Singapore Journal of Legal Studies
[2000] 120 – 135

AIDS AND THE DUTY OF CARE OWED IN NEGLIGENCE BY DOCTORS TO PERSONS WHO ARE NOT THEIR PATIENTS

In recent years cases have been brought in various jurisdictions involving claims against doctors by persons who are not their patients. The claims have related to AIDS and other sexually communicable diseases which the persons in question have contracted from the doctors' patients. In these cases, the courts have held that doctors owe a duty of care in negligence to warn the sexual partners of their patients (usually via the patients) of the risks involved in participating in a sexual relationship with these patients. This article examines and analyses the relevant cases and considers the direction which the law in this area is likely to take both in Singapore and in other Commonwealth countries.

I. Introduction

THE duty of care in negligence rarely extends to persons other than those with whom the defendant has a close and clearly identifiable relationship. In general, only persons who are directly connected – whether physically or by some other means – with the defendant may claim that he owes them a duty of care. In circumstances where a defendant gives information or advice, the requirement that there must be a close connection between the parties generally translates to a duty being owed only to the person who solicits that information or advice. However, there are situations, particularly where a defendant acts in a professional capacity, in which the law recognises that persons other than the person who actually seeks the defendant's professional services may be adversely affected if the defendant acts negligently. In such circumstances, these persons, too (or sometimes only these persons and *not* the person to whom the information or advice is given at all) are acknowledged as being entitled to bring an action in negligence.

Situations in which the defendant's 'professional responsibility' leads him to owe a duty of care to persons other than the person with whom he is dealing directly are these days not uncommon. One example is that of an employer who gives a carelessly negative reference about a past or present employee in response to an enquiry by a potential employer. Such a reference is likely to harm the subject of the reference at least as much as it will harm the potential employer who asks for and relies upon it. For this reason, an employer who writes such a reference is held to owe a duty

of care to the employee about whom the reference is written.[1] Another example is that of a lawyer who negligently drafts (or fails to draft) a will – or who gives negligent instructions with respect to the execution of a will – with the result that an intended beneficiary is deprived of his inheritance. The lawyer's act will injure the disappointed beneficiary rather than the testator who actually commissions the will, and thus a duty of care is held to be owed to that negligently disinherited beneficiary.[2]

In the medical context, too, a doctor may give (or fail to give) information or advice to his patient which affects not only the patient, but also persons who are closely connected with the patient, usually by reason of a sexual relationship. In certain circumstances in various jurisdictions the courts have recognised that a doctor may owe a duty of care to such persons – persons whom the doctor may never have met and who have never consulted him. This article will examine the criteria which the courts have applied when extending the duty of care to non-patients in a particular class of cases – those cases in which a doctor has failed to inform his patient that the patient is or may be suffering from a sexually communicable disease (usually AIDS). Having examined the cases, the article will conclude by considering whether the decisions reached by the courts in the various cases are – or are not – to be applauded.

1 See, *eg, Spring* v *Guardian Assurance plc* [1994] 3 WLR 354, in which the House of Lords held that an employer who gives a reference voluntarily undertakes responsibility for the reference being given with reasonable care, and that failure to exercise such care may make him liable in damages to an employee who is adversely affected. See, too, the recent decision in *Bartholomew* v *London Borough of Hackney* (The Times, 23 November 1999) in which it the Court of Appeal held that all references must be 'true, accurate and fair' both to the employees about whom they are written and to the prospective employers to whom they are supplied.

2 The first major case to recognise a duty of care in such a situation was *Ross* v *Caunters* [1980] Ch 297, in which Megarry V-C used a *Donoghue* v *Stevenson* [1932] AC 562 analysis of foreseeability and proximity to justify his decision to award damages to the beneficiary. This decision was subsequently applied and followed in other parts of the Commonwealth (see, *eg*, the decision of the New Zealand Court of Appeal in *Gartside* v *Sheffield, Young & Ellis* [1983] NZLR 37). More recently, the House of Lords in *White* v *Jones* [1995] 2 AC 207 also (albeit by a bare majority) allowed a claim by disappointed beneficiaries, although this decision was based on the concept of 'voluntary assumption of responsibility' derived from *Hedley Byrne & Co Ltd* v *Heller & Partners Ltd* [1964] AC 465 rather than on a simple application of *Donoghue* v *Stevenson*. During the last few years, the Australian High Court in *Hill* v *Van Erp* [1997] 142 ALR 687 ("*Van Erp's* case", for further discussion of which, see *infra*, text at note 28) has also allowed a claim on similar facts to those in *Ross* v *Caunters*, though it should be noted that the court in that case was less happy about applying the voluntary assumption of responsibility approach than was the House of Lords in *White* v *Jones*.

II. Discussion

Although there are other circumstances in which a doctor may be held to owe a duty of care to the sexual partners of his patient,[3] the main situation in which the issue arises is in cases where a doctor is treating a patient who is or may be suffering from AIDS or another sexually communicable disease. In this situation, the courts assume that any duty of care which the doctor might owe to the patient's sexual partner will be discharged if the doctor warns the patient of the dangers inherent in his condition, of the risks associated with sex in light of that condition, and of the fact that the patient should inform any potential sexual partners of his circumstances.

The 'problem' cases therefore all concern situations in which the doctor has failed to inform the patient of his condition (or of the possibility that he might be suffering from that condition and/or of the risks associated with it) and the patient has then unwittingly infected a third person. In such cases, does the third-party have a valid claim against the doctor?

A. *The American Cases*

(i) *DiMarco's case*

One of the first reported cases to give specific consideration to the question of a doctor's duty to warn his patient of the dangers of infecting other persons with a communicable disease was the decision of the Supreme Court of Pennsylvania, in *DiMarco* v *Lynch Homes-Chester County Inc*.[4] Although

[3] The question of whether a doctor owes a duty of care to the sexual partner of a patient can, for example, also arise in circumstances where the patient is (in spite of indications to the contrary) at risk of fathering an unplanned child – usually because the doctor has failed to warn him of the possibility that a vasectomy operation which he has undergone could be subject to spontaneous reversal. Cases in this area have met with varying degrees of success, depending on whether the non-patient was or was not the sexual partner of the patient at the time when the doctor failed to warn him that the effects of the operation could not be guaranteed. (Compare, *eg, Thake* v *Maurice* [1986] QB 644 with *Goodwill* v *British Pregnancy Advisory Service* [1996] 2 All ER 161.) Cases in this category overlap with other cases involving 'wrongful birth' claims, and in *McFarlane and another* v *Tayside Health Board* [1999] 4 All ER 961, the House of Lords recently regarded the policy concerns associated with awarding damages for the cost of raising a child as being the predominant consideration when deciding issues of this kind. As a result, in *McFarlane's* case their Lordships refused the plaintiff's claim for the cost of rearing her baby on the basis that it would not be fair, just and reasonable to compensate her for the birth of a healthy child (although they awarded her damages for the pain and suffering associated with her pregnancy and the child's delivery).

[4] 583 A 2d 422 (1990) ("*DiMarco's* case").

a case involving Hepatitis B rather than AIDS, the legal considerations involved in deciding the case were identical to those relevant in AIDS cases. The case involved a health worker, Ms Viscichini. While she was taking blood from a person living in a residential home, her skin was accidentally punctured by the needle which she had been using to draw the blood. Since the resident was known to be a carrier of Hepatitis B and other diseases, Ms Viscichini took medical advice from two doctors, who told her that if she was going to contract Hepatitis B as a result of the accident, she would do so within six weeks. She was not advised to refrain from sexual intercourse during that period, but she did in fact abstain for eight weeks, after which she resumed her pre-existing relationship with the plaintiff, Mr DiMarco. Both Ms Viscichini and the plaintiff were subsequently diagnosed as suffering from Hepatitis B. The risk period for Hepatitis B is in fact six months, and Ms Viscichini should have been advised that having sexual relations within six months of her exposure could cause her partner to contract the disease.

In the Supreme Court of Pennsylvania, the majority[5] held that the plaintiff's claim against the doctors who had negligently failed to advise Ms Viscichini that she should abstain from sex for six months was a valid one. They took the view that a doctor treating a patient who has been exposed to a communicable disease owes a duty to give the patient proper advice on how to prevent the spread of the disease. Such advice is necessary not for the patient himself (who is already infected, or who has at least already been exposed to the risk of infection), but for other persons, as yet unexposed to the risk, with whom the patient comes in contact. Larsen J expressed the view of the majority thus:

> ... the duty of a physician in such circumstances extends to those "within the foreseeable orbit of risk of harm" ... If a third person is in that class of persons whose health is likely to be threatened by the patient, and if erroneous advice is given to that patient to the ultimate detriment of the third person, the third person has a cause of action against the physician, because the physician should recognise that the services rendered to the patient are necessary for the protection of the third person.[6]

The dissenting judges, whose judgment was delivered by Flaherty J, considered the implications of holding that there was a duty of care in this case –

[5] The majority view was held by Cappy, Larsen, McDermott, Papadakos JJ. Nix CJ, Flaherty and Zapalla JJ dissented.

[6] *Supra*, note 4, at 424-425.

not only in the medical field, but in other professions, too. They expressed concern about the dangers inherent in extending the duty of care in negligence based merely on the scope of the risk or foreseeability:

> These dangers include not only the imposition of liability in favour of third parties in situations which are beyond the control of the professional rendering the service, but also the prospect of inducing professionals to narrow their inquiries into the client or patient situation, to the detriment of the client or patient, so as to avoid possible liability toward third parties which might come from knowing "too much".[7]

(ii) *Reisner's case*

In *Reisner* v *Regents of the University of California*,[8] another American case, a twelve year-old girl, Jennifer Lawson, was given a blood transfusion. A day later, her doctor discovered that the transfused blood was contaminated with HIV antibodies. He did not tell Jennifer or her parents that she had received tainted blood. When she was fifteen, Jennifer commenced a sexual relationship with the plaintiff, Daniel Reisner. Two years later, the doctor told Jennifer that she had AIDS, and Jennifer informed the plaintiff. Jennifer died less than a month later. Shortly after her death, the plaintiff was diagnosed as being HIV positive. The California Court of Appeal[9] held that the doctor's failure to tell either Jennifer or her parents about her condition until she was already terminally ill gave rise to a valid cause of action on the part of the plaintiff who had been infected by her.

One of the arguments made on behalf of the defendants in *Reisner's* case mirrored the minority view in *DiMarco's* case – that a duty of care owed to a third party might actually undermine the doctor's relationship

7 The minority relied heavily on the decision of the same court in *Guy* v *Liederbach* 501 Pa 47, 459 A 2d 744 (1983). In that case, the court had held that a lawyer whose negligence resulted in an intended beneficiary's legacy becoming void could be liable to the disappointed beneficiary only if there was an attorney-client relationship between them or if the lawyer had made a specific undertaking to her. As has been discussed above, few jurisdictions impose such rigid requirements before holding that a duty of care can be owed in such circumstances, (see *supra*, text at note 2) and for this reason the minority view is probably atypical. The majority in *DiMarco's* case rejected the application of *Guy* v *Liederbach* to a situation involving a doctor rather than a lawyer, observing that: "... [t]he harm caused by a lawyer to a third party cannot possibly equal the harm that a physician can do to society at large by negligently failing to act to halt the spread of contagious and communicable diseases" (*supra*, note 4, at 425, fn 1).

8 37 Cal Rptr 2d 518 (Cal App 2 Dist 1995) ("*Reisner's* case").

9 Vogel J, Ortega PJ and Masterson J, concurring.

with his patient and adversely affect his treatment of that patient. This argument the court "summarily"[10] rejected:

> ... contrary to the Defendants' contention, the duty involved in this case – a duty to warn a contagious patient to take steps to protect others – has nothing to do with a physician's decision about how to treat his patient ... Once the physician warns the patient of the risk to others and advises the patient how to prevent the spread of the disease, the physician has fulfilled his duty – and no more (but no less) is required.[11]

The argument that the doctor did not know the plaintiff's identity (or even that the plaintiff existed) and could not, therefore, be held to owe him a duty of care, was also rejected. Miriam A Vogel J, delivering the judgment of the court, held that the doctor "knew or reasonably should have known that, as she matured, Jennifer was likely to enter into an intimate relationship."[12] He therefore owed a duty of care to the person with whom that relationship took place – whoever that might be. An additional argument that a duty to the plaintiff would set an undesirable precedent by greatly extending the number of potential claims – claims, for example, by all the plaintiff's sexual partners and by all their sexual partners – was also rejected. The court held that only claims satisfying the rules of causation would be allowed, and that this would restrict the number of successful claims. However, Vogel J added that, even if the decision to compensate the plaintiff *were* to result in some additional claims being successful, "the possibility of such an extension does not offend us, legally or morally".[13]

In reaching its decision, the court in *Reisner's* case placed considerable emphasis on the decision in *DiMarco's* case, as well as on a couple of other cases *not* involving sexual relationships in which American courts had found doctors to be liable to third parties.

In the first case, *Tarasoff* v *Regents of University of California*,[14] a therapist was held liable to the family of a young woman who was killed by his patient. The therapist had been aware of his patient's intention to kill the woman, but had told neither her nor her parents.

[10] *Supra*, note 8, at 522.
[11] *Ibid*, at 523.
[12] *Ibid*, at 521.
[13] *Ibid*, at 523.
[14] (1976) 17 Cal 3d 425 ("*Tarasoff's* case").

Although the victim's identity had been known to the therapist in *Tarasoff's* case, whereas the plaintiff's identity in *Reisner's* case was not known to the doctor, the court in *Reisner's* case considered that this distinction was irrelevant. Quoting from the judgment in *Tarasoff's* case, the court agreed that the doctor's duty was to warn "others likely to apprise the victim of the danger ... or to ... take whatever steps are reasonably necessary under the circumstances."[15] In *Reisner's* case, this duty amounted to an obligation to inform Jennifer, who could then have informed any potential sexual partner (and specifically the plaintiff) of her condition and the risks associated therewith.

In the second case, *Myers* v *Quesenberry*,[16] two doctors were held liable for damage caused by their patient to the plaintiff, whom the patient injured in a road accident. The doctors had told the patient, who was pregnant and diabetic, that her foetus had died and that she would have to have it removed within the next day or so. They had sent her to get some laboratory tests conducted, but had failed to advise her that it would be dangerous for her to drive to the laboratory in her "irrational and uncontrolled diabetic condition".[17] While driving there, the patient caused the accident in which the plaintiff was injured.

In *Myers'* case, as in *Reisner's* case, the doctors had no way of knowing exactly who would be adversely affected as a result of their failure properly to advise the patient. But, as the judges in *Reisner's* case observed, this did not pose an obstacle to the duty of care being established. They agreed with the statement in *Myers'* case that: "[W]here warning the actor is a reasonable step to take ... liability is not conditioned on potential victims being readily identifiable as well as foreseeable."[18]

B. *The Commonwealth Cases*

(i) *Pittman's case*

A year before *Reisner's* case was decided, the Canadian courts were faced with a similar AIDS case, which raised the question of whether a doctor owed a duty of care to the wife of a patient who had been infected with the HIV virus. The case was *Pittman Estate* v *Bain*,[19] and it was decided by Lang J in the Ontario Court (General Division).

[15] *Ibid*, at 431, as referred to in *Reisner's* case, *supra*, note 8, at 520.
[16] (1983) 144 Cal App 3d 888 ("*Myers'* case").
[17] *Ibid*, at 890-91.
[18] *Ibid*, at 892-893, as referred to in *Reisner's* case, *supra*, note 8, at 521.
[19] (1994) 112 DLR (4th) 257 ("*Pittman's* case").

In *Pittman's* case, the patient, Mr Pittman, underwent cardiac surgery in 1984. During the surgery, he was given a blood transfusion. Unknown to anyone, the blood was contaminated with the HIV virus, for which there was no test at that time. By the time the donor who had given the contaminated blood returned to donate more blood the following year, there was a test available. He was tested, and it became apparent then that he was HIV positive. However, it was not until 1987 that the blood which he had donated in 1984 was traced to the hospital in which the patient had undergone his surgery, and only in 1989 was the patient's family doctor informed by the head of the hospital blood bank that the blood which his patient had received almost five years earlier was contaminated with HIV.

The patient's doctor was concerned about both the patient's heart condition and his mental well-being, and so, since he (wrongly) assumed that the patient and his wife (the plaintiff) were no longer having sexual relations, he did not tell his patient what had happened. Only after the patient died, in 1990, did it become apparent that he had been HIV positive. The plaintiff was subsequently tested, and it was found that she, too, was HIV positive. It was concluded that she had probably contracted the virus during the last year of her husband's life (*ie*, after the date when the patient's doctor had been informed of the patient's condition).

The case is a long and complicated one, dealing for the most part with the standard of care applicable to the collection and tracing of the contaminated blood. However, the decision is also noteworthy for Lang J's finding that, with respect to the non-disclosure of the patient's HIV positive status, the patient's doctor owed a duty of care both to his patient and to the plaintiff. Having held that the doctor owed a duty to disclose to his patient the details of his condition, his Honour added:

> Further, Dr Bain was obliged to consider the risk to Mrs Pittman, a risk that he could reasonably assume that the Pittmans would not be prepared to take. In this context, it is unnecessary for me to determine whether Dr Bain had an independent duty to Mrs Pittman, because Dr Bain did have an obligation to tell Mr Pittman, and if he had told Mr Pittman, the evidence established that Mr Pittman would have told his wife.

The factual finding in *Pittman's* case – that the doctor owed the plaintiff a duty of care – was significant. The decision, though, offers little to assist future courts in determining when a similar duty will be owed. Given that Lang J did not discuss the nature of the duty, nor ascertain whether it could exist independently of that owed to the plaintiff's husband, the case is of limited use in indicating the circumstances in which a plaintiff who is not a patient may claim to be owed a duty in his own right.

(ii) *BT's case*

Recently, however, in the Australian case of *BT* v *Oei*,[20] the New South Wales Supreme Court gave detailed consideration to this very issue. The case concerned a doctor in Sydney whose patient came to him in 1992 suffering from symptoms which, the court held, would have led a reasonably competent doctor at the time to conclude that the patient might be HIV positive (which it later transpired he was). However, although the doctor asked the patient about his sexual practices, and, in light of his reduced liver function, diagnosed that he was probably suffering from Hepatitis B, he never suggested that the patient should undergo an HIV antibody test.

The patient met the plaintiff in the same year. The patient was very open with the plaintiff about his sexual history (including a visit to a brothel). He also told her that he was suffering from Hepatitis B. A month or so later, the patient and the plaintiff started a sexual relationship. The plaintiff underwent a course of vaccinations to immunise her against Hepatitis B, and she was told by her own doctor not to have unprotected sex with the patient until she had completed the full course. However, even before the course of vaccinations had been completed, the plaintiff did have unprotected sex with the patient.

In 1993, the plaintiff became ill. Her symptoms were of a nature which led the court (with the benefit of hindsight) to conclude that she was already at that time suffering from the HIV virus, with which she had been infected by the patient. In 1994, the plaintiff was given an HIV test, which proved to be positive. She and the patient planned to marry soon. Since she was sure that she had contracted HIV from the patient, and since she was also afraid that he would not marry her if he knew of her condition, the plaintiff did not tell the patient about her HIV positive status. (They did in fact marry). Later that year, the patient, who was then being treated by a specialist doctor for his liver condition, underwent an HIV test. It proved to be positive, and he immediately advised the plaintiff to undergo a similar test. (His concern about the plaintiff's well-being in this respect, coupled with his earlier openness about his sexual history, was sufficient to convince the court that, had he been aware of his condition earlier, he would have warned the plaintiff of the relevant risks). Early in 1995, the plaintiff also had an HIV antibody test (without telling the patient that she had already been tested). This, too, proved positive. A month later, the patient was admitted to hospital for a liver transplant, and he died there of liver failure a few days later. The cause of his death was not related to either AIDS or HIV.

[20] [1999] NSWSC 1082, unreported, 1-35, ("*BT's* case").

The plaintiff sued the patient's doctor, whom she argued had owed her a duty of care. She claimed that the nature of the doctor's duty to the patient was to diagnose the patient's condition or to advise him of the need for an HIV test, and that this duty extended to her, since she was "within the class of persons who were at risk of foreseeable injury if the defendant failed to properly counsel and advise AT (the patient) to have an HIV test".[21]

The doctor argued that he did not owe the plaintiff a duty of care. In this respect, he drew the attention of the court to several facts. The first was that he had never treated the plaintiff and had not even been informed by the patient of the patient's sexual relationship with the plaintiff. Secondly, the patient had never sought his advice about HIV, which he was not responsible for the patient contracting. And thirdly, HIV can be transmitted and retransmitted in various ways, not all of which involve sex. Moreover, while accepting that the plaintiff, as the patient's sexual partner, was a person at risk of foreseeable injury, the doctor submitted that something more than mere foreseeability was required to establish a duty of care.[22]

In a judgment which considered *Pittman's*, *Reisner's* and *DiMarco's* cases, the judge, Bell J, held that the doctor *did* owe a duty of care to the plaintiff. While accepting that something more than foreseeability was required before a duty could be established, her Honour held that such additional closeness as was required to give rise to a duty was satisfied on the facts of the case. In this respect, she referred to the recent decision in *Perre* v *Apand Pty Ltd*,[23] in which the Australian High Court, although confirming what Bell J described as "the move away in recent years from seeing proximity as the unifying criterion of the duty of care,"[24] nevertheless recognised the need in each case for closeness between the parties – a closeness for which, in the words of Gummow J "there is no simple formula which can mask the necessity for examination of the particular facts".[25]

In reaching her decision in *BT's* case, Bell J took into account the factors identified by Gummow J in *Perre's* case (the defendant's knowledge of the risk and the fact that the plaintiff had no way of appreciating the existence

[21] *Ibid*, at 10.

[22] In this respect, counsel for the doctor referred to the decisions of the Australian High Court in *Jaensch* v *Coffey* (1984) 155 CLR 549 (*per* Gibbs CJ at 553 and *per* Deane J at 581-583), *Bryan* v *Maloney* (1995) 182 CLR 609 (*per* Mason CJ, Deane and Gaurdron JJ at 617-619) and *Esanda Finance Corporation Ltd* v *Peat Marwick Hungerford* (1997) 188 CLR 241 (*per* McHugh J at 272).

[23] [1999] HCA 36; (1999) AJLR 1190 ("*Perre's* case").

[24] *Supra*, note 20, at 11. Bell J referred to the judgments of various judges in *Perre's* case, including that of Gleeson CJ at para 9, Gaudron J at para 27, McHugh J at paras 74 and 78, Gummow J at paras 198-201 and Hayne J at paras 330-333. (See *supra*, note 23).

[25] *Supra*, note 23, at paras 198-201, as cited in *BT's* case, *supra*, note 20, at 11.

of the risk and thus no means by which to protect herself). She also considered the emphasis placed by McHugh J in the same case on the vulnerability of the plaintiff to incurring loss in consequence of the defendant's conduct.[26] Bell J referred, too, to the decision in *Pyrenees Shire Council* v *Day*,[27] in which the court had determined that a duty of care was owed based – among other considerations – on the risk of danger and the inability of the claimants to protect themselves.

Just as the defendants in *DiMarco's* case and *Reisner's* case had done, the defendant in *BT's* case argued that if the court were to hold that a doctor owed a duty of care to a third party, this might conflict the duty which he owed to his patient and that, for policy reasons, it would therefore be wrong to extend the duty to other persons. As in the American cases, this argument was given short shrift by Bell J. Her Honour referred in this respect to the decision of the Australian High Court in *Van Erp's* case.[28] In that case – where a solicitor was held liable to an intended beneficiary who was deprived by the solicitor's negligence of his inheritance under a will – the court rejected the suggestion that the imposition of a duty in favour of the third party would conflict with the solicitor's duty to her client, and held that the interests of the solicitor's client and the plaintiff were "co-incident."[29]

Bell J took the view that the same was true in the medical context, and that the duty owed by the defendant doctor to warn the patient of the risk that he might be HIV positive co-existed with the duty to ensure that the patient's sexual partners were also made aware of this risk. In concluding that there could be no policy arguments to suggest the contrary, Bell J referred to the Public Health Act 1991, and to the Act's requirement that a medical practitioner who reasonably believes his or her patient to be suffering from AIDS must inform the patient of the public health implications of the condition and of the means of protecting others.[30] Based on this requirement, she was unable to see any conflict between the duty to the patient and the duty to the patient's sexual partners, particularly since the doctor's duty was not personally to inform those partners of the risk, but merely to provide the patient with the necessary information about the risk to pass on to them.[31]

[26] *Supra*, note 23, at paras 104, 105 and 129, as referred to by Bell J in *BT's* case, *supra*, note 20, at 11.
[27] (1998) 192 CLR 330.
[28] *Supra*, note 2.
[29] *Ibid*, as referred to by Bell J in *BT's* case, *supra*, note 20, at 11.
[30] *Supra*, note 20, at 15-16.
[31] In this respect, Bell J's judgment echoes that of Vogel J in *Reisner's* case (see *supra*, note 11).

Nor did Bell J consider that any therapeutic privilege could justify the doctor in withholding information about the patient's condition. Given the doctor's statutory obligation both to inform the patient of his condition and to counsel the patient on how to reduce the risk of infecting others, the argument that it would be in the patient's best interests not to be informed of his condition could not succeed.[32]

Bell J was not swayed either by the defendant doctor's argument that, when treating the patient, he had been unaware of the plaintiff's identity or existence. Referring to the case of *Voli* v *Inglewood Shire Council*,[33] in which an architect had been held to owe a duty of care to a person whose existence was foreseeable to but not known (or even capable of being readily identified) by him, she concluded:

> I do not consider that the fact that the members of the class may not be known or be capable of ready identification by the defendant is determinative of there being no duty of care.[34]

Thus, based on the considerations that (a) the plaintiff was a foreseeable sexual partner of the patient; (b) the patient was unaware of his HIV status; (c) the defendant had the necessary specialist knowledge and training to identify the risk that the patient might indeed be HIV positive; (d) the defendant's failure to diagnose and counsel the patient exposed the plaintiff to real risk of contracting HIV; and (e) there was no conflict between the defendant's duty to the patient and his duty to the plaintiff – and taking into account, too, the public policy considerations behind the Public Health Act of 1991 – Bell J held that the defendant had owed the plaintiff a duty of care (which she went on to hold he had breached).[35]

III. Analysis

This writer would argue that the position adopted by the courts in America,

[32] *Supra*, note 20, at 16.

[33] (1963) 110 CLR 74 ("*Voli's* case").

[34] *Supra*, note 20, at 14.

[35] *Ibid*, at 17. In deciding that the duty had been breached, Bell J placed heavy reliance on *Rogers* v *Whitaker* (1992) 175 CLR 479, the case which established that, in Australia, the standard of care required of a doctor is the standard which a prudent patient would expect the doctor to observe. In the context of *BT's* case, this required the doctor to exercise the reasonable care and skill expected of a general practitioner in 1992, and it was held that a general practitioner exercising reasonable care and skill would, at that time, have recognised that the patient showed symptoms of being HIV positive, which would have prompted such a practitioner to advise the patient to undergo an HIV test as well as a test for Hepatitis B.

Canada and Australia with respect to a doctor's failure to warn a patient of the risk that he might transmit a serious disease to his sexual partners is both legally and ethically correct. A doctor who fails to ensure that his patient understands the risk that he might infect another person should be held to owe a duty of care to that other person, who has no other way of finding out about the relevant risk. It is not, and ought not to be, relevant that the doctor cannot specifically identify that person as a present or future sexual partner of the patient at the time when he fails to give the appropriate advice. The crucial points are that any sexual partner of the patient will foreseeably be imperilled if the doctor fails to give this advice, and that such a person will have no other means of knowing the existence of the peril. The legal relationship between this person and the doctor is therefore based on a closeness which arises from these circumstances – circumstances which obviate the need for the doctor actually to know the person's identity.

In several of the cases involving sexually transmitted diseases brought against doctors by the sexual partners of their patients, the courts have drawn an analogy with cases involving disappointed beneficiaries who sue the lawyers whose acts or omissions have caused them to lose their inheritances.[36] It is an analogy which is easily understood. Although in the disappointed beneficiary cases the defendant lawyer knows the identity (or at least the name) of the person who will suffer if he fails to do his job properly, in other respects there are notable parallels between the two situations, particularly when the crucial question: "Who will suffer if the defendant fails to act properly?" is asked. For – as has already been discussed[37] – just as it is not the testator but the intended beneficiary who suffers if a lawyer fails to give proper advice to the testator on the drafting or execution of a will, so it is usually not the patient (who is already suffering from the disease) but his as yet uninfected sexual partner who suffers if a doctor fails to warn the patient of the risk that he could spread the disease.

If one compares the two types of case, though, it is clear that the sexually transmitted disease cases have an even stronger claim to be recognised by the courts than do the disappointed beneficiary cases. For situations in which a person is infected with a sexually communicable disease involve serious (and even life-threatening) physical damage, whereas the disappointed beneficiary cases, by definition, can only ever involve purely economic loss. Given this distinction, it would be both illogical and unfair if the courts in jurisdictions which have already allowed claims by disappointed beneficiaries but have not yet been faced with a communicable disease case

[36] See *supra*, notes 2 and 28.
[37] *Supra*, note 2.

were subsequently to deny such a claim if and when it came before them.

The other point to consider in this respect is the existence of statutory provisions which might oblige a doctor to inform a patient – and possibly other persons – of the condition from which the patient is (or is believed by the doctor to be) suffering. As can be seen from the decision of the New South Wales Supreme Court in *BT's* case, the common law position adopted in a jurisdiction which is framing the duty of care owed to non-patients by a doctor in a communicable disease case will inevitably be influenced by any relevant statutory provisions in that jurisdiction. If, as in *BT's* case, there is legislation requiring the doctor to warn any patient whom he believes to be suffering from AIDS (or any other communicable disease) of the dangers of that condition both to the patient himself and to others, then the courts will almost certainly take account of the statutory requirement in framing the common law duty of care.

In Singapore, very strong statutory measures are in place to attempt to control the spread of communicable diseases. Section 6(1) of the Infectious Diseases Act,[38] (in Part III of the Act) requires every medical practitioner "who has reason to believe or suspect that any person attended or treated by him is suffering from an infectious disease or is a carrier of that disease" to inform the Director of Medical Services of this belief or suspicion. The Director has extensive powers to make orders with respect to the relevant person.[39] Moreover, Part IIIA of the Act (which was introduced in 1992 and expanded in 1999)[40] contains specific requirements with respect to AIDS and HIV. Under section 22, where a patient has been diagnosed as suffering from AIDS or HIV, the Director may require that person to undergo counselling by a registered medical practitioner and may also require him to comply with any precautions and safety measures which the Director deems appropriate. Section 23 provides that a person who knows that he has AIDS or HIV may not have sexual intercourse with another person unless the other person has been informed of and has voluntarily accepted the accordant risk.

Of particular significance from a doctor's standpoint is section 25(6) of the Act, under which "a medical practitioner may disclose information

[38] Cap 137 (1999 Rev Ed).

[39] Under section 8, the Director may require such a person to undergo any medical examinations and/or treatment which he may specify. And under section 10, the Director has the power to make any orders stating specific measures or procedures for investigating and treating infectious diseases. Failure by a medical practitioner to comply with any or all of these measures or procedures will render him liable to prosecution.

[40] See No 5 of 92 and No 13 of 1999.

relating to any person whom he reasonably believes to be infected with AIDS or HIV infection to the spouse, former spouse or other contact" of that person.[41] Under the Act "contact" is defined as "any person who has been exposed to the risk of infection from that disease". Such disclosure may be made as long as the medical practitioner "reasonably believes that it is medically appropriate and that there is significant risk of infection to the spouse, former spouse or other contact" (section 25(7)). Under the same subsection, the medical practitioner should normally only make such disclosure if, having counselled his patient about the need to inform the patient's spouse, former spouse or other contact of his condition, the medical practitioner reasonably believes that his patient will not in fact inform the relevant person or persons, and if he has told his patient of his intention to disclose details of the patient's condition to such person or persons. However, under section 25(8) and (9), these last two requirements can be waived by the Director where the medical practitioner is unable to counsel the patient and where the Director considers it to be medically appropriate to disclose the information on the ground that there is a significant risk of infection to the spouse, former spouse or other contact.

Although the provisions of section 25 do not actually *require* a doctor to counsel a patient whom he only *believes* to be suffering from AIDS or HIV that the patient should inform his sexual partners of his possible condition, such a requirement *is* imposed on a doctor to whom a *known* AIDS or HIV patient has been referred under section 22. And even where the patient's condition has not been confirmed, there is a strong suggestion that counselling the patient to tell his sexual partners of his suspected condition is the desirable and appropriate course of action. Furthermore, although under section 25(6) the doctor is not personally *obliged* to inform the known sexual partners of a person whom he believes to be suffering from AIDS or HIV of the patient's probable condition where there is doubt that the patient will pass this information on, the provisions certainly create a framework within which such a practice is overtly encouraged. The provisions make clear the importance of the doctor's role both in counselling (or attempting to counsel) the patient to tell his sexual partners of the dangers inherent in his condition, and in himself communicating the dangers to those partners – if their identities are known – in circumstances where the patient is unlikely to do so either in spite of the counselling or because it has not been possible to counsel him.

[41] Alternatively, the medical practitioner may disclose the information to a Health Officer for the purpose of passing the information on to the patient's spouse, former spouse or other contact.

If a court in Singapore were to be faced with an action brought by a non-patient who claimed that a doctor owed him a duty of care to ensure that he was informed of the fact that a patient was – or was believed to be – suffering from AIDS or HIV, it is extremely likely that the court would take account of the provisions of the Infectious Diseases Act in reaching its conclusion. And given the Act's provisions, it is also likely that the court would conclude that the doctor owed a common law duty of care to advise the patient to tell his sexual partners of his condition, and even that the doctor owed a duty to tell those partners himself (assuming their identities were known to him) if it was clear that the patient was unlikely to fulfil his obligations in this respect. Although the Act is not quite so clear where other diseases are concerned, the tenor of its general provisions suggests that in cases involving other types of communicable disease a court would also be likely to find that a doctor owed a duty of care to attempt to ensure that those at risk of infection by his patient were informed of that risk.

IV. Conclusion

The continuing spread of the HIV virus makes it unlikely that *BT's* case will be the last case of its kind to be decided by Commonwealth courts. Should similar cases arise in Singapore or other Commonwealth jurisdictions, this writer is of the opinion that they should – and, for the reasons given in the preceding paragraphs, probably will – be decided in accordance with the same principles as those espoused in *BT's* case (and indeed in *Reisner's* and *Pittman's* cases). Justice requires that a doctor who has failed to warn his patient of the risk of passing on AIDS or the HIV virus to sexual partners should be found to owe those sexual partners a duty of care. The principle which applies in HIV/AIDS cases ought also to apply in situations involving the sexual transmission of other serious diseases (as in *DiMarco's* case). It is to be hoped that no court will regard either the unspecified nature of the plaintiff's identity or the confidential nature of the relationship between doctor and patient as sufficient reasons for denying a duty in such a case.

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