

Should Caregivers Be Compelled to Disclose Patients' HIV Infection to the Patients' Sex Partners Without Consent?

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The emergence of the HIV/AIDS pandemic has added to the tension between patients' private interests and public health interests regarding medical confidentiality. Many people become infected with HIV because they are unaware of the positive serostatus of their sexual partners. Informing or warning the sexual partners of HIV-positive patients of the patients' serostatus could assist in curtailing the spread of HIV/AIDS because sexual partners can thereby choose to avoid having unprotected sex with infected persons. By law, however, doctors have a duty to their patients to protect their medical confidentiality. Doctors, therefore, face a dilemma concerning which should prevail: patients' right to privacy and confidentiality or the importance to society of controlling the spread of the pandemic. Most medical regulatory bodies do not take clear-cut positions on the issue, leaving the decision to the discretion of individual doctors. The question of whether doctors should be legally empowered to breach the confidence of patients to protect the patients' sexual partners is discussed here with reference to the existing laws of Canada, the United States, and Nigeria. (STUDIES IN FAMILY PLANNING 2007; 38[4]: 297–306)

The position is widely held that safeguarding the basic rights of people living with HIV / AIDS (PLWHA) offers a good chance of preventing HIV / AIDS transmission and can generally control the pandemic. Among the rationales for this point of view is that PLWHA would not be discouraged from undergoing the testing considered necessary for halting the spread of the infection (Mason et al. 1999). PLWHA are particularly prone to stigmatization and discrimination because of their HIV-positive serostatus. To shield them from these and other disadvantages that may inhibit them from undergoing HIV testing or from frank disclosure of their HIV status, their rights to privacy must be protected. In the context of medical practice, this necessity underscores and invigorates the argument that doctors, who have the ethical obligation to respect patients' confidentiality, should be strictly bound not to disclose the HIV-positive status of patients without those patients' consent or other legal justification.

Competing with the need to safeguard the privacy of PLWHA is the equally important public health necessity of curtailing the spread of HIV / AIDS. The drive to

halt the spread of the pandemic, some argue, requires the adoption of measures such as informing the sexual partners of people whose HIV-positive serostatus has been ascertained through testing. Ostensibly, such notification would enable the partners to protect themselves against HIV infection, either by avoiding unprotected sex with PLWHA or by abstaining from sexual intercourse with them.

For some classes of professionals, striking a balance between these competing private and public health interests can engender serious ethical and professional dilemmas. This article examines these dilemmas in the context of the work of medical doctors. According to long-standing professional codes of practice, doctors' obligation to keep patients' conditions confidential has been well established. Moreover, in some cases, laws have intervened to further solidify this area of medical ethics. Doctors, by the nature of their duties, are more likely to learn the HIV status of their patients before any other person does. Therefore, doctors present good case subjects for examining this conflict of interest.

The Recalcitrant Patient

Let us imagine that a doctor is confronted with the following scenario: His patient, a married man, has tested

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HIV-positive. Rebuffing the doctor's suggestion and advice, the patient insists that he will not disclose his HIV status to his wife. The couple does not practice safe sex, and the man has declared that despite his knowledge of his infected status, he does not intend to practice safe sex with his wife. Aware that she may be at risk of HIV infection, the doctor intends to contact the wife to inform and advise her of her peril. What is the ethical and legal position of the doctor?

Since its emergence, HIV/AIDS has remained incurable. Efforts to control the disease have focused on prevention of its spread and on giving care and treatment to people infected with the virus. In the struggle to curtail transmission, various measures have been suggested, tried, or adopted (Fombad 2005). One measure, described here, is partner notification and contact tracing. In the context of medical practice concerning HIV/AIDS, partner notification and contact tracing are the processes by which doctors directly or indirectly disclose the HIV-positive status of patients to the patients' sexual partners in order to protect the partners from becoming infected (Berger 1993). Where a link or access to the partner exists, the doctor may inform her or him directly. Alternatively, the doctor may pass the information to appropriate authorities who will trace the patient's sexual partner and inform him or her.¹

Notifying partners, however, poses an ethical concern for doctors, who are duty-bound not to breach the confidence of their patients without clear justification or in certain exceptional cases. This study examines whether, in the battle against the transmission of HIV/AIDS, the force of law should be used to compel doctors to engage in partner notification in disregard of patients' consent. The discourse is undertaken within the framework of the legal positions on partner notification that exist in Canada, Great Britain, and Nigeria. Generally, in these countries, doctors have no legal duty or empowerment to disclose patients' HIV status in the interest of the patient's sexual partners.² The legal systems of these countries are substantially similar,³ and doctors are subject to similar codes of medical ethics as prescribed by the World Medical Association. These three countries' systems are apt settings for examining the issue of the desirability of compelling doctors to undertake partner notification. Germane examples, in terms of legal principles, case law, and policy statements, are also drawn from other countries, including New Zealand, the United States, and Zimbabwe.

Because doctors in Canada, Great Britain, and Nigeria have no legal obligation to notify sexual partners of the HIV status of their patients, the issue for determination is whether the law should institute mandatory dis-

closure. Should doctors, in order to prevent a third party from acquiring HIV/AIDS infection, disregard the right of their patients to confidentiality? The point of view posited here is that such a mandatory legal duty should not be imposed upon doctors. The violation of the right of patients to medical confidentiality and their right to privacy may not, in fact, be an effective measure in controlling the spread of HIV/AIDS. Such a measure may even be harmful to existing HIV/AIDS-control efforts because people may resist testing when they become aware that their HIV status may be revealed to their partners. In addition to "underground" transmission of infection that may result from such a policy, access to infected individuals for treatment will be made difficult.

Patients' Right to Privacy

Medical confidentiality is a branch of the long-standing, broad, basic right to privacy. The right to privacy connotes the right to control information about oneself (Shattuck 1977). It is viewed by some as the epicenter of all human freedoms and rights (Westin 1967) and has become so important that it is a recurring provision of international human rights treaties and countries' constitutions throughout the world.⁴

The word privacy evolved from *privatus*, Latin for "apart from the state; peculiar to one's self; of or belonging to an individual; private" (Samar 1991:19). Although the right to privacy now accommodates a number of seemingly unrelated legal situations, historically, it has been applied to safeguard citizens against unlawful encroachment or trespass on their properties, especially by agents of the state (Shattuck 1977). Speaking of England, William, Earl of Chatham, declared:

The poorest man may in his cottage bid defiance to the Crown. It may be frail—its roof may shake—the wind may enter—but the King of England cannot enter—all his force dares not cross the threshold of the ruined tenement!

The importance of privacy in the context of a person's home has also been highlighted in Cicero's statement, "*Quid est sanctius, quid omni religione munitius, quam domus unius cuiusque civium?*" (What is more sacred, what more rewarding than all religion, than the home of each and every citizen?) From safeguarding proprietary interests per se, the right to privacy extended to the protection of citizens against unlawful searches and seizures. To illustrate, the Fourth Amendment of the Constitution of the United States provides:

The rights of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures, shall not be violated, and no warrants shall issue, but upon probable cause, supported by oath or affidavit and particularly describing the place to be searched, and the persons or things to be searched.

The Nigerian Constitution illustrates the modern scope of the right to privacy. In section 37, it declares "the privacy of citizens, their homes, correspondence, telephone conversations and telegraphic communications is hereby guaranteed."

An aggrieved person in these three countries may sue for violation of the right to privacy under the law of tort or as a constitutional issue. The courts have accommodated various situations within the ambit of privacy. In relation to medical jurisprudence, the right of a woman to have an abortion, for example, has been upheld as a right to privacy (USSC 1973; SCC 1988). Similarly, the right to privacy has been adopted to justify a minor's right to receive contraceptives (USSC 1977). Generally, the door to privacy is not closed (Samar 1991).

Privacy and Medical Confidentiality

In the areas of medical law and practice, the right to privacy translates as medical confidentiality, which requires that a doctor, save in exceptional circumstances, must not disclose confidential information obtained in the course of the doctor-patient relationship. Indeed, any information obtained by a doctor in breach of medical confidentiality will be inadmissible in court and, where wrongfully admitted, will be excluded from the court's record (see Williams 1982:23-24).

Medical confidentiality is justifiable by several means. The right of every citizen to autonomy is one. Another is the likely consequences that the unguarded disclosure of information may have on a patient. In cases of information that may expose the patient to stigmatization and discrimination, the consequences of such disclosure can be immense.⁵ Medical confidentiality has also been justified because it enables patients to give their doctors information about their health conditions and behaviors freely and confidently. According to the British Medical Association:

Patients have a right to expect that information about them will be held in confidence by their doctors. Confidentiality is central to trust between doctors and patients. Without assurances about confidentiality, patients may be reluctant to give doctors the information they need in order to provide good care (GMC 2004; see also BMA 1999).

The Doctors' Duty to Maintain Patients' Confidentiality

Protecting a patient's confidentiality is among the inherent ethical obligations of a doctor. The legal sources of the duty traverse professional self-regulation, common law, and statutory provisions. As a self-regulatory mechanism, the medical profession imposes a moral or ethical duty on its members to respect the confidences of patients. Historically, this found expression in the *Oath of Hippocrates*, which provides:

I swear by Apollo Physician and Asclepius and Hygieia and Panacea and all the gods and goddesses, making them my witnesses, that I will fulfill according to my ability and judgment this oath and this covenant: What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself, holding such things shameful to be spoken about (Mason et al. 1999:551).

The oath, in modified form, survives today in medical practice. The World Medical Association's *Declaration of Geneva* states, "I will respect secrets which are confided in me, even after the patient has died." Apart from this oath, most national medical associations have codes of ethics that oblige doctors to protect their patients' confidentiality. For example, in Great Britain, the General Medical Council (GMC) *Ethical Guidance* states, "doctors hold information about patients which is private and sensitive. This information must not be given to others unless the patient consents or you can justify the disclosure" (GMC 1995; see also BMA 1999). Such professional guidelines are particularly important; they constitute the medical profession's self-imposed standards on the basis of which the public deals with doctors. The standard is a scale by which courts of law can base an assessment of the minimum standard of behavior expected of a doctor in relevant cases (GMC 1995). Although these ethical guidelines are not legally binding, their importance is underscored by the practice of doctors who undertake to emphasize them at medical school graduation ceremonies. The violation of such guidelines exposes a doctor to a wide range of intraprofessional sanctions.⁶

Common law is another source of the code of medical confidentiality. It imposes a duty on doctors to keep and respect the confidences of their patients. Courts have acknowledged and upheld this duty in many cases (*A-G v Guardian Newspapers* 1990; see also Mason et al. 1999:91). Legislation is a third source of doctors' obligation to keep patients' information confidential. Legislators in some

countries make direct or indirect provisions for medical confidentiality (London 1980; Mason et al. 1999).

The *Personal Health Information Protection Act* of the Province of Ontario, Canada (2004), is an example of such legislation. In section 29, the Act provides that a "health information custodian" (defined in the section to include individual and group caregivers and others) "shall not collect, use or disclose personal health information about an individual unless it has the individual's consent under this Act and the collection, use or disclosure, as the case may be, to the best of the custodian's knowledge, is necessary for a lawful purpose." To underscore the importance of not breaching the confidence of patients, in section 72, the Act makes it an offense for anyone to disclose personal health information in contravention of the Act; the penalty for transgressing is \$50,000 where the offender is a natural person and \$250,000 where not a natural person.

The doctor and patient also may enter into a contract concerning the manner of the doctor's disclosure of the patient's health information. Where such a contract exists, the patient may base a court action on it to restrain the doctor from breaching medical confidentiality. Such a contract can only be drawn up in a jurisdiction where no law compels doctors to report HIV / AIDS serostatus or information about other communicable diseases. If such a law exists, the contractual obligation could be unenforceable because the contract would be considered illegal.⁷

Not all information divulged to a doctor by the patient is protected under the cloak of confidentiality. To qualify for protection, such information must satisfy particular criteria (*Coco v A.N. Clark* 1969). The information must be considered to have been confidential, and it must have been imparted in circumstances imposing an obligation of confidence. Moreover, to obtain legal remedy of violation, an unauthorized use of that information must have occurred to the detriment of the patient. What constitutes detriment has been debated. The subject of contention is whether a patient claiming for breach has to establish that he or she has suffered or is likely to suffer financial, physical, or psychological harm as a result of the breach of confidentiality (Jones 2003). The popular position appears to be that, where the patient seeks, by way of injunction, to prevent a breach, the issue of any distinct loss is immaterial (Jones 2003:171–172; see also *Cornelius v Taranto* 2001). Where the patient seeks to recover for a past breach, however, he or she may be required to establish that he or she has suffered detriment (Jones 2003). For a patient to recover for breach of confidentiality, the information disclosed must be identified and connected with the particular patient. As Lord Simon Brown has pointed out, "the confidence is not breached where the confider's identity is protected" (*R v Department of Health* 2001:431).

HIV/AIDS, Public Interest, and Confidentiality

The patient's right to confidentiality is not absolute. At different points, the doctor has to balance the right of his patient to confidentiality against the public interest. In some circumstances, the doctor can legitimately disclose confidential information about the patient (Jones 2003; see also Mason et al. 1999). One such circumstance is when the consent of the patient has been obtained. If the patient directly (or indirectly, for example, through his legal advisers) has consented that his doctor may divulge his confidential information, then the doctor can disclose such information legitimately to a third party. A doctor may also legitimately divulge confidential information when it is in the patient's interest to disclose such information or when seeking consent to do so is deemed undesirable for medical reasons (BMA 1992:43; Mason et al. 1999). Thus, in a case where the doctor suspects that the patient is a victim of sexual or physical abuse, the doctor may disclose the patient's confidential information to a third party (Mason et al. 1999). In some situations, a doctor may also override the patient's right to confidentiality and share his or her information with other medical professionals when doing so is in the patient's interest. Usually, this sharing would occur when it is necessary to enable the patient to receive optimal care (BMA 1992:47). Similarly, a doctor may legitimately divulge a patient's health information (generally not including his or her identity) if such information is necessary for medical research that has been approved by a recognized research ethics committee (BMA 1992:48–49; Mason et al. 1999).

An important exception to the legitimate sharing of patients' medical information that is particularly relevant to this analysis is the breach of a patient's confidentiality in the public interest. A doctor's social responsibility to safeguard the well-being of the public creates a dilemma when it is set against the doctor's duty to keep the patient's information private. Mason and colleagues (1999:195) consider this obligation to be "arguably the most controversial permissible exception to the rule of confidentiality." Historically, the doctor's role in safeguarding the public interest with respect to confidentiality concerned the effort to oppose crime. This role is now manifest in other areas, some of which are examined below.

Today, a doctor may breach the confidentiality of his patient in cases where the failure to do so would endanger public safety. For example, the British General Medical Council (GMC 2004) states:

In cases where there is a serious risk to the patient or others, disclosures may be justified even

where patients have been asked to agree to a disclosure, but have withheld consent. . . . Disclosure of personal information without consent may be justified in the public interest where failure to do so may expose the patient or others to risk of death or serious harm.

Judicial recognition of the public interest exception to medical confidentiality has emerged as well. The case of *W v Egdell* (1990) in England offers an illustration whereby W, a patient sentenced to imprisonment for manslaughter, was detained in a special hospital. For the purpose of making an application for review of his case and possible discharge from prison, W, through his legal representatives, engaged Dr. Egdell, an independent psychiatric consultant, to report on W's mental state. Dr. Egdell's report was unfavorable to W, and the application was withdrawn. Subsequently, W was due for routine review of his detention. Dr. Egdell, aware that his report would not be incorporated in W's patient notes, was concerned that the decision concerning W's discharge would be made based on insufficient information and that W's discharge would constitute a danger to the public. Dr. Egdell, on his own accord, sent a copy of the report to the hospital where W was detained and also to the British Home Office. W brought an action alleging the doctor's breach of medical confidentiality. The judgment held that although maintaining medical confidentiality is important and beneficial to society, in this case the doctor's obligation was greater to protect the public against risk of danger. Therefore, a doctor in Dr. Egdell's position can legitimately bypass the obligation to uphold a patient's confidentiality in order to disclose information if, in the doctor's estimation, the public interest is served by doing so.

Doctors may also legitimately bypass patient's confidentiality and divulge health information in cases where a patient's health condition may constitute a danger to the public when he or she is handling a vehicle. In such cases, however, the health information should be disclosed only to the authorities who are charged with taking appropriate action, not to just any third party. In New Zealand, the case of *Duncan v Medical Practitioners' Disciplinary Committee* (1986) offers an illustration of the judicial attitude in this sort of situation. A bus driver, X, underwent heart surgery and later was certified by his surgeon as being fit to drive a bus. Dr. Duncan, X's general practitioner, was concerned, however, that if his patient drove a vehicle, he would constitute a danger to the public. The doctor, therefore, asked that X's driver's license be withdrawn; the doctor also warned X's passengers about the potential danger they faced if X drove their bus. Dr. Duncan was

reported to the Medical Practitioners' Disciplinary Committee and was found guilty of professional misconduct in breaching his patient's medical confidentiality by revealing X's medical history to the bus passengers. The doctor sought a judicial review of the Disciplinary Committee's decision. The High Court accepted that medical confidentiality may properly be breached in cases of clear public interest. The court refused the doctor's application, however, on the grounds that "a doctor who has decided to communicate should discriminate and ensure the recipient is a responsible authority" (*Duncan v Medical Practitioners' Disciplinary Committee* 1986:521).

The case of *Duncan v Medical Practitioners' Disciplinary Committee* can be regarded as an example of the common-law rule that no duty of care exists in the absence of a special legal relationship; that is, in the absence of such a relationship, no duty exists to rescue (Mason et al. 1999; see also Street 1976:104–108). Thus, a doctor is not legally bound to warn or inform a third party about the danger constituted by the doctor's patient to a third party when the doctor holds no special duty of care to the third party. Conversely, a doctor has a legal and ethical duty to maintain the confidentiality of the patient and clearly holds a duty of care to keep that confidentiality diligently.

The right of a doctor to refrain from rescuing is related to the question of likely consequences that a doctor may face when he or she keeps the patient's confidentiality and a third party—one without a legal relationship to the doctor—is injured as a result. In the United States, the case of *Tarasoff v Regents of the University of California* (1976) illustrates this question. In the *Tarasoff* case, a mental patient informed his doctor about his intention to kill someone, which subsequently he did. The deceased's relatives sued the doctor, who was found liable for his failure to warn the victim of the potential danger his patient posed. In Canada, Nigeria, and the United Kingdom, however, in the absence of a precedent or express legislation on the issue, the legal judgment upon a doctor in a *Tarasoff* scenario remains unclear (Mason et al. 1999).

Clearly, doctors can face dilemmas in balancing patients' interest with those of third parties or of the general public. The dilemma is evident and acute in the case of partner notification. The law has not taken a clear-cut position to aid doctors in this circumstance in the countries considered here. The potential public health benefits of partner notification in the curtailment of HIV/AIDS transmission cannot be overlooked. Therefore, the law should empower or compel doctors to notify the sexual partners of their HIV-infected patients, thereby resolving the dilemma. Consequences of such legal empowerment are examined below.

Disclosure to a Third Party

The scenario depicted in the opening section of this article illustrates a major quandary confronting doctors in balancing the medical obligation of maintaining the confidentiality of a patient with HIV infection against the interest of others who might be vulnerable to the infection. Since its emergence, HIV/AIDS has constituted a serious health, socioeconomic, and even moral issue. The devastating impacts of the disease across the world have been well documented (Gostin and Lazzarani 1997).⁸ The situation is most critical in the poorest countries of Africa, where resources to confront the scourge are lacking.

In the past, medical practitioners have had to deal with issues concerning sexually transmitted diseases (Garrett 2005). HIV/AIDS differs from other STIs because it is “a disease which is fatal, for which there is as yet no vaccine and no known cure” (Spencer 1990:105). In many societies, people living with HIV/AIDS face stigmatization, discrimination, loss of employment, and a host of other disadvantages (see *Hoffman v South African Airways* 2001). Moreover, activists have expressed concern that the rights of HIV/AIDS sufferers may be sacrificed in the frenzy to control the spread of the disease. According to one writer (Spencer 1990:105),

politicians and members of the public worldwide have called for extreme measures, violating the rights of those with HIV or AIDS, in the belief that such measures will help to curb the spread of the disease. The rights of the individual, we are told, must be sacrificed to protect the rest of the community.

Many people become infected with HIV because they are not aware of the HIV-positive serostatus of their sex partners. Presumably, if a person were aware of his or her partner's positive serostatus, that person would choose to use a condom during sex or abstain from intercourse. Warning an identified sex partner of the positive HIV status of his or her partner would seem to be a reasonable measure to take in the effort to control the spread of HIV/AIDS (Berger 1993).

The issue, then, is whether, in the public interest, the doctor who becomes aware of his patient's HIV-positive status should breach the patient's confidentiality to inform or warn the patient's identified sex partner—that is, whether the right of the patient to confidentiality or privacy should “be sacrificed to protect the [sex partner or] the rest of the community” (Spencer 1990:105). Different and seemingly irreconcilable views have emerged on this point (Mason et al. 1999; see also London 1980 and Casswell 1989). In the eye of the ethical storm, the doctor

must act in one way or the other. The situations in different countries vary. The positions in Great Britain, Nigeria, and Canada are examined below.

In Great Britain, the GMC's guideline titled *Serious Communicable Diseases* (1997) provides that a doctor may disclose information about a patient, living or dead, so as to protect another person from risk of death or harm. Specifically, a doctor “may disclose information to a known sexual contact of a patient with HIV” where the doctor reasonably believes that the patient has not informed the third party and the patient cannot be persuaded to do so (GMC 1997: paragraph 22). A doctor who adopts such an approach must be prepared to justify this action, however.

The GMC guideline is neither a code nor a legally binding provision. Generally, in England, protection of the public interest with respect to a third party is undertaken at the discretion of the doctor and is not a legal duty (Mason et al. 1999; Jones 2003). Moreover, AIDS is not a statutorily notifiable disease in Britain (Mason et al. 1999), and the existing legislation relating to HIV/AIDS does not empower the doctor to breach patients' confidentiality to inform or warn sex partners of patients' positive HIV serostatus. Under common law applicable in Great Britain, no duty of care exists in the absence of a special legal relationship. Therefore, a doctor has no legal duty to rescue from infection an identified sex partner of a patient infected with HIV/AIDS (Mason et al. 1999). The legal position in Great Britain is that the right of the patient to confidentiality concerning HIV serostatus supercedes the need to protect an identified sex partner from being infected.

The legal position in Nigeria is similar to that of Great Britain. The legislation relating to sexually transmitted diseases, and therefore relevant to HIV/AIDS, is the *Venereal Diseases Ordinance* of 1958.⁹ The kernel of the legislation, as presently contained in the *Venereal Diseases Laws* of Oyo State of Nigeria (FRN 2000), is contained in section 3(1), which states:

Any person suffering from any venereal disease or suspecting that he is so suffering shall, on becoming aware of his condition, immediately consult (a) the medical officer of health for the area in which he is residing; or (b) a qualified medical practitioner, and shall place himself under treatment by that medical officer of health or qualified medical practitioner, who may direct that such person shall attend for treatment at an approved place.

The original legislation predates the HIV/AIDS crisis. Moreover, the legislation does not classify HIV/AIDS

as a venereal disease, and nothing in the legislation expressly relates to HIV/AIDS. In the absence of any case law concerning the pandemic, the extent to which the provisions encompass HIV/AIDS is unclear. In any case, nothing in the legislation states that a doctor can breach a patient's confidentiality to warn a third party of the patient's HIV/AIDS infection. The common law applicable in England is one of the sources of Nigerian law (Obilade 1979:55–56). Therefore, the position in English common law relating to rescue, as discussed above, applies equally in Nigeria. In the absence of any express prescription by the Nigerian Medical Association (NMA) that compels or empowers doctors to disclose patients' HIV status to the patients' sexual partners, the Nigerian position, arguably, is that the disclosure decision is the doctor's own.¹⁰

Government policies concerning HIV/AIDS in Nigeria emphasize the need to protect the rights of people infected with the disease. For example, the *Armed Forces HIV/AIDS Control Policy Guidelines* (FRN Minister of Defence 2003) states:

Medical records and other aspects of care of service Personnel with HIV/AIDS must be protected by full confidentiality, with release of information strictly on a "need to know" basis. All persons who "need to know" shall also be bound by the principle of confidentiality.

Although Nigeria's HIV/AIDS policies are not legally binding, they hold significant status as the national standard for dealing with HIV/AIDS, being products of the federal government. In the absence of supervening legislation providing for a doctor's duty to warn, the position in Nigeria is that, in the face of conflict between the interests of a third party and the confidentiality of a patient, the patient's interest prevails.

In Canada, the issue of a doctor's duty to warn appears to be an admixture. While all the provinces and territories have enacted legislation that requires doctors to report AIDS-related information to medical health officers, the Yukon Territory requires a physician to inform "any known contacts" of a patient having a communicable disease (Casswell 1989:231–233).¹¹ In the Northwest Territories, a doctor, by means of contact tracing, is required to disclose a patient's HIV/AIDS serostatus to the patient's contacts, or, alternatively, request that the Chief Medical Health Officer do so. Some provinces, including Alberta, Manitoba, and Prince Edward Island, have enactments that permit but do not require or compel a doctor to disclose a patient's communicable diseases, subject to certain conditions. In other provinces, the question of whether to disclose a patient's confidential informa-

tion to sexual partners is usually subject to common law (Casswell 1989). In these jurisdictions no specific legislation requires or authorizes a doctor to disclose a patient's confidential information to the patient's sexual contacts. Thus, the situation in Canada varies by location: where legislation so provides, the doctor has a duty to warn, and where it does not, the doctor uses his discretion, as in England and Nigeria.

Imposing on Doctors a Duty to Warn

Generally, in the three countries considered here, no legal duty is imposed on a doctor to warn an identified sexual partner of a person infected with HIV/AIDS except, as described above, in those Canadian territories that have enacted legislation to that effect. Therefore, an issue to be determined is whether doctors should be so bound by law through specific legislation or by modification of common law.

Several reasons can be advanced to support a call for such legislation. First, imposing a general duty to warn may be a means of preventing the spread of the disease between spouses. Once the uninfected partner is aware, he or she may be able to negotiate safe sex. In many parts of Africa, such a warning may prevent chains of infection that can arise in polygamous unions.

Second, that an infected person should keep his or her right to confidentiality while an innocent sex partner is exposed to a deadly virus would appear to be unconscionable. If the consequences of HIV/AIDS infection were weighed against confidentiality alone, the odds should surely favor saving another person from infection.

Third, where a doctor has a legal obligation to warn an infected patient's spouse, performing that duty may remove doubt as to which spouse might have transmitted the infection. Clarification of this point can be significant in relationships bedeviled by mutual distrust.¹² Legislating an obligation for doctors to warn could ensure that at least some sexual partners would have a reasonable chance of being saved from HIV infection, possibly reducing the spread of the disease.

At the same time, some reasons can be enumerated for safeguarding the privacy of infected patients, thereby withholding information about their condition from their sexual partners. Medical confidentiality is widely considered to encourage patients to make full and effective disclosure of their health conditions to their doctors. HIV/AIDS remains a highly stigmatizing disease, however, especially in developing countries. It exposes the sufferer to many disadvantages, including job discrimination. It isolates the sufferer and often imposes great medical hard-

ship on the infected. People would likely be more willing to submit to HIV / AIDS testing or to cooperate in control measures if they were confident that they would not suffer negative consequences. An example from the experience of the United States' military illustrates this point. According to the US Department of Defense (1985) *Policy on Identification, Surveillance, and Disposition of Military Personnel Infected with Human T-Lymphotropic Virus Type III*, evidence obtained in the course of epidemiological assessment interviews¹³ could be used in "adverse personnel action" against military personnel. The arrangement discouraged service members from participating in follow-up epidemiological assessment interviews because they did not wish to implicate themselves. This policy hampered the collection of crucial epidemiological data. In view of the negative impact it had on HIV / AIDS control, the Department of Defense changed the policy (Weber 1997:149).

Without assurance of confidentiality, many people are not willing to undergo HIV testing. Although patients whose test results are positive can be encouraged or persuaded to inform their sexual partners about their serostatus, such an advantage is lost when they refuse to be tested because they cannot be assured of confidentiality (Casswell 1989). Therefore, the public health interest is better served where doctors are not compelled to disclose patients' HIV-positive serostatus to their patients' sexual partners. Clearly, patients' confidentiality should be safeguarded. Requiring that spouses of those who test positive be informed has appeal upon first blush, but the threat of doing so may dissuade infected people from being tested. Protection of sexual partners may be better achieved through education and by gaining the confidence of those who are infected, rather than by regulating disclosure by law.

Apart from human rights and public health implications, partner notification faces some practical and logistical challenges. First, the success of contact tracing depends largely on the cooperation and honesty of the infected person. Some people being tested for HIV infection use pseudonyms (Berger 1993; Gostin 2004). Some infected people may not fully disclose the identities of their partners, either purposefully or because they are unable to recollect the partners' names, or because of genuine oversight (Berger 1993). The level of cooperation required of the infected person highlights once again the importance of assuring patients that their information will be held in confidence.

Beyond this potential lack of cooperation, contact tracing requires enormous resources to implement (Berger 1993). Named contacts must be located, counseled, and

tested. In large countries such as Nigeria, the financial and human resources required to locate and test an infected person's sexual partners in remote places is prohibitive. Few if any developing countries, already facing resource constraints in many areas, can afford such an effort. This realization may have prompted some developing countries to downplay partner notification as an HIV / AIDS-control measure. For example, the Republic of Zimbabwe's *National Policy on HIV/AIDS* (1999: clause 63, page 20) states:

Contact tracing for sexually transmitted infections has proven difficult and the rate of contact tracing is low. It is problematic for health professionals and counsellors to breach the confidentiality of their patient/client and to inform the partner without consent. If not handled sensitively and appropriately it may destroy the confidence of the patient in the health advisor and may reduce the effectiveness of care.

Conclusion

Like other issues borne of the HIV / AIDS pandemic, the question of partner notification may not have one absolute answer. The odds favor maintaining the patient's confidentiality, which safeguards his or her right to privacy and offers some assistance to public health in controlling the spread of HIV / AIDS. Warning vulnerable partners may rescue some individuals, but will not be of long-term benefit to public health. Doctors should not breach the confidence of patients in an attempt to curtail HIV / AIDS transmission. If patients are not assured of the confidentiality of the information they give to their doctors, they have little incentive to communicate such personal information freely and frankly.¹⁴ Although in some circumstances the collective interests of a society may override the right to medical confidentiality, bypassing confidentiality should occur only in special situations. Doctors should continue to protect the confidentiality of their patients in the context of HIV / AIDS.

Although this analysis focuses on medical doctors, the ethical issues addressed here are not limited to physicians, but apply to anyone who carries an ethical burden to keep another's confidence in any capacity. The issues concern policymakers and professional regulatory bodies who must determine their positions in safeguarding the individual's right to privacy and all other pertinent rights of patients in the ongoing effort to improve public health.

Notes

- 1 Where the context warrants, the terms “partner notification” and “contact tracing” will be used interchangeably.
- 2 In Great Britain and Nigeria, no such legal duty is imposed on doctors, whereas in Canada only one province has a semblance of partner notification.
- 3 Great Britain, Canada (apart from the Province of Quebec), and Nigeria operate under English common law. Common law can be explained simply as English law that did not emerge from legislation made by the parliament, but from judicial adoption and application of the customs and practices existing among the people of England. Historically, it is a body of law that evolved from the widespread or “common” customs and practices of the English people. The systematic application of such common laws by the English courts in adjudication of disputes led to the creation of a body of legal principles and rules now known as “common law.” In a more modern context, the term connotes English law (as described), and this genre of law as applicable in some other countries, such as Canada and Nigeria, that have adopted English law as a component or source of their legal systems (see Williams 1982).
- 4 For example, see section 37 of the Constitution of the Federal Republic of Nigeria, 1999 (hereafter “Nigerian Constitution”).
- 5 As a European Commission Working Group (EC-WGESLA 1992) asserts: “The use of information about genetic variability in relation to life insurance, health or social security raises fundamental questions of discrimination against those with genetic risks and of confidentiality of personal health information. These issues need urgent attention.”
- 6 See, for example, sections 15 and 16 of the *Medical and Dental Practitioners Act*, Cap 221 *Laws of the Federation of Nigeria* (FRN 1990) [hereinafter “Medical and Dental Practitioners Act”]; see also Mason et al. (1999:192).
- 7 Under the Law of Contract, a contract that is illegal, immoral, or contrary to public policy cannot be enforced by the court. A contract is considered illegal if it is in violation of an existing law or made to carry out unlawful or immoral activities. In the scenario under consideration, the contract between a doctor and a patient relating to nondisclosure of the patient’s condition could, therefore, be unenforceable because it contravenes the law imposing upon doctors a legal duty to disclose. For a discussion of the principles relating to illegal contracts, see Furmston (2001:421).
- 8 As Gostin (2004:xxi) notes: “Over 13 million children have lost their mothers or both parents to AIDS. The media has vividly portrayed the tragic images of people living with HIV / AIDS, once young and vibrant, then desperately ill, and wasting away.”
- 9 The legislation made during the colonial era now forms part of the state legislation applicable in particular states. The legislation of Oyo State, one of the states constituting the Federal Republic of Nigeria, is discussed here.
- 10 The NMA is the regulatory body of medical practice in Nigeria, the equivalent of the British Medical Association or Canadian Medical Association. Research for this study did not reveal the existence of any relevant code.
- 11 See the (Yukon) Communicable Diseases Regulations, Y.T. Reg. 1961/48, s. 5(1) as amended by Y.T. Reg. 1970/46. With reference to the legislation, only AIDS has been specifically declared as a com-

municable disease; HIV has not. It is thus open to debate whether the provision extends to HIV or is limited to full-blown AIDS.

- 12 This approach is not the only means, or even an infallible means, of proving who transmitted the infection, however.
- 13 An epidemiologic assessment interview involves questioning a member of the armed forces for purposes of medical treatment or counseling or for epidemiologic or statistical purposes (see USDOD 1991).
- 14 As a report by the *Canadian HIV/AIDS Legal Network* (2001) asks:
What will occur if it becomes generally known that clinicians breach confidentiality to protect third parties? Will patients cease to speak with candour about their behaviour? Will the public health suffer as a consequence? Although in highly exceptional cases there may be justifications for overriding confidentiality, the requirement of medical confidentiality is a very strong, though not absolute obligation. Patients, their contacts, doctors and their staff, and the common good are most likely to be best served if that tradition continues to be honoured.

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Acknowledgments

The author expresses his heartfelt appreciation to the the International Union for the Scientific Study of Population (IUSSP), Paris, France, for funding his travel to and participation at the seminar on Ethical Issues in Reproductive Health held in September 2006 in Wassenaar, the Netherlands, and also wishes to thank his fellow participants at the seminar for their contributions to the article in the course of debates.