Constructing risk: HIV, hysteria and anti-discrimination laws

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Introduction

Whilst the Human Immunodeficiency Virus (HIV) pandemic may no longer be termed a recent phenomenon, it continues to raise a range of social, legal and policy dilemmas. Public fear and misconceptions have meant that society has, as yet, failed to come to terms with the advent of HIV, and the full participation of HIV positive persons in all spheres of public and private life is yet to be accepted.

The recent case in the Victorian Civil and Administrative Tribunal (VCAT) of *Matthew Hall v Victorian Amateur Football Association*[1] is an important example of the intersection between HIV and discrimination laws, and illustrates an inherent yet misinformed construction of conflicting rights and risk.

HIV, Moral Panic and Discrimination

Public attitudes in Australia toward HIV/AIDS continue to be informed by fundamental myths and misconceptions which posit HIV as a disease of deviance, of the 'Other'. Indeed, the advent of the HIV pandemic has been accompanied by a moral panic,[2] a morally manufactured social response based in fear and hysteria rather than rationality. This moral panic has focused on fears of contagion, transmission, defilement and stigmatisation, and is informed by the popular (though inaccurate) homosexualisation of the virus.[3] The result has been the construction of fictions of risk and responsibility, using a discourse which invokes guilt rhetoric and metaphors of punishment, resulting in the designation of HIV as belonging to the guilty Other. Imputed by the concept of guilty victims, as a necessary corollary, is the existence of innocent ones, and innocence/guilt rhetoric has become fundamental to the way in which society treats people living with HIV/AIDS (PLWHAs). In this way, fictions of responsibility have been written around HIV, positing fundamentally misconceived notions of 'predators' and 'victims'.

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The moral panic surrounding HIV has meant that the virus has provoked high levels of fear and discriminatory conduct, perhaps more so than any illness or disease since the debates surrounding syphilis and public sanitation in the nineteenth century. Given the high risk of discrimination against PLWHAs, it is vitally important that strong legal avenues, including anti-discrimination legislation, can be utilised to dispel and counteract HIV hysteria.

In this context, it is troubling to note that anti-discrimination laws have not been widely used by PLWHAs, and that HIV-related complaints are further diminishing. The number of HIV-related complaints made under the *Disability Discrimination Act 1992* (Cth) dropped by 93%, from 28 in 1994-95, to just 2 in 1997-98, whilst the total number of complaints under that Act dropped by 52% in the same period. In NSW, the number of HIV-related complaints made under the *Anti-Discrimination Act 1977* (NSW) dropped by 25% in the same period, from 8 in 1994-95, to 6 in 1997-87, whilst the total number of disability complaints rose by 13% in the same period.[4] It would be unwise to assume that this decrease in HIV-related complaints indicates a fixing of the problem. As Cabassi discusses, the decreasing number of complainants is far more likely to indicate the growing inaccessibility of anti-discrimination laws, for reasons including excessive delays and formalities, high costs and under-resourcing.[5]

Anti-Discrimination Laws and HIV

Both Commonwealth and State/Territory legislation make it unlawful to discriminate against a person on the basis of a disability or impairment.[6] There is no doubt that HIV is a disability or impairment within the meaning of the Acts, as those terms are defined to encompass "the presence in the body of organisms capable of causing disease or illness".[7] The Federal Court has recently confirmed in *Commonwealth of Australia v HREOC & 'X'*[8] that HIV amounts to a disability for the purposes of the Commonwealth Act. The decision of the VCAT in *Hall v VAFA* also confirms that HIV is an impairment within the terms of the *Equal Opportunity Act 1995* (Vic).

Matthew Hall

Matthew Hall, an asymptomatic[9] HIV positive amateur footballer, applied for registration with the Victorian Amateur Football Association (VAFA) in April 1998. At the time of seeking registration, Hall discussed his HIV positive status with the President of his Club, the Old Grammarians Football Club. With Hall's consent, the President wrote on Hall's application form: "Please note that this player is HIV Positive". The VAFA rejected Hall's application for registration in July 1998, effectively preventing Hall from participating in the VAFA competition. Hall lodged an application with the Victorian Equal Opportunity Commission, which was then referred to the VCAT.

In the hearing before VCAT, the VAFA conceded that its decision to refuse Hall registration amounted to an act of direct discrimination within the meaning of section 65 of the Victorian Act. Section 65 provides that:

"65. *Discrimination in Sport*

A person must not discriminate

against another person -

a) by refusing or failing to select the other person in a sporting team;
b) by excluding the other person from participating in a sporting activity."

However, the VAFA sought to argue that the discrimination was lawful as it fell within the scope of the legislative exemptions.

Photo of Matthew Hall by Joe Armao, The Age Photo Library

Lawful Discrimination

Anti-discrimination laws do not make discrimination an absolute wrong. Legislative exemptions in both Commonwealth and State/Territory Acts provide that certain acts of discrimination are acceptable. *Hall v VAFA* would appear to be the first HIV discrimination case in Australia in which a Respondent has sought to rely upon a 'health and safety' exemption.[10] Under the Victorian Act, section 80(1)(a) provides:

"80. Protection of health, safety and property

(1) A person may discriminate against another person on the basis of impairment or physical features if the discrimination is reasonably necessary -

(a) to protect the health or safety of any person (including the person discriminated against) or of the public generally..."

The onus of proof under section 80 lies upon the Respondent.[11] The Tribunal held in *Hall v VAFA* that there is no particular magic in construing the words "reasonably necessary", and that their meaning should be taken from the context of section 80 and the Act generally. The Tribunal noted the non-accidental differences between sections 73, 75 and 80, which refer to "reasonable", "necessary", and "reasonably necessary".[12] The Tribunal took the view that what is reasonably necessary must be determined objectively, and its analysis followed the following steps:

1) identify the class of persons to be protected by the discriminatory act;
2) identify the risk to that class, its magnitude and consequences;
3) consider the degree to which the discriminatory act will reduce the risk to the health and safety of the protected class;
4) consider whether the discriminatory act itself poses a risk to the health and safety of the protected class;
5) ask whether sufficient measures currently exist to protect the health and safety of the protected class, and if so whether the discriminatory act adds any further protection;
6) ask whether there are any alternatives for risk prevention which are equal to or better than the discriminatory act, and if so whether there is any reason why those alternatives are impracticable;
7) consider whether the Respondent believed that the discriminatory act was reasonably necessary to protect the health and safety of the protected class, and if so what information and inquiries that belief was based upon.[13]

It is important to note that whilst the Tribunal referred to its task as an objective one, it was prepared to look at point (7), at the subjective intent of the Respondent.[14]

The Calculus of Risk

Hall v VAFA illustrates that the calculus of risk with respect to HIV and discrimination complaints is a particularly problematic exercise. At point (2), above, of the Tribunal's analysis, the Tribunal asks: "What is the magnitude of the risk?" The assessment of transmission risk is an indeterminate task, and one with which the Tribunal clearly had difficulty. There has never in any country been any confirmed documented case of HIV transmission occurring in a sporting context. The resulting absence of any *observable* risk of transmission in the course of a football match was apparently of considerable concern to the Tribunal. The Applicant submitted that in the absence of any observable data, risk quantum must be determined through the use of theoretical statistical probability modelling. In this respect, the Applicant relied on the evidence of Dr Andrew Grulich, a leading epidemiologist specialising in HIV. Dr Grulich's model looked at the probability of a player being infected, the probability of bleeding episodes involving a risk of transmission, and the probability of HIV infection occurring after such exposure. Using this model, Dr Grulich estimated that the approximate risk of a B Grade VAFA player contracting HIV in the course of participating in the competition is somewhere between 1 in 125 million and zero. The Respondent relied upon the opinion evidence of an actuary, Mr Cumpston, who estimated the risk to be in the vicinity of 1 in 10,000.

The Tribunal was clearly uncomfortable with the theoretical nature of the expert evidence. They found that there was "no epidemiological basis" for Dr Grulich's assumptions, and stated that "the epidemiological data is not particularly useful in estimating the risk of transmission of HIV virus (sic) in Australian Rules Football because there are no actual cases on which to base risk calculations".[15] The Tribunal chose not to make any assessments about the relative value of either expert's evidence or methodology, determining that the risk is "something between 1:6,000 and 1:125,0000,000...".[16]

The difficult task of identifying the quantum of transmission risk in any given circumstance is one which the Tribunal ▶

will no doubt be required to revisit in the future. In this respect, it is troubling to note that in *Hall v VAFA* the Tribunal did not come to terms with the necessarily inherent theoretical nature of epidemiological probability modelling. Whilst theoretical models are never a complete substitute for empirical data, one may well ask in such a case as this, "What else is there?"

When is a Risk Acceptable?

There is nothing inherently prohibitive about risk. In most public and private spheres, absolute safety is something rarely expected or demanded. As a society, we engage in risk behaviour on a daily basis. Indeed, we negotiate a set of socially-sanctioned risk-taking behaviours, informed by culturally defined values.

It is interesting to note that in relation to point (2) of the Tribunal's analysis, above, the Tribunal stated that the *gravity* of the consequences of the risk will assist in the determination of what measures are reasonably necessary to prevent it, even where the *magnitude* of that risk is very low.[17] There is some validity in this approach, which in essence reflects the subconscious risk assessment processes conducted by us all every day. Certain risk consequences may be virtually assured but not particularly harmful, and do not deter us from taking a certain course of action. Other risks may be very remote, but of such a grave nature that we avoid the risk-behaviour. Most times we accept a risk of some gravity because its magnitude is low enough not to pose a deterrent to us.

The danger when dealing with HIV discrimination is that of being 'blinded' by the gravity of the consequences of HIV infection. It is true that the ramifications of HIV infection are particularly nasty, and though this is becoming less predictable given the increasing success of retroviral combination therapies it is still a very real factor for consideration. Yet the gravity of risk cannot be considered without also considering the magnitude of risk. Ultimately, a risk of minimal magnitude, albeit a risk greater than zero, has to be tolerated. Whilst the Applicant in *Hall v VAFA* recognised the seriousness of HIV transmission, he submitted that the risk of transmission was such an utterly remote possibility that it ought to be judged as an acceptable risk.

Responding to Risk

It is not disputed that the risk of HIV transmission requires preventative and precautionary action. The real choice is in determining the best form of precautions. Ultimately the choice is one of exclusion versus inclusion. Policies of exclusionism are informed by moral panic, and are premised in a demand for 'zero tolerance', or zero risk. They involve practices such as mandatory blood testing and disclosure requirements, and result in the isolation and disenfranchisement of PLWHAs. The negative elements of such an approach are numerous. First, there are theoretical flaws in assuming the feasibility of zero risk at all. Second, to demand disclosure or testing of a person's HIV status (for example, in sporting or employment contexts) is arguably unlawful if it amounts to requiring a person to give information which may be used for a discriminatory purpose,[18] and in any case is impractical, ineffective and unnecessary. Third, exclusionism and isolation amount to a fundamental denial of the human rights of PLWHAs to participate fully in public and private life.

The alternative, upon which the *National HIV/AIDS Strategy*[19] is based, is to adopt a policy of inclusionism. The National Strategy promotes an approach of mutual responsibility for public health prevention strategies, which avoids notions of 'predator' and 'victim' and focuses instead upon community responsibility and the use of *universal precautions*. The principle underpinning the use of universal precautions is that all blood is to be treated as potentially infectious. It is considered unnecessary to have knowledge of the viral status of the donor. Instead, a set of standard safety procedures is devised for each context (sporting fields, hospitals, schoolyards, surgeries, sexual contact, drug use) which if followed correctly reduce the risk of transmission of blood-borne diseases to an absolute minimum. These practices have been adopted in a range of professional contexts and are widely endorsed by the medical community.[20]

In *Hall v VAFA* the Respondent sought to argue that exclusion provided the only solution to the risk posed by Hall's participation in the competition. The Applicant argued, and the Tribunal accepted, that such a position amounted to nonsense. Though it was not disclosed until a late stage of the trial during the cross-examination of the VAFA's Chief Executive Officer, the VAFA had in fact possessed since 1992 an "Infectious Diseases Policy", which included a statement that:

> "It should be stressed at this point that the risk factor of transmission of such infections is very low but having regard to the potential outcomes of such infections the Association believes it must take reasonable steps to minimise that risk..."[21]

It then went on to outline those "reasonable steps", which included the implementation of a 'blood rule' in relation to on-field cuts and abrasions, and in all aspects amounted to a perfect example of universal precautions. The policy concluded that:

> "all players, umpires and officials with prior evidence of these diseases are strongly advised to obtain confidential medical advice and clearance from a doctor prior to participation or involvement."[22]

The Tribunal aptly concluded that the risk of any transmission posed by Matthew Hall to other players in the VAFA B Grade competition would be adequately reduced if the VAFA were to simply implement and enforce its own Infectious Diseases policy. It found that the exclusion of Hall from the competition would be neither necessary nor appropriate. In any case, the Tribunal found that the risk posed by Hall's proposed participation in the competition "is so low (and can be further reduced by the proper application of the VAFA policy) that it is not 'reasonably necessary' to discriminate against him by banning him from playing football".[23]

The Tribunal's decision is a clear endorsement of the 'universal precautions' approach, and a clear rejection of exclusionism. The Tribunal states:

> "Save that the banning of Matthew Hall will exclude the risk of transmission from him, the banning of him will not give the class in question any increased protection from other players who might be HIV positive. On the contrary, the proper application of the policy will give the class in question increased protection from such other players. From this viewpoint, it is logical to conclude that the proper

application of the VAFA's policy gives the class a protection from risk that the mere banning of Matthew Hall does not."[24]

The Victorian AIDS Council (VAC) (Intervener) sought to take this argument to a higher level, submitting that a policy of exclusion would in fact *increase* the risk of transmission of blood borne diseases within the VAFA competition. This, they argued, would occur in two ways. First, it would create a false sense of security amongst players. In other words, it was submitted that the VAFA's suggestion that the mere banning of Hall in itself would provide a sufficient means of preventing transmission amongst players, would send a dangerous message to players that they would henceforth be 'safe' and could result in less rigorous applications of universal precautions. Second, it was submitted that an exclusionary policy would effectively dissuade other competitors from either discovering or disclosing their HIV status for fear of discrimination, thereby failing to receive anti-viral treatment, thereby increasing their viral load and infectiousness, thereby creating an even greater risk to other players.

The VAC called on substantial evidence from medical and sociological experts to support their submissions, including Chris Puplick, President of the Anti-Discrimination Board; Dr Andrew Grulich, Director of the National Centre for HIV Epidemiology and Clinical Research; and Professor Doreen Rosenthal, Director of the Centre for the Study of Sexually Transmitted Diseases. The Tribunal did not accept those submissions, stating:

"In our view, the evidence relating to these matters, such as it was evidence, was of a highly speculative nature and not of substantial assistance in the determination of the issues before us. We are unable to conclude that any ban on Matthew Hall playing football will in itself create any substantial risk to the health and safety of the class of person within consideration".[25]

To some extent the rejection of the VAC's submission on this point was a result of the Respondent's narrowing of the class of persons it claimed to be protecting, such that evidence relating to the impact of HIV discrimination upon public health had to be confined to evidence relevant to the specified class.[26] Nevertheless, the Tribunal's rejection of the VAC's submission is a disappointing one, and illustrates a generally conservative understanding of the nature of HIV discrimination and the broader public health strategies employed in Australia. Policies of exclusionism are not only infringements of individual human rights; they can engender a false 'comfort zone', or false sense of security, in the community at large, and as such can pose significant detriment to public health objectives.

Overcoming the Rhetoric of Risk

Following the VCAT's decision, the VAFA published an editorial in its journal, the *Amateur Footballer*, stating that the decision "failed to deal with the real issue behind the case in that the question of legal liability was largely left untouched." It then continued to say that:

"the very fabric upon which all sport in this country is built, the role of the voluntary administrator, is still unknown. Society now runs the risk ▶

of a potential collapse of the backbone behind sport in this nation."[27]

Displays of moral panic such as these are not only inflammatory, but sadly illustrate that the "real issue" is still being missed.

The risk rhetoric employed by the VAFA, as well as various media and observers, during the course of *Hall v VAFA* illustrates that most commentators continue to subscribe to a construction of HIV discrimination informed by fear and moral panic which posits a collision of 'rights', and pits an individual's rights to liberty against the rights of a broader group ("society") to protection. This kind of constructed conflict is largely false, and patently unhelpful.

It is extremely encouraging that the VCAT has in *Hall v VAFA* endorsed an inclusive approach based on concepts of mutual responsibility and universal precautions. The judiciary is often accused of lagging behind contemporary standards. The decision in *Hall v VAFA*, notwithstanding its flaws, demonstrates a rare example of innovative and responsible judicial leadership. It should not go unnoticed. ■

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Footnotes:

1 [1999] Victorian Civil and Administrative Tribunal AD 30 (23 April 1999).

2 The concept of 'moral panic' was originally raised by Stanley Cohen: see Cohen 1980, *Folk Devils and Moral Panic: The Creation of the Mods and Rockers*, Oxford, Martin Robertson (first published 1972).

3 For discussion, see C. Patton 1985, *Sex and Germs, The Politics of AIDS*, Boston, South End Press; and S. Sontag 1989, *AIDS and Its Metaphors*, London, Allen Lane The Penguin Press.

4 see Cabassi, HIV/AIDS Legal Link, vol 10, no.2, pp. 9-17, at 10.

5 Cabassi, ibid, at 17.

6 for example, *Disability Discrimination Act* 1992 (Cth); *Equal Opportunity Act* (Vic), s. 6.

7 *Disability Discrimination Act* (Cth), s.4; *Equal Opportunity Act* 1995 (Vic), s. 4.

8 [1998] 3 FCA (13 January 1998).

9 An asymptomatic HIV positive person carries HIV antibodies but has not experienced an AIDS-defining illness.

10 Note that the 'inherent requirements of the job' exemption under the *Disability Discrimination Act* (Cth) was used successfully in *Cth v HREOC & "X"*, n. viii, where the Cth refused to allow an HIV positive man to be employed by the Defence Force. The scope of this paper does not allow discussion of the Commonwealth Act, and will be limited to the Victorian Act, and in particular section 80.

11 n. i, at 4; and see Ellis in the name of Ellis v Mount Scopus Memorial College (1996) EOC 92-824.

12 n. i, at 5.

13 n. i, at 6-7.

14 n. i, at 6, 23-24.

15 n. i, at 10, 13.

16 n. i, at 15.

17 n. i, at 14.

18 See, for example, *Equal Opportunity Act* 1995 (Vic), s. 100; for a discussion of employment and disclosure, see Orme 1991, "Employment Law and HIV/AIDS", a Discussion Paper produced by the Intergovernmental Committee on AIDS, Legal Working Party, published for the Department of Health Housing and Community Services, Canberra, AGPS.

19 Department of Community Services and Health 1989, National HIV/AIDS Strategy: A Policy Information Paper, Canberra, AGPS.

20 See, for example, Brown et al 1994, "HIV/AIDS Policies and Sports: The National Football League", *Medicine and Science in Sports and Exercise*, Journal of the American College of Sports Medicine, at 403-407; and Australian National Council on AIDS (ANCA) and Australian Sports Medicine Federation (ASMF) 1994, *HIV and Sports*, Bulletin published by ANCA and ASMF, March 1994, Canberra; and ANCA and ASMF 1994, *HIV Positive People and Sport*, Bulletin published by ANCA and ASMF, April 1994, Canberra.

21 Transcript, *Hall v VAFA*, at 628-629.

22 n. xxi, at 633.

23 n. i, at 24.

24 n. i, at 20.

25 n. i, at 16.

26 C. Ward 1999, "Making his Mark", *HIV/AIDS Legal Link*, vol. 10, no.2, pp1, 6-7, at 7.

27 P. Stevens 1999, "HIV Decision", *The Amateur Footballer*, May 1 1999, vol. 99, no. 4, pp1, 37, at 1.