26 weeks, with a mean period of 22 weeks.⁶⁵ Since screening tests only reflect the situation prior to the 'window period', they provide no insurance against future transmission (and future 'window periods') if a person continues to engage in high risk activities off-field.

(a) The Legality of HIV/Hepatitis Testing in Sport

(i) *Legal Basis for Testing*

Medical testing is an ordinary part of participation in sport at an elite level, although not at a community level in Australia. Random and pre-competition testing for performance-enhancing drugs in sport is already carried out in many sports played at the elite level, prompting some to argue that 'if players can be tested for steroids, why not HIV?'⁶⁶ Consent to medical examination and drug-testing is provided for in entry forms, scholarship and representative team membership agreements,⁶⁷ and in contracts between professional athletes and their clubs. Such mechanisms could arguably be extended by clubs or competition organisers wishing athletes to undergo HIV/hepatitis testing either as a precondition to participation in an event (for example, a boxing match), or to membership of a club or entry into a competition.

In some cases, HIV/hepatitis screening might arguably be authorised under existing contractual provisions. The standard playing contract of the Victorian Country Football League, for example, requires players to

do everything reasonably necessary to obtain and maintain the best possible physical condition . . . and to submit from time to time and as and when required by the Club to a complete and thorough medical fitness test and examination.⁶⁸

The standard playing contract which until recently has governed all AFL players requires players to 'obey all reasonable directions of the Senior Coach, Chief Executive, General Manager and Board of Directors of the Club' and to 'do everything reasonably necessary to obtain and maintain the best possible physical condition'.⁶⁹ Players seeking selection by the Australian Basketball Federation in the Australian team must 'disclose forthwith to the Team

⁶⁵ K Watson, 'Hepatitis C Infection in Australia' (1991) 34(7) *Modern Medicine of Australia* 18, 22.

⁶⁶ J Niall, 'AIDS in Sport', *Inside Sport*, No 16S, April 1993, 14, 21.

⁶⁷ H Opie, 'Legal Regimes for the Control of Performance-Enhancing Drugs in Sport' (1990) 12 *Adel LR* 332, 348.

⁶⁸ Clause 2.7.

⁶⁹ Clauses 2.3 and 2.10.

Manager, the Team Medical Officer any injury or illness that might prejudice my proper participation in any events'.⁷⁰

Some combat sports, notably martial arts, wrestling and boxing, are regulated by legislation. The medical examination of participants in contests is mandated by legislation as part of a wider policy to ensure that contestants are not injured. In Victoria, for example, participants in professional martial arts contests and amateur martial arts (full contact) contests, as well as professional boxers, must be registered, must provide certificates of fitness prior to registration, and must submit to medical examination both before and after contests.⁷¹ Current regulations require professional boxers to disclose whether they have or have had hepatitis prior to registration,⁷² and martial arts contestants must do the same.⁷³ It is possible that regulations could be amended to require competitors to produce negative HIV/HBV/HCV reports as a prerequisite to competition or registration.⁷⁴ Direct imposition of requirements by the legislature would avoid some of the possible legal obstacles to mandatory HIV/HBV/HCV testing which arise under the common law.

The following discussion considers legal issues which mandatory testing for infectious diseases raises, whether imposed as a condition precedent to a contract, as a term of an extant contract, or quite independently of any contract.

(ii) *Legislative Regulation of Diagnostic Testing*

Subject to the effect of anti-discrimination legislation, and one Tasmanian provision discussed below, there is no Australian legislation which would *prohibit* the HIV/hepatitis screening of athletes. *HIV testing*, however, is governed by legislation in some jurisdictions, and the doctor drawing blood for the test would need to comply with relevant statutory provisions, including

⁷⁰ 1989–1992 Team Membership Agreement, cl 2.6.

⁷¹ *Martial Arts Control Act 1986* (Vic), ss 8, 10; *Professional Boxing Control Act 1985* (Vic), ss 10, 12; similarly, *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.

⁷² *Professional Boxing Control Regulations 1986* (Vic), reg 71; Eleventh Schedule (Certificate of Fitness).

⁷³ *Martial Arts Control Regulations 1989* (Vic), Sch 12 (the form of schedule suggests That the contestant's declaration concerning hepatitis and other conditions may be relevant at pre- or post-competition medical examinations).

⁷⁴ South Australian boxers are currently required to prove that they do not have HIV before being allowed to compete professionally: 'HIV Check in Boxing', *Age* (Melbourne), 13 May 1993, 28.

those requiring pre- and post-test counselling,⁷⁵ and regulating the identifying information which may be included in HIV test request forms.⁷⁶

In Tasmania, legislation prohibits any person from inducing another person to undergo an HIV test 'for the purpose of any employment or the provision of goods or services'.⁷⁷ The Secretary of the Health Department may, however, upon application, exempt a person from the application of this provision.⁷⁸ In the absence of such an exemption, this provision would prevent the HIV screening of professional footballers and other athletes as a condition precedent to, or under a term of a contract entered into in Tasmania.⁷⁹ Such tests would be 'for the purposes of' an employment contract. The provision would also, presumably, prevent amateur sports clubs from requiring members to be tested, in so far as this had any bearing upon the provision of facilities and services offered by the club. Indirectly, the provision protects against discrimination on the basis of HIV status, in so far as a person is required to undergo testing and to test negative in order to obtain employment, or to obtain goods or services. The practical effect is thus to make HIV testing (although not HBV testing) a voluntary matter in Tasmania, except where the exemption applies, or where testing is otherwise mandated under the *HIV/AIDS Preventive Measures Act 1993* (Tas) and other legislation.⁸⁰

In Tasmania, legislation also requires that an HIV test shall not be performed without the (specific) consent of the test subject.⁸¹ Pre- and post-

⁷⁵ Pre- and post-test counselling is required by statute in Tasmania: *HIV/AIDS Preventive Measures Act 1993* (Tas), ss 14–15, and in Victoria in respect of persons who have requested the test: *Health Act 1958* (Vic), s 127. Counselling is also required in New South Wales in respect of persons whom the doctor reasonably believes to be suffering from a sexually transmissible medical condition (which would include HIV/HBV): *Public Health Act 1991* (NSW), s 12 and *Public Health Regulation 1991* (NSW), reg 4, and in the Northern Territory in respect of persons diagnosed with an infectious disease: *Notifiable Diseases Act 1981* (NT), s 10.

⁷⁶ In Victoria, medical practitioners are prohibited from 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). In New South Wales, medical practitioners are prohibited from requesting an HIV test using the patient's name and address, unless the patient is in hospital: *Public Health Act 1991* (NSW), s 17(1)(b) and *Public Health Regulation 1991* (NSW), reg 7(1). In Tasmania, information which would identify the HIV test subject must not be included in a test request form, except in accordance with privacy guidelines issued with the approval of the Minister: *HIV/AIDS Preventive Measures Act 1993* (Tas), ss 17–18. These guidelines are in the process of development, but had not been released at the date this paper went to press.

⁷⁷ *HIV/AIDS Preventive Measures Act 1993* (Tas), s 6(2).

⁷⁸ *HIV/AIDS Preventive Measures Act 1993* (Tas), s 6(4).

⁷⁹ If the governing body of a national league required clubs to test players, the effect of this provision would be to undermine that national policy. Arguably, it would be unlawful for a governing body to penalise a Tasmanian club which did not comply with a mandatory HIV testing policy, since this would amount to imposing a penalty for refusing to perform an unlawful act.

⁸⁰ The Secretary of the Health Department may, for example, require a person to be tested after an incident where there was a risk of transmission, in order to determine the medical treatment of the person who may have been infected, and where a person reasonably thought to have HIV is behaving in such a way as to place other persons at risk: *HIV/AIDS Preventive Measures Act 1993* (Tas), s 10(2)–(3).

⁸¹ *HIV/AIDS Preventive Measures Act 1993* (Tas), s 7(1).

HIV-test counselling requirements also necessitate that the test subject will be informed of, and will consent to, the testing of blood for HIV antibodies.

(iii) Consent

Consent to diagnostic testing is also a requirement imposed by the common law. Regardless of whether an athlete has entered into a contractual relationship with a sports organisation, the administration of HIV/hepatitis tests involve medical procedures which require the athlete's consent. The withdrawal of a blood sample *without consent*, or in the face of an athlete's objections, may constitute a criminal or tortious assault, regardless of whether the athlete's refusal to undergo testing constitutes a breach of contract, team agreement or other rule.⁸²

However, the real issue which arises in this context is whether a general acquiescence to medical treatment and examination, or to the withdrawal of a blood sample, includes consent to HIV/hepatitis testing, or whether in the absence of specific consent to such a test, a doctor (and vicariously, his or her employer), will be liable in negligence for breach of the duty to provide information and to obtain adequate consent to medical procedures.^{82a} An AFL player, for example, may have a contractual obligation to obey the directions of his coach, and may willingly put out his arm for a 'blood test' as part of a medical examination carried out by the team doctor, but will this, without more, be a sufficient consent if an HIV test is subsequently performed? Current academic opinion appears to assume not.⁸³

The general principle is that every patient (every athlete) has the right 'to decide for himself or herself whether or not to submit to the medical treatment proposed',⁸⁴ which in turn requires adequate disclosure of the nature of the procedure and of *material risks*.⁸⁵ In *Rogers v Whitaker*,⁸⁶ the High Court held that a doctor's duty to inform the patient of material risks will be discharged by disclosure of such risks as a reasonable person in the patient's

⁸² Opie, 'Legal Regimes for the Control of Performance-Enhancing Drugs in Sport', op cit (fn 67) 348.

^{82a} For a more detailed discussion, see R S Magnusson, 'Specific Consent, Fiduciary Standards and the Use of Human Tissue for Sensitive Diagnostic Tests and in Research' (1994) 2 *Journal of Law and Medicine* (forthcoming).

⁸³ See 'Human Immunodeficiency Virus (HIV) Antibody Testing' (1987) 295 *British Medical Journal* 911; 'HIV Antibody Testing: Summary of BMA Guidance' (1987) 295 *British Medical Journal* 940; A Grubb and D Pearl, *Blood Testing, AIDS and DNA Profiling* (1990) 3-27; J Hamblin, 'Health Care: Rights and Responsibilities' *Law Society Journal*, May 1992, 66, 67; W T West, 'Assault and Battery — Testing for "AIDS"' *Justice of the Peace*, 22 December 1990, 812; M S Swartz, 'AIDS Testing and Informed Consent' (1988) 13 *Journal of Health Politics, Policy and Law* 607; J Godwin, J Hamblin, D Patterson and D Buchanan, *Australian HIV/AIDS Legal Guide* (2nd ed, 1993) 181-2; cf J Keown, 'The Ashes of AIDS and the Phoenix of Informed Consent' (1989) 52 *MLR* 790. It is quite unlikely that the doctor would be liable for battery, where the patient has been informed in broad terms of the nature of the procedure, ie, has consented to the withdrawal of blood: see *Chatterton v Gerson* [1980] 3 *WLR* 1003, 1013; *Rogers v Whitaker* (1992) 175 *CLR* 479, 490.

⁸⁴ *Rogers v Whitaker* (1992) 175 *CLR* 479, 486 per Mason CJ, Brennan, Dawson, Toohey and McHugh JJ.

⁸⁵ *Id* 490.

⁸⁶ (1992) 175 *CLR* 479.

position would be likely to attach significance to, if warned of them.⁸⁷ Assuming that an athlete would wish to take the potentially enormous medical, psychological, social and financial consequences of a positive HIV test result into account as factors in deciding whether to undergo the test, it is tempting to argue that HIV testing without specific consent and counselling would be in breach of the doctor's duty to disclose material risks.

However, this argument fails to distinguish between risks inherent in a medical procedure, and the risk that a person may suffer harm on being informed of the results of a diagnostic procedure, or as a result of being an HIV positive person. In *Rogers v Whitaker*,⁸⁸ the patient knew and had consented to the medical procedure performed, although it was alleged that material risks associated with the procedure were not disclosed. This case is quite different from the situation where a doctor fails to inform a patient that a particular diagnostic test will be performed on a blood sample drawn from the patient without incident, which reveals the fact that a patient is already HIV infected. The athlete may not have wanted to be tested for HIV (had he or she been consulted), but that does not mean the doctor will be liable for the medical, financial and emotional consequences the athlete suffers as a result of being *diagnosed* as HIV positive.⁸⁹ The argument fails at the level of causation. For a start, an HIV test result would be confidential in the hands of the doctor; the doctor could not be liable if the athlete 'went public', thereby losing employment or sponsorships. Nor could the doctor be liable for the medical consequences of the patient's diagnosis merely for bringing them to the patient's knowledge; indeed, one could argue that the patient's health would benefit from early HIV diagnosis. It is conceivable, however, that a doctor could be liable for a nervous shock reaction suffered by the patient, in extremely rare circumstances where the failure to obtain specific consent and to counsel the patient were, without more, responsible for a 'nervous shock' reaction amounting to an enduring physical or psychogenic illness, over and above the normal distress of being diagnosed as HIV positive.⁹⁰

It is nevertheless arguable that, at least in circumstances where the medical information revealed by a diagnostic test is sensitive, or where the reasonable patient would wish to be informed that a particular diagnostic test was being performed, the interest or right of a patient to decide his or her own medical

⁸⁷ Id 490.

⁸⁸ (1992) 175 CLR 479.

⁸⁹ See *Doe v Dyer-Goode* 566 A 2d 889 (1989) (action against a doctor for performing unauthorised HIV test on blood sample failed on all grounds, including assault and battery, negligence and invasion of privacy).

⁹⁰ Except as provided under the nervous shock cases, there is no action in Anglo-Australian law for negligently caused psychiatric or other emotional injury suffered alone: *Alcock v Chief Constable of South Yorkshire Police* [1992] 1 AC 310, 400-1 per Lord Ackner. Courts have generally only imposed liability for nervous shock where the plaintiff's injury was caused by apprehended physical injury (ie, violent impact) to the plaintiff or third parties. It is less clear whether the doctrine applies in the information disclosure context; see however: *Owens v Liverpool Corporation* [1939] 1 KB 394, 400 (principles not limited to cases in which apprehension to human safety is involved); *Barnes v Commonwealth* (1937) 37 SR (NSW) 511 (accepting there could be liability for negligent disclosure of information causing nervous shock); *Furniss v Fitchett* [1958] NZLR 396.

future supports the duty to obtain specific consent. If competent adult patients have the right to refuse medical treatment, 'however unreasonable or foolish this may appear in the eyes of [their] medical advisers',⁹¹ they would also seem to have the right to refuse diagnostic procedures, even if this conflicted with the doctor's view of what was in the patient's best interests. Ultimately, this raises the issue of whether patients should have the right to veto certain investigations undertaken by the doctor in diagnosing a patient.

In our view, the argument that HIV testing requires specific consent is reasonable in view of the sensitivity of HIV test results, and the disastrous consequences which their disclosure may bring for the individual concerned.⁹² The appropriate legal basis for this position is not, however, negligence, but the fiduciary quality of the doctor/patient relationship, which imposes on the doctor a standard of conduct requiring undivided loyalty. The doctor/patient relationship is not among the core relationships which are presumed by law to be fiduciary in character. Outside of the core relationships, however, a fiduciary standard of conduct may nevertheless be imposed upon an ascendant party to a relationship 'as a matter of fact arising out of the specific circumstances of the relationship'.⁹³ In recent years courts have been more willing to regard the doctor/patient relationship as involving obligations of a fiduciary character, at least for some purposes.⁹⁴ Canadian and New Zealand courts have pointed to the fiduciary nature of the relationship as the basis for the doctor's duty of confidence.⁹⁵ The Canadian Supreme Court has also recently held that since medical records contain highly private information which 'goes to the personal integrity and autonomy of the patient', and since the doctor/patient relationship is a fiduciary one, the medical record will be held by the doctor 'on trust' for the patient, in the sense that a

⁹¹ *Smith v Auckland Hospital Board* [1965] NZLR 191, 219 per Gresson J; *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218, 309-10. The law respects this right, even if it will have fatal consequences; see, eg, *In re T (Adult: Refusal of Treatment)* [1992] 3 WLR 782.

⁹² Turkington, for example, makes the point that some argue that informed individualized consent is not necessary because the consent to perform blood tests and other diagnostic procedures is implied from the general consent required of the patient. This argument relies upon a dis-analogy, namely that testing for HIV is like testing for cholesterol or other conditions in the blood that involve no significant risk of adverse consequences to the subject if the condition is known. *Comparing testing for cholesterol with testing for HIV is like comparing firecrackers to the hydrogen bomb.*

R C Turkington, 'Confidentiality Policy for HIV-Related Information: An Analytical Framework for Sorting Out Hard and Easy Cases' (1989) 34 *Villanova Law Review* 871, 892 (emphasis added).

⁹³ *Lac Minerals Ltd v International Corona Resources Ltd* (1989) 61 DLR (4th) 14, 29.

⁹⁴ *Hospital Products Ltd v United States Surgical Corporation* (1984) 156 CLR 41, 69 per Gibbs CJ.

⁹⁵ *McInerney v MacDonald* (1992) 93 DLR (4th) 415, 423; *Duncan v Medical Practitioners' Disciplinary Committee* [1986] 1 NZLR 513, 520-1.

patient will have the right of control over the information contained in the record, including a right of access to that information.⁹⁶

In our view, it does not unduly strain legal principle to argue that doctors owe a fiduciary duty to ensure that patients are informed of proposed *sensitive* diagnostic tests, including HIV tests, and not to act contrary to the perceived interests of patients by performing non-consensual testing.⁹⁷ On this view, therefore, clubs and sports organisations wishing to test athletes for HIV must inform them and obtain specific consent to the withdrawal of blood for this purpose.

It is less clear whether non-consensual hepatitis testing would amount to a breach of fiduciary duty, in view of the fact that hepatitis can be treated somewhat more successfully than HIV, and in the relative absence of the public fear which surrounds AIDS. Sports administrators would be advised, however, always to obtain specific consent to 'sensitive' diagnostic tests performed on athletes.

(iv) *Mandatory HIV/Hepatitis Testing and Discrimination*

Few legal issues arise where a sports organisation implements a *voluntary* HIV/hepatitis testing program for athletes in a particular team, club or competition. As with drug-testing, however, to obtain reliable information, sports organisations may wish to screen all incoming players in a season, or to reserve the right to *require* a player who is reasonably suspected of being HIV/hepatitis infected to be tested. Legal issues arise where compliance with testing procedures is linked to one's entrance into, or continued participation in, a sport. These include discrimination, restraint of trade, and breach of contract.

Turning first to discrimination, the issue here is whether it is discriminatory to *require* athletes to undergo mandatory testing for infectious diseases, not whether the exclusion of infected athletes is discriminatory. The *Disability Discrimination Act 1992* (Cth), s 28(1) 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

⁹⁶ *McInerney v MacDonald* (1992) 93 DLR (4th) 415; *Emmett v Eastern Dispensary and Casualty Hospital* 396 F 2d 931 (1967); *Cannell v Medical and Surgical Clinic* 315 NE 2d 278, 280 (1974). In *Norberg v Wynrib* (1992) 92 DLR (4th) 449, McLachlin and L'Heureux-Dubé JJ based a physician's liability for entering into a 'drugs-for-sex' arrangement with a patient on breach of fiduciary duty, in circumstances where there was no liability for negligence as there was no evidence of physical injury as a result of the drugs prescribed by the physician for the patient's addiction.

⁹⁷ The loss suffered by patients in this context would presumably be the 'burden' of having unwanted information thrust upon them. It may be that no more than nominal compensation would be awarded for breach of the fiduciary duty, although there is some authority that equitable compensation for breach of fiduciary duty can perform a deterrent function, reflecting the fact that the trust relationship between the parties has been damaged: *KM v HM* (1992) 96 DLR (4th) 289, 340 per McLachlin J.

person's associates by excluding that other person from a sporting activity.⁹⁸

This provision relies largely on the Commonwealth's power to make laws with respect to enacting into domestic law various obligations which Australia has assumed under international law pertaining to human rights. It applies to any person and this would include the members of an unincorporated association operating as a sports club, an incorporated sports club whether at the community, governing body or professional level, and those individuals who control the affairs of such clubs. In addition, s 27 of the Act provides that it is unlawful for a club⁹⁹ or incorporated association, its committee of management and the members of the committee to discriminate on the ground of a person's disability by: (i) refusing membership or imposing terms on membership to an applicant; and, inter alia, (ii) imposing terms and conditions, denying access to facilities or benefits or subjecting to detriment a member of the club or association.

A 'disability', for the purposes of the Act, includes the presence in the body of organisms causing or capable of causing disease or illness.¹⁰⁰ A 'disability' is also defined to include a presently existing or previously existing disability, and a disability which may exist in the future, or is imputed to a person. Symptomless, or symptomatic infections, including HIV and HBV/HCV infection, therefore, are 'disabilities' which attract the protection of ss 27-8. Under s 48 of the Act, however, it is lawful to discriminate against a person on the ground of their having an infectious disease where the discrimination is 'reasonably necessary to protect public health'.

In so far as a sports organisation, or persons having effective control of it, require athletes to be tested for an infectious disease such as HIV/hepatitis in circumstances where being diagnosed with HIV/hepatitis will result in their exclusion from a club, event or competition, it is arguable that such testing is discriminatory, since it is a necessary precursor to refusing membership or imposing some detriment, ie, to the performance of an unlawful act under s 27 or s 28. In that sense, compulsory testing is an integral part of an act of discrimination. In some cases, legislation prohibits requests for information which will be used as a basis for discriminating against a person,¹⁰¹ or information which a person without an impairment would not be required to provide.¹⁰² Alternatively, if a person is excluded from an event, club or competition because they have refused to comply with a condition that they undergo HIV testing, it is arguable that such an exclusion is an act of

⁹⁸ A number of exceptions are created by s 28(3) mainly relating to a person's ability to perform the actions required of the sporting activity. These are not relevant for present purposes.

⁹⁹ A 'club', for the purposes of the Act, includes an association, whether incorporated or unincorporated, which exists for sporting or athletic purposes: *Disability Discrimination Act 1992* (Cth), s 4(1).

¹⁰⁰ *Disability Discrimination Act 1992* (Cth), s 4(1).

¹⁰¹ *Anti-Discrimination Act 1991* (Qld), s 124(1); *Discrimination Act 1991* (ACT), s 23.

¹⁰² *Disability Discrimination Act 1992* (Cth), s 30; *Equal Opportunity Act 1984* (WA), s 66o.

discrimination on the basis that its effect is to impute a disability to the person refusing to undergo the test.

A club or sports organisation, may, of course, seek to show that there are no adverse consequences which follow from being diagnosed with HIV/hepatitis, and that testing is only carried out so that athletes can be made aware of their health status and take necessary precautions, or so that the sports organisation can take necessary precautions for infection control. Under these circumstances, it is likely that a mandatory testing requirement would not breach ss 27–8. Furthermore, even if a mandatory testing program, like exclusion from a sport on the basis that an athlete is HIV/HBV/HCV infected, is literally discriminatory, it will not be unlawful if the risk of transmission of HIV/HBV/HCV in sport is such that discrimination is 'reasonably necessary to protect public health'. This exception is discussed below.¹⁰³

Finally, mention should be made of the selective screening of those suspected of having HIV/hepatitis, such as Aborigines, or known homosexuals. It might be argued, for example, that in view of the fact that the carrier rate for HBV is significantly higher among Aborigines, it is justifiable to single them out for HBV testing. A similar argument might be made about known or suspected homosexuals, in view of the higher carrier rates for HIV/HBV among homosexual men.

The first point is to recall that because discrimination on the grounds of having an infectious disease is unlawful (subject to the public health exception in s 48), the argument that it is discriminatory to test athletes in order to exclude infected ones, or to exclude athletes who refuse testing, will apply, regardless of whether the test subject is an Aborigine or a homosexual.

The more difficult issue concerns the relationship between selective testing, the public health exception, and other discrimination statutes. If, as we believe, the exclusion of infected athletes may, in some sports, be justified as 'reasonably necessary to protect public health',¹⁰⁴ it follows that requiring athletes to undergo testing for HIV/hepatitis would also be justified in these sports. A potential conflict may arise, however, where a club or sports organisation wishes to limit testing to Aborigines or homosexuals, perhaps in view of the cost of testing, and the higher probability that Aborigines or homosexuals will be infected. It is likely that such practices would be in breach of legislation protecting Aborigines¹⁰⁵ and homosexuals¹⁰⁶ from discrimination.

¹⁰³ See Section 5(c) *infra*.

¹⁰⁴ See Section 5(c) *infra*.

¹⁰⁵ The *Racial Discrimination Act* 1975 (Cth), s 9 prohibits discrimination on the grounds of race or ethnic origin.

¹⁰⁶ Discrimination on the ground of sexual orientation is prohibited in some jurisdictions: *Anti-Discrimination Act* 1977 (NSW), s 49ZG; *Equal Opportunity Act* 1984 (SA), s 29(3); *Anti-Discrimination Act* 1991 (Qld), s 7(1) (outlaws discrimination on the grounds of lawful sexual activity); *Discrimination Act* 1991 (ACT), ss 4(1), 7(1)(b); *Anti-Discrimination Act* 1992 (NT), ss 4, 19. Discrimination on the grounds of sexual orientation is not prohibited in the remaining Australian jurisdictions. At the Commonwealth level, the *Human Rights and Equal Opportunity Commission Act* 1986 (Cth), ss 20–35 gives the Commission power to inquire into and to conciliate complaints of discrimination on the grounds of sexual preference (by virtue of *Human Rights and Equal Opportunity Commission Regulations* 1989 (Cth), reg 4(a)(ix)). Tasmania is now the only Australian

While exclusion on the basis of the risk to health of other athletes may be justified (regardless of whether the infected athlete is an Aborigine or a homosexual), legislation may nevertheless protect such groups from being 'picked on' by virtue of their aboriginality or homosexuality, if efforts were not made to identify *all* potentially infected athletes, and thus to apply the exclusion without reference to racial origin or sexual orientation.

(v) *Mandatory HIV/Hepatitis Testing and Restraint of Trade*

The compulsory HIV/hepatitis testing of athletes might also be challenged as being in restraint of trade, provided that (i) the athlete earns an income from participation in sport, and (ii) it is clear that the athlete will be denied entry into an event or club or competition for refusing to undergo testing.

It is well established that an athlete who earns all or some of their income from engaging in sport, or who has a real potential to do so, will be within the ambit of the restraint of trade doctrine.¹⁰⁷ Restraints on an athlete's ability to pursue his or her sporting trade are prima facie contrary to public policy and therefore void. The restraint will only be saved if it can be shown to be reasonable.¹⁰⁸

A common type of restraint of trade case brought before the courts over the past two decades has concerned some rule which restricts the athlete from freely contracting with an employer of his or her choice¹⁰⁹ or from entering into a rival competition.¹¹⁰ Examples of these rules are the transfer, zoning and draft rules in professional sports leagues. Usually, that rule will be a rule of the sport's governing body rather than of the body which is paying the athlete to participate. Furthermore, the restraint of trade doctrine will apply even if the athlete does not directly receive income from participation.¹¹¹ For example, an athlete may not receive income from the act of participation, but derive income from other sources such as sponsorships, appearances and advertising which are dependent on the ability of the athlete to participate. This is more likely to be the case with 'amateur' athletes from sports such as track and field and swimming. Thus, compulsory HIV testing as a condition precedent to entry into a club, league, event or competition, whether a condition precedent to a contract or not, can operate as a restraint on all or any of

jurisdiction where homosexuality remains a crime: see *Criminal Code Act 1924* (Tas), ss 122-3, although the Commonwealth Parliament may soon intervene to alter this.

¹⁰⁷ *Hughes v Western Australian Cricket Association (Inc)* (1986) 69 ALR 660, 700.

¹⁰⁸ *Nordenfelt v Maxim Nordenfelt Guns and Ammunition Co Ltd* [1894] AC 535, 565; *Buckley v Tutty* (1971) 125 CLR 353, 380.

¹⁰⁹ For example, *Adamson v New South Wales Rugby League Ltd* (1991) 31 FCR 242; *Adamson v West Perth Football Club Inc* (1979) 27 ALR 475; *Blackler v New Zealand Rugby Football League (Inc)* [1968] NZLR 547; *Buckley v Tutty* (1971) 125 CLR 353; *Hall v Victorian Football League* [1982] VR 64; *Kemp v New Zealand Rugby Football League Inc* [1989] 3 NZLR 463.

¹¹⁰ For example, *McCarthy v Australian Rough Riders Association Inc* (1988) ATPR ¶40-836.

¹¹¹ Cf *Hughes v Western Australian Cricket Association (Inc)* (1986) 69 ALR 660, 700.

the identified income sources.¹¹² Thus, HIV testing must be shown to be a reasonable restraint in order to have legal effect.

Reasonableness is determined having regard to the legitimate interests of the parties concerned, and the public.¹¹³ The defendant bears the onus of showing that the restraint goes no further than is reasonably necessary to protect its legitimate interests. There is some uncertainty, however, over whether or not the reasonableness of the restraint should be determined or influenced by balancing the strength of the defendant's interests against the effects which the restraint will have on the person restrained (the plaintiff), and on other third parties.¹¹⁴

A club or organisation intending to refuse athletes entry into a club, league, event or competition (or to exclude them if they had already entered) unless they can prove that they are not infected with HIV/hepatitis, is likely to seek to justify this by pointing to the possibility of liability for transmission of infectious diseases,¹¹⁵ and to the health interests of other athletes (both teammates and opponents), trainers and doctors. Avoiding liability and preventing transmission are doubtless legitimate interests; however, the defendant bears the onus of showing that exclusion from participation in sport of those athletes who refuse to comply with HIV/hepatitis testing is a measure which *goes no further than reasonably necessary* in protecting these interests.

It is in this context that alternative means of protecting the club's or organisation's interests, and those of third parties, will become relevant. It is worth stressing that the issue here from the viewpoint of restraint of trade is whether the exclusion of athletes who refuse to be tested is necessary to prevent liability/transmission, not whether compulsory testing is necessary to identify infected athletes. With respect to the former issue, blood and body fluid contact procedures,¹¹⁶ education, the option of HBV inoculation of players, as well as the initial low risk of transmission, and the relatively low prevalence of HIV/hepatitis in undiagnosed athletes generally, would certainly point to the unreasonableness of such a restraint in collision and non-contact sports. This does not follow, however, in combat and contact sports. A promoter of professional kickboxing competitions, for example, who required those who might be contracted to produce an 'HIV/hepatitis free certificate', might well justify this in view of the inevitability of blood-to-blood contact, or blood to mucous membrane contact in kickboxing, the inability of infection control procedures to eliminate the initial risk of transmission in an incident causing

¹¹² The same considerations would apply in circumstances where the athlete had already gained admission to the club, league, event or competition and HIV testing was sought to be imposed as a new or additional condition. Of course, where the athlete was contracted, the other party to the contract could not impose such a new condition unless it was agreed to by the athlete.

¹¹³ *Nordenfelt v Maxim Nordenfelt Guns and Ammunition Co Ltd* [1894] AC 535, 565.

¹¹⁴ See *Adamson v New South Wales Rugby League Ltd* (1991) 31 FCR 242, 266 per Wilcox J; cf 289–90 per Gummow J; A Humphreys, 'Sport, Restraint of Trade and the Australian Courts: *Adamson v New South Wales Rugby League Ltd*' (1993) 15 *Syd LR* 92, 94–7.

¹¹⁵ This issue is discussed in Sections 4(b)(v) and 6 *infra*.

¹¹⁶ Such as the Australian Sports Medicine Federation's *Infectious Diseases Policy* discussed in Section 3 *supra*.

blood flow, and the potential liability of the promoter for transmission of an infection.

(vi) *Mandatory HIV/Hepatitis Testing and Breach of Contract*

The imposition of HIV/hepatitis testing as a precondition to entry to a club, competition, contract, event or league, must be distinguished from an existing term of a contract which an athlete has entered into requiring HIV/hepatitis testing. Normally, no issue of restraint of trade will arise where testing is required pursuant to a contract which an athlete has voluntarily entered into. The contractual term authorising HIV/hepatitis testing might be specific; alternatively, as discussed previously, it may arise from a general provision to 'submit to medical examinations and fitness checks as and when required', or 'to obey the reasonable directions' of club management. Unless the athlete could show that testing, if conducted pursuant to some general power with a reasonableness limit, was in fact, unreasonable, or that it was discriminatory under relevant legislation, the term would be valid and the athlete would be in breach for non-compliance with it. The fact that, in refusing to be tested, the athlete was breaching a contract would not excuse a club doctor from battery if a blood sample was withdrawn without the athlete's consent.

(vii) *An Obligation to Conduct Mandatory HIV/Hepatitis Testing?*

So far, the discussion has focused on possible legal obstacles to a sports organisation *wanting* to test. Another issue is whether it may be *obliged* to test in order to provide a safe playing environment.

This could arise from a general duty of care under the tort of negligence owed by a sports organisation to people in its teams or league, or using its facilities. Furthermore, the obligation to test may arise under the implied contractual duty of care where the organisation has employees. 'This duty will also usually be enforceable as a wider statutory duty under occupational health and safety legislation'¹¹⁷ such as s 21 of the *Occupational Health and Safety Act* 1985 (Vic). These duties and their possible application will be considered in Section 6.

To complete this discussion of the legality of mandatory HIV/hepatitis testing, it should be noted that public health legislation in most jurisdictions authorises the compulsory medical examination of individuals thought to be HIV/hepatitis infected as a first step under legislative schemes providing for isolation and quarantine of persons whose infection or behaviour creates a risk to public health.¹¹⁸ Health Department guidelines or protocols in some States provide for the staged exercise of these powers where an HIV infected

¹¹⁷ H Opie and G Smith, 'The Withering of Individualism: Professional Team Sports and Employment Law' (1992) 15 UNSWLJ 313, 330.

¹¹⁸ *Public Health Act* 1991 (NSW), ss 22–3 (would apply to HIV, but not hepatitis); *Health Act* 1958 (Vic), s 121; *Public and Environmental Health Act* 1987 (SA), ss 31–2; *Health Act* 1911 (WA) s 251(5); *Health Act* 1937 (Qld), s 36; *HIV/AIDS Preventive Measures Act* 1993 (Tas), s 10(3); *Notifiable Diseases Act* 1981 (NT), ss 11, 14; cf *Public Health (Infectious and Notifiable Diseases) Regulations* (ACT), reg 5 (authorises testing where a source of infection is found).

person continues to share injecting equipment, or to engage in unprotected penetrative anal or vaginal sex.¹¹⁹ The possible application of these powers to HIV positive athletes engaging in combat or contact sports does not appear to have arisen and is highly unlikely while infection control and 'blood-bin' procedures are being complied with.

(b) Finding Out About an Athlete's Status: Confidentiality and the Duty to Warn

The other issue, apart from HIV/hepatitis testing, which is relevant to the ascertainment by sports administrators of the existence of infectious diseases in sport, is confidentiality. As envisaged by the ASMF draft *Guidelines for Sport on Infectious Diseases*, an athlete may voluntarily inform club or team officials of his or her infection, or permit someone else to inform them. The doctor/patient relationship is, however, a confidential one, regardless of whether the 'patient' is an athlete. Where an athlete does not consent to the disclosure of their HIV/hepatitis infection to team or club officials, the issue of the limits of the diagnosing doctor's duty of confidence will arise.

Diagnosis of HIV/hepatitis is by way of blood testing carried out in laboratories, with results being returned to the doctor who first requested the test. What are the legal considerations relevant to dissemination of an athlete's HIV/hepatitis status? We will commence with an examination of relevant legislative controls before turning to an athlete's consent either express, or implied under the 'athlete/team/doctor' relationship. Finally, there are the issues of whether the public interest exception to the doctor's duty of confidence authorises disclosure and whether there may be legal liability for not having made disclosure in the event that a third party contracts the infectious disease.

(i) Legislative Regulation of Disclosure of Medical Information

Legislation in some jurisdictions regulates (i) the disclosure of all medical information acquired by particular categories of health professionals, and (ii) the disclosure of certain kinds of medical information, most notably, in this context, HIV information. The legislation is significant in that, in some cases, it excludes the 'public interest' exception which exists under the common law, as discussed below. In some jurisdictions, it would also appear to preclude the 'team doctor' justification for disclosure of HIV information, discussed in the following section.

¹¹⁹ In August 1989 a Sydney prostitute known as 'Charlene' was detained at the Prince Henry Hospital under s 32A of the then *Public Health Act 1902* (NSW): see 'Govt Orders AIDS Prostitute Held in Hospital', *Sydney Morning Herald*, 1 August 1989, 1. In March 1991 in Melbourne, police charged an HIV infected trans-sexual prostitute with 'conduct recklessly endangering life', after the Health Department refused to exercise its powers under the *Health Act 1958* (Vic), ss 121-2: see 'Prostitute with AIDS Charged by Police', *Age* (Melbourne), 26 March 1991, 1. A second prostitute was subsequently charged. Both charges were eventually dropped for lack of evidence. See also 'Detectives Seek Man in Resort HIV Scare', *Australian*, 20 January 1994, 3; 'HIV Man Detained as a Public Risk', *Age* (Melbourne), 17 September 1994, 3.

Legislation in New South Wales, Victoria, South Australia, Queensland and the ACT imposes duties of non-disclosure with respect to medical information acquired during the course of employment of health professionals employed in public hospitals and other government funded facilities.¹²⁰ In New South Wales and South Australia, respectively, the general statutory duty is lifted when disclosure is 'authorised or required by law' or where the confidant has a 'lawful excuse'. It appears, therefore, that common law exceptions to the duty, including the public interest exception, are thereby preserved.¹²¹ In Victoria and the ACT, the statutory duty is lifted where the Minister certifies disclosure to be in the public interest,¹²² and in Queensland, where disclosure is required by operation of law.¹²³ Where an athlete attends a private practitioner, however, none of these statutory restrictions, or exceptions, would be relevant.

Overlapping with the abovementioned provisions, but not limited to public sector health professionals, is legislation which specifically regulates the disclosure of HIV information.¹²⁴ In Tasmania, the *HIV/AIDS Preventive Measures Act* 1993 imposes a duty of non-disclosure with respect to HIV test results, HIV antibody status, and information relating to the sexual behaviour and drug use of a test subject.¹²⁵ The prohibition is subject to several enumerated exceptions, including consent, disclosure to other medical professionals involved in treating or counselling the patient, and disclosure otherwise authorised or required under the Act. In New South Wales, the *Public Health Act* 1991 imposes upon persons who, in the course of providing a service, learn that a person has HIV/AIDS, a duty to 'take all reasonable steps to prevent disclosure of the information to another person'.¹²⁶ Arguably, this provision would extend to doctors drawing a blood sample, requesting an HIV test and receiving the results. The statutory exceptions authorise, inter alia, disclosure with consent, and disclosure to the Director-General if the person's behaviour places public health at risk.¹²⁷

¹²⁰ *Health Services Act* 1988 (Vic), s 141 (applies, inter alia, to employees of 'relevant health services', defined as public and private hospitals, nursing homes, community health services and day care centres); *Health Administration Act* 1982 (NSW), s 22 (arguably applies to all employees of public sector health services); *South Australian Health Commission Act* 1976 (SA), s 64 (applies to officers or employees of the Commission, incorporated hospitals and incorporated health centres); *Health Services Act* 1991 (Qld), s 5.1 (applies to officers, employees or agents of an Authority or public sector health service); *Health Services Act* 1990 (ACT), s 56 (applies, inter alia, to staff and consultants to the Board of Health).

¹²¹ *Health Administration Act* 1982 (NSW), s 22(d); *South Australian Health Commission Act* 1976 (SA), s 64(1).

¹²² *Health Services Act* 1988 (Vic), s 141(3)(h); *Health Services Act* 1990 (ACT), s 56(3)(a).

¹²³ *Health Services Act* 1991 (Qld), s 5.1(2)(a). Under this provision, disclosure would arguably be lawful if the common law imposed a duty, and not merely a licence, to warn third parties of possible harm caused by their patients.

¹²⁴ The discussion below will exclude those provisions only applying to Health Department employees, rather than doctors themselves.

¹²⁵ *HIV/AIDS Preventive Measures Act* 1993 (Tas), s 19(1).

¹²⁶ *Public Health Act* 1991 (NSW), s 17(2).

¹²⁷ *Public Health Act* 1991 (NSW), s 17(3)(e); *Public Health Regulation* 1991 (NSW), reg 7(2).

None of the exceptions to the duty of non-disclosure imposed by the Tasmanian and New South Wales legislation authorise, however, disclosure of an athlete's HIV status by a team doctor to team management, or disclosure by a non-team doctor to sports administrators or other third parties. Under the New South Wales model, a doctor could only respond to the risk presented by an HIV positive athlete to other athletes by placing the issue in the hands of the Health Department.

Finally, in Victoria, service providers acquiring knowledge that a person has HIV are required to 'take all reasonable steps to develop and implement systems to protect the privacy of that person'.¹²⁸ In contrast to the above, there is nothing to suggest that this provision excludes common law exceptions to confidentiality.

In most cases, the penalty for breach of these legislative duties is a fine. An athlete would be entitled to restrain an imminent or further release of protected information by injunction.

(ii) *Express Consent: Disclosure of Medical Information Pursuant to Contract*

Contractual arrangements may authorise medical practitioners to disclose medical information to members of a governing body. Under the 1992 Australian Olympic Team Membership Agreement, for example, athletes authorised

any medical practitioner, sports scientist or therapist whom I have consulted during the 12 months preceding the commencement of the Olympic Games to provide details of any illness and/or injury which I have sustained or may sustain or of any pre-existing medical condition to the Chief Medical Officer of the Team. . .¹²⁹

Furthermore, athletes authorised the Chief Medical Officer to disclose any information thereby obtained to the Secretary-General of the Australian Olympic Committee, and to the Chief Executive Officer of the athlete's national federation.¹³⁰

In addition, a contract may require an athlete to personally disclose any relevant medical information which may impact upon his or her participation and performance to a club or governing body. The Australian Cricket Board's Player contract, for example, includes a warranty by the player that

at the date upon which he signs this Agreement he is not suffering and has not suffered from any illness or injury or other ailment of which he is aware which may render him incapable of performing his obligations hereunder except any injury illness or other ailment of which the Selectors are aware.¹³¹

It is certainly arguable that a symptomless HIV infection, in so far as it could

¹²⁸ *Health Act 1958* (Vic), s 128.

¹²⁹ 1992 Australian Olympic Team Membership Agreement, cl 4.1.

¹³⁰ 1992 Australian Olympic Team Membership Agreement, cl 4.2.

¹³¹ Australian Cricket Board's Player contract, cl 5.2.3.

become symptomatic and affect the player's health during the course of the contract, could be included within the terms of such a warranty.

Of course, a doctor armed with information as to an athlete's HIV/hepatitis status can always seek to obtain the athlete's consent to the release of the information generally or to specified people as and when the occasion arises. The advantage from the doctor's point of view of these contractual provisions is that they secure consent in advance of the information being obtained and so the doctor does not act unlawfully in respect of any disclosure. However, complications may arise if an athlete seeks to prospectively revoke the consent, even though he or she may breach the contract by doing so.¹³²

(iii) 'Implied' Consent: The Athlete/Team/Doctor Relationship

It is important to distinguish between the bipartite relationship which arises when an athlete, of his or her own volition, consults a doctor in a private capacity, and the tripartite relationship which arises when an athlete consults a doctor engaged by a team to provide medical services for its athletes. In the latter case, the 'team doctor', like a company-employed doctor, will have legal responsibilities toward the team (or company), as well as to the athlete/patient.¹³³ These responsibilities may justify disclosures to third parties which would otherwise constitute a breach of confidence if made by an ordinary private practitioner. In *W v Egdell*,¹³⁴ for example, Bingham LJ said:

Where a prison doctor examines a remand prisoner to determine his fitness to plead or a proposer for life insurance is examined by a doctor nominated by the insurance company or a personal injury plaintiff attends on the defendant's medical adviser . . . the professional man's duty of confidence toward the subject of his examination plainly does not bar disclosure of his findings to the party at whose instance he was appointed to make his examination.¹³⁵

Arguably, a team doctor will be authorised, and an athlete will be deemed to have consented to, disclosure of such information concerning the athlete as is necessary to accomplish the purpose of the original consultation. Thus, where an athlete requests an HIV/hepatitis test from a team doctor, or where athletes are required to be tested by the team-appointed doctor pursuant to contract, the tripartite nature of the relationship is such that the doctor would be authorised to disclose the results to team management, in so far as the medical conditions disclosed impact upon the athlete's capability to perform at an appropriate level as well as not to cause harm to the athlete or third parties. It is suggested that HIV/HBV/HCV infection are all relevant in that sense. The justification for wider disclosure would not operate, however, with respect to information such as sexual orientation or sexual practices, which a club doctor may have acquired in the process of counselling an athlete, and which is not immediately relevant to the athlete's fitness.

¹³² See Section 4(b)(iii) *infra*.

¹³³ See Opie, 'The Team/Doctor/Athlete Legal Relationship', *op cit* (fn 61) 297.

¹³⁴ [1990] 1 Ch 359.

¹³⁵ *Id* 419.

Team or club management, in so far as they acquire confidential medical information relating to an athlete, will have constructive if not actual notice of its confidentiality, and will thus owe a duty of confidence with respect to it.¹³⁶ They will not be at liberty to brief the media, or to discuss it over dinner with friends, without the athlete's consent. The fact that information is interesting to the public does not automatically create an exception to the duty of confidence.¹³⁷ Unless the athlete contracts the right away, he or she would, on established principles, be able to obtain an injunction preventing the disclosure of information subject to a duty of confidence. It is not difficult to imagine a situation where information about 'athletes with AIDS' is leaked to the media. In an appropriate case, even 'innocent' third party recipients, such as newspapers may be restrained by injunction from publishing information once they receive notice that it has been acquired in breach of a duty of confidence.¹³⁸

A 'team doctor' who diagnoses an athlete with HIV/hepatitis may come under intense pressure not to report this to club management. This raises the whole question of the legal basis of the tripartite confidential relationship between athlete, doctor and team. If the athlete is regarded as *impliedly consenting* to disclosure to club officials, it is arguable that such consent could be expressly withdrawn, since consent is 'an expression of the autonomy of the confider'.¹³⁹ However, it makes more sense to regard the athlete, on consenting to diagnostic tests under the supervision of a team doctor, as being estopped from later exercising any inconsistent right to prevent disclosure of such *relevant* information as the tripartite nature of the relationship requires. A similar rationale would apply to patients who enter hospital and, by virtue of using those structures or services, impliedly consent to disclosure of medical information between professionals on a need-to-know basis, and to reasonable medical records procedures.¹⁴⁰

(iv) *The 'Public Interest' Exception to the Duty of Confidence*

We will now consider (within the gaps left by the legislation discussed above and the terms of any relevant contract), the extent to which the common law recognises a 'public interest' exception to the doctor's duty of confidence as a possible lawful basis for warning third parties of the risk of disease transmission by infected athletes playing sport.

¹³⁶ It is well established that a third party may owe a duty of confidence imposed on this basis: *Attorney-General v Guardian Newspapers Ltd (No 2)* [1990] 1 AC 109, 177, 216, 260, 268; *Ansell Rubber Co Pty Ltd v Allied Rubber Industries Pty Ltd* [1967] VR 37, 45-6; *Fraser v Thames Television Ltd* [1984] 1 QB 44, 58.

¹³⁷ See further Section 4(b)(iv) *infra*.

¹³⁸ *Malone v Metropolitan Police Commissioner* [1979] 1 Ch 344, 361; *Fraser v Evans* [1969] 1 QB 349, 361; *Foster v Mountford & Rigby Ltd* (1976) 14 ALR 71; *G v Day* [1982] 1 NSWLR 24, 35; *Talbot v General Television Corporation Pty Ltd* [1980] VR 224, 240.

¹³⁹ C Thomson, 'Records, Research and Access: What Interests Should Outweigh Privacy and Confidentiality? Some Australian Answers' (1993) 1 *Journal of Law and Medicine* 95, 96.

¹⁴⁰ See *Slater v Bissett* (1986) 69 ACTR 25, 28-30; *Duncan v Medical Practitioners Disciplinary Committee* [1986] 1 NZLR 513, 521.

The argument that disclosure is or was justified in the public interest has, in practice, been made in defence to applications for injunctions or other remedies for breach of confidence. The scope of the defence is far from clear. At its narrowest, the 'defence' has been regarded by some judges simply as an expression of the doctrine that courts will not grant equitable remedies to enforce the legal rights of iniquitous plaintiffs who do not come to equity with clean hands.¹⁴¹ This view represents one interpretation of Wood V-C's remarks in *Gartside v Outram*,¹⁴² the case from which the defence originates, although it ignores subsequent developments.

In England, the public interest defence has developed as an increasingly explicit process of balancing a widening variety of 'public interests'. The underlying rationale is that although the public interest usually favours the enforcement of duties of confidence,¹⁴³ such protection cannot be absolute, since there are opposing public interests favouring the free circulation of information which may sometimes outweigh the interest in confidentiality.¹⁴⁴ The cases have clearly undermined the 'clean hands' view by recognising, and balancing, successive categories of public interest in revealing information, in circumstances where the confider may not have acted unlawfully nor been guilty of any misconduct or iniquity.¹⁴⁵ Led by Lord Denning, courts have stated that the public interest exception extends to crimes, frauds and misdeeds,¹⁴⁶ or, indeed, wherever there is 'just cause or excuse for breaking confidence'.¹⁴⁷

The 'just cause' approach has led courts to look increasingly at the consequences of disclosure. The cases suggest that the public interest in public health and safety is an established category which may justify disclosure of

¹⁴¹ *Corrs Pavey Whiting & Byrne v Collector of Customs (Vic)* (1987) 14 FCR 434, 455; *A v Hayden* (1984) 156 CLR 532, 545; *Church of Scientology of California v Kaufman* [1973] RPC 627, 656, 657-8; *Hubbard v Vosper* [1972] 2 QB 84, 99-101; *Weld-Blundell v Stephens* [1919] 1 KB 520, 533-4, 547-8. Another narrow view is that all the 'defence' describes is the fact that courts (i) will not imply a contractual term to keep secret details of a confider's gross bad faith, or (ii) will not recognise that details of a crime, civil wrong, or serious misdeed have the requisite quality of confidentiality to be subject to a duty of non-disclosure: *Corrs Pavey Whiting & Byrne v Collector of Customs (Vic)* (1987) 14 FCR 434, 455-6.

¹⁴² (1856) 26 LJ Ch 113, 114, where the Vice-Chancellor said:

You cannot make me the confidant of a crime or a fraud, and be entitled to close up my lips upon any secret which you have the audacity to disclose to me relating to any fraudulent intention on your part: such a confidence cannot exist.

¹⁴³ Courts have frequently stated that duties of confidence are enforced because this is in the public interest: *Attorney-General v Guardian Newspapers Ltd (No 2)* [1990] 1 AC 109, 177-8, 256, 282, 283; *Lion Laboratories Ltd v Evans* [1985] QB 526, 536, 547; *W v Egdell* [1990] 1 Ch 359, 416, 419.

¹⁴⁴ See *Attorney-General v Guardian Newspapers Ltd (No 2)* [1990] 1 AC 109, 282 per Lord Goff.

¹⁴⁵ For judicial recognition of this fact, see *Lion Laboratories Ltd v Evans* [1985] QB 526, 537-8, 548, 550; *Attorney-General v Guardian Newspapers Ltd (No 2)* [1990] 1 AC 109, 268-9, 282; *Malone v Metropolitan Police Commissioner* [1979] 1 Ch 344, 361-2; *Attorney-General (UK) v Heinemann Publishers Australia Pty Ltd* (1987) 10 NSWLR 86, 171.

¹⁴⁶ *Initial Services Ltd v Putterill* [1968] 1 QB 396, 405.

¹⁴⁷ *Fraser v Evans* [1969] 1 QB 349, 362.

confidential information.¹⁴⁸ Intellectually, the 'just cause' approach is useful, since it requires courts to articulate the various factors justifying the protection or non-protection of confidences in each case. The process has, however, over-extended itself in some English cases, which have dispensed with any control device based upon the *kind* or *category* of countervailing public interest put forward, and simply regarded the whole process as requiring a balancing of the public interest in enforcing confidentiality against whatever public interests are served by disclosure. Thus, for example, it has been suggested that there is a public interest, sufficient to justify disclosure of confidential information, in 'knowing the truth' about the private lives of a pop group.¹⁴⁹ The 'unrestricted balancing' approach appears to have gained some support in England,¹⁵⁰ although it has faced a cool reception in Australia.¹⁵¹ There is strong support for the view that duties of confidence cannot be cast aside merely because confidential information is interesting to the public.¹⁵²

In a number of cases, courts have either held, or stated in obiter, that the public interest in preventing violent physical injuries to members of the public may override the doctor's legal duty of confidentiality in appropriate circumstances.¹⁵³ English¹⁵⁴ and Australian¹⁵⁵ dicta support the view that the public interest defence extends to 'matters medically dangerous to the public'.

¹⁴⁸ For example: *Hubbard v Vosper* [1972] 2 QB 84 (scientology courses regarded as 'medical quackeries . . . which may be dangerous if practised behind closed doors'); *W v Egddell* [1990] 1 Ch 359 (consultant psychiatrist justified in disclosing to Home Secretary and to medical officers responsible for the care of a paranoid schizophrenic under detention for killings, information indicating patient still a danger to society).

¹⁴⁹ *Woodward v Hutchins* [1977] 1 WLR 760, 764.

¹⁵⁰ *Attorney-General (UK) v Guardian Newspapers Ltd (No 2)* [1990] 1 AC 109, 268-9 per Lord Griffiths, 282 per Lord Goff; *Lion Laboratories Ltd v Evans* [1985] QB 526, 539; *W v Egddell* [1990] 1 Ch 359, 389, 390, 419, 420; *Attorney-General v Jonathan Cape Ltd* [1976] 1 QB 752, 765.

¹⁵¹ *Castrol Australia Pty Ltd v Emtech Associates Pty Ltd* (1980) 51 FLR 184, 214-15; *David Syme & Co Ltd v General Motors-Holden's Ltd* [1984] 2 NSWLR 294, 298-9, 306; cf 309; *Corrs Pavey Whiting & Byrne v Collector of Customs (Vic)* (1987) 14 FCR 434, 451; *Kelly v Hawkesbury Two Pty Ltd (No 3)* (unreported, Supreme Court of New South Wales, 26 November 1987, Young J); *Attorney-General (UK) v Heinemann Publishers Australia Pty Ltd* (1987) 8 NSWLR 341, 380 per Powell J; *Bacich v Australian Broadcasting Corporation* (1992) 29 NSWLR 1, 16; cf *Attorney-General (UK) v Heinemann Publishers Australia Pty Ltd* (1987) 10 NSWLR 86, 169.

¹⁵² *British Steel Corporation v Granada Television Ltd* [1981] AC 1096, 1113-14, 1168, 1175, 1189; *Lion Laboratories Ltd v Evans* [1985] QB 526, 537, 553; *Attorney-General (UK) v Heinemann Publishers Australia Pty Ltd* (1987) 10 NSWLR 86, 167; *Attorney-General for the United Kingdom v Wellington Newspapers Ltd* [1988] 1 NZLR 129, 178; *David Syme & Co Ltd v General Motors-Holden's Ltd* [1984] 2 NSWLR 294, 305, 310; *G v Day* [1982] 1 NSWLR 24, 29; *X v Y* [1988] 2 All ER 648, 658.

¹⁵³ *W v Egddell* [1990] 1 Ch 359; *R v Crozier* (1990) 12 Cr App R(S) 206; *Duncan v Medical Disciplinary Committee* [1986] 1 NZLR 513, 521; *Furniss v Fitchett* [1958] NZLR 396, 405-6; *Halls v Mitchell* [1928] SCR 125, 136; *Schering Chemicals Ltd v Falkman Ltd* [1982] 1 QB 1, 27.

¹⁵⁴ *Beloff v Pressdram Ltd* [1973] 1 All ER 241, 260 per Ungoed-Thomas J.

¹⁵⁵ *Castrol Australia Pty Ltd v Emtech Associates Pty Ltd* (1980) 51 FLR 184, 213-14 per Rath J; *David Syme & Co Ltd v General Motors-Holden's Ltd* [1984] 2 NSWLR 294, 298.

This sub-category arose from the 'scientology cases',¹⁵⁶ which concerned information relating to practices alleged to be dangerous to mental health, although no great leap of principle is required to recognise a general public interest in *preventing physical harm to third parties*, whether from violence, catastrophe or disease. The public interest in preventing disease transmission is reflected in statutory reporting requirements for infectious diseases. It is likely, therefore, that in determining the limits of the doctor's duty of confidence within the doctor/athlete relationship, Australian courts would recognise a public interest in preventing the transmission of an infectious disease and balance this interest, either explicitly or implicitly, against the public interest in protecting confidentiality. Notwithstanding that confidentiality may be seen as a private or personal interest, it is clear that courts regard the interest in maintaining confidentiality as being a public interest for the purposes of the public interest exception.¹⁵⁷

The public interest in preserving doctor/patient confidentiality is critical in cases where a patient suffers from a stigmatised, infectious disease such as HIV. In addition to the general public interest in nurturing intrinsically confidential relationships such as the doctor/patient relationship, courts have recognised the *public health interest* in protecting doctor/patient confidentiality in cases where a patient suffers from physical or mental disease.¹⁵⁸ In *X v Y*,¹⁵⁹ the leading AIDS confidentiality case, Rose J stated that

preservation of confidentiality is the only way of securing public health; otherwise doctors will be discredited as a source of education, for future individual patients "will not come forward if doctors are going to squeal on them".¹⁶⁰

Encouraging persons with, or at risk of HIV/HBV/HCV to come forward for testing, treatment *and education* is an integral part of the public interest in treating disease and improving health.

Balanced against this will be the public interest in preventing physical injury, in this case by preventing disease transmission to third parties. By far the highest risk of transmission will be to the athlete's sexual partners.¹⁶¹ The legality of a doctor's disclosure to the unsuspecting partner of an HIV infected patient has been a topic of considerable interest, uncertainty and

¹⁵⁶ *Hubbard v Vosper* [1972] 2 QB 84; *Church of Scientology of California v Kaufman* [1973] RPC 635.

¹⁵⁷ *W v Egdell* [1990] 1 Ch 359, 415.

¹⁵⁸ See *Duncan v Medical Disciplinary Committee* [1986] 1 NZLR 513, 521; *W v Egdell* [1990] 1 Ch 359, 389–90, 392; *Hammonds v Aetna Casualty & Surety Co* 243 F Supp 793, 801 (1965); *Tarasoff v The Regents of the University of California* 551 P 2d 334, 346 (1976); *Halls v Mitchell* [1928] SCR 125, 136–7.

¹⁵⁹ [1988] 2 All ER 648.

¹⁶⁰ *Id* 653.

¹⁶¹ In this context, one should note that the *HIV/AIDS Preventive Measures Act 1993* (Tas), s 20(7) authorises disclosure to the sexual contacts of an HIV infected person, if the infected person continues to act recklessly. Elsewhere, the issue will be determined under the common law, although subject to the legislation discussed in Section 4(b)(i) *supra*.

disagreement, both among lawyers,¹⁶² and doctors.¹⁶³ The Legal Working Party of the Intergovernmental Committee on AIDS has recommended that professional care-givers should be protected by legislation from actions for breach of confidence, and for breach of duty of care for *failure* to warn a third party, when acting in accordance with partner notification protocols containing specific criteria.¹⁶⁴

The issue in the present context, however, is whether (i) disclosure by a private doctor to team or club management,¹⁶⁵ or (ii) disclosure by either private or team doctors to other third parties, would be justified by virtue of the risk of HIV/hepatitis transmission to other players, trainers and doctors. The strength of the public interest in disclosure, for the purposes of the public interest defence equation, will be influenced overwhelmingly by consideration of the *likelihood* of transmission, and the *seriousness* of the disease. The likelihood of transmission will depend upon the nature and frequency of blood contact in the relevant sport, whether 'blood-bin' and other infection control procedures are enforced, and whether the athlete is likely to take care in adhering to them, and in behaving responsibly. Clearly, HIV/HBV/HCV infection are all serious conditions; the physical burden of HIV, in particular, being deepened by a social perception of HIV/AIDS as abhorrent and shameful.¹⁶⁶

Even where the factors relevant to an assessment of competing public interests have been identified, it is nevertheless difficult to predict how courts are likely to react. The issue is similar in some ways to that which faces a physician whose patient is a surgeon infected with HIV/HBV/HCV, who is carrying out invasive procedures on patients. In the latter case, the *surgeon* may be in breach of a duty of care in not informing patients of his or her

¹⁶² Prominent contributions include: M Neave, 'AIDS — Confidentiality and the Duty to Warn' (1987) 9 *U Tas LR* 1; R Paterson, 'AIDS, HIV Testing, and Medical Confidentiality' (1991) 7 *Otago Law Review* 379; R O'Dair, 'Liability in Tort for the Transmission of AIDS: Some Lessons from Afar and the Prospects for the Future' [1990] *Current Legal Problems* 219, 232–41; D G Casswell, 'Disclosure by a Physician of AIDS-Related Patient Information: An Ethical and Legal Dilemma' (1989) 68 *Can Bar Rev* 225; see also *Bradley v Jones & Adams* (1991) *Commonwealth Law Bulletin* 875–9 (Commonwealth Moot Court Judgment, New South Wales Court of Appeal, 18 April 1990).

¹⁶³ See D I Grove and J B Mulligan, 'Consent, Compulsion and Confidentiality in Relation to Testing for HIV Infection: The Views of WA Doctors' (1990) 152 *Medical Journal of Australia* 174; R S Magnusson, 'Privacy, Confidentiality and HIV/AIDS Health Care' (1994) 18 *Australian Journal of Public Health* 51, 56.

¹⁶⁴ Intergovernmental Committee on AIDS ('IGCA'), Legal Working Party, *Final Report* (November 1992) 12–13, Recommendation 2.2. These criteria are: (i) the client has refused to notify his or her partner; (ii) a real risk of HIV transmission exists; (iii) counselling to achieve behaviour change has failed; (iv) advice from colleagues, or an institutional ethics committee has been sought; (v) the client has been told that notification will occur after a reasonable time; and (vi) the partner should be obliged to keep the confidential information revealed during notification if the identity of the client is impossible to conceal.

¹⁶⁵ We argued in Section 4(b)(iii) *supra* that disclosure by a team doctor to team management would not involve a breach of confidence.

¹⁶⁶ This has been clearly recognised by both Australian and American courts: *TK' v Australian Red Cross Society* (1989) 1 *WAR* 335, 341; *Rasmussen v South Florida Blood Service* 500 So 2d 533, 537 (1987); *Doe v American Red Cross Blood Services* 125 FRD 646, 652 (1989); *Cain v Hyatt* 734 F Supp 671, 680 (1990).

infection.¹⁶⁷ However, assuming that the surgeon was using universal precautions to minimise the risk of blood or fluid contact with the patient, and in view of the low risk of transmission,¹⁶⁸ it is unlikely that the public interest would justify a disclosure by the surgeon's private *physician* to the surgeon's employers or patients.¹⁶⁹ This view has been acknowledged, explicitly or implicitly, in the guidelines of some professional medical bodies.¹⁷⁰ Similarly, it is unlikely that without an athlete's consent, a private doctor could justify disclosure of an athlete's HIV/HBV/HCV status to team officials (less still to the media), as being in the public interest. Nor, in view of the generally accepted low risk of HIV/hepatitis transmission in sport, do we believe the public interest exception would justify team doctors or team management informing other athletes of the health status of an infected athlete; less still the media.

(v) *Liability for Failure to Warn*

Although some judges have spoken (loosely) of a *duty* to disclose confidential information in the public interest,¹⁷¹ strictly, what they are identifying is a *defence* to the action for breach of confidence. When the defence applies, the confidant is at liberty to disclose confidential information. The defence does not require disclosure, it merely permits it.

This section concerns distinct but closely related issues. Where a confidant is at liberty to disclose confidential information, are there circumstances in which the law of negligence will impose liability for omitting to do so? Furthermore, could a conflict occur between the law of confidential information

¹⁶⁷ Doctors owe a duty to advise patients of such risks 'a reasonable person in the patient's position would be likely to attach significance to': *Rogers v Whitaker* (1992) 175 CLR 479, 491. Assuming that most patients would wish to be informed of even the slightest risk of acquiring HIV (or HBV/HCV) from their doctor, one may argue that a reasonable patient would also wish to be informed of this risk. While reasonable patients may accept the risks of failure or of complications inherent in various procedures, it does not follow that they would accept the risk of contracting an ultimately fatal infection from their doctor, however, remote, which could be eliminated by switching doctors.

¹⁶⁸ The Centre for Disease Control in Atlanta has estimated the risk of HIV transmission from surgeon to patient as in the range of 1/40 000 and 1/400 000, and in the range of 1 in 260 000 to 2.6 million from dentist to patient: Daniels, *op cit* (fn 52) 13. Nevertheless, the CDC has reported 20 clusters of documented transmission of HBV from health care workers to over 300 patients since 1970: *id* 11. Five Florida patients have also been reported as contracting HIV from a bisexual dentist: 'Dentist Kept Infection Secret, Five Infected', *Canberra Times*, 24 July 1991, 12.

¹⁶⁹ See *Y' v YVW Enterprises Ltd, Hinch and Parry* (unreported, Supreme Court of Western Australia, 2 February 1990, Wallwork J) (injunction granted preventing broadcasting of allegations that plaintiff health care worker had Hepatitis B). As far as an HIV infected surgeon is concerned, the results of disclosure may be devastating: see 'HIV Infection, Confidentiality and Discrimination' (1992) 157 *Medical Journal of Australia* 282; *Behringer v Princeton Medical Center* 592 A 2d 1251 (1991).

¹⁷⁰ See The Australian Nursing Federation, *HIV/AIDS and the Nursing Profession*, Policy Statement (December 1991); The New Zealand Medical Association, Policy on HIV Testing, Patient Care and Responsibility (contained in the NZMA policy document, *Policy Relating to HIV/AIDS*, developed in the period May 1990 — April 1991).

¹⁷¹ *W v Egddell* [1990] 1 Ch 359, 419; *Lion Laboratories Ltd v Evans* [1985] QB 526, 537; *Duncan v Medical Disciplinary Committee* [1986] 1 NZLR 513, 521; *Furniss v Fitchett* [1958] NZLR 396, 405-6.

and the law of negligence such that a confidant would not be at liberty to disclose, but at the same time be liable in negligence to an injured third party (plaintiff) for not having done so? In the present context, an examination of these issues includes investigating the circumstances when the law of negligence might require a private doctor, a team doctor or a sport administrator (as a knowing recipient of confidential information relating to an athlete's infection) to take action to protect third parties in sport from the risk of transmission of an infectious disease by warning others of the athlete's infection or taking other protective action. In other words, does any such omission to act constitute a breach of a duty of care in the tort of negligence owed to that third party?

It should be noted, however, that in some circumstances, legislative duties of non-disclosure will effectively resolve this potential conflict in favour of preserving confidentiality: there could be no liability in negligence for complying with the confidentiality legislation discussed above.

The issue of when there may exist an obligation to disclose confidential information has received considerable attention in American jurisprudence. Some American courts have recognised that a doctor may owe a duty to disclose confidential patient information where there is a risk that a patient may cause violent physical injury to third parties. The authority constantly referred to here is *Tarasoff v The Regents of the University of California*.¹⁷² In this case, the California Supreme Court held that the psychiatrist/patient relationship may support affirmative duties of action which exist for the benefit of third parties; in particular, the duty to protect third parties from reasonably foreseeable harm, which in this case was breached by the failure of a psychiatrist to warn the foreseeable victim of the danger posed by his patient.¹⁷³

In several early cases, American courts have also held that a doctor treating a patient for an infectious disease owes a duty to exercise reasonable care in giving notice of the existence and nature of the disease to members of the patient's family and others known by the physician to be in dangerous proximity to the patient.¹⁷⁴ More recently, in Colorado, this duty was upheld on

¹⁷² 551 P 2d 334 (1976).

¹⁷³ The facts of *Tarasoff* are well known. A voluntary outpatient at a university hospital, Poddar, told Dr Moore, his psychotherapist, that he intended to kill Tatiana Tarasoff, his girlfriend, upon her return from an overseas holiday. At Moore's request, campus police briefly detained Poddar, but released him when he appeared rational. Moore's superior then directed that no further action be taken to detain Poddar. Neither Tatiana nor her parents were warned of Poddar's threats. Poddar later murdered Tarasoff, and in a re-hearing, the Court held that a cause of action existed for the breach by the defendants of their duty to exercise reasonable care to protect Tatiana from the risk of violence.

¹⁷⁴ *Jones v Stanko* 160 NE 456 (1928) (smallpox); *Davis v Rodman* 227 SW 612, 614 (1921) (typhoid fever); *Skillings v Allen* 173 NW 663 (1919) (scarlet fever); *Wojcik v Aluminum Co of America* 183 NYS 2d 351 (1959) (tuberculosis); see also *Hofmann v Blackmon* 241 So 2d 752 (1970) (tuberculosis).

the basis that the nature of the doctor/patient relationship supported a duty to warn of 'the specific risks to specific persons' caused by a patient's illness.¹⁷⁵

In each of these cases the doctor's duty was recognised in circumstances where the patient was either a child, a person unaware of the disease they were suffering, or a person who could not, by choice, eliminate the risk of infection to others. The cases fall short of indicating that a doctor would be liable where an adult patient who was aware of their infection, and who could have prevented it, engaged in activities (for example, sport) which resulted in transmission. *Tarasoff's* case, however, supports the extension of liability in the sports-transmission context, by recognising that a doctor may be liable for a patient's voluntary, irresponsible or risk-laden behaviour, once injury to third parties becomes reasonably foreseeable. If a doctor knew that an HIV/HBV/HCV infected patient would continue to play sport, there is some American support for the view that the doctor might owe a duty to protect other athletes who might foreseeably be infected in a collision; although whether it would be discharged by excluding infected players, or by warning other athletes potentially at risk, or their team, club or governing body, is another matter. It may even be that in the case of a team doctor, a duty to warn may be more readily established toward team-mates of the infected athlete than opponents because of the team doctor's existing doctor/patient relationship with the team-mates (but not the opponents).

Arguably, the legal position in Australia is even less clear. As a matter of general principle, a duty of care in the tort of negligence will arise when: (i) there is a reasonably foreseeable risk of harm to the plaintiff; (ii) the plaintiff and the defendant are in a relationship of proximity with respect to the alleged wrongful conduct and the injury; and (iii) there is no legislative or other common law rule precluding a duty in the circumstances.¹⁷⁶ Under Australian law, a doctor, or a team or club administrator, would only be liable in negligence for omitting (intentionally or unintentionally) to warn a third party of harm caused by a patient or athlete where the omission constituted a breach of duty of care owed to that third party.¹⁷⁷

Omissions are conventionally divided into two categories: 'causal', and 'non-causal' or 'pure' omissions. Causal omissions can be regarded as occurring in the course of positive conduct; for example, omitting to apply a car's brakes. In the case of pure omissions,

apart from the defendant's failure to act there is no conduct on the part of the defendant which is causally linked with the plaintiff's harm. This is to be distinguished from instances where positive conduct on the part of the

¹⁷⁵ *Gammill v United States* 727 F 2d 950 (1984) (infectious hepatitis and gastroenteritis); similarly, *Shepard v Redford Community Hospital* 390 NW 2d 239 (1986) (spinal meningitis).

¹⁷⁶ *Jaensch v Coffey* (1984) 155 CLR 549, 586. This view, which makes the existence of a duty of care turn largely on the element of 'proximity', has received majority support in the High Court since 1986: *San Sebastian Pty Ltd v The Minister* (1986) 162 CLR 340, 354-5; *Cook v Cook* (1986) 162 CLR 376, 381-2; *Gala v Preston* (1991) 172 CLR 243, 252-3.

¹⁷⁷ See *Sutherland Shire Council v Heyman* (1985) 157 CLR 424, 443, 478.

defendant is causally responsible for the plaintiff's harm, though an omission in the course of that conduct may also be seen as a cause.¹⁷⁸

When injury to a person results from an omission in the course of positive conduct there is little doctrinal difficulty in the imposition of liability provided other elements of the tort of negligence are fulfilled. However, subject to a number of exceptions, the law imposes no liability for pure omissions which result in harm, even if that harm is reasonably foreseeable.¹⁷⁹ In its extreme applications, this principle means there is no general duty to go to the aid of drowning or other accident victims. This is usually explained by saying that where a defendant fails, by omission, to prevent a reasonably foreseeable but independently created risk of injury to the plaintiff, the relationship between the defendant and plaintiff lacks that element of 'proximity' necessary to impose on the defendant a duty of care.¹⁸⁰ The analysis appears to apply equally to risks caused by act of nature or the deliberate or negligent conduct of others (as in the present context where the medium of transmission of the disease will be the action of an independent person — the infected athlete).

Courts have, however, recognised a number of special relationships which by their nature involve the assumption or imposition of affirmative duties of action for the benefit of third parties, ie, liability for pure omissions. In rationalising the cases, it is helpful to see these relationships as arising in either of two ways.

Firstly, affirmative duties of action may be imposed or undertaken by virtue of the defendant's relationship with the direct wrongdoer. The cases suggest that protective responsibilities may arise where the defendant owes a duty to control or supervise the activities of the person who directly caused the injury, and where the injury which occurred was a reasonably foreseeable consequence of negligence in that control or supervision. In *Dorset Yacht Co v Home Office*,¹⁸¹ the Home Office was liable for failing to take reasonable care to control some Borstal boys, who escaped from an island where they were encamped and damaged a nearby yacht, on the basis that such escape and resulting damage were precisely what should have been foreseen. The 'control' principle has been applied to parents¹⁸² and kindergartens¹⁸³ in respect of

¹⁷⁸ H Luntz and D Hambly, *Torts: Cases and Commentary* (3rd ed, 1992) 494.

¹⁷⁹ *Sutherland Shire Council v Heyman* (1985) 157 CLR 424, 444, 477–8, 502; *Home Office v Dorset Yacht Co Ltd* [1970] AC 1004, 1027, 1060.

¹⁸⁰ *Sutherland Shire Council v Heyman* (1985) 157 CLR 424, 502 per Deane J. Alternatively, the intervening act of the direct wrongdoer may be seen as a *novus actus interveniens* which breaks the chain of causation between the defendant's omission and the plaintiff's loss: *Weld-Blundell v Stephens* [1920] AC 956, 986; *Smith v Littlewoods Ltd* [1987] 1 AC 241, 272.

¹⁸¹ [1970] AC 1004.

¹⁸² *Smith v Leurs* (1945) 70 CLR 256, 260, 262; *McHale v Watson* (1964) 111 CLR 384, 386–7 (parents may be liable for injuries which children have caused third parties to suffer in circumstances where the parent failed to exercise reasonable control over the activities of the child).

¹⁸³ *Carmarthenshire County Council v Lewis* [1955] AC 549 (education authority operating nursery school liable for dangerous condition created by 'escape' of children under its control).

injuries caused by children, and may also explain liability imposed upon prison authorities¹⁸⁴ and driving instructors.¹⁸⁵

Secondly, a positive duty to protect may be imposed or undertaken by virtue of the defendant's special relationship with the plaintiff who is injured, rather than with the direct wrongdoer who causes the harm. It is this basis, rather than the abovementioned 'control' rationale, which provides a possible explanation for cases in which liability for failure to act was imposed upon hotel managers,¹⁸⁶ employers¹⁸⁷ and even a local council patrolling a beach swimming area.¹⁸⁸

An alternative way of viewing some of these cases is as instances of omission in the course of positive conduct rather than as pure omissions. For example, the relationships inherent in operating a school or a prison involve respectively protecting pupils from other pupils and prisoners from other prisoners.

It is difficult to predict what other kinds of relationship between the defendant and the direct wrongdoer, or between the defendant and the injured plaintiff, would be regarded by courts as displaying that element of proximity sufficient to impose on the defendant a positive duty to act. Deane J, however, has stated that the categories of case importing affirmative duties of action should be seen as 'exceptional'.¹⁸⁹ He has suggested that apart from cases where a duty to prevent harm caused by the direct wrongdoer is implicit within a particular relationship, or is assumed under the circumstances, a duty to prevent harm caused by the independent action of another will be largely confined to cases involving reliance upon a defendant's discharge of powers, duties or functions arising from statute, from the holding of an office, or from the possession or occupation of property.¹⁹⁰ This largely explains the cases previously cited, and would appear to embrace the categorisation of cases we have offered.

The limits upon the contexts in which 'protective responsibilities' may arise appear to preclude any duty by a doctor with respect to a private patient, except when the patient is in the custodial care of an institution. This would

¹⁸⁴ *L v Commonwealth of Australia* (1976) 10 ALR 269, 281; *Nada v Knight* (1990) Aust Torts Reports ¶81-032; *Ellis v Home Office* [1953] 2 All ER 149 (prison authorities may be liable for failing to take reasonable care to prevent prisoners from assaulting other prisoners).

¹⁸⁵ *British School of Motoring Ltd v Simms* [1971] 1 All ER 317, 320 (driving instructor's duty to intervene in the interests of public safety to prevent a driving student from injuring other road users).

¹⁸⁶ *Chordas v Bryant (Wellington) Pty Ltd* (1988) 91 ALR 149 (hotel manager's duty to protect one patron from the foreseeable risk of injury from the acts of another patron).

¹⁸⁷ *Chomentowski v Red Garter Restaurant Pty Ltd* (1970) 92 WN (NSW) 1070 (restaurant owner's duty to protect employee from reasonably foreseeable risk of robbery and of injury when latter was depositing the night's takings in a night safe).

¹⁸⁸ *Glasheen v The Council of the Municipality of Waverley* (1990) Aust Torts Reports ¶81-016 (local council found liable for injuries caused to a swimmer by a surfboard rider who entered a flagged area where board riding was prohibited; it was found that there had been a negligent omission on the part of a Council employee by not excluding the board rider from the flagged area).

¹⁸⁹ *Sutherland Shire Council v Heyman* (1985) 157 CLR 424, 502.

¹⁹⁰ *Ibid.*

also generally be the case for any duty owed by team doctors or sports administrators in respect of adult athletes. However, before reaching any firm conclusion on the latter issue, it is essential to analyse both the relationship between team management and an infected athlete who transmits the infection, and the relationship between team management and other athletes at risk (potential plaintiffs), particularly those on the same team. Even so, a team's responsibilities in regard to the activities of an HIV/hepatitis infected athlete arise not from custodial responsibilities, but from contractual and other voluntary arrangements entered into by athletes and the team. Similarly, a duty to control infected athletes and to protect uninfected ones does not appear to arise from any relevant statute, or from government office or from ownership of property.¹⁹¹ Nor, unlike the parent/child relationship, is the team doctor/sports administrator and adult athlete relationship clearly one where a duty to protect is regarded by law as being undertaken or implicit from the circumstances. Nevertheless, the dividing line between the cases referred to above where there is a duty to take positive action, and the team doctor or sports administrator, who decide on the fitness of an athlete, is a narrow one.

On the basis of the principles discussed above, it is more likely that a duty to protect against HIV/hepatitis transmission would arise within a school sports context. Here, courts may regard the duty of the educational authority to control children while at school as establishing a requisite relationship of proximity which would require the school to take reasonable care to protect other school children from the risk of HIV/hepatitis transmission from a child known to be infected. Alternatively, an omission to act might be seen as arising from an obligation owed directly to the pupil who is placed at risk of contracting the disease. Professional team sports may also attract positive duties to act. Members of professional sports teams are employees¹⁹² and as such are owed various non-delegable duties by their employers.¹⁹³ Team doctors may not only be at liberty to disclose confidential information to team management, a failure to do so and a failure to act on it by team management may be a breach of the special relationship with employees.

The kind of action, if any at all, which the duty of care would require will depend on the workings of the calculus of negligence which is discussed below in Section 6. Obviously, a factor will be the likelihood of disease transmission notwithstanding that infection control procedures are followed. Also, in our view, a court deciding what a reasonable doctor or team manager would do in the circumstances for the purposes of the law of negligence, would take into account the interest in protecting confidentiality. Thus, the reasonable doctor would not be required to warn other athletes at risk because their protection can be achieved by means such as excluding the infectious person from par-

¹⁹¹ It is possible, though, that a wrestling club might have a duty to maintain mats or other equipment in a hygienic state to prevent hepatitis transmission, by virtue of the club's occupation of its own premises.

¹⁹² Opie and Smith, *op cit* (fn 117) 317–20.

¹⁹³ *Kondis v State Transport Authority* (1984) 154 CLR 672.

ticipation. In this way there is no conflict between the law of confidentiality and the duty of care requirements.

In summary, it is our view that in the 'bloody combat and contact sports' where there appears to be some meaningful risk of transmission of HIV/HBV/HCV notwithstanding implementation of infection control procedures, schools and professional team doctors and management will have to take reasonable steps (positive action) to protect their own pupils and employees from the risk of contraction of infectious diseases from other pupils or employees in the same school or team. Also, the control exercised over pupils at school suggests that a protective duty might extend to pupils from other schools participating in inter-school sport. However, as noted above, this control does not extend to employee athletes and, therefore, it is unlikely that a duty to take positive action for the protection of opponents of professional athletes will arise. No doubt this will seem curious to many, but it derives from the quite restricted responsibilities which the law recognises in regard to pure omissions. Where a protective duty exists, the requirement to take reasonable steps may be satisfied by exclusion of the athlete should counselling not achieve voluntary withdrawal. Confidentiality requirements would not permit nor would the duty of care in negligence (given counselling and/or exclusion) require disclosure of the athlete's status to team-mates, opponents or the media.^{193a}

On the other hand, the current state of the law leads us to conclude that there is no obligation on private doctors to warn potential team-mates and opponents of the infected athlete of the applicable risks. As a matter of commonsense, it might be expected that a private doctor would counsel the infected athlete on the risks to which he or she was exposing others, but it is unlikely that a court would impose a duty in negligence on the doctor in favour of third parties to do so. That would be akin to requiring private doctors to warn third parties. However, it is conceivable that the private doctor could still become indirectly liable for the transmission by a patient to a team-mate or opponent. As will be considered below in Section 6(b), a patient may be personally liable for that transmission. In that event, the patient may claim that he or she would not have participated if properly counselled and therefore would not have become liable for the transmission. Thus, the doctor might be liable to the patient for the whole or a part of the damages awarded to the infected person.

Finally, it is worth noting some implications for community (as opposed to professional or school) sport. On the basis of existing authority, community sport does not give rise to the special relationships necessary for the existence of liability for pure omissions. However, it may be that the organisation and undertaking of community sport programmes can be regarded as positive conduct in relation to which there is a duty to take reasonable care for the protection of those who participate. On this basis, those managing community sport who are aware of an athlete's infectious condition could owe a

^{193a} See Section 4(b)(iv) *supra*. Care would need to be taken when giving reasons for an athlete's exclusion in order to maintain confidentiality.

duty to exclude infected athletes participating in bloody contact and combat sports. In fact, this approach could even be applied to sport in general, including professional and school sports.

The duty to warn remains speculative. It is clear, however, that a resolution of the legal problems which infectious diseases pose for sport requires that 'protective measures', such as the duty of confidence, anti-discrimination protection and restraint of trade on the one hand, should not conflict with 'public health measures', such as the duty to warn, and permissible discrimination on the basis of public health. Sport in Australia might well benefit from the law reform proposals recommended by the Legal Working Party of the Intergovernmental Committee on AIDS with respect to warning sexual partners of the risk of HIV transmission, which protects a doctor from civil actions for breach of confidence, and negligence for failure to warn, provided an appropriate protocol is followed.¹⁹⁴ That protocol might well differ according to the nature of the sport: combat, contact, collision or non-contact.

5. LEGAL CONSTRAINTS UPON SPORTS ORGANISATIONS SEEKING TO MINIMISE TRANSMISSION

The discussion has so far concentrated mainly on legal issues relevant to ascertaining whether an athlete has HIV/HBV/HCV. Assuming, however, that sports administrators acquire knowledge that an athlete is infected, the next question is: what can they do about it?

The World Health Organisation Concensus Statement on AIDS and Sports, as well as the ASMF draft *Guidelines for Sport on Infectious Diseases*, leave it up to the individual concerned to decide whether they will continue playing despite HIV/HBV/HCV infection. While continued participation in sport at the physically demanding highest elite levels may impair an athlete's immune function,¹⁹⁵ it remains true, as Magic Johnson demonstrated during the Olympic Games in Barcelona in 1992, that symptomless HIV infection does not 'impair a person's strength, agility, or ability to breath'.¹⁹⁶ The same may be true of chronic HBV. Where an athlete wishes to continue participating in sport, or where a sport organisation wishes an infected athlete to withdraw from the sport, several legal issues arise. These relate to confidentiality, contractual obligations, discrimination and restraint of trade.

(a) Confidentiality

Where the confider of confidential medical information (that is, the athlete), reveals to the world that they are HIV/hepatitis infected, this information will, on general principles, cease to be confidential. Information may also lose

¹⁹⁴ See fn 164 supra.

¹⁹⁵ L T Mackinnon, E Ginn and G Seymour, 'Effects of Exercise During Sports Training and Competition on Salivary IgA Levels' in A J Husband (ed), *Behaviour and Immunity* (1992) 169; N Sharp and Y Koutedakis, 'Sport and the Overtraining Syndrome: Immunological Aspects' (1992) 48(3) *British Medical Bulletin* 518.

¹⁹⁶ *Doe v District of Columbia* 796 F Supp 559, 563 (1992).

its confidential quality by virtue of a *confidant's* breach of confidence: courts may refuse to further protect the information by injunction, although an action for damages or equitable compensation may be maintained against the confidant.¹⁹⁷ As discussed above,¹⁹⁸ sports administrators or team officials informed of an athlete's infection by the athlete, in confidence, or by a team doctor, would, subject to any contract, owe a duty of confidence with respect to that information enforceable by an injunction. So long as the risk of infection in the particular sport concerned did not impose upon the club doctor or team administrators a duty to protect third parties from the risk of infection, no issue of a duty to warn, and with it the issue of the limits of the public interest exception to the duty of confidence, would arise. As noted, however, this is one area where the law should be clarified to prevent a conflict between legal duties.

(b) Contractual Obligations of Sports Organisations

The second issue relates to contractual obligations. Many representative team member agreements and professional player contracts provide for the termination of the agreement or contract either immediately or after a period of time if the physical condition of the athlete precludes his or her participation at the appropriate level. An athlete suffering an illness caused by HIV/HBV/HCV infection which was severe enough to produce this effect might well have his or her agreement or contract terminated in this way.

Where an injury is sustained in the course of sport participation, the contract may make provision for continued match payments and for benefits under a health-care agreement or pension fund. Thus, if an athlete acquired an infection during the course of duties performed under a contract (for example, from a bloody collision on the field), these provisions would also apply. These benefits will be payable on an 'occurrence' or 'no-fault basis'.

Contractual issues may also arise concerning whether the athlete was in breach of a warranty as to fitness made when the contract was executed.

Indeed, some contracts, such as the 1992 NSWRL Playing Contract, include a warranty that the player will remain fit and able 'to perform his obligations under this contract without exposing himself to greater than any usual risk to health or to greater than usual risk of injury'.¹⁹⁹ The NSWRL contract provides that it may be terminated where, because of the player's physical or mental condition, he would be exposed to a greater than usual risk of injury by playing rugby league football. While symptomless HIV infection, for example, may in the future cause illness, there would appear to be no scientific basis for arguing that an HIV infected player was more likely to sustain injury than any other player.²⁰⁰

¹⁹⁷ See, generally, *Attorney-General v Guardian Newspapers Ltd (No 2)* [1990] 1 AC 109.

¹⁹⁸ See Section 4(b)(iii) *supra*.

¹⁹⁹ 1992 NSWRL Playing Contract, cl 7.

²⁰⁰ See Mitten, *op cit* (fn 53) 28-9.

(c) Exclusion from Sport and Discrimination

The third issue which arises is discrimination. As with any illness or physical or mental disability, it is not unlawful to discriminate against another person in sport on the basis of an infection if that person is 'not reasonably capable of performing the actions reasonably required in relation to the sporting activity'.²⁰¹ It is conceivable that this provision might even extend to an HIV infected athlete, such as a boxer, if it could be shown that his or her infection caused slowed reflexes which predisposed him to cerebral injury in the ring.²⁰² However, under the *Disability Discrimination Act* 1992 (Cth), an athlete with a symptomless HIV/HBV/HCV infection who is excluded from participation in sport or subject to peculiar restrictions because of his or her infection may complain to the Human Rights and Equal Opportunity Commission, alleging breach of ss 27–8 of the Act.²⁰³ An athlete suspended on suspicion of infection pending production of a 'clean' report would have the same grounds for complaint, given that the definition of 'disability', for the purposes of the Act, includes an imputed disability.²⁰⁴

Complaints under the Act are investigated and conciliated by the Disability Discrimination Commissioner, who has power to obtain information and documents, and convene compulsory conferences.²⁰⁵ Matters unable to be resolved by conciliation are referred to the Commission, which may, if it finds the complaint substantiated, make a declaration that the respondent should re-employ the complainant, or that the termination of a contract should be varied to redress any loss or damage suffered by the complainant, or that the respondent should engage in a course of conduct or pay damages by way of compensation to redress any loss suffered by the complainant.²⁰⁶ Arguably, this would include reinstating membership of a club or competition. The Commission's declarations are not binding upon the parties, although the Commission may institute proceedings in the Federal Court to enforce its determinations.²⁰⁷

Discrimination in sport on the basis of HIV/HBV/HCV status is not unlawful where 'the discrimination is reasonably necessary to protect public health'.²⁰⁸ The relative lack of documented cases of sports-related transmission make this defence a difficult one to rely upon. Although *public health* is nowhere defined, in our view, athletes participating in a sport with another HIV/hepatitis infected athlete would be entitled to the benefit of the provision, if the risk of transmission were high enough.

²⁰¹ *Disability Discrimination Act* 1992 (Cth), s 28(3)(a). Some State Acts contain similar provisions: *Equal Opportunity Act* 1984 (Vic), s 33(3)(a); *Anti-Discrimination Act* 1991 (Qld), s 111(1)(b); *Equal Opportunity Act* 1984 (SA), s 81(a); *Equal Opportunity Act* 1984 (WA), s 66N(3)(a); *Discrimination Act* 1991 (ACT), s 57(a); *Anti-Discrimination Act* 1992 (NT), s 56(1)(b).

²⁰² B D Jordan, 'AIDS and Boxing' in B D Jordan (ed), *Medical Aspects of Boxing* (1992) 317, 321.

²⁰³ These provisions were previously discussed in Section 4(a)(iv) *supra*.

²⁰⁴ *Disability Discrimination Act* 1992 (Cth), s 4(1).

²⁰⁵ *Disability Discrimination Act* 1992 (Cth), ss 67(1)(a), 68–9, 71(1), 73–5.

²⁰⁶ *Disability Discrimination Act* 1992 (Cth), s 103(1).

²⁰⁷ *Disability Discrimination Act* 1992 (Cth), ss 103(2), 104.

²⁰⁸ *Disability Discrimination Act* 1992 (Cth), s 48.

In this respect, it is clear that the initial risk of transmission from collisions and blows occurring in combat and contact sports cannot be eliminated by 'after-the-event' procedures such as the 'blood-bin' rule. Thus, if it could be shown that blood spillage, body contact, and reciprocal blood contact during the sport were sufficiently frequent, the Commission might regard it as reasonable to exclude infected players from the sport. It is suggested that the public health exception could well apply to combat sports such as wrestling, boxing and some martial arts, and possibly to rugby union and league, in view of the high incidence of lacerations requiring medical attention.²⁰⁹ As mentioned previously, however, the risk of bloody contact between players must be distinguished from the risk of disease transmission, and the Commission might well uphold an athlete's right to participate in sport despite a theoretical risk, in the absence of stronger evidence of collision or blow-associated infection transmission. The issue is difficult to predict.

Where an athlete has chosen to reveal their infection to team-members, or where confidentiality has otherwise been broken, the infected athlete may come under intense pressure not to participate from team-mates fearful of acquiring a disease.²¹⁰ American courts have rejected the argument that the misconceived fears of the public justify discrimination under federal discrimination statutes.²¹¹

If a known infected player remains in a competition, it is possible that opponents will be fearful to play as aggressively, and that this may give the infected player an advantage in the sport. Alternatively, opponents and others may refuse to play the sport with the infected player. Unless the club, governing body, or team applied for and was granted an exemption from the Commission,²¹² however, neither of these grounds would justify excluding an infected player under the *Disability Discrimination Act 1992* (Cth).

Under s 27(3), clubs and incorporated associations are permitted to discriminate where, 'because of the person's disability, the person requires the benefit to be provided in a special manner and the benefit cannot without unjustifiable hardship be so provided'. However, as the definition of 'unjustifiable hardship' in s 11 suggests, s 27(3) would appear to apply where the burden of financial expenditure, or of provision of facilities by the club was so heavy, having regard to the benefit to the person with the disability, that discrimination may be permitted. It would not apply where a club faced hardship in maintaining the integrity of competition due to attitudes of its members or of other clubs based on misconceptions or fears *in circumstances*

²⁰⁹ Seward, Orchard, Hazard and Collinson, *op cit* (fn 45).

²¹⁰ The draft *Guidelines for Sport on Infectious Diseases* produced by the Infectious Diseases in Sport Working Party provide that where other participants refuse to continue to participate in the sport with the infected person, then the infected person must be informed of the other participants' attitude. The guidelines then provide that 'the infected person may then wish to reconsider whether they want to continue to play their sport and if so, the others must decide whether they will remain in the team or sport'.

²¹¹ See *Doe v District of Columbia* 796 F Supp 559, 570 (1992); *Casey v Lewis* 773 F Supp 1365, 1370-1 (1991); Mitten, *op cit* (fn 53) 33-4.

²¹² *Disability Discrimination Act 1992* (Cth), s 55.

where discrimination on the grounds of protecting public health was not justified.

Although the *Disability Discrimination Act 1992* (Cth) applies throughout Australia, it is worth noting that State legislation may also offer a measure of protection. Anti-discrimination legislation in seven jurisdictions variously prohibits discrimination on the grounds of a real or imputed (physical) 'impairment' ('disability' in NSW): in the provision of employment;²¹³ in the provision of facilities²¹⁴ or access to premises;²¹⁵ by clubs, including sporting clubs;²¹⁶ and in sport.²¹⁷ In Victoria, NSW, Queensland, the ACT and the NT, the legislation would cover symptomless infections, since the definition of impairment includes 'the presence in the body of organisms causing disease'. In South Australia and Western Australia, however, the legislation would only prohibit infection-related discrimination if the subject could show that the infection had caused a 'defect or disturbance [or, in South Australia, a malfunctioning] in the normal structure and functioning of the person's body'. This may be more difficult to show in the case of a symptomless HIV infection,²¹⁸ although not in the case of a chronic hepatitis infection which, for example, may have caused physical damage (for example, liver damage), although not necessarily physical symptoms.

²¹³ *Equal Opportunity Act 1984* (Vic), s 21 (s 21(4)(h) provides an exception where in view of the impairment and the work environment there is likely to be a risk that the person will infect others and it is not reasonable to take that risk); *Anti-Discrimination Act 1977* (NSW), s 49D; *Equal Opportunity Act 1984* (SA), s 67 (s 71 provides an exception where the person suffering the impairment would be unable to perform adequately without endangering himself or herself or other persons); *Equal Opportunity Act 1984* (WA), s 66B (subject to s 66Q); *Anti-Discrimination Act 1991* (Qld), ss 14–15 (subject to (discriminatory) actions which are reasonably necessary to protect public health or to protect the health and safety of people at a place of work: ss 107–8); *Discrimination Act 1991* (ACT), s 10 (discrimination is lawful if necessary and reasonable to protect public health: s 56); *Anti-Discrimination Act 1992* (NT), s 31 (discrimination is lawful if reasonably necessary to protect public health: s 55).

²¹⁴ *Equal Opportunity Act 1984* (WA), s 66K; *Discrimination Act 1991* (ACT), s 20 (s 31 exempts voluntary bodies; s 56 provides that discrimination is lawful if necessary and reasonable to protect public health); *Anti-Discrimination Act 1992* (NT), s 41 (s 41(2) exempts persons supplying goods, services or facilities for or on behalf of a sporting association; s 55 provides that discrimination is lawful if reasonably necessary to protect public health); *Anti-Discrimination Act 1977* (NSW), s 49M (applies to goods and services).

²¹⁵ *Discrimination Act 1991* (ACT), s 19; (s 31 exempts voluntary bodies; s 56 provides that discrimination is lawful if necessary and reasonable to protect public health).

²¹⁶ *Equal Opportunity Act 1984* (Vic), s 31; *Anti-Discrimination Act 1977* (NSW), s 49C (registered clubs only); *Equal Opportunity Act 1984* (SA), s 72; *Equal Opportunity Act 1984* (WA), s 66M (clubs and incorporated associations); *Anti-Discrimination Act 1991* (Qld), ss 94–5, 116 (subject to (discriminatory) actions which are reasonably necessary to protect public health or to protect the health and safety of people at a place of work: ss 107–8); *Discrimination Act 1991* (ACT), s 22 (clubs holding a liquor licence; s 56 provides that discrimination is lawful if necessary and reasonable to protect public health); *Anti-Discrimination Act 1992* (NT), s 46 (s 55 provides that discrimination is lawful if reasonably necessary to protect public health).

²¹⁷ *Equal Opportunity Act, 1984* (Vic) s 33; *Equal Opportunity Act 1984* (WA), s 66N.

²¹⁸ Although some courts have been prepared to regard asymptomatic HIV infection as a 'defect' or 'impairment' under the legislation: *Hoddy v Executive Director Department of Corrective Services* (1992) EOC 192–397.

(d) Exclusion from Sport and Restraint of Trade

The general principles of the restraint of trade doctrine applied to sport, and its relation to infectious diseases, have been discussed above.²¹⁹ The issue here is whether a sports club or organisation would be able to show that the exclusion of an athlete from a club or competition was a *reasonable* restriction, which went no further than was reasonably necessary to protect the legitimate interests of the club or organisation. The effect of the restriction on the plaintiff pleading restraint of trade, and the special interests of other parties may also be considered.²²⁰

Courts have not considered whether the prevention of possible transmission of an infectious disease to other athletes, or avoiding liability for such transmission, are legitimate interests of a sports organisation, but there appears little doubt that they are. From a practical viewpoint, a club's success in justifying the restriction would depend upon the strength of the evidence establishing the likelihood of transmission in sport, and thus the degree of danger to the club's legitimate interests if an infected player were allowed to participate. Secondly, the sports organisation would need to show that the danger to those interests could not be avoided by taking other precautionary measures, in order to show that the restraint provided *no more than adequate protection*.

In view of the relative lack of evidence of disease transmission in sport, and the fact that it has only recently been appreciated as a serious issue, it is difficult to predict those situations where the exclusion of an infected athlete would be upheld as a reasonable restraint. In this respect, the limits of restraint of trade are as murky as the duty to warn, and the public health exception to discrimination. As with the public health exception, however, it is likely that the *initial risk* of disease transmission from the grinding contact of wrestling, from blows in boxing and from tackling in bloody contact sports would be regarded by courts as justifying the exclusion of infectious athletes. As noted previously, the stopping of contests when bleeding occurs, and other infection control procedures cannot reduce the initial risk in sports which produce frequent bloody contacts. We believe that it can be asserted with some confidence that exclusion would not be regarded as a reasonable restraint upon the trade of athletes earning income from a collision or non-contact sport.

6. LEGAL LIABILITY FOR INFECTIOUS DISEASE TRANSMISSION IN SPORT

This section will consider the legal liability which may be incurred when someone becomes infected with HIV/HBV/HCV within the context of sport. The discussion will focus on the liability of the carrier of the infection and of

²¹⁹ See Section 4(a)(v) *supra*.

²²⁰ *Adamson v New South Wales Rugby League Ltd* (1991) 31 FCR 242, 266, 289-90.

the sports organisation. For simplicity, we will assume that both the carrier and the infected person are athletes.

(a) Proof of Transmission

Legal liability for disease transmission in sport requires proof that the disease was contracted through sport, and not in some other way. Ideally, baseline testing of athletes involved in any 'risky incident' would be necessary to prove the absence of infection prior to the incident, follow-up testing after the 'window period' to prove the presence of infection, and the exclusion of other risk factors or possible causes.

Under the *HIV/AIDS Preventive Measures Act 1993* (Tas), a person may be required to undergo HIV testing after an incident in which there was a risk of transmission.²²¹ Similar legislation exists in Victoria, but would currently apply only to those who may have infected accredited health care workers, police officers and prison officers with HIV.²²²

(b) Liability of the Carrier Athlete²²³

The law is clear that a participant in a sporting contest owes a duty to take reasonable care not to injure other participants.²²⁴ The operation of the duty will take into account the inherent risks of the sport, so that an accidental collision in a basketball game, one athlete stumbling into another in a running race and a tackle in rugby league will not normally be regarded as involving a breach of the duty of care. It is likely, however, that the risk of infection with HIV/hepatitis would not be regarded as an inherent risk of playing sport, since it is not the sort of ordinary, accidental or unavoidable injury inherent in playing the sport. The issue becomes, therefore: what steps must an HIV/HBV/HCV infected athlete take to avoid breaching his or her duty of care to other athletes?

The steps an infected athlete must take to avoid liability will be determined by what the reasonable athlete in similar circumstances would have done. If the defendant athlete falls short of the objective standard so fixed, the duty will be broken. This will involve two inquiries. First, there is a threshold issue to be satisfied. The reasonable athlete will only take steps to guard against those risks of injury which are foreseeable,²²⁵ in the sense that the risk is not

²²¹ *HIV/AIDS Preventive Measures Act 1993* (Tas), s 10(2).

²²² *Health Act 1958* (Vic), ss 120A-D.

²²³ It should be noted that statutory offences exist in Victoria, South Australia, Queensland and Tasmania for recklessly or knowingly infecting another person with an infectious disease: *Health Act 1958* (Vic), s 120; *Crimes Act 1958* (Vic), s 19A (intentionally causing HIV); *Health Act 1937* (Qld), s 48; *Public and Environmental Health Act 1987* (SA), s 37(1); *HIV/AIDS Preventive Measures Act 1993* (Tas), s 20(2). For other, possibly relevant generic offences: see J Godwin, J Hamblin, D Patterson and D Buchanan, *Australian HIV/AIDS Legal Guide* (2nd ed, 1993) ch 2; S Bronitt, 'Criminal Liability for the Transmission for HIV/AIDS' (1992) 16 *Criminal Law Journal* 85. It is not proposed to consider further the possible application of these offences in this paper.

²²⁴ *Rootes v Shelton* (1967) 116 CLR 383; *Condon v Basi* [1985] 1 WLR 866, [1985] 2 All ER 453; *Johnston v Frazer* (1990) 21 NSWLR 89.

²²⁵ *Wyong Shire Council v Shirt* (1980) 146 CLR 40, 47.

'far-fetched or fanciful'.²²⁶ Secondly, if there is a foreseeable risk, the court must

determine what a reasonable [athlete] . . . would do by way of response to the risk. The perception of the reasonable [athlete's] . . . response calls for a consideration of the magnitude of the risk and the degree of probability of its occurrence, along with the expense, difficulty and inconvenience of taking alleviating action and any other conflicting responsibilities which the defendant may have. It is only when these matters are balanced out that the [court] . . . can confidently assert what is the standard of response to be ascribed to the reasonable [athlete] . . . placed in the defendant's position.²²⁷

Although the standard of conduct required of the reasonable athlete will be determined by a court of law, the issue of reasonableness will be influenced by the state of scientific knowledge current at the time. If knowledge and understanding of HIV/hepatitis and its means and chances of transmission change over time, it is possible that the factual decisions of courts and the opinions of observers would be correspondingly modified.

It is strongly arguable that the risk of collision between participants in open, non-contact sports such as croquet, golf and lawn bowls and, therefore, of transmission of HIV/hepatitis during play is quite far-fetched. However, infections could occur in other ways in the context of those sports²²⁸ and so the reasonable golfer will at least have to consider the possible precautions. In collision, contact and combat sports, the chances of HIV/hepatitis infection range from small to very slight, but they cannot be dismissed as far-fetched. In our view, courts would regard the risk of HIV/hepatitis transmission in such sports as foreseeable.

Given the presence of a foreseeable risk, it is clear that the reasonable athlete may, in balancing the various factors mentioned above, decide to ignore that risk.²²⁹ Bearing in mind that a court in Australia and, to our knowledge, in any other common law jurisdiction is yet to decide the issue in regard to transmission of HIV/hepatitis in sport, we believe that the reasonable athlete would not be entitled to ignore the risk and to fail to take precautions to guard against it. The more difficult question is to identify the precautions dictated by the athlete's duty to take reasonable care.

When examining the magnitude and probability of the risk, we can only rely on the limited knowledge and statistics which are available. The chance of contracting HIV through sport in general is extremely small, although apparently greater in combat sports (such as boxing) and bloody contact sports (such as the rugby codes). However, this chance must be weighted by the catastrophic consequences of HIV (death following prolonged illness and significant ostracism). The chances of contracting hepatitis, especially HBV, are

²²⁶ *Ibid*; *Overseas Tankship (UK) Ltd v The Miller Steamship Co Pty Ltd (the Wagon Mound (No 2))* [1967] 1 AC 617.

²²⁷ *Wyong Shire Council v Shirt* (1980) 146 CLR 40, 47-8.

²²⁸ For example, transmission of HBV as a result of poor hygiene in locker rooms and showers.

²²⁹ *Bolton v Stone* [1951] AC 850; *Wyong Shire Council v Shirt* (1980) 146 CLR 40.

significantly larger. However, HBV does not necessarily lead to the same fatal consequences and can be a disease from which there is full recovery. Thus, while the chances of transmission of hepatitis are higher, there is a range of consequences with most being less severe than for HIV.

The other side of the balancing up process requires examination of the 'expense, difficulty and inconvenience of taking alleviating action and any other conflicting responsibilities which the defendant may have'. This examination must be made in respect of identifiable precautions which a reasonable athlete might take. The first of these would be to adhere to the relevant provisions of the ASMF *Infectious Diseases Policy*.²³⁰ This would include such measures as strict personal hygiene, not spitting or urinating in team areas, not participating in communal bathing and not sharing towels, shaving razors and drink containers. It would be expected that an athlete *in any sport* would adopt such measures as much for his or her own safety as for that of others, and irrespective of whether the athlete knew or had reason to know that he or she was infected with HIV/hepatitis. We regard these measures as not onerous when balanced against the risks of transmission to others and, therefore, it would be a breach of the duty of care not to implement them. Accordingly, if it could be established that one athlete had infected the other by a failure to follow the ASMF *Infectious Diseases Policy*, we believe that, absent complicating considerations, the transmitter of the infection would be legally liable for the harm suffered by the infected athlete.

Other precautions which a reasonable athlete might countenance are (i) to warn others that he or she is infectious so that they can make their own decisions whether or not to participate in the sport with the infectious athlete, or (ii) to withdraw from the sporting activity altogether. This is on the premise that the athlete knows of his or her infectious state. The corollary of this is that an athlete who suspects that he or she might be HIV/hepatitis infected or, perhaps, is in a high risk group, has a responsibility to find out about his or her health status.

If the athlete participates in a non-contact sport, we do not believe that there is an obligation to warn or to withdraw from play. The chances of transmission of HIV/hepatitis are far-fetched in connection with play and at least extraordinarily rare in other contexts if the ASMF *Infectious Diseases Policy* is adhered to. In expressing this view, we believe that a court in deciding what a reasonable athlete would do would be influenced by the consideration that an individual who follows sensible infection control procedures should not be cut off from normal social activity. The counter-argument is that non-infected individuals are entitled to know who is infected so that they can take their own precautionary measures and not rely on infectious persons

²³⁰ It should be noted that conformity with a code of practice will not always be regarded as *ipso facto* reasonable behaviour. The courts will look behind common practice to ascertain what is reasonable: *Mercer v Commissioner for Road Transport & Tramways (NSW)* (1936) 56 CLR 580; *O'Dwyer v Leo Buring Pty Ltd* [1966] WAR 67; *Rogers v Whitaker* (1992) 175 CLR 479. However, in the case of the ASMF Infectious Diseases Policy, it would arguably be regarded as up-to-date and representing best practice. Accordingly, it would be unlikely that a finding of negligence would be made which was inconsistent with the Policy's terms.

to do so. These 'precautionary' measures are not those contemplated by the ASMF *Infectious Diseases Policy* (which one might be expected to follow in any event) but are necessarily and undesirably exclusionary in nature.

If the athlete participates in collision, contact or combat sports, we believe the position is more difficult because there is the prospect that infection could be transmitted during play notwithstanding strict adherence to the ASMF *Infectious Diseases Policy*. That prospect appears to increase from collision through contact to combat sports. An announcement that an athlete has, say, HIV could have catastrophic consequences for a professional playing career. It might be expected to end it notwithstanding that the player is quite capable of continuing at the highest levels. Magic Johnson is a case in point. It is, therefore, largely an unreal expectation that an athlete will announce that he or she is infectious with HIV/hepatitis and expect to continue to participate as before. In reality, the issue becomes one of whether the duty of care requires a reasonable athlete to withdraw. Cessation of risky activity has been contemplated by the courts as appropriate if it cannot be continued without creating a substantial risk.²³¹ Putting aside the substantial emotion which the issue is capable of generating and bearing in mind that this is a novel point, we believe that it is arguable that an athlete who plays a bloody contact or combat sport would be obliged to cease playing the sport while HIV/hepatitis infectious. Accordingly, if it could be established that one athlete had infected the other by a physical contact in a bloody contact or combat sport we believe that, absent complicating considerations, the transmitter of the infection would be legally liable for the harm suffered by the infected athlete.

(c) Personal Liability of the Sports Organisation

Leagues, clubs, schools and others conducting sports events and competitions owe a duty of care to see that the events and competitions are conducted with reasonable care for the safety of the participants. There is enormous scope for variation in the manner in which the duty may arise. For instance, it may be linked to the employment relationship and occupational health and safety in professional sports, to safety of playing facilities and equipment, to inadequate supervision, coaching and first-aid facilities and to conditions under which play occurs (for instance, during electrical storms and extreme heat or cold).

Various organisations may have different responsibilities in regard to different aspects of the same safety issue. In the present context, this would mean that the duty of care falling on a league or other governing body would require that an edict be issued requiring all clubs to implement the ASMF *Infectious Diseases Policy*. Individual clubs would then be responsible for a failure to implement the Policy on a specific occasion, not the league.

The principles enunciated above in Section 6(b) about the nature of a duty of care and its breach are equally applicable to sports organisations as to athletes.

²³¹ *Bolton v Stone* [1951] AC 850, 867 per Lord Reid.

As with the responsibilities of individual athletes, the balancing up process to be undertaken by the reasonable sports organisation to determine what must be done to fulfil its duty of care has to occur in light of identifiable precautions to deal with foreseeable risks. The first precaution would be to implement the ASMF *Infectious Diseases Policy* unless there was good reason not to do so in whole or in part. Mention has been made of the possible respective roles of leagues and clubs. Specifically, the Policy recommends that all participants in collision and contact sports played according to adult rules (which we take to include combat sports as defined above) be inoculated against HBV. This could be given force by leagues stipulating in their rules that no athlete shall be admitted to a competition unless he or she can produce an appropriate current inoculation certificate.

It is also arguable that sports organisations are obliged by their duties of care to undertake an educative role. Just as coaches must inform athletes of the risks of their respective sports and train them in how to deal with those risks, so there must be education in appropriate hygiene and locker-room behaviour. Thus, dissemination of and education in the ASMF *Infectious Diseases Policy* insofar as it governs athlete behaviour might be expected to be a part of the fulfilment of a sport organisation's duty of care. Thus, an isolated case²³² of spread of, say, HBV through a team of young footballers because hygiene was not observed in a locker-room could lead to liability for the resultant harm being placed on the relevant club if it had not educated the boys appropriately. This may be regarded as an onerous responsibility for sport and we are inclined to agree. The messages which the Policy conveys are just as much the responsibility of parents, schools and public health authorities. For this reason, government through its sport and health agencies should consider extending financial and other support to sport at all levels to undertake the necessary education. Also, high-profile leagues and sports should be influenced to adopt the Policy as an example to others.

We have considered above in Section 4(b)(v) in relation to bloody contact and combat sports the circumstances where a sports organisation may be obliged under its duty of care in negligence to exclude an infectious athlete from participation. Also, we have concluded that such an exclusion would not contravene the restraint of trade doctrine or the *Disability Discrimination Act 1992* (Cth).

If such a duty exists to use this information when it is to hand as a basis to exclude an infectious athlete, is there an obligation to actively gather such information in the first place? This issue is mentioned above in Section 4(a)(vii). In practice, this issue will arise where an athlete has contracted HIV/hepatitis from another and argues that the other athlete should have been tested and excluded. Must sports organisations implement HIV/HBV/HCV screening programs in order to fulfil their respective duties of care to those who participate in their competitions and events?

For the reasons mentioned earlier, we do not believe that there is any such

²³² We confine ourselves to an isolated case to eliminate another possible ground of liability: failure to take steps to implement the Policy generally.

obligation in sports which do not fall within the bloody contact and combat sports category which we have identified. Even for these bloody sports the position is problematic. A test result which is negative does not necessarily mean that the athlete is not infectious because of the 'window' period.²³³ Further, how often must testing occur? A negative test today is no guarantee that in a month's time that athlete will not have become infected. Also, using information which is to hand is not especially onerous, whereas establishing and implementing a screening program is administratively and financially burdensome. These costs and practical difficulties are permitted to be taken into account in the balancing up process which would guide the reasonable sports organisation in deciding whether to test. This is a factual issue which courts and, in the meantime, sports organisations will have to resolve.

(d) Vicarious Liability of the Sports Organisation

A part-time or full-time professional athlete playing for a sports team will almost certainly be an employee of that team.²³⁴ Just as any employer is vicariously liable for the negligent acts of an employee performed in the course of his or her employment, so will the sports team be liable for negligent acts performed in the course of employment by the athlete. If an athlete is liable for transmission of infection on the field or in the locker-room as canvassed in Section 6(a) above, will that make the employer vicariously liable? There would seem reason to believe that the employer team might be held liable, notwithstanding that the athlete may have deliberately disobeyed instructions to inform the team of his or her state of health.²³⁵ This view seems to be supported by a recent decision of the New South Wales Court of Appeal which upheld the liability of a rugby league club for a deliberate on-field blow executed by its employee player which amounted to a battery and was in breach of his contractual obligations to his employer club.²³⁶ However, deliberate fighting not connected with the play and motivated by personal spite or resentment is likely to be outside the scope of employment.

Perhaps the best protection available to clubs is to obtain consent under their player contracts to test for HIV/hepatitis and to provide for the exclusion of the player from competition or termination of contract, but, for the reasons identified above, only in bloody contact and combat sports.

²³³ Footnotes 64–65 *supra* and accompanying text.

²³⁴ Opie and Smith, *op cit* (fn 117) 317–20.

²³⁵ See further *id* 320–3.

²³⁶ *Canterbury Bankstown Rugby League Football Club Ltd v Rogers* (1993) Aust Torts Reports 181–246.

7. INFECTIOUS DISEASES IN SPORT — GENERAL CONSIDERATIONS

(a) Rationalising Conflicting Rights and Obligations

The tension between (i) the interest a club or sports organisation may have in reducing the risk of infection transmission, and liability for such transmission, by introducing mandatory HIV/hepatitis testing, and by excluding infected athletes, and (ii) the career and professional interests of infected athletes, has been evident in several contexts in this paper. We have discussed how these conflicting interests will be affected by the law relating to discrimination, restraint of trade and confidentiality, by the imposition of protective duties, and by the principles regulating liability in negligence for HIV/hepatitis transmission.

It must be emphasised that the application of these doctrines to the issue of HIV/hepatitis transmission in sport will always be influenced by scientific evidence about the risk of HIV/hepatitis transmission in sport, as it emerges. We have sought to develop a legal methodology for mediating the conflicting interests mentioned above, in the light of current knowledge about the risk of HIV/hepatitis transmission in different sports contexts. While new scientific evidence may emerge, the underlying framework through which the law will examine and resolve these issues will be relatively stable.

In seeking to rationalise the effect of all the legal doctrines and issues we have discussed, the legal criterion of *reasonableness* stands out.²³⁷ Whether restraint of trade protects an athlete from exclusion for refusing to undergo a test or for being infected depends upon the criterion of reasonableness. Whether an HIV/hepatitis infected athlete will be liable if he or she transmits an infection in the course of participating in a sport will depend upon whether, *by not issuing a warning or excluding himself or herself*, the athlete was taking reasonable care with respect to an otherwise foreseeable risk. Likewise, whether a team doctor or administrator with knowledge of an athlete's infection, would be liable for failing to warn other participants in the sport of the athlete's infection, or for failing to withdraw the athlete, would depend upon whether reasonable care with respect to an otherwise reasonably foreseeable risk required a warning, or exclusion, assuming the relationship was one into which a protective duty for the benefit of other athletes was imposed.

The criterion of reasonableness does not, of course, determine the application of every doctrine relevant to the issue of infectious diseases transmission. In breach of confidence, for example, it is the balancing of competing public interests, and not 'reasonableness', which determines whether the disclosure of confidential information may be justified under the public interest exception. Reasonableness is nevertheless important in maintaining a coherent relationship, and in avoiding conflict between different legal doctrines. How these doctrines interact with the risk of HIV/hepatitis transmission will,

²³⁷ Of course, this criterion will be strongly influenced by the state of scientific knowledge from time to time.

as noted above, depend on scientific evidence of the risk. As presently advised, however, there would appear to be three general conclusions which we can make about the application of law to the issue of HIV/hepatitis transmission in sport.

Firstly, we have argued that there is a critical point at which the risk of HIV/hepatitis transmission in sport is likely to outweigh the legal protection otherwise afforded to infected athletes, particularly through discrimination statutes, and restraint of trade. In bloody contact and combat sports, mandatory HIV/HBV/HCV testing and exclusion of infected athletes may well be legally justified on the basis that such discrimination is reasonably necessary in the interests of public health, and that any restraint of trade involved is reasonable.

Secondly, although the duty of confidence owed by a 'team doctor' must be viewed in the different light of the tripartite team/doctor/athlete relationship, we have argued that private doctors are unlikely to be legally justified in disclosing an athlete's infection to third parties on the basis of the public interest (public health) exception. It is not inconceivable, however, that team doctors and sports administrators may owe a duty to protect some classes of third parties from harm at the hands of identified infectious athletes. This duty can be discharged by excluding the athlete rather than by breaking confidentiality.

Thirdly, we have argued that there is a critical point where an infected athlete, and vicariously, his or her club, may be liable for participating in sport, notwithstanding the implementation of infection control guidelines, in view of the initial risk of blood-to-blood and blood-to-mucous membrane contact inherent in the sport. Again, we see this possibility arising in bloody contact and combat sports. In these situations, reasonable care would require the athlete to issue a warning or not to participate in the sport at all in view of the risk of transmission to other athletes. As we have already indicated above, the *reasonableness* 'exception' to the restraint of trade doctrine, and the public health exception to the *Disability Discrimination Act 1992* (Cth) would also operate to authorise sports administrators to exclude athletes in circumstances where the club or governing body could be liable for transmission, if the athlete continued to participate.

(b) Recommendations

These arguments, as emphasised at the outset, arise from the application of general principles to the novel context of infectious diseases in sport; any conclusions are necessarily tentative, as courts have not yet been called upon to resolve the competing interests involved. While doubt remains, however, there are some important recommendations we can usefully make. Firstly, it is important that sports policy be guided by scientific fact, and that sports administrators, and athletes, be educated of the risk of HIV/hepatitis transmission both on and off the field. Secondly, sports administrators at all levels would be advised to implement infection control guidelines such as those advocated by the Australian Sports Medicine Federation, in order to mini-

mise the risk of infectious disease transmission. Thirdly, the HBV immunisation of athletes playing combat, contact and even collision sports, as a means of minimising HBV transmission, is an obviously important option for sports organisations, subject to financial constraints. Fourthly, in view of our analysis, sports administrators responsible for bloody contact and combat sports would appear to be justified in excluding infected athletes and possibly advised to implement mandatory testing.